COLORADO

Department of Health Care Policy & Financing

Fiscal Year 2024–2025 Compliance Review Report

for

Health Colorado, Inc.

Region 4

May 2025

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

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Summary of Results

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

Health Colorado, Inc. (HCI) showed a strong understanding of federal regulations with an overall score of 100 percent on all four standards reviewed. HCI's score of 100 percent for Standard VIII—Credentialing and Recredentialing and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services increased from the previous review period. HCI's score of 100 percent for Standard III—Coordination and Continuity of Care and Standard IV—Member Rights, Protections, and Confidentiality remained the same from the previous review period.

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

Table 1-1—Summary of Scores for Standards

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

* The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements from the standards in the compliance monitoring tool.

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

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

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

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

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Credentialing	90	70	70	0	20	100%~
Recredentialing	70	50	50	0	20	100%~
Totals	**160**	**120**	**120**	**0**	**40**	**100%**

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

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

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

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

Standard III—Coordination and Continuity of Care

Evidence of Compliance and Strengths

As the Administrative Service Organization (ASO), Carelon Behavioral Health (Carelon) provided oversight of the care coordination and continuity of care for members in Region 4. Care coordination services were provided directly to members through partner organizations and five contracted care coordination entities (CCEs): Health Solutions, Valley-Wide Health Systems, Sol Vista Health, San Luis Valley Health, and High Plains Community Health Center. Policies and procedures described that care coordination was accessible to all members attributed to HCI, using a tiered model with three competencies: Care Management, Care Navigation, and Low Risk Care Coordination. Low Risk Care Coordination focused on members at low risk of poor outcomes, utilization, and unnecessary cost of care and is a short-term level of service for members. Care Navigation focused on members of moderate risk and included the use of analytics to identify a gap in care for member needs, as well as utilized community partners to support health-related social needs. Care Management focused on high-risk members with complex needs and included all functions of Care Navigation as well as transitional care and chronic disease support. Care coordination for members engaged in Care Management was provided by a licensed care coordinator, such as a registered nurse (RN) or licensed behavioral health professional.

During the interview, staff described that members are engaged with care coordination as a result of the health needs survey from Health First Colorado, risk stratification, self-referrals, provider referrals, utilization management, condition management, and other population triggers. The member would then be outreached by the assigned coordinator, introduced to the program, and once needs were determined, complete a standardized intake assessment addressing health-related social needs, if appropriate. The care coordinator would then develop a care plan and act as the primary point of contact for coordinated mental and behavioral health services, ensuring communication with primary and specialty care teams, facilitating service delivery, and making referrals to appropriate agencies or connecting members to resources. Staff members also described how the assessment results are shared to prevent duplication. With member consent, care coordinators coordinated services and shared treatment information with providers, and other external stakeholders, complying with the Health Insurance Portability and Accountability Act (HIPAA) and Title 42 of the Code of Federal Regulations (42 CFR) Part 2. Coordinators documented all activities, including contact with members, within the care coordination tool, Essette.

HCI described how it monitors its partners and coordinates care entities to ensure they are adequately providing care coordination. In addition to providing its CCEs with a monthly scorecard, HCI described annual care coordination audits to ensure alignment with HCI principles and contractual obligations completed by the quality team, where findings and recommendations were discussed on an individual

level and also presented to the overall care coordination team. Entities failing audits received education and training, follow-up audits, and corrective action plans (CAPs).

Recommendations and Opportunities for Improvement

HSAG identified no opportunities for improvement.

Required Actions

HSAG identified no required actions.

Standard IV—Member Rights, Protections, and Confidentiality

Evidence of Compliance and Strengths

As the ASO, Carelon maintained policies and procedures for member rights. The Member Rights and Responsibility policy ensured compliance with applicable federal and State laws that pertain to member rights (i.e., non-discrimination, Americans with Disabilities Act [ADA], or HIPAA) and outlined member rights and responsibilities. During the interview, staff members described how member rights and responsibilities were communicated. Beyond the information contained within the member handbook, members were informed through HCI's website, mandatory posters displayed in provider offices, member-centric "getting started" webinars, and active participation of the member experience advisory council. Furthermore, staff articulated that members were consistently engaged in dialogues concerning their rights through interactions with call center personnel, member advocates, and the community outreach manager. HCI ensured the practical application of member rights during service delivery, describing the safeguarding of member privacy and the established escalation procedures for rights-related concerns, managed through grievance or quality of care processes.

HCI provided education for staff members and contracted providers to ensure member rights are understood, observed, and protected. HCI conducted annual employee training, supplemented by mandatory staff attestations. Further, HCI communicated member rights and responsibilities to providers through the provider manual, website resources, and comprehensive provider training.

HCI's Member Privacy Rights and HIPAA Compliance policies outlined HCI's process for ensuring members' information is protected. During the interview, staff members described various safeguards in place, including encrypted emails and dual-factor authentication. Staff members and contracted providers were trained on these policies annually.

The Advance Directive policy described HCI's process for assisting members with advance directives, including establishing training for members, staff, and providers. In addition to trainings, information on advance directives was disseminated to members through welcome outreach, benefit messaging, website

resources, and community events. HCI made information on advance directives publicly accessible, enabling community members and other interested parties to readily obtain it.

Recommendations and Opportunities for Improvement

HSAG identified no opportunities for improvement.

Required Actions

HSAG identified no required actions.

Standard VIII—Credentialing and Recredentialing

Evidence of Compliance and Strengths

Carelon, as the ASO, oversaw the activities pertaining to credentialing and recredentialing. During the interview, staff members provided detailed descriptions of its credentialing department, associated software systems, credentialing committee structure, and the application review process. Staff members demonstrated that practitioners and organizations were consistently reviewed for credentialing and recredentialing in accordance with established policies and procedures.

The credentialing process included a thorough file verification. Clean files were approved by the medical director, while files with identified issues required in-depth review and discussion by the National Credentials Committee (NCC), which met biweekly. Additionally, practitioners were notified within 60 calendar days of the decision. In conjunction, credentialing policies described how credentialing and recredentialing decisions are conducted in a nondiscriminatory manner. Further, HCI submitted evidence that demonstrated how audits are conducted on credentialing files to ensure nondiscrimination. The audit report was presented to the NCC annually for discussion.

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

Recommendations and Opportunities for Improvement

HSAG identified no opportunities for improvement.

Required Actions

HSAG identified no required actions.

Standard XI—EPSDT Services

Evidence of Compliance and Strengths

HCI used multiple modalities (mailings, text, automated phone calls, etc.) to inform members and families about the EPSDT benefit within 60 days of Medicaid eligibility determination, at eligibility reinstatement after a 12-month lapse, or when there was an identified pregnancy. For members 20 years of age and under, HCI coordinated screenings with providers and agencies, referring members and assisting with appointments and transportation when needed. Screening results informed service planning. Families received provider contact information, and referrals were made to Title V programs and other state agencies such as vocational rehabilitation; maternal and child health; and Women, Infants, and Children (WIC). When appropriate, members were linked with a care coordinator. For members 12 years of age and older, direct outreach was possible, especially for confidential behavioral health services, adhering to legal consent requirements.

Through its EPSDT program, HCI ensured covered access to well-child, preventive, dental, vision, hearing, behavioral health, developmental, and specialty services. Medically necessary services were covered at no cost, even if not standard benefits. EPSDT services included program information, screening, diagnosis, treatment, wraparound services, referrals, care coordination, maintenance treatment, and transportation assistance. HCI followed Bright Futures Guidelines for well-child visits for members from birth to age 20.

HCI educated members and guardians about preventive care and the Bright Futures Guidelines, informing them about service availability and cost, and assisting with appointments and transportation. Mental and behavioral health screenings were provided by qualified providers. Medically necessary behavioral health services were provided for primary diagnoses, including various therapies and support services.

HCI provided evidence that providers were trained on EPSDT at least biannually. HCI emphasized preventive care and audited charts for EPSDT service documentation. HCI provided referral assistance for medically necessary treatments. HCI participated in meetings with the Department of Health Care Policy & Financing (the Department) and educated providers about mental health referrals. Collaboration with the Department focused on best practices, outreach, and defining at-risk groups. Quarterly updates and annual plans regarding outreach activities were provided to the Department.

Recommendations and Opportunities for Improvement

HSAG recommends that HCI recruit Spanish-speaking members to review and provide feedback on Spanish language EPDST correspondence to solicit feedback and ensure ease of understanding.

Required Actions

HSAG identified no required actions.

3. Background and Overview

Background

In accordance with its authority under Colorado Revised Statute 25.5-1-101 et seq. and pursuant to Request for Proposal 2017000265, the Department executed contracts with the Regional Accountable Entities (RAEs) for the Accountable Care Collaborative (ACC) program, effective July 1, 2018. The RAEs are responsible for integrating the administration of physical and behavioral healthcare and managing networks of fee-for-service primary care providers (PCPs) and capitated behavioral health providers to ensure access to care for Medicaid members. In accordance with 42 CFR, RAEs qualify as both Primary Care Case Management (PCCM) entities and Prepaid Inpatient Health Plans (PIHPs). The CFR requires PIHPs to comply with specified provisions of 42 CFR §438—managed care regulations—and requires that states conduct a periodic evaluation of their managed care entities (MCEs), including PIHPs to determine compliance with Medicaid managed care regulations published May 6, 2016. Additional revisions were released in December 2020, February 2023, and May 2024. The Department has elected to complete this requirement for the RAEs by contracting with an external quality review organization (EQRO), HSAG.

To evaluate the RAEs' compliance with federal managed care regulations and State contract requirements, the Department determined that the review period for fiscal year (FY) 2024–2025 was calendar year (CY) 2024. This report documents results of the FY 2024–2025 compliance review activities for HCI. Section 1 includes the summary of scores for each of the standards reviewed this year. Section 2 contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 3 describes the background and methodology used for the FY 2024–2025 compliance monitoring review. Section 4 describes follow-up on the corrective actions required as a result of the FY 2023–2024 compliance review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the credentialing and recredentialing record reviews. Appendix C lists the HSAG, RAE, and Department personnel who participated in the compliance review process. Appendix D describes the CAP process that the RAE will be required to complete for FY 2024–2025 and the required template for doing so. Appendix E contains a detailed description of HSAG's compliance review activities consistent with the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023.[1]

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Mar 12, 2025.

Overview of FY 2024–2025 Compliance Monitoring Activities

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

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

Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the RAE's contract requirements and regulations specified by the federal Medicaid managed care regulations published May 6, 2016. Additional revisions were released in December 2020, February 2023, and May 2024. HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable.* The Department determined that the review period was CY 2024. HSAG reviewed materials submitted prior to the compliance review activities, materials requested during the compliance review, and considered interviews with key RAE personnel to determine compliance with applicable federal managed care regulations and contract requirements. Documents consisted of policies and procedures, staff training materials, reports, committee meeting minutes, and member and provider informational materials.

The compliance review processes were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Appendix E contains a detailed description of HSAG's compliance review activities consistent with those outlined in the CMS EQR protocol. The four standards chosen for the FY 2024–2025 compliance reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services; Standard II—Adequate Capacity and Availability of Services; Standard V—Member Information Requirements; Standard VI—Grievance and Appeal Systems; Standard VII—Provider Selection and Program Integrity; Standard IX—Subcontractual Relationships and Delegation; Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems; and Standard XII—Enrollment and Disenrollment.

Objective of the Compliance Review

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

- The RAE's compliance with federal healthcare regulations and managed care contract requirements in the four areas selected for review.
- Strengths, opportunities for improvement, and actions required to bring the RAE into compliance with federal healthcare regulations and contract requirements in the standard areas reviewed.
- The quality, timeliness, and accessibility of services furnished by the RAE, as assessed by the specific areas reviewed.
- Possible interventions recommended to improve the quality of the RAE's services related to the standard areas reviewed.

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

FY 2023–2024 Corrective Action Methodology

As a follow-up to the FY 2023–2024 compliance review, each RAE that received one or more *Partially Met* or *Not Met* scores was required to submit a CAP to the Department addressing those requirements found not to be fully compliant. If applicable, the RAE was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the RAE and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with HCI until it completed each of the required actions from the FY 2023–2024 compliance monitoring review.

Summary of FY 2023–2024 Required Actions

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

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

Related to Standard VII—Provider Selection and Program Integrity, HCI was required to complete four required actions:

- Update the policy to include language stating Carelon does not "discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification."
- Revise its policies to include the terms "excluded, suspended, and debarred" to ensure that Carelon does not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulations or Executive Order 12549.
- Modify the primary care medical provider (PCMP) agreement to include language stating that it does not prohibit, or otherwise restrict, healthcare professionals acting within the lawful scope of practice from advising or advocating on behalf of the member who is the provider's patient, for the following:
  - The member's health status, medical care, or treatment options, including any alternative treatments that may be self-administered.

  - Any information the member needs in order to decide among all relevant treatment options.
  - The risks, benefits, and consequences of treatment or non-treatment.
  - The member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment and to express preferences about future treatment decisions.
- Strengthen its compliance program to ensure that the compliance officer, leadership team, and compliance committee develop the compliance plan and strategic goals for its RAE. While some aspects of the compliance activities may be delegated, the ongoing strategy, monitoring, and oversight must be led by HCI and not by any delegate.

Related to Standard IX—Subcontractual Relationships and Delegation, HCI was required to complete two required actions:

- Have direct oversight and evidence of ongoing monitoring performed by HCI of any delegated activities pertaining to 42 CFR 438.
- Ensure, via revisions or amendments, that its subcontractor agreements include the following language:
  - The State, CMS, the U.S. Department of Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State.
    - The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems related to members.
    - The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
    - If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

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

Summary of Corrective Action/Document Review

HCI submitted a proposed CAP in July 2024. HSAG and the Department reviewed and approved the proposed CAP and responded to HCI. HCI submitted final documentation and completed the CAP in November 2024.

Summary of Continued Required Actions

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

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. A. *For the Capitated Behavioral Health Benefit,* the RAE implements procedures to deliver care to and coordinate services for all members. B. *For all RAE members*, the RAE's care coordination activities place emphasis on acute, complex, and high-risk members and ensure active management of high-cost and high-need members. The RAE ensures that care coordination: • 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. • Addresses potential gaps in meeting the member's interrelated medical, social, developmental, behavioral, educational, informal support system, financial, and spiritual needs. • Is documented, for both medical and non-medical activities.	**Documents Submitted/Location Within Documents:** 1. R4_PopMangPln_FY24-25_V2, Page 2-4, 5, 10-12, 24 2. CareCoordinationGeneralPolicy_FY24-25, *Misc, Page 2-3, 15, 16 3. PrimaryCareProviderHandbook,*Misc, Page 18-19, 31-32 4. BehavioralHealthProviderHandbook, *Misc, Page 29, 68-69 5. ECCPerformanceDashboard, Entire Document 6. CCEMonthlyScorecard_HS, Entire Document 7. QM33FHealthEquityProgram, Entire Document 8. CulturalCompetencyTraining, Entire Document 9. HCI_CC_MOU_FY2425, Page 4 10. CareCoordAuditPlan2023, Entire Document 11. CareCoordinationAuditTools, *Misc, Entire Document 12. Q16.404MonitoringTrtmtRecordReviewGuidelines, Entire Document 13. MonthlyCCLeadershipMeetingMinutesJuly2024, Page 3 14. EssetteScreenShots, 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**
42 CFR 438.208(b) Contract Amendment 17: Exhibit B—11.3.1, 11.3.7	15. PCMP_Agreement,*Misc, Pages 3-4 **Description of Process:** Health Colorado Inc. (HCI), as the Regional Accountable Entity (RAE), has established comprehensive policies and procedures to ensure the delivery and coordination of care for all members. The framework and overall strategic approach is articulated in our Annual Population Health strategic plan (R4_PopMangPln_FY24-25_V2) and further supported in the General Care Coordination Policy and Procedures (CareCoordinationGeneralPolicy_FY24-25). These documents outline our robust stratification frameworks and procedures for care management, care navigation, and low-risk care coordination, ensuring that all members receive the necessary services effectively, equitably, and in a timely manner. The HCI Population Health strategic plan (R4_PopMangPln_FY24-25_V2) focuses on ensuring the health needs of Health First Colorado recipients are met efficiently, equitably, and in alignment with the goals of HCPF. Pages 2-4 provide an overview of the main categories of the risk-stratified care management framework. Page 5 addresses HCI's care coordination intervention model. Our population health strategy leverages the following overarching themes, which have	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	been maintained from the previous fiscal year (FY23-24): 1. Utilizing our Population Health Strategic Framework to Evaluate and Facilitate Improvement 2. Efficient and Effective Stratification 3. Creating a Culture of Continuous Improvement Across Our RAE 4. Rewarding our Care Delivery System for Improving Value for Our Members HCI's stratification leverages an advanced analytics system that utilizes predictive risk stratification to analyze utilization data, intensity of care, SDOH data, complex and chronic conditions, medication management, functional limitations, gaps in care, and total costs of care. This enables the effective targeting of high-cost members, high clinical complexity members, and those approaching these thresholds for care coordination programming. CareCoordinationGeneralPolicy_FY24-25 provides an overview of comprehensive care coordination services for members of the RAE. This policy is 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,	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	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. HCI's CareCoordinationGeneralPolicy_FY24-25 ensures that care coordination services are accessible to all attributed members. Program introduction and/or communication, which includes contact information for the assigned HCI Care Coordinator and instructions on how to access the 24/7 toll free number for care coordination services is included in the PrimaryCareProviderHandbook, Page 31-32 and BehavioralHealthProviderHandbook, Page 29. Care coordination will be accessible to all Health Colorado members.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Care coordination can be a compilation of single interventions or multiple interventions, as determined by the member's needs, preference, and agreed upon Care Plan. Our holistic, person-centered, culturally competent, and integrated approach to condition management takes into consideration members' well-being, SDOH, disease management, and utilization management. Standardized intake workflows, which include SDOH needs and acuity, lay the groundwork for an official integrated, whole-person care plan. This strategy is detailed in the R4_PopMangPln_FY24-25_V2 document. Central to our care coordination model is implementing holistic care management. This entails the identification of member care coordination needs (utilizing standardized assessments, data analysis, and predetermined conditions), engaging care coordination entities to reach identified members, and supporting these members with their healthcare needs. HCI's care coordination model has three components: care navigation, care management, and low-risk care coordination. The definitions for these tiers are located on Pages 10-12 of R4_PopMangPln_FY24-25_V2. Per HCPF documentation requirements, HCI Care Coordinators are responsible for the creation, monitoring, and updating of the Care Plan for all	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	members enrolled in care coordination. This documentation must be entered into the HCI care coordination tool, Essette. The initial assessment is used to create the member's Care Plan, and the minimum requirements for the Care Plan are detailed in CareCoordinationGeneralPolicy_FY24-25. All care coordination activities, whether medical or non-medical, are documented in the care coordination platform Essette as outlined in CareCoordinationGeneralPolicy_FY24-25. To ensure that HCI's care coordination activities emphasize acute, complex, and high-risk members and enable active management of high-cost and high-need members, both the population health strategic framework in the R4_PopMangPln_FY24-25_V2 as well as our CareCoordinationGeneralPolicy_FY24-25 (starting on page 2-3) defines tiered member cohorts. These cohorts are stratified as follows: 1. Care Management: Focuses on the most complex and highest risk members, involving nursing or behavioral health licensed staff and Master's level providers in pursuit of licensure. This model includes all functions of Care Navigation as well as transitional care support and chronic disease self-management support,	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	providing a hands-on approach to improve health outcomes. 2. Care Navigation: Targets members at moderate risk of poor outcomes and unnecessary costs. This model utilizes analytics to identify members needing this level of care, defines standard work to address gaps in care, and leverages community partners to support Social Determinants of Health (SDOH) needs, focusing on removing barriers to accessing care. 3. Low-Risk Care Coordination: Focuses on members at low risk of poor outcomes and unnecessary costs, involving deliberate care coordination activities and short-term service levels for plan-identified or otherwise referred members who do not meet criteria for higher intensity care coordination. These frameworks and models ensure that all members, particularly those with acute, complex, and high-risk conditions, have access to the necessary behavioral health services and coordinated care required to improve their health outcomes. For all RAE members, the RAE's care coordination activities place emphasis on acute,	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	complex, and high-risk members to ensure active management of high-cost and high-need members. HCI closely tracks the percentage of unique complex members involved in Extended Care Coordination (ECC) using monthly data analyses, Fiscal Year to Date (FYTD) data, and rolling twelve-month data. This ongoing review ensures we consistently meet our targets and performance objectives. Our quality-of-care team and data analysts collaborate with care coordinators each month to examine the dashboard, identify data trends, and pinpoint areas for improvement. The documents titled ECCPerformanceDashboard is an example of the data visualization that is used to monitor the contracted care coordination entities performance on the ECC Metric. HCI also implemented individual entity score cards which are provided on a monthly basis to each entity with the individual entities' performance, see document CCEMonthlyScorecard_HS for an example of a monthly scorecard. The performance standards are outlined in the CareCoordinationGeneralPolicy_FY24-25 (see page 16). To ensure early and prompt engagement of complex members and members with gaps in care HCI has added to the CareCoordinationGeneralPolicy_FY24-25 (page 15) the requirement that care coordination entities	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	will outreach 80% or more of the new complex and new care navigation members within 30 days. Our CareCoordinationGeneralPolicy_FY24-25 mandates that care coordination is provided at the point of care to maximize efficiency and effectiveness. This includes the integration of physical health, behavioral health, Long Term Services and Supports (LTSS), and other services ensuring comprehensive care delivery. As detailed in CareCoordinationGeneralPolicy_FY24-25, HCI Care Coordinators establish proper coordination with medical and behavioral health providers as well as access to community resources for all members. Care coordination can encompass single interventions or multiple interventions, as determined by the member's needs, preferences, and agreed-upon Care Plan. HCI's approach to care coordination incorporates both immediate and future health needs. This dual perspective enhances the overall well-being of our members and is embedded within our strategic population health plan (R4_PopMangPln_FY24-25_V2) and supporting care coordination policy. CareCoordinationGeneralPolicy_FY24-25 emphasizes this requirement by defining care coordination as the deliberate organization of client care activities between two or more participants (including the client and/or family members/caregivers) to facilitate the appropriate	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	delivery of various services, ranging from physical health to behavioral health and beyond. Care coordinators are responsible for the development of an individualized care plan that includes SDOH, Access to Care barriers, behavioral health and medical health needs for complex members. This integrated whole person care plan is developed with shared decision-making practices between the members and health care staff. The integrated whole person care plan will be referred to as "Care Plan" throughout the CareCoordinationGeneralPolicy_FY24-25 document. At HCI, cultural competence is a cornerstone of our care coordination services. HCI's strategy toward culturally competent care remains unchanged from prior state fiscal years. We enforce the creation of culturally competent shared goals with the members and their support system through our delegated care coordination policy and procedures, as detailed in R4_PopMangPln_FY24-25_V2, Page 24. According to CareCoordinationGeneralPolicy_FY24-25, care coordinators are instructed to design culturally competent goals with members and connect them to providers who respect and understand their cultural backgrounds, thus addressing the needs of our diverse population. One of the essential	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	program components from HCPF for HCI Care Coordination includes the incorporation of culturally competent specialized care teams. HCI Care Coordinators are trained to be member- and family-centered, using motivational interviewing, trauma-informed principles, mental health first aid training, and other evidence-based practices to communicate effectively with members in a culturally and cognitively appropriate manner. This includes providing care and care coordination activities that are linguistically and culturally appropriate to the member and consistent with the member's cultural beliefs and values. QM33FHealthEquityProgram underscores the commitment to developing and implementing policies and procedures that will enhance cultural competency. To continuously improve the health care status of members through: 1. Assessment of the race, ethnicity, and language needs of its health 2. Plan partners' membership 3. Improvement of culturally and linguistically appropriate services 4. Improvement of access and availability of language services 5. Improvement of cultural competency in materials and communications	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	6. Information, training and tools for staff and practitioners to support culturally competent communication The Cultural Competency Section in the PrimaryCareProviderHandbook Page 18-19, and BehavioralHealthProviderHandbook, Pages 68-69, 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. HCI provides annual cultural competency training to providers, community partners, and in each of our committees we bring the standards forward. HCI and Carelon provide a variety of cultural competency training resources to providers which can be located on the website at Webinars & Trainings | Health Colorado and the Carelon website to assist providers. The provider handbooks (PrimaryCareProviderHandbook, page 18-19 and BehavioralHealthProviderHandbook, page 68), with which all providers are contractually obligated to comply, contains additional information on cultural competency requirements. HCI leveraged the provider roundtable meetings and provider newsletters to educate providers about the cultural competency	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	training provided by Carelon and resources available on our website under the RAE Roundtables menu. An example of one such training is the slide deck titled CulturalCompetencyTraining. Our care coordination model, as defined in the R4_PopMangPln_FY24-25_V2, is centered around the preferences of our members. HCI ensures that care plans are member-centered, actively involving members and their families (if applicable) in the decision-making process. This approach is upheld through our CareCoordinationGeneralPolicy_FY24-25, which mandates that all care coordination services are member and family-centered in accordance with Trauma-Informed Care principles and practices, considering the preferences, goals, and cultural beliefs of the members. Our CareCoordinationGeneralPolicy_FY2425 policy requires regular and structured communication between care coordinators and practitioners delivering services to ensure seamless collaboration, continuity of care, and optimal health outcomes for our members. HCI Care Coordinators are responsible for initial and ongoing assessments of the member's health status and needs, and they establish proper coordination with healthcare providers to facilitate the delivery of services as appropriate. This	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	requirement is detailed in CareCoordinationGeneralPolicy_FY24-25. HCI's care coordination model prioritizes collaboration to minimize service duplication and enhance care continuity. This includes identifying a lead care coordinator for members receiving services from multiple care systems, streamlining care coordination efforts. CareCoordinationGeneralPolicy_FY24-25 outlines that care coordination involves the deliberate organization of client care activities between multiple participants to facilitate appropriate delivery of services, reducing duplication, and promoting continuity of care. As outlined in the CareCoordinationGeneralPolicy_FY24-25, the HCI Care Coordinator is responsible for managing their assigned membership, including multi-system involved members. Often, these members have other service or treatment plans in place with external agencies. Therefore, it is crucial that the HCI Care Coordinator documents all external leads and plans involved in the member's care within the HCI care coordination documentation in Essette. Depending on individual member needs, the HCI Care Coordination Entity may take a lead or secondary role. The HCI Care Coordinator is required to communicate with	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	other entities (e.g., SEPs/CCBs) to determine the lead HCI Care Coordinator as well as the lead external care coordinator and document this in the member's care coordination record in Essette. CareCoordinationGeneralPolicy_FY24-25 adheres to this requirement and addresses all components starting with the definition of care coordination: The deliberate organization of client care activities between two or more participants (including the client and/or family members/caregivers) to facilitate the appropriate delivery of physical health, behavioral health, functional Long Term Services and Supports (LTSS), oral health, specialty care, and other services. Care Coordination may range from deliberate provider interventions to coordinate with other aspects of the health system to interventions over an extended period by an individual designated to coordinate a member's health and social needs. HCI Care Coordinators are responsible for: • Establishing proper coordination with medical and behavioral health providers as well as access to community resources for all members. • Care coordination will be accessible to all Health Colorado members and can encompass single or multiple	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	interventions, as determined by the member's needs, preferences, and agreed-upon Care Plan. • Ensuring care coordination is provided at the point of care whenever possible and is culturally responsive. • Respecting member preferences and maintaining regular communication between HCI Care Coordinators and the practitioners delivering services to members. • The HCI Care Coordinator assesses or arranges for the assessment of the member's need for services, coordinates mental health services rendered by multiple providers, coordinates behavioral health services with other health care and human service agencies, and refers to other health care and human service agencies as appropriate. HCI care coordinators employ a holistic approach to identify and fill potential gaps in services across various domains of a member's life, ensuring comprehensive support. This approach encompasses medical, social, developmental, behavioral, educational, informal support, financial, and spiritual needs.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI_CC_MOU_FY2425, Pg 4: Contractors who participate in Care Coordination Programs will document all care coordination activities in HCI's electronic care coordination tool per HCI Care Coordination Policy. To ensure care coordination services and related activities are aligned with HCI principles, best practices, evidence-based and contractual obligations, Carelon will engage in routine audits of contracted care coordination services. The procedure for audits is outlined in the CareCoordinationGeneralPolicy_FY24-25 and CareCoordAuditPlan2023, compliance with these standards is monitored using the CareCoordinationAuditTools. HCI monitors compliance with these standards through annual quality audits of care coordination records, as outlined in Q16.404MonitoringTrtmtRecordReviewGuidelines. The policy details the process for treatment record reviews to monitor performance, determine if positive outcomes for members have been achieved, and ensure adherence to treatment record standards. This process ensures that care coordination remains consistent with member preferences and meets established quality standards.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	CareCoordinationGeneralPolicy_FY24-25 policy was disseminated to our care coordination entities via email on 06/12/24 and reviewed in the monthly care coordination leadership meeting on 07/03/2024 (MonthlyCCLeadershipMeetingMinutesJuly2024, Page 3). Additionally, the policy was attached to meeting minutes and distributed to all participants following the meeting. Documentation of the member's identifying information, as well as additional information such as spoken and written language preferences are displayed in the Care Coordination Documentation Platform (EssetteScreenShots). There are fields to display the acuity and intensity of the member's stratification, the care coordination program the member is engaged in as well as the assigned care coordination staff. The platform includes an intensity field where CC can select how frequent the member should be attempted to be contacted based up on the assessment and care plan developed with the member. The correspondence tab includes options for HCI's PCMP Notification Letter based on stratification. The Primary Care Medical Provider (PCMP) will fulfill all obligations to serve Health First Colorado Members as both a primary care provider and a medical home within the	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Accountable Care Collaborative (ACC) Program, as outlined in the PCMP's contract with the Department (PCMP_Agreement, Page3-4). This agreement is designed to support routine clinic operations and promote the adoption and demonstration of Patient-Centered Medical Home (PCMH) principles. The care provided will be: (i) centered on the member and their family; (ii) oriented towards the whole person and comprehensive; (iii) coordinated and integrated; (iv) delivered in partnership with the member, encouraging self-management; (v) focused on outcomes; (vi) consistently offered by the same provider whenever possible to build a trusting relationship; and (vii) provided in a culturally competent and linguistically sensitive manner. The PCMP agrees to offer services and care to members in a non-discriminatory, culturally, and linguistically appropriate manner in accordance with nationally recognized standards, Health First Colorado and ACC Program rules and requirements, and all relevant state and federal laws and regulations.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The RAE ensures that each behavioral health member has an ongoing source of care appropriate to the member's needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member. • The member must be provided information on how to contact the designated person or entity. *42 CFR 438.208(b)(1)* Contract Amendment 17: Exhibit B—None	**Documents Submitted/Location Within Documents:** 1. CareCoordinationGeneralPolicy_FY24-25 *Misc, Entire Document 2. CareCoordinationAuditTools*Misc, Section 3 3. CREF105.19MemberRiskAsmtandTriage, Entire Document 4. HCPFWelcomeLetter *Misc, Entire Document 5. GettingStarted*Misc, Entire Document 6. CareCoordinationFactSheet_EN *Misc, Entire Document 7. CareCoordinationFactSheet_SP *Misc, Entire Document 8. PrimaryCareProviderHandbook, *Misc, Page 30-31 9. BehavioralHealthProviderHandbook, *Misc, Page 27-28 10. WelcomeandBenefitTextMessages *Misc, Entire Document 11. Q16.404MonitoringTrtmtRecordReviewGuidelines, Entire Document **Description of Process:** HCI initiates this process internally by providing each of the care coordination entities in Region 4 with a list of designated members assigned to	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	them. The member's "Member ID" (Medicaid ID) is bumped up to the 834-member eligibility dataset to confirm that the member is attributed to the RAE. Once complete, a set of queries assigns a care coordination entity to the members based off of the attributed PCMP location. The assignment lists are then sent out to the care coordination entity via secure email or through File Connect. The care coordination entity conducts outreach to the members on their list with a frequency based upon the member's stratification as outlined in the CareCoordinationGeneralPolicy_FY24-25. Attempts by HCI care coordinator to engage complex and care navigation tier members must include bidirectional modalities including in-person, phone calls, texts, emails, and Electronic Medical Record (EMR) portal features. When a member is identified as having any care coordination need, the assigned HCI Care Coordinator will provide program introduction and/or communication, which includes contact information for the assigned HCI Care Coordinator and instructions on how to access the 24/7 toll free number for care coordination services. See CareCoordinationGeneralPolicy_FY24-25.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Members, providers or any community entities can request care coordination information via the HCI RAE website (https://www.healthcoloradorae.com/members/care-coordination/) through several options: • Calling a designated care coordination phone number (Care Coordination: 888-502-4186 (toll free)) listed under the "Contact" tab on the website (https://www.healthcoloradorae.com/contact/). • Sending an email to the HCI contact email on posted on the HCI website under the "Contact" tab: healthcolorado@Carelon.com • Completing a referral form provided on the website https://www.healthcoloradorae.com/members/care-coordination/care-coordination-referral-form/ Members who utilize the contact information are routed to their assigned care coordination entity as needed. Additionally, when care coordination services are requested the assigned care coordination entity is provided the member information in the request and will outreach the member to follow up on the request.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The CareCoordinationGeneralPolicy beginning on 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. The HCI Care Coordinator 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 HCI 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. The HCI Care Coordinator is responsible for initial and ongoing assessment of the member's health status and healthcare needs. They will communicate regularly with the member's primary care team and with medical specialty providers who are engaged with the member. Care coordination delegated entities are monitored on compliance with this requirement through	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	existing audit procedures. See CareCoordinationAuditTools, Section 3 Care Team. CREF105.19MemberRiskAsmtandTriage outlines that all member requests are handled expeditiously. To ensure a timely response to the needs of members or member representatives, when they contact Carelon Behavioral Health for assistance in locating and receiving care from a network provider. To assist members or member representatives in facilitating his/her request by appropriately categorizing the type of call and providing the appropriate information and service resources as necessary. This process should be followed even when a third party is calling for referrals, and the member is not available to speak to the clinician A Welcome Letter from The Department of Health Care Policy and Finance (HCPF) with an URL link to HCI's website is sent to members (See HCPFWelcomeLetter). HCI has a Getting Started Guide available in English and Spanish which includes HCI's welcome letter as well as other resources and can be located on the HCI website (https://www.healthcoloradorae.com/members/ne	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	w-member-welcome-packet/) under New Member and EPSDT Resources. 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 GettingStarted. Members are provided information on the HCI website (https://www.healthcoloradorae.com/members/care-coordination/) 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 CareCoordinationFactSheet_EN , Entire Document and CareCoordinationFactSheet_SP, Entire Document . The tip sheet was distributed to care coordinators, practice transformation coaches, member advocates and was uploaded to the HCI website. See https://www.healthcoloradorae.com/members/care-coordination/. PrimaryCareProviderHandbook, Page 30-31 articulates that 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	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	and address complex member needs spanning multiple agencies. BehavioralHealthProviderHandbook, Page 27-28 describes the role of care coordination including: • Identifying and Collaborating with Providers • Link Between Providers, Systems, and Settings • Multisystem Involvement • Scope of Care Coordination • Single Point of Contact • Documentation All providers participating in a member's care are encouraged to identify and collaborate with any additional providers involved in the member's medical and/or behavioral health care. WelcomeandBenefitTextMessages, Entire 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	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	messages, members are also provided information to access care coordination, connection to community resources and crisis services. Providers are monitored on compliance with this requirement through existing audit procedures, see Q16.404MonitoringTrtmtRecordReviewGuideline .	
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 17: Exhibit B—6.8.1	**Documents Submitted/Location Within Documents:** 1. AttributionClaimsDataValidationProcess, Entire Document 2. PrimaryCareProviderHandbook, *Misc, Page 22-23 3. R4_PopMangPln_FY24-25_V2, Page 11 4. CareCoordinationGeneralPolicy_FY24-25 *Misc, Page 15 **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. AttributionClaimsDataValidationProcess document outlines the standard operating	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	procedure to verify the attribution list provided by the Department of Health Care Policy and Finance (HCPF) contains the correct member to provider attribution based on claims activity. An attribution list aligned with claims activity ensures Members are being assigned to providers with which they have an active relationship. This process is intended to ensure that this alignment exists in the attribution files provided by HCPF. PrimaryCareProviderHandbook, Page 22-23 describes the member attribution process for PCMP providers as well as how a member can change their PCMP and how PCMPs can check the eligibility of members via the state portal. HCI Employs a comprehensive strategy to ensure effective follow-up with members through various targeted approaches. Practices collaborating with our Practice Transformation (PT) team receive lists of members who have not visited a provider in over a year, as well as those requiring attention due to specific condition measures. This proactive sharing of information aids practices in reaching out effectively to their patients. Furthermore, our PT team utilizes the "Attribution Insights" report through the HCPF Data Analytics Portal (DAP) at the PCMP level to educate practices.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Care Coordinators (CC) play a vital role by conducting outreach to members classified under the Care Navigation tier, a focus of the CN tier is closing gaps in care, one of which is a member with a condition has not visited a PCMP with in the last 12 months (R4_PopMangPln_FY24-25_V2, Page 11). Members who are new to the CN list must receive an outreach attempt with in the first 30 days they are new on the CN list per the CareCoordinationGeneralPolicy_FY24-25, page 15. During targeted outreach, CCs assess potential barriers to care during intake assessments for complex and CN members, allowing for tailored intervention strategies. Children under the age of 21 receive outreach in compliance with EPSDT requirements if they have not utilized any services, ensuring that younger members maintain regular healthcare interactions. In addition, all members who have not had a well visit in the prior year, regardless of age, receive reminders through a text campaign urging them to schedule their PCMP appointments (See Standard XI for more information about EPSDT Services). By focusing on these initiatives, we have identified key areas for addressing higher-risk members, including youth under 21 with no	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	service claims, CN members with conditions lacking recent PCMP visits, and practices working with PT to receive member lists for outreach. Additionally, PCMPs are empowered to use the DAP report to identify members attributed to their practice and attempt to reach them. Through collaboration with care coordinators, these initiatives ensure members with barriers to accessing care receive the necessary support to stay engaged with their healthcare providers.	
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 extensive assistance and include appropriate interventions. Contract Amendment 17: Exhibit B—11.3.3	**Documents Submitted/Location Within Documents:** 1. R4_PopMangPln_FY24-25_V2, Entire Document 2. CareCoordinationGeneralPolicy_FY24-25*Misc, Page 1-3, 11-12, 15-16 3. HCI_CC_MOU_FY2425- Page 3-4 4. CareCoordinationAuditTools *Misc, Entire Document 5. CreativeSolutionsFlyer *Misc, Entire Document 6. ComplexSolutionsFlyer *Misc, Entire Document 7. BehavioralHealthProviderHandbook, *Misc, Page 27-28 8. PrimaryCareProviderHandbook, *Misc, Page 23-24	☒ 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: 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, which addresses the member's prioritized needs. The deliberate organization of Client care activities between two or more participants (including the Client and/or family members/caregivers) to facilitate the appropriate delivery of physical health, behavioral health, functional Long-Term Services and supports (LTSS), oral health, specialty care, and other services. Care Coordination may range from deliberate provider interventions to coordinate with other aspects of the health system to interventions over an extended period of time by an individual designated to coordinate a member's health and social needs.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The framework and overall strategic approach is articulated in our Annual Population Health strategic plan (R4_PopMangPln_FY24-25_V2) and further supported in the General Care Coordination Policy and Procedures (CareCoordinationGeneralPolicy_FY24-25). These documents outline our robust stratification frameworks and procedures for care management, care navigation, and low-risk care coordination, ensuring that all members receive the necessary services effectively, equitably, and in a timely manner. As previously described (see Requirement 1) HCI Care Coordination is a tiered and stratified model with three separate competencies (Care Management, Care Navigation, Low Risk Care Coordination). HCI requires HCI care coordination entities to provide competencies to address all levels of stratification, see definitions section of CareCoordinationGeneralPolicyFY24-25 Page 1-3, for further information about the differences in these required competencies. Our current policy (CareCoordinationGeneralPolicyFY24-25) addresses all components of this requirement, including that care coordination is defined as identifying the needs of members and/or family	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	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 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. The procedure for when a member is identified as having any care coordination need is outlined in the CareCoordinationGeneralPolicyFY24-25 beginning on Page 8 which includes communication, completing the standardized intake assessment which guides HCI Care Coordinators in assisting members with SDOH, such as access to healthy food, exercise, transportation, housing, and employment support. Care Coordinators notify the member's PCMP of	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	member engagement in HCI care coordination programming per HCI standard work process. Care Coordinators also complete a Care Plan, developed with shared decision-making practices between the member, their family members or caretakers, and care coordination staff. Extended care coordination services are aimed at members identified as complex (definition on Page 2-3 of CareCoordinationGeneralPolicyFY24-25) who require more intense and prolonged assistance. Procedures for complex members are detailed beginning on Page 11-12 of the CareCoordinationGeneralPolicyFY24-25. The contractor must engage complex members in HCI's evidence-based condition/disease self-management program based upon the complex member's condition(s). 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. Care managers must include a highly individualized range of interventions in their Care Plans to support the management of serious and complex conditions that are persistent and substantially disabling or life threatening. To ensure Care Plans are active,	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI Care Managers must be able to demonstrate at least quarterly successful engagement with complex members, in-person or virtual, until needs are met, or member declines further participation. HCI_CC_MOU_FY2425, Page 3-4 outlines expectations of care coordination. Care Coordination may range from deliberate provider interventions to coordinate with other aspects of the health system to interventions over an extended period of time by an individual designated to coordinate a member's health and social needs. HCI developed resource sheets to educate members, providers and stakeholders about the Creative Solutions and Complex Solutions processes. Creative Solutions (CreativeSolutionsFlyer) helps Health First Colorado Medicaid members who are children and youth ages 17 years and younger and their families navigate complex health situations and crises. The Creative Solutions process is appropriate when the member needs assistance beyond Health Colorado, Inc.'s ability to provide support. At that point various parties may request Creative Solutions support. Complex Service Solutions (ComplexSolutionsFlyer) helps Health	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	First Colorado Medicaid members who are adults ages 18 years and older to address issues with community placement and other complex health needs and situations. These resource sheets were distributed to partners and stakeholders and are available on the Care Coordination tab on our website. BehavioralHealthProviderHandbook, Page 27-28, and PrimaryCareProviderHandbook, Page 23-24 describes HCI's regional strategy for CC and that it incorporates the deliberate integration of patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of health care services. Audits ensure compliance with standards of care coordination and documentation outlined in the CareCoordinationGeneralPolicyFY24-25. Beginning on Page 15-16 of the CareCoordinationGeneralPolicyFY24-25 is the procedure for audits, the CareCoordinationAuditTools is utilized to score each entities performance on the audit.	
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.	**Documents Submitted/Location Within Documents:** 1. R4_PopMangPln_FY24-25_V2- Page 15-16, 23-24	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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. • Including Medicaid-eligible individuals being released from incarceration to ensure they transition successfully to the community. *Note: Contractor shall ensure that care coordination is provided to members who are transitioning between health care settings and to populations who are served by multiple systems, including, but not limited to, children involved with child welfare; Medicaid-eligible individuals transitioning out of the criminal justice system; members receiving long-term services and supports (LTSS); members transitioning out of inpatient, residential, and institutional settings; and members residing in the community who are identified as at-risk for institutionalization.* *42 CFR 438.208(b)(2)*	2. CareCoordinationTransitionalCareProcedureFY23-24, Entire Document 3. CareCoordinationGeneralPolicyFY24-25*Misc, Page 12 4. CareCoordinationAuditTools *Misc, Section 9. 5. TransitionBetweenCareSettings_CDEP3.11, Entire Document 6. JusticeConnect, Entire Document 7. WelcomeLetter_DOC, Entire Document 8. VisionBenefits, Entire Document 9. DentalBenefit, Entire Document 10. CDOC_SNAPHandout, Entire Document 11. PCMP_Agreement, *Misc, Page 2-3, 4, 5-6 12. BehavioralHealthProviderHandbook, *Misc, Page 64 13. PrimaryCareProviderHandbook, *Misc, Page 24-25 14. EssetteSceenShots, Page 4 **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.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract Amendment 17: Exhibit B—14.1, 14.3, 11.3.10, 11.3.10.4.2.3, 11.3.20.2.1	Beginning with the R4_PopMangPln_FY24-25 page 23-24, provides the overarching strategy for population health including the administration of the Care Coordination benefit. Coordinating transitions of care is central in all of HCI's care coordination workflows and standard work for both care management and care navigation. Transitions of care happen anytime a patient goes from one setting to another or has a change in their care team. HCI realizes that transitional care can expand this definition to include transitions in any healthcare setting including changes in specialty care, the judicial system, waivers, PDN needs, and treatment locations. HCI's transitions of care efforts include the implementation of standard workflows that will improve communication between primary and specialty care providers, thereby improving members' care. HCI Care Coordinators will use the results of lists including but not limited to admission/discharge/transfer (ADT) data received from a Colorado health information exchange, monthly claims data, the CMA case manager data feeds, hospital electronic health records, social health information exchange platforms, statewide health information exchange platforms (Contexture) and other lists provided by HCPF	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	and HCI to inform member outreach and care coordination activities. See CareCoordinationTransitionalCareProcedureFY23-24. HCI's Hospital Transformation Program (HTP) liaison continues to meet monthly with hospitals and collaborate with PCMP and BH teams, care coordination teams, and crisis teams to facilitate clear communication and uncover barriers in workflow and referral processes. HCI's most recent HTP effort in supporting TCM includes enhancing information provided to our care coordination entities by enhancing the current Admission Discharge Transfer (ADT) data feed with valuable fields from HTP data. July through October of 2023 were focused on ensuring that hospitals could provide relevant data to HCI via HIE or manual secure upload, and January through June 2024 were focused on building out an enhanced ADT report that could be built into existing care coordination processes for improved member outreach. As outlined in the CareCoordinationTransitionalCareProcedureFY23-24, it is the policy of Health Colorado Inc. (HCI) to assist members in transition from one system of care to another with minimal disruption in their	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	health care services as part of their Health First Colorado (Medicaid) benefits. The current health system in Colorado is complex and sometimes fragmented by varying payment streams, eligibility requirements, and benefits. Members may need assistance in navigating this complex landscape to achieve optimal health outcomes. The following is a list of some of the most-commonly utilized systems that provide health care services: • Regional Accountable Entities (RAE) • Hospitals and Mental Health Institutes • Primary Care Medical Providers (PCMP) • Specialty Care Providers • Long-term Services and Supports (LTSS) • Department of Human Services Adult and Child Welfare Programs • Colorado Department of Corrections and Community Corrections • Managed Service Organizations • The Colorado Crisis System HCI Care Coordinators will ensure that members have continued access to services during a transition from one RAE to another RAE by accepting or submitting the member Transition of Care Coordination (RAE to RAE) form and coordinate with the referral source. See	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	CareCoordinationTransitionalCareProcedureFY23-24, Page 4. When a member is identified as having a transitional care need, the assigned HCI Care Coordinator will comply with all the elements listed in the Care Coordination General Policy procedure (CareCoordinationGeneralPolicyFY24-25, Page 12). The HCI Care Coordinator will also complete the following tasks: • Complete the standardized HCI Transition of Care (TOC) Assessment • Embed transitional care coordination goals into an integrated whole person care plan for priority populations enrolled in care coordination. • HCI Care Coordinator will work with the care team to ensure continuity of care across all services. There will be an emphasis placed on the prevention of duplication of services and provision of services that are mutually reinforcing. • HCI care coordinator will advocate that the member is placed in or remains at the most appropriate, least restrictive setting that meets the member's needs. • Difficult to reach member outreach may include meeting members where they are seeking care (i.e. PCP offices, Specialty Care offices, ERs, Hospitals, Crisis	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	centers, etc.), or meeting members where they are seeking community resources (i.e. Homeless shelters, food banks, etc.). Compliance with the transitional care is monitored through the CareCoordinationAuditTools, Section 9. TransitionBetweenCareSettings_CDEP3.11 describes the process of the collaboration between Carelon Behavioral Health, Inc. (on behalf of HCI as the ASO) and providers to minimize unnecessary complications related to care setting transitions and hospital readmissions, to ensure the safety of the enrollee and how Carelon Behavioral Health monitors transfers and hospital readmissions. Carelon Behavioral Health care management (CM) is notified of hospital admission through daily census reports. If the admission is a behavioral health (BH) event, the Carelon Behavioral Health CM conducts or reviews the utilization review and collaborates on the enrollee's care with the inpatient facility and/or when applicable the identified plan clinician, primary care provider, LTSS, or another appropriate provider. In addition to addressing procedures for transitional care, HCI's	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	CareCoordinationTransitionalCareProcedureFY23-24 specifically addresses that care coordination entities partner with the Department and the Colorado Department of Corrections (CDOC) to identify and provide services to Medicaid-eligible individuals being released from incarceration to enable them to transition successfully to the community. Services include, but are not limited to, in-reach services, care transition support, and care coordination (see Page 4). R4_PopMangPln_FY24-25_V2, Page 15-16 details HCI's approach for justice involved members. Understanding SDOH in healthcare is a critical element to addressing some systemic inequalities facing our Health First Colorado members. In alignment with SDOH, the term "criminogenic risk factors" is used in criminal justice and drives how the criminal justice system addresses systemic inequalities facing members who are experiencing reentry after incarceration. Removing barriers by addressing housing, food insecurities, access to healthcare, and economic stability are goals in both healthcare and criminal justice. Through HCI's partnership with Care and Share, the short form for SNAP enrollment was introduced to DOC facilities and continues to be	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	administered within the facilities where HCI has in reach. See CDOC_SNAPHandout. This short form allows members to enroll in SNAP benefits within a week of release rather than waiting 45 to 60-days post-release to apply. The CDOC_SNAPHandout provides members with information about the SNAP program as well as pantry and other food assistance programs in the HCI region. Following completion of the Case Management Redesign and announcement of the new CMA awards, HCI partnered with the CMAs to establish a referral process for individuals identified as candidates for home and community-based services (HCBS) screening. HCI's work with the DOC started on July 1, 2017, and will end on June 30, 2025. HCI avoided any lapse in work with our justice-involved members, and our interventions and efforts helped to ensure that we continue to address and remove systemic barriers. HCI has historically remained among the top performers with the DOC metric in ensuring individuals are assessed for behavioral health services within 14 days of their release.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	During the reporting period SFY23-24 Q3Q4, HCI utilized the High-Intensity Behavioral Health Treatment (HIT) expansion funding to award Gateway to Success, Crossroads, and Front Range Clinics funds to expand services for our justice-involved members. HCI's goal for these awards was to strengthen the stability of our provider network so they can continue to provide services for years to come. HCI worked with the grant recipients to add new billable services for sustainability and continued growth. Members without a robust transition plan or positive social support often drive our recidivism rates; therefore, HCI has worked to build the provider network to increase the number of providers willing to learn cultural and linguistic methods to work with justice-involved members. Crossroads and Gateway to Success implemented FACT teams across four counties during this reporting period. FACT programs are designed to assist providers in working with people with serious mental illness who have histories of incarceration. The goal is to help these members successfully transition from correctional to therapeutic settings and adjust back into the community.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI has worked cooperatively within the full spectrum of the criminal justice systems and created interventions for members to address all levels of the Sequential Intercept Model (SIM). Jails and prison staff have previously collaborated and HCI has not experienced any opposition or barriers to accessing members prior to their release from incarceration. However, the implementation of the Colorado Division of Parole "Client Choice" program during the COVID pandemic caused the return to a culture in which HCI's Health First Colorado members are dependent on the Division of Parole for behavioral healthcare needs and utilize the RAEs as secondary resources. Division of Parole staff planted within the facilities have caused the Health First Colorado referral process to lean more on the criminal justice system and less on the healthcare system. Due to this shift, HCI has faced difficulty gaining access to entry with many facilities; however, we remain in a few while working through the DOC programs department. Historically, HCI's in reach addressed three of the eight criminogenic risk factors, giving timely access to mental health, substance use, and physical health care. Addressing economic inequities, low levels of education or employment, unstable peer relations, criminal orientation or	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	thinking, and community or neighborhood instability simultaneously while addressing mental health SUD, and physical health, HCI will wrap up our work by giving our justice-involved members access to the larger health neighborhood. Introducing targeted case management to our care coordinators, community-based organizations, and providers doing wraparound and transition of care to this population will create a billable service to support sustainability in anticipation of the 1115 waiver. These efforts will continue into Q1Q2 of FY24-25. Carelon developed the first data sharing technology in Colorado called Justice Connect. Justice Connect extrapolates data to identify the highest need, highest-risk, individuals who have frequent contact with county jails. Using objective data-driven inquiries, Justice Connect not only captures prior mental health services but also captures prescription medication history. This increases the information sharing between jail and mental health providers and decreases the potential for laps in medications and promotes a smooth transition out of the correctional system. See the JusticeConnect document for detailed process flow of data to care coordination provider.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Justice involved members who are contacted receive a specific welcome letter (WelcomeLetter_DOC) to describe their benefits and orient them to the RAE. Additional informational documents such as the VisionBenefits and DentalBenefit are provided as well. The PCMP_Agreement is a critical component in supporting the coordination of care for special populations and addressing the medical needs of all members. On page 2 of the agreement, "Care Coordination" is defined as the deliberate organization of member care activities across various participants, including family members and caregivers. This coordination is particularly responsive to special populations such as the physically or developmentally disabled, children and foster children, adults, the aged, non-English speakers, and the Health First Colorado Expansion populations. The agreement ensures that members requiring assistance with medical transitions or those with complex health needs receive targeted and effective care coordination. The agreement emphasizes that PCMPs are required to provide referrals for necessary services outside their scope to other providers within the Health First Colorado network, consistent with program requirements. This ensures members	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	have access to a comprehensive network of care. Additionally, PCMPs are expected to provide input to Carelon regarding medical management and any Care Coordination activities, highlighting issues identified by members, which may necessitate education or community resource intervention (PCMP_Agreement, Page 4). The expectation set forth mandates that providers and Care Coordination entities involved in a member's care share appropriate treatment records in compliance with professional standards. This facilitates continuity of care, prevents unnecessary re-hospitalizations, and enhances communication among providers, which is vital for optimal health outcomes (PCMP_Agreement, page 5-6). Additionally, the PCMP_Agreement underscores the willingness and capability of PCMPs to collaborate with Carelon on medical management and care coordination, reflecting a commitment to comprehensive case management for members (see PCMP_Agreement, page 6). BehavioralHealthProviderHandbook, Page 64 outlines that the continuity and coordination of care throughout HCI's 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	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	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	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	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 within the guidelines of protecting a member's privacy and confidentiality. Communication and Continuity of Care is additionally addressed in the PrimaryCareProviderHandbook on Page 24-25. Document titled EssetteSceenShots provides an example for members who are served by multiple populations, the care team members are listed and/or can be updated in Essette Platform (Page 4).	
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)*	**Documents Submitted/Location Within Documents:** 1. HealthNeedsSurveyProcess_HCI, Entire Document 2. CareCoordinationGeneralPolicy_FY24-25, *Misc, Page 4, 10 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract Amendment 17: Exhibit B—7.5.2–3	The RAE uses the results of the Health Needs Survey (HNS), 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 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. 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-	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	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. Once the HNS is distributed via FileConnect to the CC entities they are handled as a referral, the procedure for which is detailed on Page 10 of the CareCoordinationGeneralPolicy_FY24-25. Although we receive the Health Needs Survey data stream and distribute it to our Care Coordinators, it frequently contains minimal or no information. When there is relevant information, Care Coordinators utilize it to inform their work with members. However, to better evaluate the needs of our members, the intake assessment has incorporated questions to address needs and barriers to care. Our intake assessment is specifically designed to address the gaps often found in the Health Needs Survey. It includes components that evaluate the missing information typically absent from the survey. The intake assessment is a tool designed to evaluate individual members' health risks, social	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	determinants of health (SDOH) needs, quality of life issues, and to identify high-priority member needs for healthcare and care coordination. This tool incorporates evidence-based assessment and screening instruments, such as the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) and the What Matters Index (WMI). See CareCoordinationGeneralPolicy_FY24-25, Page 4.	
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 17: Exhibit B—14.7.1	**Documents Submitted/Location Within Documents:** 1. CareCoordinationGeneralPolicyFY24-25*Misc, Page 3, 5, 8, 9,10, 15 2. CareCoordinationTransitionalCareProcedureFY23-24, Entire Document 3. CareCoordAuditPlan2023, Entire Document 4. CareCoordinationAuditTools*Misc, Entire Document 5. Q16.404MonitoringTrtmtRecordReviewGuidelines, Entire Document 6. ProviderContract, *Misc, Page 16 7. TransitionBetweenCareSettings_CDEP3.11, Entire Document 8. PrimaryCareProviderHandbook, *Misc, Page 31, 32	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	9. EssetteSceenShots, Page 4 10. BehavioralHealthProviderHandbook, *Misc, Page 43, 64-65 11. ClinicalDocumentationTraining, Entire Document 12. CareCoordinationAuditTools, *Misc, 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, a service planning system that uses the information gathered in the member's intake and an assessment to build a service plan. HCI utilizes a standardized intake assessment defined in the CareCoordinationGeneralPolicyFY24-25, Page 3 as a tool to assess individual members' health risks, SDOH needs, and quality of life issues, and identify high priority member needs for health care and care coordination. This tool incorporates evidenced based assessment and screening devices such as the Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE) and What Matters Index	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	(WMI). The frequency of HCI Care Coordinator (CC) contact with each member enrolled and/or receiving care coordination will be based on the individualized Care Plan that includes members' needs and preferences around timing and modality of care access. When a member is identified as having any care coordination need the assigned Care Coordinator will complete the standardized HCI Intake Assessment. This Intake Assessment guides HCI Care Coordinators in assisting members with SDOH, such as access to healthy food, exercise, transportation, housing, and employment support. See CareCoordinationGeneralPolicyFY24-25, Page 8. As the HCI Care Coordinator completes the intake assessment, needs are identified as goals and tasks used to create the Care Plan. This documentation must be entered into the HCI care coordination tool, Essette. The minimum requirements for the care plan are outlined in the CareCoordinationGeneralPolicyFY24-25 and are built into the Essette platform. The Integrated Whole Person Care Plan (Robust Care Plan or Care Plan) is defined in the	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	CareCoordinationGeneralPolicyFY24-25 as an Individualized care plan that includes SDOH, Access to Care barriers, behavioral health and medical health needs. This integrated whole-person care plan is developed with shared decision-making practices between the member and health care staff. The frequency of HCI Care Coordinator contact with each member enrolled and/or receiving care coordination will be based on the individualized Care Plan that includes members' needs and preferences around timing and modality of care access. See CareCoordinationGeneralPolicyFY24-25, Page 9. HCI Care Coordinators will ensure that care coordination is provided to members who are transitioning between health care settings and populations who are served by multiple systems including (but not limited to) children involved with child welfare, Medicaid-eligible individuals transitioning out of the criminal justice system, members receiving Long Term Services and Supports (LTSS), members transitioning out of institutional settings, members with waivers, and members experiencing homelessness. See CareCoordinationGeneralPolicyFY24-25, Page 10. The HCI Care Coordinator is responsible for assessing or arranging for the assessment of the	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	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 HCI 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. The HCI Care Coordinator is responsible for initial and ongoing assessment of the member's health status and healthcare needs. They will communicate regularly with the member's primary care team and with medical specialty providers who are engaged with the member. See CareCoordinationGeneralPolicyFY24-25, Page 5. As identified in the CareCoordinationTransitionalCareProcedureFY23-24, it is the policy of Health Colorado Inc. (HCI) to assist members transition from one system of care to another with minimal disruption in their health care services as part of their Health First Colorado (Medicaid) benefits. This policy is aligned with the requirements of 42 C.F.R. 438.62 and the Colorado Department of Healthcare Policy and Financing's Transition of Care Policy	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	to ensure continued access to services during a transition. To ensure compliance with policies and procedures, Carelon will randomly sample individual care coordination encounters from Essette as described in the CareCoordAuditPlan2023. These encounters will be audited using the HCI CareCoordinationAuditTools, which will be provided to HCI Care Coordination Entities, and which reflects the contractually identified elements of a Care Plan and care coordination activities. See CareCoordinationGeneralPolicyFY24-25, Page 15. Providers are monitored on compliance with this requirement through existing audit procedures. See CareCoordinationAuditTools. Specifically auditing the intake assessment and treatment planning requirements. Q16.404MonitoringTrtmtRecordReviewGuidelines outlines how the Quality Management (QM) Department regularly conducts treatment record audits of service providers to ensure compliance with documentation requirements. Assessments of provider performance will be based on	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	standardized criteria, such as treatment record audit tools, performance measure data, and contract requirements. The ProviderContract underscores the vital role of data and information sharing in effective case management for members, as detailed on Page 16. Providers are required to participate in case management initiatives directed by Carelon, ensuring comprehensive care coordination, including discharge planning. This participation involves assisting with member outreach and emphasizes the collaboration between different types of providers—such as outpatient and inpatient—thereby guaranteeing continuity of care. This collaborative approach ensures that members receive well-coordinated treatment, seamless transitions in care, and effective medication management. Additionally, providers are expected to support the collection and evaluation of performance measurement data, aiming to enhance the quality of care through informed decision-making and continuous improvement. This integration of data sharing into the broader scope of care initiatives enables a robust framework for managing the diverse needs of members effectively.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	TransitionBetweenCareSettings_CDEP3.11 describes the process of the collaboration between Carelon Behavioral Health, Inc. (on behalf of HCI as the ASO) and providers work together to minimize unnecessary complications related to care setting transitions and hospital readmissions, ensure for the safety of the enrollee and how Carelon Behavioral Health monitors transfers and hospital readmissions. Carelon Behavioral Health care management (CM) is notified of a hospital admission through daily census reports. If an admission is a behavioral health (BH) event, Carelon Behavioral Health CM conducts a utilization review and collaborates on the enrollee's care with the inpatient facility and/or when applicable the identified plan clinician, primary care provider, LTSS, or another appropriate provider. As outlined in the PrimaryCareProviderHandbook, Page 31 and 32 delegated Care Coordination entities are responsible for completing a comprehensive assessment of members assigned to their care. The required assessment identifies elements through regional organization policy and is monitored through an auditing process. Providers get feedback about their performance and are directed to complete additional training, if necessary, to	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	achieve compliance with the regional organization's standards. Providers will receive training about the needs assessment requirements through the onboarding process and through regularly scheduled webinars or other training programs. Providers are also required to document an individualized care plan/treatment plan that is consistent with the member's needs identified during the needs assessment process. This documentation is also subject to oversight monitoring from the regional organization. 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 BehavioralHealthProviderHandbook, pg. 43. CC and/or Clinical Care Managers (CCM) 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	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Reflect the use of relevant therapies • Show appropriate involvement of pertinent community agencies • Demonstrate discharge planning from the time of admission • 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 BehavioralHealthProviderHandbook, Page 64. 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:	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• 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) The "Treatment Record Standards and Guidelines" (see BehavioralHealthProviderHandbook Page 64-65) 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.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Compliance with these standards of care are monitored through treatment record reviews, audits and associated requests for copies of member records. Providers receive training on these requirements and the training can be found on the HCI's Website under Providers Webinars & Trainings | Health Colorado and as outlined in the document ClincalDocumentationTraining (entire document). HCI ensures compliance through the CareCoordinationAuditTools (Section 1 and Section 4), upon notification of a member with a care coordination need a standardized intake assessment is completed. And when needs are identified an integrated whole person care plan is completed within 90 days of contact with the member. The document titled EssetteSceenShots provides examples of a member's active Care Plan goals and tasks are listed along with the creation date, who they were created by and if the goal has been completed or not. Additionally, for members who are served by multiple populations, the care team members are listed and/or can be updated in Essette Platform (Page 4).	
8. *For the Capitated Behavioral Health Benefit:*	**Documents Submitted/Location Within Documents:**	☒ Met ☐ Partially Met

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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 17: Exhibit B—None	1. CareCoordinationGeneralPolicyFY24-25*Misc, Page 7, 8 2. CareCoordinationAuditTools*Misc, Entire Document 3. PCMP_Agreement *Misc, Page 3 4. PrimaryCareProviderHandbook, *Misc, Page 31 5. BehavioralHealthProviderHandbook,*Misc, Page 28-29 **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 facilitating the creation of new connections and improved processes, while avoiding duplication of existing local and regional efforts. Care Coordination (CC) expectations directly align with this requirement. As described in CareCoordinationGeneralPolicyFY24-25, Page 7-8, the HCI Care Coordinator is responsible for assessing or arranging for the assessment of the member's need for services, coordinating mental health services rendered by multiple providers,	☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	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 HCI 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. The HCI Care Coordinator is responsible for initial and ongoing assessment of the member's health status and healthcare needs. They will communicate regularly with the member's primary care team, behavioral health providers and with medical specialty providers who are engaged with the member. Providing services that are not duplicative of other services and that are mutually reinforcing. The HCI Care Coordination Entity shall not duplicate Care Coordination provided through Long Term Services and Supports (LTSS) or Home and Community Based Service (HCBS) waivers and other programs designed for special populations; rather, HCI will work to link and organize the different care coordination activities to promote a holistic approach to a member's care. See CareCoordinationGeneralPolicyFY24-25, Page 7. HCI CC are expected to maintain relationships with community organizations such as specialty	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	care, managed service organizations and their networks of substance use disorder (SUD) providers, hospitals, pharmacies, dental, nonemergency medical transportation, regional health alliances, public health, Area Agencies on Aging, Aging and Disability Resources for Colorado, Department of Human Services (Adult and Child protective services), 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 programs, and other agencies that serve special populations such as those engaged with Community Center Board (CCB) and/or Single Entry Point (SEP) agencies. See CareCoordinationGeneralPolicyFY24-25, Page 7. The HCI Care Coordinator 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	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	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 (MCO) • Other behavioral health providers • Other physical health care providers 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 (including county DHS Offices) • Other provider organizations that provide wraparound services • The SEP, CCB organization, or Case Management Agency (CMA) • Other parties as required by HCPF • Colorado Crisis System/Behavioral Health Administration (BHA) • Oral healthcare providers We work to improve care coordinators' knowledge through ongoing training/meetings regarding contract requirements. We have monthly care	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	coordination subcommittee meetings with Delegated Care Coordination Entities. Care coordination providers are monitored on compliance with this requirement through existing audit and performance improvement procedures (See CareCoordinationAuditTools). PCMP_Agreement, Page 3 details that HCI does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: 1. The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered. 2. Any information the member needs in order to decide among all relevant treatment options. 3. The risks, benefits, and consequences of treatment or non-treatment. 4. The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	PrimaryCareProviderHandbook, Page 31 states that the delegated care coordinator is responsible for coordinating mental health and behavioral health services rendered by multiple providers and coordinating with other healthcare and human service agencies. They are also responsible for referring members to appropriate services and sharing assessment results with other providers to prevent duplication of services and reduce fraud, waste, and abuse. BehavioralHealthProviderHandbook, Page 28-29 provides tips for improving care coordination including requesting release of information, using a standard form for information sharing, following standard processes, documenting care coordination and keeping the member and their team informed.	
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)*	**Documents Submitted/Location Within Documents:** 1. BehavioralHealthProviderHandbook,*Misc, Page 24 2. PrimaryCareProviderHandbook, *Misc, Page 17-18 3. CareCoordinationGeneralPolicyFY24-25, *Misc, Page 4, 8 4. EssetteUserAgreement_ScreenShot, Entire Document 5. PCMP_Agreement*Misc, Page 10	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract Amendment 17: Exhibit B—11.3.7.10.6, 15.1.1.5	6. P05.1B_UseandDisclosureofPHIandPI, *Misc, Entire Document 7. IT201.10HIPAA Standard1_SecurityManagement, Entire Document 8. IT208.11HIPAAStandard 8SecurityEvaluation, Entire Document 9. IT216.9HIPAAComplianceStandard16_Integrity, Entire Document 10. IT217.10HIPAAStandard17_PersonorEntityAuthentication, Entire Document 11. PrivacyNotice, *Misc, Entire Document 12. ProviderContract, *Misc, Page 26-27, 47 **Description of Process:** Health Colorado maintains policies and procedures that all protected health information (PHI) providers submit is maintained on a confidential basis in accordance with all applicable regulatory (e.g. HIPAA, 42 CFR Part 2) and accreditation requirements. All information obtained is used solely for the purposes of utilization management, quality management, disease management, discharge planning, case management, and claims payment. In addition, Health Colorado maintains information systems to collect, maintain, and analyze information that incorporate adequate safeguards to ensure the confidentiality and security of PHI received, as	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	well as a plan for secure storage, maintenance, tracking, and destruction of member-identifiable clinical information. Both provider handbooks are available and accessible on Health Colorado Inc. (HCI)'s website under Provider Handbook and Policies Menu: • Health Colorado's Physical Health Provider Handbook: https://s18637.pcdn.co/wp-content/uploads/sites/26/HCI-Primary-Care-Provider-Medicaid-Provider-Handbook.pdf • Health Colorado Behavioral Health Provider Handbook: https://s18637.pcdn.co/wp-content/uploads/sites/26/HCI-Behavioral-Health-Medicaid-Provider-Handbook.pdf BehavioralHealthProviderHandbook, Page 24 and PrimaryCareProviderHandbook, Page 17-18 outlines that Providers/participating providers are: • Expected to comply with applicable federal and state privacy, confidentiality, and security laws, rules, and/or regulations, including without limitation the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	and the rules and regulations promulgated thereunder, and C.F.R. Part 2. • Responsible for retaining and maintaining a release of information, compliant with 42 C.F.R. § 2.31, authorizing the provider to disclose information related to the member and his or her receipt of Substance Use Services for claims payment purposes. Such consent shall additionally authorize the re-disclosure of such information by the regional organization to the Department of Health Care Policy and Financing (the "Department"), as required by and for the purposes set forth in the regional organization's contracts with the Department. • Providers shall retain and maintain each such consent for a period of at least six (6) years from the last effective date of such consent. If a member refuses to sign such a consent, providers shall document their efforts to obtain such a consent and shall notify the regional organization prior to billing for the provision of Substance Use Services for such members. • Responsible for meeting their obligations under these laws, rules, and regulations, by implementing such activities as	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	monitoring changes in the laws, implementing appropriate mitigation and corrective actions, and timely distribution of notices to patients(members), government agencies and the media when applicable. BehavioralHealthProviderHandbook, Page 28-29 provides tips for improving care coordination including requesting release of information, using a standard form for information sharing, following standard processes, documenting care coordination and keeping the member and their team informed. The CareCoordinationGeneralPolicyFY24-25, Page 4, defines Protected Health Information (PHI) as any protected health information including, without limitation, any information whether oral or recorded in any form or medium: • That relates to the past, present or future physical or mental condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual. • That identifies the individual or with respect to which there is a reasonable basis to believe the information can be	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	used to identify the individual. PHI includes, but is not limited to, any information defined as Individually Identifiable Health Information by the federal Health Insurance Portability and Accountability Act (HIPAA). The HCI Care Coordinator will ensure that all communications with other providers are in accord with all applicable federal and state requirements related to the protection of individually identifiable health information. These requirements include those specifically identified in 45 CFR, parts 160 and 164, subparts A and E (HIPAA), to the extent that they are applicable. When there are questions about whether particular information can be exchanged, consultation with the HCI Compliance Officer to resolve these questions prior to releasing the information is advised. HCI Care Coordinators will comply with the requirements of 42 CFR Part 2 to ensure that drug and alcohol information remain confidential. Consent is required before disclosing any such information. See CareCoordinationGeneralPolicyFY24-25, pg. 8. Additionally, within the Care Coordination electronic platform, Essette is a user agreement (EssetteUserAgreement_ScreenShot) that must be	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	agreed to up every login which reads: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The PCMP_Agreement, Page 10, includes provisions for confidentiality. The parties agree to have and implement procedures designed to preserve the privacy and confidentiality of Member records; and (ii) maintain, retain, use and/or disclose such Member records and any Protected Health Information in accordance with HIPAA, HITECH, 42 C.F.R. Part 2 as related to alcohol and/or substance abuse services and/or records, and all applicable other federal and state laws, rules and regulations regarding the confidentiality, privacy and/or security of	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Protected Health Information and/or medical/behavioral health/alcohol-substance abuse records and any patient consent required there under. PCMP shall also ensure that any records maintained electronically meet all applicable federal and state laws and regulations related to the storage, transmission and maintenance of such records. P05.1B_UseandDisclosureofPHIandPI details that Carelon Behavioral Health as a wholly owned subsidiary of Elevance Health, has adopted the Elevance Health Corporate Policy and Procedure P-05.1: Use and Disclosure of Protected Health Information (PHI) within Elevance Health Policy and Procedure. Elevance Health Associates may access, use, and share with other Elevance Health Associates the minimum amount of PHI necessary to perform Elevance Health's Treatment, Payment, and Health Care Operations (TPO) without needing Individual Authorization. Elevance Health Associates shall adhere to the guidelines outlined in the applicable Notice of Privacy Practices (Notice Policy) when collecting, using and disclosing PHI. Any collection, Use or Disclosure of PHI not covered in the Notice requires prior approval from the Privacy Department.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The Security Management Process outlined in the document IT201.10HIPAA Standard1_SecurityManagement provides a security "foundation" that is based on the four required HIPAA implementation specifications listed in this policy. These measures have been developed and applied by Information Technology and implemented by each Carelon Behavioral Health business unit to ensure the confidentiality, integrity and availability of protected health information (PHI) held by the company. IT208.11HIPAAStandard 8SecurityEvaluation outlines Carelon's policy governing compliance to HIPAA Security Rule requirements for Administrative Safeguards for a Security Evaluation. IT216.9HIPAAComplianceStandard16_Integrity outlines Carelon's policy and procedures governing compliance to HIPAA Security Rule requirements for Technical Safeguards (Section 164.312) – Integrity. IT217.10HIPAAStandard17_PersonorEntityAuthentication outlines Carelon's policy and procedures governing compliance to HIPAA Security Rule	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	requirements for Technical Safeguards (Section 164.312) – Person or Entity Authentication. The document, PrivacyNotice, also 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 https://www.healthcoloradorae.com/hci-notice-of-privacy-practices/ The ProviderContract, on page 26-27 details the confidentiality of member records including implementation of procedures designed to preserve the privacy and confidentiality of member records. The provisions outlined in the ProviderContract illustrate the structured approach taken to ensure network adequacy and continuity of care in the event of provider departure or network termination. On Page 23, the contract specifies that if Carelon's contract with a plan is terminated, or if Carelon ceases business operations, the responsibility for care coordination, authorization, and reimbursement shifts to the plan. This ensures that members continue to receive necessary services without disruption, as providers will recognize the plan as they did Carelon, maintaining continuity of care unless prohibited	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	by applicable regulations such as those involving EOHHS or CMS. Page 47 of the ProviderContract further underscores the commitment to continuity of care. If the agreement is terminated without cause by Carelon, and members have not been adequately notified as required by C.R.S. §10-16-705(7), they are allowed to continue receiving covered services from the provider for sixty days post-termination. Additionally, if coverage under a health benefit plan ends for reasons other than nonpayment of premiums, fraud, or abuse, providers are obligated to continue treating members admitted to inpatient facilities until discharge, as mandated by C.R.S. §10-16-705(4). During such continuation periods, providers agree to deliver services in accordance with the existing rates and terms stipulated in the agreement, as per C.R.S. §25-37-111(1). These measures collectively uphold network integrity, assure compliance with regulatory standards, and address potential dissatisfaction by ensuring providers and members experience minimal disruption during transitions.	
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:	**Documents Submitted/Location Within Documents:** 1. CareCoordinationGeneralPolicyFY24-25*Misc, Page 9, 10, 15 2. HCI_CC_MOU_FY2425, Page 4 3. EssetteScreenShots, 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**
• 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. The care coordination tool, at a minimum: • Works on mobile devices. • Supports HIPAA and 42 CFR Part 2 compliant data sharing. • Provides role-based access to providers and care coordinators. *Note: The Contractor shall collect and be able to report the information identified in Section 15.2.1.3 for its entire network. Although network providers and subcontracted care coordinators may use their own data collection tools, the Contractor shall require them to collect and report on the same data.*	4. EssetteUserGuide, Entire Document 5. HCICareCoordinationTrainingMaterials, Entire Document 6. CareCoordinationAuditTools*Misc, Entire Document 7. PCMP_Agreement, *Misc, Page 6 8. EssetteAttestation, Entire Document 9. EssetteRoles, Entire Document 10. PrimaryCareProviderHandbook, *Misc, Page 34 **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. CareCoordinationGeneralPolicyFY24-25, Page 9 outlines HCPF documentation requirements, HCI Care Coordinators are responsible for the creation, monitoring, and updating of the Care Plan for all members enrolled in care coordination. This	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract Amendment 17: Exhibit B—15.2.1.1, 15.2.1.2, 15.2.1.3–5	documentation must be entered into the HCI care coordination tool, Essette. The initial assessment will be used in the creation of the member's Care Plan and the Care Plan must include at minimum: Member name, Medicaid ID of member for whom interventions were provided, Member's age, Member's self-identified gender, Member's race and ethnicity including preferred language, Member's caregiver or family member if applicable, name of entity or entities providing care coordination, designation of a lead HCI Care Coordinator, including the member's choice of lead care navigator if there are multiple care coordinators, this person is the point of contact for the member and works, as appropriate, all aspects of care coordination for the member, team members identified to show team-based integrated care, care coordination notes, activities, and member needs, and stratification level. EssetteScreenShots provides visualizations of where the information is listed in the Essette platform with screen shots from a test member. The HCI Care Coordinator is responsible for managing the members assigned to them including the multi-system involved members. Many times, these members have other service or treatment plans in place with external agencies. Therefore, it is important that the HCI Care	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Coordinator documents all external leads and plans involved in the member's care as part of the HCI care coordination documentation in Essette. More specifically, the HCI Care Coordination Entity may take a lead or secondary role depending on the individual member's needs. The HCI Care Coordinator will be required to communicate with other entities (e.g. SEPs/CCBs) to determine lead HCI Care Coordinator as well as lead external care coordinator and document this in the member's care coordination record in Essette. See CareCoordinationGeneralPolicyFY24-25, Page 10. HCI_CC_MOU_FY2425, Page 4 specifies that the contractor will utilize HCI's electronic care coordination tool, Essette, per HCI Care Coordination Policy for all care coordination activities and reporting. In the event of an ad-hoc request directed by HCPF, Carelon and/or HCI will communicate the request, and the contractor shall respond to Carelon and/or HCI in the format and deadline required. The report(s) shall be evaluated for completeness, timeliness and accuracy. The report(s) that do not meet specifications will be returned to the contractor for correction and resubmission.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	EssetteUserGuide is available on the HCI Website within the Care Coordination Training Materials (site only accessible by contracted CC Entities) https://www.healthcoloradorae.com/care-coordination-training-materials/. The HCICareCoordinationTrainingMaterials document provides screen shots of the resources available on the HCI CC Training website to include links to the Essette User Guide as well as Essette Basics and Essettte Workflow training materials. HCI CC entities are audited on compliance of entity of key member demographics through the CareCoordinationGeneralPolicyFY24-25, Page 15 procedure for audits section and as demonstrated in the CareCoordinationAuditTools document. All though the contracted delegated care coordination entities are required to document in the Essette platform, network providers are also required to collect and report on data as identified in the PCMP_Agreement, Page 6: Committed to working as a partner with HCI and Carelon in providing the highest level of care to Members. This commitment includes data-sharing and 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	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	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 Members and their health needs. This communication expectation will promote continuity of care. The document titled EssetteAttestation outlines that the Essette platform works on mobile devices, supports HIPAA and 42 CFR Part 2 compliance as well as provides role-based access to providers and care coordinators. The EssetteRoles document provides a screen shot example of the role-based access options HCI is using in the platform to providers and care coordinators. In the "Medical Record Documentation Standard" section of the PrimaryCareProviderHandbook, Page 34 details that Health Colorado has specific documentation standards related to CC entities care coordination documentation. Care coordination documentation must support communication and coordination among members of the provider network and health neighborhood.	

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 17: Exhibit B—7.3.7.1–2	**Documents Submitted/Location Within Documents:** 1. 304L_MemberRandRPolicy, Entire Policy **Description of Process:** Health Colorado Inc. (HCI) has written policies regarding member rights and strictly follows Carelon's Member Rights and Responsibilities Policy, underscoring our commitment to safeguarding member rights and ensuring every member is treated with respect and dignity. HCI ensures that members are informed about their rights as stipulated in 42 CFR 438.100. This policy is fully compliant with applicable state and federal laws, as well as contractual requirements. To review the complete policy, please refer to document 304L_MemberRandRPolicy in its entirety.	☒ 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 17: Exhibit B—17.10.7.2	**Documents Submitted/Location Within Documents:** 1. 304L_MemberRandRPolicy, Pages 1,11 2. RAEAttestationofMemberRights, Entire Document 3. 310L_NonDiscriminationPolicy, Entire Document 4. NonDiscriminationNotice, Entire Document 5. ProviderContract, Pages 15, 17. *Misc	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	6. BehavioralHealthProviderHandbook, Pages 20-21, 24 *Misc. 7. PrimaryCareProviderHandbook, Pages 14, 20 *Misc 8. Feb2024ProviderRoundtable, Slides36-38 *Misc 9. July2024ProviderRoundtable, Slides10-13 10. FeedbackDatabase, Page 2 11. ChartAuditTool, Line 12 12. IT206.13_HIPAACompliance_SecurityIncidentProceduresPolicy, Entire Document 13. ProviderDirectorySearchOptions, Entire Document **Description of Process:** HCI strictly adheres to all pertinent federal and state laws regarding member rights, ensuring that both our employees and contracted providers respect and protect these rights. HCI follows two of Carelon's key policies and procedures focused on member rights: 1) 304L_Member Rights and Responsibilities Policy 2) 310L_Non-Discrimination Policy	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI mandates that all employees read and sign the 304L_Member Rights and Responsibilities Policy, confirming their understanding and commitment to treating members with respect. See 304L_MemberRandRPolicy, Page 11 and for examples of employee confirmation, see RAEAttestationofMemberRights, Entire Document. Moreover, HCI adheres to the 310L_Non-Discrimination Policy, ensuring that no member faces discrimination 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 AIDS or an AIDS-related condition), the need for health care services, or political beliefs in the context of receiving care and services from HCI. For full details, refer to the 310L_NonDiscriminationPolicy, Entire Policy. Additionally, HCI's non-discrimination notice is available on our website at https://www.healthcoloradorae.com/non-discrimination-notice/. See NonDiscriminationNotice, Entire Document. HCI also provides information regarding rights and responsibilities, disenrollment rights, civil rights, the Americans with Disability Act, and transgender equality on our website. These resources are available in both English and Spanish at	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	https:/www.healthcoloradorae.com/members/rights-responsibilities/ HCI requires its contracted providers to sign an agreement ensuring that members with disabilities receive the same standard of care as other members without facing discrimination and respect and uphold members' rights. HCI educates contracted providers about member rights and responsibilities twice a year during the provider roundtable forums. For evidence refer to 304L_MemberRandRPolicy, Page 1, ProviderContract, Pages 15 and 17, BehavioralHealthProviderHandbook, Pages, 20-21 and 24, PrimaryCareProviderHandbook, Pages 14 and 20, Feb2024ProviderRoundtable, Slides 36-38, and July2024ProviderRoundtable, Slides 10-13. HCI is committed to keeping members informed about available disability accommodations. We offer electronic and mobile-enabled provider directories accessible through the Find a Provider tab on our website. HCI has three resources to help members find a provider based on their needs. • Find a Primary Care Medical Provider, Hospital, Pharmacy, or Specialist which links to Health First Colorado's site to find a medical provider.	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Find a Behavioral Health Provider which links to Carelon Behavioral Health to find a behavioral health provider. • Find a Dentist which links to DentaQuest to find a dental provider. See ProviderDirectorySearchOptions, Entire Document. Members can view and print HCI's provider directory if they have access to a printer. Additionally, they may call and request that a printed copy of the provider directory be mailed to them. Many HCI members opt to contact our call center for assistance in finding a local provider. Our call center associates use these provider search tools to help members locate providers based on their preferences. Clinical Service Assistants (CSAs) can perform searches 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	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Access for disabilities • Telehealth Members may ask a call center associate if there is specialized equipment for their disability. If this occurs, the call center associate will outreach the provider to ascertain if the provider can accommodate a disability. In cases where a member believes their rights have been violated, they or their designated client representative (DCR) can file a complaint via phone, letter, in person, or email at any time. HCI delegates the oversight of member complaints to Carelon, who monitors, documents, and categorizes all complaints, particularly those related to the violation of member rights. See FeedbackDatabase, Page 2. HCI's quality team performs chart audits for our contracted providers to ensure compliance with reviewing rights and responsibilities with members. This information is documented in the chart audit tool. See ChartAuditTool, LineA3. In the event of a data security breach, HCI follows Carelon's IT206.13_HIPAA Compliance – HIPAA Standard 6: Security Incident Procedures Policy, ensuring violations are prevented, detected,	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	contained, and corrected in line with federal HIPAA Security Regulations. See IT206.13_HIPAACompliance_SecurityIncidentProceduresPolicy, Entire Document.	
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 the member's 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 17: Exhibit B—7.3.7.2.1–6	**Documents Submitted/Location Within Documents:** 1. 304L_MemberRandRPolicy, Entire Document 2. 307L_MemberInfoReqPolicy, Pages 1-3 **Description of Process:** HCI has implemented policies to ensure each member's rights are protected according to federal guidelines. The "Rights and Responsibilities Policy" includes the following provisions. Refer to 304L_MemberRandRPolicy, Pages 2-3: • Members will receive information in compliance with the information requirements (42 CFR 438.10) (Section V.f). • Members will be treated with respect and due consideration for their culture, dignity, and privacy (Section II.a.v). • Members will be informed about available treatment options and alternatives in a manner appropriate to their condition and understanding (Section II.a.xxii).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Members have the right to participate in decisions regarding their healthcare, including the right to refuse treatment (Section II.a.viii). • Members have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation (Section II.a.xxiii). • Members can request and receive a copy of their medical records and request amendments or corrections (Section ii.a.xxxii). • Members will receive healthcare services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210) (Section II.a.xiii). Refer to 304L_MemberRandRPolicy, Entire Policy for additional details. Additionally, HCI adheres to the "Member Information Requirements Policy and Procedures" to ensure compliance with the information requirements outlined in 42 CFR 438.10. Refer to 307L_MemberInfoReqPolicy, Pages 3-4.	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The RAE ensures that each member is free to exercise their rights and that the exercise of those rights does not adversely affect how the RAE, its network providers, or the Department treat(s) the member. *42 CFR 438.100(c)* Contract Amendment 17: Exhibit B—7.3.7.2.7	**Documents Submitted/Location Within Documents:** 1. Rights&Responsibilities, Entire Document 2. Rights&ResponsibilitiesSpanish, Entire Document 3. RightsandResponsibilitiesPoster, Entire Document 4. RightsandResponsibilitiesPosterSpanish, Entire Document 5. EvidenceofDisplay, Entire Document 6. GettingStarted, Slide14, *Misc 7. ComplaintGuide, Page 3 8. ComplaintGuideSpanish, Page 3 9. MEACMeeting, Slide 7 10. DHSEligibilityEmail, Page 2 11. 304L_MemberRandRPolicy, Page 7 12. BehavioralHealthProviderHandbook, Page 22 *Misc. 13. PrimaryCareProviderHandbook, Pages 15-16 *Misc 14. Feb2024ProviderRoundtable, Slides 36-38, *Misc 15. July2024ProviderRoundtable, Slides 10-13 16. AdvocateMeetingPresentation, Slides 19-20 17. CallCenterMemberEngagementTraining, Slides 2-5	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	18. CareCoordinationPresentation, Slides 3-4 19. WelcomeandBenefitTextMessages, Line 14*Misc **Description of Process:** HCI has established a comprehensive complaint process to ensure that each member can freely exercise their rights without fear of adverse treatment by HCI, network providers, or Health First Colorado (Colorado's Medicaid Program). This process is managed by Carelon, who handles complaints, but a complaint can come through anyone and any venue (face to face, providers, state, email, call). Carelon's member engagement team is responsible for educating both members and providers about member rights, emphasizing that members cannot face retaliation for exercising these rights. Additionally, the team assists in resolving any violations of members' rights and investigates any instances of perceived or actual retaliation. HCI educates members about their rights through several platforms: 1. Website: Our member rights and responsibilities statement is available as both a PDF document and as a poster (for	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	providers to display in their practices). The documents and posters are available in both Spanish and English and outlines that members can exercise their rights and file a complaint without fear of adverse treatment. Both formats are accessible on the RAE website https://www.healthcoloradorae.com/members/rights-responsibilities/. See Rights&Responsibilities, Entire Document, Rights&ResponsibilitiesSpanish, Entire Document, RightsandResponsibilitiesPoster, Entire Document, and RightsandResponsibilitiesPosterSpanish, Entire Document. 2. Provider Locations: Member rights and responsibilities are prominently displayed at provider locations. See EvidenceofDisplay, Entire Document. 3. Monthly Webinars: HCI conducts a monthly "Getting Started" webinar for members, family members, and staff, informing them about their rights and how to exercise these rights without retaliation. Refer to GettingStarted, Slide 14. 4. Complaint Guide: The complaint guide, available in both English and Spanish, states that members can file a complaint without being treated differently. This guide is	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	accessible at Complaint Guide English and Complaint Guide Spanish. See ComplaintGuide, Page 3 and ComplaintGuideSpanish, Page 3. 5. Member and Community Meetings: Rights and responsibilities are reviewed during Member Experience Advisory Council Meetings and with County DHS Eligibility teams. Refer to MEACMeeting, Slide 7 and DHSEligibilityEmail, Page 2. 6. Member Advocate Meetings: HCI partners with member advocates at shareholder sites to research grievances. HCI educates member advocates on our member rights and responsibilities statements to ensure member's rights are upheld and protected. See AdvocateMeetingPresentation, Slides 19-20. 7. Staff Meetings: The HCI call center and care coordinators are educated on our Member Rights and Responsibilities statements. See CallCenterMemberEngagementTraining, Slides 2-5, CareCoordinationPresentation, Slides 3-4 8. Text Messaging: Members receive a text message stating, "As a Health Colorado member, you have rights and responsibilities! Read about them in your	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	handbook online at www.healthcoloradoRAE.com." See WelcomeandBenefitTextMessages, Line 14. Health Colorado adheres to the Member Rights and Responsibilities Policy to ensure that each member is free to exercise their rights without adverse treatment by the RAE, network providers, or Health First Colorado. See 304L_MemberRandRPolicy, Page 7. HCI educates providers about members' rights through two avenues: 1. Provider Handbook: The handbook describes how members can file a complaint and ensures that members will not lose their Health First Colorado benefits, be treated differently, or face restricted access to services for filing a complaint. Refer to BehavioralHealthProviderHandbook, Page 22 and PrimaryCareProviderHandbook, Pages 15-16. 2. Provider Roundtables: These bi-annual education forums teach providers that members can file a complaint if they believe their rights have been violated and reassure providers that members cannot be treated differently for exercising these rights. See Feb2024ProviderRoundtable, Slides 36-38 and July2024ProviderRoundtable, Slides 10-13.	

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 identify a particular member, the RAE uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42 CFR 438.224* Contract Amendment 17: Exhibit B—11.3.7.10.6, 15.1.1.5	**Documents Submitted/Location Within Documents:** 1. P05.1B_UsesandDisclosureofPHIandPI, Entire Document, *Misc 2. 304L_MemberRandRPolicy, Pages 8-9 3. LC400_MemberPrivacyRightsPolicy, Page 5, Section c,1-2. Page 7. Section D.1-2, and Page 10, Section F, G 4. PCMP_Agreement, Page 10 *Misc 5. ProviderContract, Page 26, Page 54 *Misc 6. BehavioralHealthProviderHandbook, Pages 24, *Misc 7. PrimaryCareProviderHandbook, Pages 18-19, *Misc 8. PrivacyNotice, Entire Document, *Misc 9. ChartAuditTool, Line A4 **Description of Process:** HCI uses and discloses members' health information in strict accordance with HIPAA privacy requirements (45 CFR parts 160 and 164, subparts A and E) when applicable. All HCI staff and care coordination entities adhere to Carelon's policy P05.1B_Uses and Disclosure of PHI and PI regarding the use and disclosure of Protected	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Health Information (PHI) and Personally Identifiable Information (PI). This policy mandates compliance with federal and state privacy laws and ensures that only the "minimum necessary" information is used or disclosed for the required purpose. See P05.1B_UsesandDisclosureofPHIandPI, Entire Document. Additionally, HCI staff follow policy 304L Member Rights and Responsibilities Policy, which stipulates that confidentiality procedures must conform to all relevant laws. Members have the right to access, obtain copies, and request amendments to their PHI. See 304L_MemberRandRPolicy, Pages 8-9 and supporting policy LC400_MemberPrivacyRightsPolicy, Page 5, Section c,1-2. Page 7. Section D.1-2, and Page 10, Section F, G. HCI's privacy notice, available on our website, details how medical information may be used and disclosed, and how members can access this information. The privacy notice also provides contact information for the privacy officer in case of any privacy concerns. The document can be accessed at HCI Notice of Privacy Practice, see PrivacyNotice, Entire Document for additional details.	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Primary Care Medical Providers (PCMPs) must sign an agreement to comply with all applicable laws regarding members' medical records. Additionally, behavioral health providers sign contracts to uphold state and federal confidentiality laws. These requirements are also outlined in both the Behavioral Health Provider Handbook and the Primary Care Provider Handbook. For evidence of both, see PCMP_Agreement, Page 13, ProviderContract, Pages 26, 54, BehavioralHealthProviderHandbook, Page 24, and PrimaryCareProviderHandbook, Pages 18-19. The Quality Department conducts chart audits to ensure providers review privacy notices with members, as documented in the chart audit tool. See ChartAuditTool, Line A4.	
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, Entire Document 2. AdvanceDirectivesTrainingFlyer, Entire Document 3. AdvanceDirectivesTrainingFlyerSpanish, Entire Document 4. AdvanceDirectivesTraining, Entire Document	☒ 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.	5. AD_SocialMedia, Entire Document 6. CareCoordinationPresentation, Slides 8-9 7. DHSEligibilityEmail, Page 3 8. GettingStarted, Slide 15, *Misc 9. AdvocateMeetingPresentation, Slide 26-27 10. PTLearningCollaborative, Slides 23-34 11. July2024ProviderRoundtable, Slides 30-31 12. ProviderNewsletter, Page 2 13. BehavioralHealthProviderHandbook, Pages 23-24 *Misc. 14. PrimaryCareProviderHandbook, Page 17 *Misc. 15. ChartAuditTool, Line A6 **Description of Process:** HCI has a comprehensive policy and procedure in place regarding advance directives for adult members receiving treatment from our providers. This policy is accessible online, and members may request a free printed copy by visiting Advance Directives and Living Will. The website includes links to: • Our Advance Directives policy • Colorado Medical Advance Directives • Colorado Psychiatric Advance Directives	

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 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. *Note: The RAE must be able to document its community education efforts.* *42 CFR 438.3(j)* *42 CFR 422.128* Contract Amendment 17: Exhibit B—7.3.11.2, 7.3.11.3.3	• Five Wishes • Information on quarterly Life Care Planning/Advance Directives training sessions for members, providers, and community members HCI's Advanced Directive policy, 269L_AdvanceDirectivesPolicy, contains the following key points: • Annual Information: Members have the right to request and obtain information about advance directives at least once per year (Page 5, Section V.H). • Conscientious Objections: Clear statements regarding limitations if the RAE cannot implement an advance directive as a matter of conscience, and details on both institution-wide and individual physician objections, including State legal authority (Page 3, Section IV). • Medical Conditions: Description of the range of medical conditions or procedures affected by conscientious objections (Page 3, Section IV). • Family or Surrogate Information: Provisions for providing advance directive information	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	to the member's family or surrogate if the member is incapacitated at the time of initial enrollment (Page 4, Section V.D.4). • Incapacitated Member Information: Provisions for providing advance directive information to the incapacitated member once they are no longer incapacitated (Page 4, Section V.D.5). • Medical Record Documentation: Documentation in a prominent part of the member's medical record indicating whether the member has executed an advance directive (Pages 3-4, Section V.A). • Non-Discrimination: Assurance that care is not conditioned on whether the member has executed an advance directive, and members are not discriminated against based on whether they have executed an advance directive (Page 2, Section II.D and Page 6, Section V.K). • State Law Compliance: Ensuring compliance with State laws regarding advance directives (Page 1, Section II.A). • Complaint Information: Informing individuals that complaints concerning noncompliance with advance directive	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	requirements may be filed with the Colorado Department of Public Health and Environment (Page 5, Section V.H). • State Law Changes: Informing members of changes in State laws regarding advance directives no later than 90 days following the changes (Page 1, Section II.B). • Staff Education: Educating staff on policies and procedures related to advance directives (Page 4, Section V.E). • Community Education: Components for community education on advance directives, including what constitutes an advance directive, the purpose of advance directives, and applicable State laws (Page 5, Section V.I). Please refer to 269L_AdvanceDirectivesPolicy, Entire Document for the complete policy. HCI offers quarterly Advance Directives training for members, families, care coordinators, and providers. Our community outreach manager, a certified advance directives facilitator, arranges group or individual training sessions as needed. HCI also has a member engagement staff member to assist with Spanish interpretation if needed. For evidence, see AdvancedDirectivesTrainingFlyer, Entire Document,	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	AdvancedDirectivesTrainingFlyerSpanish, Entire Document, HCI promotes Advance Directives training through various channels and trains staff on advanced directives. These promotion and training opportunities include: 1. Social media 2. Care coordination meetings 3. Department of Human Services (DHS) quarterly meetings 4. "Getting started" webinars 5. Member advocate meetings 6. Practice transformation coaches 7. Provider roundtables 8. Provider newsletters For more information, see AdvanceDirectivesTrainingFlyer, Entire Document, AdvanceDirectivesTrainingFlyerSpanish, Entire Document, AdvanceDirectivesTraining, Entire Document, AD_SocialMedia, Entire Document, CareCoordinationPresentation, Slides 8-9, DHSEligibilityEmail, Page 3, GettingStarted, Slide 15, AdvocateMeetingPresentation, Slide 26, PTLearningCollaborative, Slides 23-34, JulyProviderRoundtable, Slides 30-31, and ProviderNewsletter, Page 2.	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Providers are informed about advance directives through provider handbooks. Refer to the BehavioralHealthProviderHandbook, Pages 23-24, and the PrimaryCareProviderHandbook, Page 17. The Quality Department conducts chart audits to ensure providers discuss advance directives with members aged 18 and older. This information is documented in the chart audit tool. See ChartAuditTool, Line A6.	

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

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. • The Contractor shall use National Committee on Quality Assurance (NCQA) credentialing and recredentialing standards and guidelines as the uniform and required standards for all applicable providers. *42 CFR 438.214(b)* NCQA CR1 Contract Amendment 17: Exhibit B—9.3.5.2.1	**Documents Submitted/Location Within Documents:** 1. CR203.17PractitionerCredentialingProcessPolicy, Section VI, Pages 2-5 2. CR209.15PractitionerRecredentialingProcessPolicy, Section VI, Pages 3-6 3. CR224.7DevelopmentApprovalCredentialingCriteriaPolicy, Section V, Page 2 **Description of Process:** Health Colorado Inc (HCI) maintains credentialing and recredentialing processes to align with state, federal, regulatory and NCQA standards and requirements. Credentialing files are screened through Intake Staff and assigned by credentialing management to a credentialing specialist for processing. Once it is determined that a practitioner type is within scope of credentialing, the credentialing specialist reviews each application and the supporting documentation for completeness and begins primary source verifying the required elements applicable to each practitioner type. CR203.17PractitionerCredentialingProcessPolicy details the credentialing process for initial practitioners to ensure turn-around-time of performance guarantees as applicable to state requirements, review of the	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	practitioner application, supporting documentation, and currently attested information within the application. Files that meet established criteria outlined in this policy are submitted to the Medical Director for clean approvals and the credentialing system is updated to reflect the practitioner's status as Credentialed. Should a practitioner not meet the established criteria the file is forwarded for further review and decision to the National Credentialing Committee. CR 209.15PractitionerRecredentialingProcess details the process for recredentialing existing network practitioners within thirty-six months of the previous credentialing decision. Outreaches to notify practitioners of their recredentialing begin four months prior to their recredentialing date and once a current application and the supporting documentation is received, this information is updated and uploaded into the credentialing system and assigned to credentialing staff for processing. The practitioner files are reviewed by credentialing staff for completeness following the detailed criteria in this policy. While certain criteria initially reviewed during the initial credentialing process are not reviewed during the recredentialing process (i.e. education verification and work history review), Potential Quality Issues are also reviewed. Recredentialing files deemed clean are forwarded to the Medical Director for approved submission and the	

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	credentialing system is updated to reflect the practitioner's status as Recredentialed. Should the credentialing staff determine that the practitioner file has been found to include findings requiring further review, the file is forwarded to the National Credentialing Committee for this review for final decision. Credentialing policies and procedures are developed to follow NCQA, state, federal and CMS standards and regulations, as indicated in CR224.7DevelopmentApprovalPolicies CredentialingCriteriaPolicy.	
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners it credentials and recredentials. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. The Contractor shall document and post on its public website policies and procedures for the selection and retention of providers. *Examples of behavioral health practitioners include psychiatrists, physicians, addiction medicine specialists, doctoral or master's level psychologists, master's level clinical social workers, master's level clinical nurse*	**Documents Submitted/Location Within Documents:** 1. CR225.22DisciplineSpecificCredentialingCriteriaPractitionersPolicy, Section VI.B, Page 3 2. MasterGridCOCriteria, Entire Document 3. NWCO_003_NetworkDevelopmenAccessStandards, Entire Document **Description of Process:** CR225.22DisciplineSpecificCredentialingCriteriaPractitioners outlines the independently practicing practitioner types within scope for credentialing who meet the educational and licensure requirements of their practicing state, CMS, state-specific Medicaid,	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
specialists or psychiatric nurse practitioners, and other behavioral health care specialists. *42 CFR 438.214(a)–(b)(1)* NCQA CR1—Element A1 Contract Amendment 17: Exhibit B—9.1.6	and NCQA standards to be eligible for HCI network approval. Practitioners wishing to join the HCI network must be independently practicing as a behavioral health or substance use disorder and fully licensed within the scope of their practice and must submit verifiable evidence of education and training, work history, and professional liability insurance coverage. Prescribing practitioners must submit verifiable evidence of applicable federal certification through the Drug Enforcement Administration and/or state-specific controlled dangerous substance certification. Prescribing practitioners who do not possess this certification must submit the details of the covering practitioner for prescriptions. Board certification, as applicable by practitioner type, must be verifiable; should the practitioner not be board certified during the credentialing process, completed training for the specialty the practitioner is applying for must be verifiable. Please see the MasterGridCOCriteria as evidence of the state-specific practitioner types implemented for Colorado that must meet the credentialing criteria outlined in CR225.22DisciplineSpecificCredentialingCriteriaPractitioners Policy NWCO_003_NetworkDevelopmentAccessStandards outlines the policies and procedures HCI follows to select and retain providers. The provider network is	

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	reviewed quarterly to ensure network adequacy is met. This helps with the provider selection process. HCI recruits and retains qualified, diverse, and culturally responsive PCMPs and behavioral health providers including, but not limited to, those who represent racial and ethnic communities, the deaf and hard of hearing community, the disability community, and other culturally diverse communities who may be served. HCI also monitors access to high-quality, general and specialized care, from a comprehensive and integrated provider network. The PCMP and behavioral health networks are monitored to meet access to care standards and allow for adequate Member choice. Any provider that meets Medicaid and credentialing standards will be brought into the network via an online enrollment portal. The Network Department will assist providers in enrollment and education through monthly roundtables, newsletters or meetings with providers one on one as needed. These policies can also be found on the RAE's website at Provider Handbook and Policies | Health Colorado.	

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.B. The verification sources it uses. NCQA CR1—Element A2	**Documents Submitted/Location Within Documents:** 1. CR206.22PrimarySourceVerificationPolicy, Section VI, Pages 3-6 **Description of Process:** Upon assignment of a practitioner credentialing or recredentialing file to process, CR206.22PrimarySourceVerificationPolicy outlines and details the types, methods, and the approved sources to utilize to primary source verify the required elements for each applicable practitioner type by the credentialing staff.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	**Documents Submitted/Location Within Documents:** 1. CR225.22DisciplineSpecificCredentialingCriteriaPractitionersPolicy, Section V, Page 2; Section VI.A-C, Pages 2-3 **Description of Process:** HCI reviews independently practicing credentialing and recredentialing applications for compliance of the required licensure, education and training for their licensure type, board certification, work history, and state and federal statutes and regulations, as applicable by practitioner type. Practitioners with prescriptive authority must possess a current federal Drug Enforcement Administration certificate (DEA) and/or a state-issues Controlled Dangerous Substance certificate	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	(CDS), as applicable by state; a written statement indicating the authorized agent who handles prescriptions on a practitioner's behalf should that practitioner not carry a DEA and/or CDS. Practitioners must also provide evidence of current professional liability insurance either by submitting a hard copy of the face sheet or attesting to the professional liability details within the credentialing application. Practitioners must not be opted-out of Medicare or be found on a sanction and preclusion list. Reference CR225.22DisciplineSpecificCredentialingCriteriaPractitionersPolicy, Section V, Page; Sections VI.A-C, Pages 2-3.	
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	**Documents Submitted/Location Within Documents:** 1. CR203.17PractitionerCredentialingProcessPolicy, Section VI.F, Page 3-5 2. CR209.15PractitionerRecredentialingProcessPolicy, Section VI.F.4, Page 5 3. CR210.9 RolesResponsibilitiesReimbursementNCCPolicy, Section VI.C-E, Page 3 **Description of Process:** Following the credentialing staff's review and primary source verification of an initial or recredentialing file of its required criteria, the determination is made for files	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	which meet criteria to be approved as a clean approval are submitted to the Medical Director and the practitioner's status in the credentialing system is updated to reflect 'Credentialed' status. In the event credentialing staff's review of a practitioner's file leads to findings that do not meet required criteria are prepared and forwarded for review by the National Credentialing Committee, which makes the final determination for or against network participation. The details and criteria are detailed in credentialing policies CR203.17PractitionerCredentialingProcessPolicy and CR209.15PractitionerRecredentialingProcessPolicy. Additionally, CR210.9RolesResponsibilitiesReimbursementNCCPolicy outlines the direct involvement of the Medical Director and the National Credentialing Committee in the credentialing and recredentialing decisions, including approval of clean files and review and final determination of files requiring escalated review of files that do not meet established credentialing criteria.	
2.E. The process for managing credentialing/recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	**Documents Submitted/Location Within Documents:** 1. CR202.11OverviewNationalNetworkServices Policy, Section VI.C.4, Pages 3-4 **Description of Process:** HCI, via Carelon, manages and maintains access to its network of compliant practitioners and organizational providers following the credentialing and	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	recredentialing approvals through monitoring of quality of care, disciplinary actions, augmenting coverage areas to ensure access to required practitioner types and administrative disenrollments, resignations, and reporting to authorities. Reference CR202.11OverviewNationalNetworkServicesPolicy, Section VI.C.4, Pages 3-4.	
2.F. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. *Examples include nondiscrimination of applicant, a process for preventing and monitoring discriminatory practices, and monitoring the credentialing/recredentialing process for discriminatory practices at least annually.* *42 CFR 438.214(c)* NCQA CR1—Element A6	**Documents Submitted/Location Within Documents:** 1. CR226.12PreventionMonitoringNon-DiscriminatoryPolicy, Section VI, Page 2-3 2. CR210.9RolesResponsibilitiesReimbursementNCC Policy, Section VI.F, Page 4 3. CR202.11OverviewNationalNetworkServicesPolicy, Section VI.C, Page 3 4. CR202AAnnualMonitoringPotentialDiscriminationReportTemplate, Entire Policy 5. 2023CRMonitoringAuditNon- Discrimination2.6, Entire Document **Description of Process:** HCI does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, age, sexual orientation, licensure or certification type, or the type(s) of procedure(s) or patients in which the practitioner specializes, or in the conditions that require costly treatment. Annually, the	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	designated credentialing auditor randomly selects credentialing and recredentialing files from all states' services areas which fall under Carelon Behavioral Health's legal entities and audits these files to ensure no discrimination occurred during the processing of the files including during the method of the credentialing decision. Documentation submitted to the National Credentialing Committee for clean approvals, denied and pending practitioners are reviewed, and findings are notated on the Non-Discrimination Audit Report Template, which is then forwarded to the Director of Credentialing or designee. The Director of Credentialing/designee then forwards these results to the National Credentialing Committee, as detailed in CR226.12PreventionMonitoringNon-DiscriminatoryCredentialingRe-CredentialingPolicy. The NCC receives this audit report and reviews it for any potential discrimination findings found by the auditor and the specific credentialing file is then again reviewed following advisement of the NCC Chairperson to the committee members of the inappropriate and irrelevant demographics and discriminatory criteria during its review, as detailed in CR210.9 RolesResponsibilitiesReimbursementNCCPolicy. The process of this audit review is detailed in CR202.11OverviewNationalNetworkServicesPolicy; audit review criteria of the randomly selected credentialing and recredentialing files is recorded on the	

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	CR202AAnnualMonitoringPotentialDiscriminationReportTemplate. Please reference 2023CRMonitoringAuditNon-Discrimination2.6 as evidence of non-discrimination audit.	
2.G. The process for notifying practitioners if information obtained during the Contractor's credentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A7	**Documents Submitted/Location Within Documents:** 1. CR205.12ProviderRightsNotificationPolicy, Section VI.C.1-6, Page 3 **Description of Process:** During the credentialing process and review of a file's completeness and primary source verification of required credentialing elements, should information provided by a practitioner in the attested application be found to conflict with verified information obtained by third party primary verification source, CR205.12ProviderRightsNotificationPolicy details the process HCI implements to notify the practitioner to review the conflicting information, make necessary corrections, and the timeframe the practitioner has to respond to this request, as well as the processes of determining whether or not a practitioner's response resolves the discrepancy and the process should a practitioner not respond to this notification.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.H. The process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the Credentialing Committee's decision. NCQA CR1—Element A8	**Documents Submitted/Location Within Documents:** 1. CR203.17PractitionerCredentialingProcessPolicy, Section VI.F.2, Page 3; VI.F.7, Pages 4-5 2. CR209.15PractitionerRecredentialingProcessPolicy, Section VI.F.4.2, Page 5 **Description of Process:** CR203.17PractitionerCredentialingProcessPolicy details the processes following the complete review of a practitioner credentialing file, primary source verification of applicable elements, and approval of a clean file by Medical Director, on behalf of the NCC, the practitioner's status is updated in the credentialing system to 'Credentialed'. HCI generates a welcome letter notifying the practitioner of the credentialing decision within sixty calendar days of the decision date. HCI notifies practitioners of the decision to deny or disenroll the practitioner within ten business days. Notification of continued participation in the HCI network for recredentialed practitioners is not required by NCQA, however, should the review of a practitioner's recredentialing file lead to disenrollment, CR209.15PractitionerRecredentialingProcessPolicy details the notification process of this disenrollment decision that must be sent to the practitioner within ten business days.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.I. The medical director or other designated physician's direct responsibility and participation in the credentialing program. NCQA CR1—Element A9	**Documents Submitted/Location Within Documents:** 1. CR203.17PractitionerCredentialingProcessPolicy, Section VI.F.2, Page 3 2. CR209.15PractitionerRecredentialingProcessPolicy, Section VI.F.4. Page 5 3. CR210.9RolesResponsibilitiesReimbursementNCC Policy, Section IV, Page 2 **Description of Process:** Following credentialing staff's review of credentialing and recredentialing applications for completeness and deemed clean, all clean files are forwarded to the Medical Director on behalf of the National Credentialing Committee for review and approval. The Medical Director signs-off on all clean files submitted utilizing a unique electronic signature through the DocuSign system. Reference CR 203.17 Practitioner Credentialing Process, Section VI.F.2, Page 3; CR 209.15 Practitioner Recredentialing Process, Section VI.F.4. Page 5; and CR 210.9 Roles, Responsibilities and Reimbursement of the National Credentialing Committee, Section IV, Page 2.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.J. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law. NCQA CR1—Element A10	**Documents Submitted/Location Within Documents:** 1. CR207.13CredentialingSystemControlsPolicy, Entire Document **Description of Process:** HCI safeguards confidential practitioner and facility/organizational provider information in accordance with state laws and regulations. CR207.13CredentialingSystemControlsPolicy outlines the roles assigned to credentialing staff and the permissions available to assign to each member of the credentialing staff in the use of the credentialing information system. Unique user identifiers and stringent password requirements are assigned to credentialing staff, whose function-specific access is limited within the credentialing information system. To ensure only appropriate data is updated in the system, data entries made by users are tracked and only credentialing managers and team leads have authorization to modify data within the credentialing system. These modifications are automatically tracked within the credentialing information system's feature. Additional tracking of modifications involves an internal audit team, which reviews whether a modification made to a practitioner's data was or was not inappropriate. Furthermore, this policy details the criteria for Credentialing Process Audits, reports that are generated to capture all modifications made within	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	practitioners' data records in the credentialing information system, and the resulting root causes and impacts. In the event an external entity requests practitioner-specific information, HCI must obtain prior written consent before providing this information in accordance with applicable state and federal laws.	
2.K. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification (including board certification, if applicable) and specialty. NCQA CR1—Element A11	**Documents Submitted/Location Within Documents:** 1. CR208.10PractitionerProviderDirectoriesData Integrity Policy, Section VI, Pages 2-3 2. QM37.11UsabilityTestingforWebBasedResources Policy, Entire Policy 3. NW006.34ProviderDatabaseProviderDirectory Policy, Entire Policy **Description of Process:** HCI ensures credentialing and recredentialing practitioner and provider data entered during these processes and the available credentialing documentation into the credentialing information system is current and accurate through internal quality review referenced in CR208.10PractitionerProviderDirectoriesDataIntegrity Policy. Additionally, QM37.11UsabilityTestingforWeb-BasedResources, which details the process of ensuring the functionality and interface of the external Provider Directory meets the criteria of ease of navigation for HCI members.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	NW006.34ProviderDatabaseProviderDirectoryPolicy outlines the methods of collecting practitioner and provider information during the credentialing process and supporting documentation that will be listed on the Provider Directory as well as updates to practitioner and provider information for existing practitioners/providers.	
3. The Contractor notifies practitioners about their rights: 3.A. To review information submitted to support their credentialing or recredentialing application. *The Contractor is not required to make references, recommendations, or peer-review protected information available.* NCQA CR1—Element B1	**Documents Submitted/Location Within Documents:** 1. CR205.12ProviderRightsNotificationPolicy, Section VI.A, Pages 2-3; Section VI.B, Page 3 2. PractitionerRightsNotificationLetter, Entire Document 3. BehavioralHealthProviderHandbook, Page 18*Misc **Description of Process:** Prior to the Credentialing process and following the nomination of a practitioner into the HCI network, Contracting sends each practitioner a letter with an addendum informing of their rights, where to find these rights, and the methods the practitioner may use to outreach to HCI to exercise these rights. Please reference PractitionerRightsNotificationLetter. Providers are also able to find this information in the BehavioralHealthProviderHandbook Page 18. HCI practitioners and facility/organizational providers have the right to review the contents of their	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	credentialing application, which HCI will oblige by forwarding only those specific documents being requested by credentialing management within thirty days from the date of receipt of the request via certified mail, as detailed in CR205.12ProviderRightsNotificationPolicy, Section VI.A, Pages 2-3; Section VI.B, Page 3.	
3.B. To correct erroneous information. NCQA CR1—Element B2	**Documents Submitted/Location Within Documents:** 1. CR205.12ProviderRightsNotificationPolicy, Section VI.C, Page 3 **Description of Process:** During the credentialing process and review of a file's completeness and primary source verification of required credentialing elements, should information provided by a practitioner in the attested application be found to conflict with verified information obtained by third party primary verification source, CR205.12ProviderRightsNotificationPolicy details the process HCI implements to notify the practitioner to review the conflicting information, make necessary corrections, and the timeframe the practitioner has to respond to this request, as well as the processes of determining whether or not a practitioner's response resolves the discrepancy and the process should a practitioner not respond to this notification.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3.C. To receive the status of their credentialing or recredentialing application, upon request. NCQA CR1—Element B3	**Documents Submitted/Location Within Documents:** 1. CR205.12ProviderRightsNotificationPolicy, Section VI.D, Page 3 **Description of Process:** HCI practitioners and facility/organizational providers have the right to request the status of their credentialing application, and should any further information be required, the practitioner/provider will be notified of this, as referenced in CR205.12ProviderRightsNotificationPolicy, Section VI.D., Page 3.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor designates a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions. NCQA CR2	**Documents Submitted/Location Within Documents:** 1. CR210.9RolesResponsibilitiesReimbursement NCCPolicy, Section V, Page 2 **Description of Process:** The National Credentialing Committee (NCC), which includes the Medical Director and Co-Chair(s) along with members of the NCC who are experts in their fields representative of the practitioners in scope for credentialing to be reviewed. CR210.9 RolesResponsibilitiesReimbursementNCCPolicy, Section V, Page 2 details the NCC's direct involvement	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	in the review, oversight, monitoring and decision-making for clean files and files requiring escalated review for found issues during the credentialing and recredentialing processes.	
5. The Credentialing Committee: • Uses participating practitioners to provide advice and expertise for credentialing decisions. • Reviews credentials for practitioners who do not meet established thresholds. • Ensures that clean files are reviewed and approved by a medical director or designated physician. NCQA CR2—Element A1–3	**Documents Submitted/Location Within Documents:** 1. CR210.9RolesResponsibilitiesandReimbursementoftheNationalCredentialing Committee, Section VI.A, Pages 2-3, Section VI.E.1, Page 3, Section VI.E.2, Page 3 **Description of Process:** The National Credentialing Committee (NCC) membership represents credentialed practitioner types that are within Carelon's Behavioral Health network. Practitioner files that do not meet credentialing criteria are prepared and submitted to the NCC for review. After a thorough review the NCC makes a decision to approve or deny the credentialing application. The Medical Director, or a qualified physician designee, signs off on all clean files for approval using a unique electronic identifier following the review of practitioners/providers submitted for clean-file approval. See CR210.9 RolesResponsibilitiesReimbursementNCCPolicy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. For credentialing and recredentialing, the Contractor verifies the following within the prescribed time limits.: • A current, valid license to practice (verification time limit is 180 calendar days). • A current, valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (verification time limit is prior to the credentialing decision). • Education and training—the highest of the following: graduation from medical/professional school; completion of residency; or board certification (verification time limit is prior to the credentialing decision; if board certification, time limit is 180 calendar days). • Work history—most recent five years; if less, from time of initial licensure—from practitioner's application or CV (verification time limit is 365 calendar days). – If a gap in employment exceeds six months, the practitioner clarifies the gap verbally or in writing and notes clarification in the credentialing file. If the gap in employment exceeds one year, the practitioner clarifies the gap in writing. • History of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner—most recent five years (verification time limit is 180 calendar days).	**Documents Submitted/Location Within Documents:** 1. CR206.22PrimarySourceVerificationPolicy, Section VI.B.1, Page 3; Section VI.B.2, Page 3; Section VI.B.3-4; Section VI.D.1, Page 5; Section VI.B.6, Page 4 **Description of Process:** HCI verifies all licenses held by a practitioner in the state(s) in which the practitioner provides care to its members prior to and within 180 days of the approval date, as applicable by practitioner type and state licensing requirements; all state licenses verified must be current at the time of credentialing and recredentialing decision date. Reference CR206.22PrimarySourceVerificationPolicy, Section VI.B.1, Page 3. HCI will verify the Federal DEA and/or the Controlled Substance Certificate – as required by state – for prescribing practitioners within 180 days of the practitioner's approval date through the DEA Diversion Control Division website or a copy of the DEA certificate; the state-specific website or a copy of the CDS certificate is used to verify the CDS within 180 days of the approval date. The Federal DEA and applicable CDS must be current at the time of decision date for credentialed and recredentialed practitioners. Reference CR206.22PrimarySourceVerificationPolicy, Section VI.B.2, Page 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– The organization is not required to obtain this information for practitioners who had a hospital insurance policy during a residency or fellowship. *Note: Education/training and work history are NA for recredentialing. Verification of board certification does not apply to nurse practitioners or other health care professionals unless the organization communicates board certification of those types of providers to members.* NCQA CR3—Element A	HCI verifies the highest level of education/training completed by an initial credentialing practitioner within 180 days of the approval date, as applicable by practitioner type and is not reverified during the recredentialing process. Board certification for applicable practitioners is verified within 180 days of the approval date for both initial and recredentialing practitioners through the type-specific specialty board; if board certification has not been obtained by an applicable practitioner during the initial process, the practitioner's education and training is verified within 180 days of decision date. Reference CR206.22PrimarySourceVerificationPolicy, Section VI.B.3-4. HCI verifies an initial practitioner's work history within one year of the approval date for a lookback period of five years, reviewing the attested information within the credentialing application and/or on the practitioner's curriculum vitae, as available. Gaps in work history greater than six months require a verbal or written explanation from the practitioner. Work history gap(s) greater than one year requires a written explanation from the practitioner. Reference CR206.22PrimarySourceVerificationPolicy, Section VI.D.1, Page 5. HCI verifies a practitioner's malpractice history within 180 days of the credentialing and recredentialing decision through a query result obtained from the	

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	National Practitioner Data Bank and any returned results are reviewed for paid claims within the last five years. This verification must be current at the time of the credentialing and recredentialing decision date. Reference CR206.22PrimarySourceVerificationPolicy, Section VI.B.6, Page 4.	
7. The Contractor verifies the following sanction information for credentialing and recredentialing (verification time limit is 180 days): • State sanctions, restrictions on licensure, or limitations on scope of practice. • Medicare and Medicaid sanctions. *42 CFR 438.214(d)(1)* NCQA CR3—Element B	Documents Submitted/Location Within Documents 1. CR206.22PrimarySourceVerificationPolicy, Section VI.B.6,14, Page 4; Section VI.B.7, Page 4; Section VI.B.9, 15, Page 4 **Description of Process:** HCI verifies through the National Practitioner Data Base licensure sanctions/restrictions reported by licensure boards and any limitations on the practitioner's scope of practice within 180 days of the decision date for credentialing and recredentialing practitioners. Reference CR206.22PrimarySourceVerificationPolicy, Section VI.B.6,14, Page 4 Medicare and Medicaid sanction statuses are verified by HCI within 180 days of the credentialing and recredentialing decision dates. Reference CR206.22PrimarySourceVerificationPolicy, Section VI.B.7, Page 4; Section VI.B.9, 15, Page 4.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. Applications for credentialing include the following (attestation verification time limit is 365 days): • Reasons for inability to perform the essential functions of the position, with or without accommodation. • Lack of present illegal drug use. • History of loss of license and felony convictions. • History of loss or limitation of privileges or disciplinary actions. • Current malpractice insurance coverage (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate). • Current and signed attestation confirming the correctness and completeness of the application. NCQA CR3—Element C	**Documents Submitted/Location Within Documents:** 1. CR203.17PractitionerCredentialingProcessPolicy, Section VI.E.1-7, Page 3; Section VI.E.5, Page 3; Section V, Page 2 2. CR209.15PractitionerRecredentialingProcessPolicy, Section VI.D.1-6, Page 4; Section VI.D.5, Page 4; Section V, Page 3 3. CR206.22PrimarySourceVerificationPolicy, Section VI.D.2, Page 5 **Description of Process:** During the credentialing and recredentialing practitioner file review, HCI reviews the application disclosure questions for completeness and responses regarding inability to perform essential function of the practitioner's position, history of loss of license and/or limitation of privileges, felony convictions, and illegal drug use. Reference CR203.17PractitionerCredentialingProcessPolicy, Section VI.E.1-7, Page 3 and CR209.15PractitionerRecredentialingProcessPolicy, Section VI.D.1-6, Page 4. During the credentialing and recredentialing practitioner file review, HCI reviews the application section for attested-to current malpractice insurance coverage which must be current at the time of attestation. Reference	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	CR203.17PractitionerCredentialingProcessPolicy, Section VI.E.5, Page 3, CR209.15PractitionerRecredentialingProcessPolicy, Section VI.D.5, Page 4, and CR206.22PrimarySourceVerificationPolicy Section VI.D.2, Page 5. During the credentialing and recredentialing practitioner file review, HCI reviews the application attestation date which must be within 180 days of the decision date to ensure accuracy of the complete credentialing and recredentialing file review. Reference CR203.17PractitionerCredentialingProcessPolicy, Section V, Page 2 and CR209.15PractitionerRecredentialingProcessPolicy, Section V, Page 3.	
9. The Contractor formally recredentials its practitioners within the 36-month time frame. NCQA CR4	**Documents Submitted/Location Within Documents:** 1. CR209.15PractitionerRecredentialingProcessPolicy, Section V, Page 3 **Description of Process:** Credentialing staff reviews a practitioner's recredentialing application for completeness and existing practitioners must be recredentialed within 36 months of the previous credentialing date to remain in compliance with NCQA standards. Reference	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	CR209.15PractitionerRecredentialingProcessPolicy, Section V, Page 3	
10. The Contractor implements policies and procedures for ongoing monitoring and takes appropriate action, including: • Collecting and reviewing Medicare and Medicaid sanctions. • Collecting and reviewing sanctions or limitations on licensure. • Collecting and reviewing complaints. • Collecting and reviewing information from identified adverse events. • Implementing appropriate interventions when it identifies instances of poor quality related to the above. *42 CFR 438.214(d)(1)* NCQA CR5—Element A	**Documents Submitted/Location Within Documents:** 1. CR211.16OngoingMonitoringPractitionerOrganizationalSanctionsPolicy, Section VI.A.1-3, 5, Page 3-4; Section VI.B, Page 4 2. CR216.12PractitionerProviderDisenrollmentPolicy, Entire Document 3. CR211BOIGGSAOFACSanctionMedicareOpOutReportReviewLogTemplate, Entire Document 4. SanctionsReviewLog2023, Entire Document 5. QM_4H_MemberSafetyProgram_SeriousReportableEvent_QOCGIssuesandOutlierPracticePatterns, Entire Document 6. QOC_AcknowledgementLtr_QM, Entire Document 7. QOC_ResolutionLtr_QM, Entire Document 8. QOCC_Minutes_Draft_2024September24, Entire Document 9. QOCC_Minutes_Draft_2024October8, Entire Document 10. QOCC_Minutes_Draft_2024November5, Entire Document 11. QOC_MHProvider_ProcessFlow_QM, Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	12. QOC_PHProvider_ProcessFlow_QM, Entire Document **Description of Process:** To ensure existing HCI providers are monitored for possible sanctions, credentialing staff reviews published reports monthly, within 30 days of their release, which detail sanctions for the Office of Inspector General, the General Service Administration, System Awards Management, the Office of Foreign Assets Control, state agency sanctions, Medicare Opt Out preclusions and exclusions, adverse state license sanctions, as well as potential quality issues and complaints between recredentialing cycles. Reference CR211.16OngoingMonitoringPractitionerOrganizationalSanctionsPolicy, Section VI.A.1-3, 5, Page 3-4. Should a practitioner be found on these reports to have been sanctioned and excluded/debarred, on the Medicare Opt Out listing, or found with potential quality issues and complaints, HCI initiates the disenrollment process for the practitioner to have the practitioner removed from all Medicare networks. Reference CR211.16OngoingMonitoringPractitionerOrganizationalSanctionsPolicy, Section VI.B, Page 5. For the practitioner and provider disenrollment process, reference CR216.12PractitionerProviderDisenrollmentPolicy, Entire Document.	

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Following review of the published sanction reports, credentialing staff documents these reviews on the sanction review logs. Reference CR211BOIGGSAOFACSanctionMedicareOptOutReportReviewLogTemplate and SanctionsReviewLog2023 As indicated in the Quality of Care (QOC) policy, QM_4H_MemberSafetyProgram_SeriousReportableEvent_QOCGIssuesandOutlierPracticePatterns, an acknowledgement letter is sent, QOC_AcknowledgementLtr_QM, and an investigation completed when a QOC is reported. Upon receipt, each QOC issue is evaluated to determine the urgency of the issue and assess immediate follow-up actions to assure well-being of the Member. Once the QOC is closed, a resolution letter will be sent to the parties involved. See QOC_ResolutionLtr_QM Since adverse incidents may also be quality of care issues, all serious reportable events are evaluated upon receipt to determine whether there are any urgent safety issues to be addressed. The QOCC reviews the results of the investigation, QOCC_Minutes_Draft_2024September24, QOCC_Minutes_Draft_2024October8, and QOCC_Minutes_Draft_2024November5 and makes a determination as to whether the investigation has identified a quality of care issue, and provides direction as to the appropriate follow-up, which may include	

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	obtaining more information, developing and monitoring a corrective action, etc. The following documents demonstrate the process flow for a Quality of Care incident submission. • QOC_MHProvider_ProcessFlow_QM • QOC_PHProvider_ProcessFlow_QM	
11. The Contractor has policies and procedures for taking action against a practitioner who does not meet quality standards that include: • The range of actions available to the Contractor. • Making the appeal process known to practitioners. *Examples of range of actions: how the organization reviews practitioners whose conduct could adversely affect members' health or welfare; the range of actions that may be taken to improve practitioner performance before termination; reporting actions taken to the appropriate authorities.* NCQA CR6—Element A	**Documents Submitted/Location Within Documents:** 1. CR213.11PractitionerProviderAppealRightsRangeActionsAppealProcessPolicy, Section VI.C, Page 4-5; Section VI.B, Page 3 2. CR216.12PractitionerProviderDisenrollmentPolicy, Entire Document **Description of Process:** Findings of adverse conduct that have potential impact on member safety, HCI implements actions to attempt to improve practitioner performance by means of continued monitoring, improvement actions plan(s), leading up to and including suspension or termination from the network. These actions are implemented by the National Credentialing Committee (NCC), who will recommend, oversee and monitor these actions. Quality investigations may lead to reporting to the health plan, the National Practitioner Data Bank and/or	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	state agency(s) and is reported to the program director(s) and the legal department to coordinate appropriate actions regarding this reporting. Reference CR213.11PractitionerProviderAppealRightsRangeActionsAppealProcessPolicy, Section VI.C, Pages 4-5. Practitioner/providers notified of denial of network participation, HCI makes the appeal process known of the NCC's decision at the time of the denial decision via written notification detailing reason(s) for the action. Reference CR213.11PractitionerProviderAppealRightsRangeActionsAppealProcessPolicy, Section VI.B, Page 3.	
12. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of *organizational* health care delivery providers and specifies that before it contracts with a provider, and for at least every 36 months thereafter: 12.A. The Contractor confirms that the organizational provider is in good standing with State and federal regulatory bodies. *Policies specify the sources used to confirm good standing—which may only include the applicable State or federal agency, agent of the applicable State or federal agency, or copies of credentials (e.g., State licensure) from the provider. Attestations are not acceptable.* *42 CFR 438.214(d)(1)*	**Documents Submitted/Location Within Documents:** 1. CR218.15CredentialingCriteriaFacilityOrganizationalProvidersPolicy, Section VI.N.1-2, Page 6, Section VII, Page 13 2. FacilityMasterGridDetails, Entire Document **Description of Process:** Credentialing staff reviews an organizational provider's application and its supporting documentation to verify licensure and any potential issues through applicable state agency(s), hard copy(s) of the license(s) issues by the state agency in charge, primary source verification via through the licensing state agency and licensing review reports to ensure compliance with state and federal regulations for each	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
NCQA CR7—Element A1	license and/or certification held by the organization provider for each service location; this is re-verified at least once during the recredentialing process for organizational providers in the HCI network. Reference CR218.15CredentialingCriteriaFacilityOrganizationalProvidersPolicy, Section VI.N.1-2, Page 6 for further details. Our working Facility Master Grid for all states is attached to the policy and includes contacts for license verification, referenced in CR218.15CredentialingCriteriaFacilityOrganizationalProvidersPolicy, Section VII, Page 13. The screen shots to the specific license verification contacts are provided – please reference FacilityMasterGridDetails for sources and site links specific to Colorado facilities.	
12.B. The Contractor confirms that the organizational provider has been reviewed and approved by an accrediting body. *Policies specify the sources used to confirm accreditation—which may only include the applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, or copies of credentials (e.g., licensure, accreditation report, or letter) from the provider. Attestations are not acceptable.* NCQA CR7—Element A2	**Documents Submitted/Location Within Documents:** 1. CR218.15CredentialingCriteriaFacilityOrganizationalProvidersPolicy, Section VI.G, Page 4; Section VI.N.6, Page 6-7 **Description of Process:** Credentialing staff reviews an organizational provider's application and its supporting certificates to primary source verify accreditation through the accrediting body's official website; this verification must be current at the time of credentialing decision. Reference	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	CR218.15CredentialingCriteriaFacilityOrganizationalProvidersPolicy, Section VI.G, Page 4. Accrediting bodies recognized by HCI for verification of accreditation include The Joint Commission, The Rehabilitation Accreditation Commission, Council on Accreditation, American Osteopathic Association, Healthcare Facilities Accreditation Program, Accreditation Association for Ambulatory Care, Det Norske Veritas, Community Health Accreditation Program, or the Institute for Medical Quality. Reference CR218.15CredentialingCriteriaFacilityOrganizationalProvidersPolicy, Section VI.N.6, Pages 6-7.	
12.C. The Contractor conducts an on-site quality assessment if the organizational provider is not accredited. *Policies include on-site quality assessment criteria for each type of unaccredited organizational provider, and a process for ensuring that the provider credentials its practitioners.* *The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: The CMS or State review is no more than three years old; the organization obtains a survey report or letter from CMS or the State, from either the provider or from the agency, stating that the facility was reviewed and passed inspection; the report meets the organization's quality assessment criteria or standards. (Exception: Rural areas.)*	**Documents Submitted/Location Within Documents:** 1. CR218.15CredentialingCriteriaFacilityOrganizationalProvidersPolicy, Section VI.H, Pages 4-5 **Description of Process:** For organization provider applicants wishing to join the HCI network (with the exception of organization providers in rural areas), but are found to not be accredited by a recognized accreditation body, HCI may substitute a Center for Medicare & Medicaid Services (CMS) or a state review site visit which meet the requirements for site visit review and the resulting	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
NCQA CR7—Element A3	survey report/CMS letter indicates a passing inspection score and upon review, is forwarded to the Medical Director for approval. Structured site visits, as needed, are requested by appropriate staff and once returned, the results are reviewed for favorable passing inspection score. Reference CR218.15CredentialingCriteriaFacilityOrganizationalProvidersPolicy, Section VI.H, Pages 4-5.	
13. The Contractor's organizational provider assessment policies and processes includes: • For behavioral health, facilities providing mental health or substance abuse services in the following settings: – Inpatient – Residential – Ambulatory NCQA MBHO CR7—Elements B and C	**Documents Submitted/Location Within Documents:** 1. CR218.15CredentialingCriteriaFacilityOrganizationalProvidersPolicy, Section I, Page 1 **Description of Process:** HCI reviews organizational providers providing mental health and substance abuse services during the credentialing and recredentialing processes in inpatient, residential and ambulatory settings. Reference CR218.15CredentialingCriteriaFacilityOrganizationalProvidersPolicy, Section I, Page 1.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor has documentation that it assesses providers every 36 months. NCQA MBHO CR7—Elements D and E	**Documents Submitted/Location Within Documents:** 1. CR218.15CredentialingCriteriaFacilityOrganizationalProvidersPolicy, Section V, Page 3; Section VI.U-CC, Pages 9-10	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Description of Process: Participating organizational providers in the HCI network are recredentialed within thirty-six months of the previous credentialing decision upon receipt of a completed and signed application. Reference CR218.15CredentialingCriteriaFacilityOrganizationalProvidersPolicy, Section V, Page 3; Section VI.U-CC, Pages 9-10.	
15. The RAE shall submit a monthly Credentialing and Contracting Report to the Department with information about Provider contracting timelines, using a format determined by the Department. Contract Amendment 17: B-13—9.1.6.5.5	**Documents Submitted/Location Within Documents:** 1. CredConRpt_06-24, Entire Document 2. CredConRpt_07-24, Entire Document 3. CredConRpt_08-24, Entire Document **Description of Process:** The RAE extracts data from the system on providers who are contracted and credentialed within the reporting period. This report is due monthly to HCPF to ensure providers are credentialed and contracted within 90 days of receiving a clean application. The contracting team matches the providers who were credentialed and contracted with our internal online application report to ensure accuracy. See CredConRpt_06-24, CredConRpt_07-24, CredConRpt_08-24.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. If the Contractor delegates credentialing/recredentialing activities, the Contractor has a written delegation document with the delegate that:	**Documents Submitted/Location Within Documents:**	☒ Met ☐ Partially Met

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Is mutually agreed upon. • Describes the delegated activities and responsibilities of the Contractor and the delegated entity. • Requires at least semiannual reporting by the delegated entity to the Contractor (and includes details of what is reported, how, and to whom). • Describes the process by which the Contractor evaluates the delegated entity's performance. • Specifies that the organization retains the right to approve, suspend, and terminate individual practitioners, providers, and sites, even if the organization delegates decision making. • Describes the remedies available to the Contractor (including circumstances that result in revocation of the contract) if the delegate does not fulfill its obligations, including revocation of the delegation agreement. NCQA CR8—Element A	1. CR220.15DelegationCredentialingRecredentialingPolicy, Section V.E, Page 3; Section B.6, Pages 6-7; Section V.E.2, Page 3; Section VI.D, Pages 10-11; Section V.E.4, Page 3; Section VI.C.17, Pages 9-10; Section V.E.5, Page 3; Section VI.C, Page 7; Section V.E.6, Page 3; VI.C.8, Page 8 **Description of Process:** This required element is delegated to Carelon Behavioral Health by HCI. Carelon Behavioral Health does not delegate any of its credentialing functions. If Carelon Behavioral Health wishes to delegate credentialing functions and decision-making to an outside organization, this must be mutually agreed-upon between Carelon and the delegate. Reference CR220.15DelegationCredentialingRecredentialingPolicy, Section V.E, Page 3; CR220.15DelegationCredentialingRecredentialingPolicy, Section B.6, Pages 6-7. The delegation agreement outlining the specific delegated function(s) responsibilities must be included to inform the delegate that Carelon reserves the right to approve, suspend, or terminate practitioners and organizational providers. Reference CR220.15DelegationCredentialingRecredentialingPolicy, Section V.E.2, Page 3; Section VI.D, Pages 10-11.	☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The delegate must provide Carelon at least semi-annual reports to ensure any and all updates to practitioner and provider changes notifications including data for new and existing practitioners, providers and provider closures. Reference CR220.15DelegationCredentialingRecredentialingPolicy, Section V.E.4, Page 3; CR220.15DelegationCredentialingRecredentialingPolicy, Section VI.C.17, Pages 9-10. The delegated function(s) must be evaluated in its performance and reporting, leading up to and including appropriate actions taken to terminate the delegation should the delegate fail to fulfill its obligations to Carelon. Annual evaluations of the delegate are performed by Carelon to determine if the delegate has performed its specified delegated functions according to NCQA standards and Carelon expectations. Reference CR220.15DelegationCredentialingRecredentialingPolicy, Section V.E.5, Page 3; CR220.15DelegationCredentialingRecredentialingPolicy, Section VI.C, Page 7. The delegation agreement between Carelon and the delegate specifies that Carelon has the right to approve, suspend and terminate practitioners and organizational providers, and retains this right regardless of Carelon delegates decision-making. Reference	

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	CR220.15DelegationCredentialingRecredentialingPolicy, Section V.E.6, Page 3; CR220.15DelegationCredentialingRecredentialingPolicy, Section VI.D, Pages 10-11. Should a deficiency(ies) of a delegate's specific function(s) be found during evaluation of its performance, Carelon will issue a recommendation (CAP) to the delegate detailing the deficiency(ies) and the opportunity to respond within 30 days of the issued CAP and to demonstrate correction of the deficiency(ies) within 90 days. If the delegate fails to respond favorably to the CAP, Carelon reserves the right to revoke and terminate the delegation agreement. Reference CR220.15DelegationCredentialingRecredentialingPolicy, Section VI.C.8, Page 8.	
17. For new delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity to meet NCQA requirements before delegation began. *The requirement is NA if the Contractor does not delegate or if delegation arrangements have been in effect for longer than the look-back period.* NCQA CR8—Element B	**Documents Submitted/Location Within Documents:** 1. CR220.15DelegationCredentialingRecredentialingPolicy, Section V.C, Page 3; Section B.1-4, Pages 5-6 **Description of Process:** This required element is delegated to Carelon Behavioral Health by HCI. Carelon Behavioral Health does not delegate any of its credentialing functions. If Carelon wishes to initiate delegation of credentialing functions to a potential delegate, Carelon performs a	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	pre-delegation evaluation which aligns with NCQA standards and the requirements of Carelon prior to an executed agreement. The finalized pre-delegation summary of this evaluation is forwarded to the National Credentialing Committee (NCC) for approval if the standards and requirements are met for delegation; an approval with recommendations must be responded to within 30 days of notice of the issued. Reference CR220.15DelegationCredentialingRecredentialingPolicy, Section V.C, Page 3; Section B.1-4, Pages 5-6.	
18. For delegation agreements in effect 12 months or longer, the Contractor: • Annually reviews its delegate's credentialing policies and procedures. • Annually audits credentialing and recredentialing files against its standards for each year that delegation has been in effect. • Annually evaluates delegate performance against its standards for delegated activities. • Semiannually evaluates regular reports specified in the written delegation agreement. • At least annually, monitors the delegate's credentialing system security controls to ensure the delegate monitors its compliance with the delegation agreement or with the delegates policies and procedures. • At least annually, acts on all findings from above monitoring for each delegate and implements a	**Documents Submitted/Location Within Documents:** 1. CR220.15DelegationCredentialingRecredentialingPolicy, Section VI.C.1-2, Page 7; Section VI.C.17-18, Pages 9-10; Section VI.C.22.a-b, Page 10; Section VI.C.22.c, Page 10 **Description of Process:** This required element is delegated to Carelon Behavioral Health by HCI. Carelon Behavioral Health has no existing delegation agreements of twelve months or longer. If Carelon entered a delegation agreement to delegate specific credentialing functions, Carelon annually evaluates the delegate's performance against NCQA standards and Carelon's agreed expectations. The delegate's policies and procedures are requested and reviewed to ensure the language	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters. NCQA CR8—Element C	aligns with NCQA, CMS, state and federal regulations and Carelon standards. Reference CR220.15DelegationCredentialingRecredentialingPolicy, Section VI.C.1-2, Page 7. During the annual evaluation of the delegate, Carelon will request a sample of credentialing and recredentialing files to be reviewed for compliance with NCQA, CMS, applicable state regulations, and Carelon standards. Reference CR220.15DelegationCredentialingRecredentialingPolicy, Section VI.C.2, Page 7. Carelon evaluates the delegate's performance against NCQA and Carelon standards. Reference CR220.15DelegationCredentialingRecredentialingPolicy, Section VI.C.2, Page 7. At least semi-annually, delegates must submit reports to Carelon which detail the specified data in the delegation agreement; Carelon analyzes these reports for any data changes including any terminated practitioners and/or organizational providers. Reference CR220.15DelegationCredentialingRecredentialingPolicy, Section VI.C.17-18, Pages 9-10.	

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	At minimum annually, Carelon on behalf of HCI, will request the delegate's credentialing system controls policy(s) and procedures(s) for review to ensure this documentation has met NCQA standards and aligns with the delegation agreement. The delegate must forward to Carelon its credentialing systems control reports for analysis and determination of compliance. Reference CR220.15DelegationCredentialingRecredentialingPolicy, Section VI.C.22.a-b, Page 10. Should the credentialing system control report submitted by the delegate be found to have deficiencies, quarterly monitoring for three consecutive quarters is implemented until the delegate demonstrates correction and improvement. Reference CR220.15DelegationCredentialingRecredentialingPolicy, Section VI.C.22.c, Page 10.	
19. For delegation agreements that have been in effect for more than 12 months, at least once in each of the past two years, the Contractor identified and followed up on opportunities for improvement, if applicable. NCQA CR8—Element D	**Documents Submitted/Location Within Documents:** 1. CR220.15DelegationCredentialingRecredentialingPolicy, Section VI.C.8-9, Page 8 **Description of Process:** This required element is delegated to Carelon Behavioral Health by HCI. Carelon Behavioral Health has no existing delegation agreements of twelve months or longer. If Carelon did enter into a delegation agreement, it affords delegates the opportunity for	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	improvement following a completed annual evaluation of the delegate's performance which resulted in an Approval with Recommendations (CAP). The delegate must respond to the CAP thirty days upon receipt of the CAP notification and the CAP must be completed within ninety days of submission. An extension may be granted upon Carelon's discretion and consideration of extenuating circumstances requiring additional time to respond. Reference CR220.15DelegationCredentialingRecredentialingPolicy, Section VI.C.8-9, Page 8.	

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	32	X	1.00	=	32
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	32	**Total Score**		=	32
Total Score ÷ Total Applicable						=	100%

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE onboards and informs members and their families regarding the services provided by EPSDT. This includes: • 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 AAP "Bright Futures Guidelines," services available under EPSDT, where services are available, how to obtain services, that services are without cost to the member, and how to request transportation and scheduling assistance. Contract Amendment 17: Exhibit B—7.3.12.1, 7.6.2	**Documents Submitted/Location Within Documents:** 1. HCPFWelcomeLetter, Entire Document *Misc 2. OnboardingIVRScript, Entire Document 3. PregnantWelcomeLetter_EN Pages 3-4 4. PregnantWelcomeLetter_SP, Pages 3-5 5. ChildWelcomeLetter_EN, Pages 3-4 6. ChildWelcomeLetter_SP, Pages 3-5 7. WellVisitIVRScript, Entire Document 8. WellVisitLetter_EN, Page 3 9. WellVisitLetter_SP, Page 3 10. WelcomeandBenefitTextMessages, Entire Document *Misc 11. WellVisitTextCampaign, Entire Document 12. Text4Baby, Entire Document 13. Text4Baby_TempCampaign, Entire Document 14. Text4Kids, Entire Document 15. Text4Kids_TempCampaign, Entire Document 16. EPSDTTipSheet_EN, Entire Document 17. EPSDTTipSheet_SP, Entire Document 18. R4_EPSDTRpt_Q3FY23-24, 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**
	19. R4_EPSDTRpt_Q3FY23-24_Accepted, Entire Document 20. R4_EPSDTRpt_Q4FY23-24, Entire Document 21. R4_EPSDTRpt_Q4FY23-24_Accepted, 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). This includes informing members and their families about EPSDT services within 60 days of the members' initial eligibility determination with Health First Colorado, within 60 days of a member being identified as pregnant, or if a member regains eligibility following a greater than 12-month period of ineligibility. HCI collaborated with Colorado's Department of Health Care, Policy, and Financing (HCPF) in 2020 to utilize HCPF's welcome letter as one of the first contacts used for EPSDT-eligible members and their families. HCI's goal was to reduce the volume of correspondence members received based on members' concerns with the amount of literature sent. HCPF's welcome letter offers HCI's website link and toll-free	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	number as well as instructions on how to obtain a member handbook. Members can access the HCI welcome letter, our "Getting Started" guide, and additional EPSDT service details on our website under the New Member & EPSDT Resources section. See HCPFWelcomeLetter, for content of the initial contact to members. HCI's IT department (managed by Carelon Behavioral Health (Carelon)) downloads the weekly EPSDT member eligible files sent from HCPF at the beginning of each week. HCI's IT department sends this information to our Data Analytic Reporting Team (DART), managed by Carelon. DART sorts the member data to create two outreach lists. The first outreach list (for households with a valid phone numbers) is scrubbed to remove duplicate numbers or phone numbers on the do not call list and sorted by English and Spanish language preference. HCI has identified that the majority of our members are English or Spanish speakers. The second outreach list (households without a valid phone number) is sorted by language preference and member type (pregnant members or members under 21) to receive a specific welcome letter based on member type and language preference. The DART team sends the outreach lists to HCI's member engagement team, who is responsible to	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	oversee our IVR automated calls to outreach households within the first sixty (60) days of enrollment. Our IVR system 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's member engagement team also mails unique letters to pregnant members and a separate letter mailed to EPSDT-eligible households in either English or Spanish, based upon language preference. Additionally, HCI runs monthly IVR optout reports for our onboarding telephonic campaigns. Members who have opted out of our IVR system are also mailed a unique welcome letter. See OnboardingIVRScript, PregnantWelcomeLetter_EN, PregnantWelcomeLetter_SP, ChildWelcomeLetter_EN, ChildWelcomeLetter_SP. HCI also utilizes a texting campaign for all newly enrolled members, which has been used to onboard and inform members about their benefits. HCI sends eligibility data to our texting vendor who enrolls members in the welcome and benefit campaign. See WelcomeandBenefitTextMessages. HCI annually outreaches members who have not utilized their EPSDT services in the previous 12 months in accordance with the American Association of Pediatrics (AAP) "Bright Futures Guidelines" and	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	"Recommendations for Preventive Pediatric Health Care". HCI creates a monthly report to identify non-utilizing EPSDT eligible members that have not had a well visit or dental visit within the past year and creates outreach lists for these members. DART sorts identified members to create three outreach lists. One outreach list is for members/households with valid phone numbers, which is also scrubbed to remove duplicate numbers or phone numbers on the do not call list and sorted by English and Spanish language preference. These members are sent an automated call in either Spanish or English. The second outreach list is for members/households without a valid phone number and is sorted by language preference to receive a well visit/dental visit reminder letter. The third list is sent to our texting vendor who sends specially tailored messages for our Well Visit Texting Campaign. Members are instructed to contact HCI's toll-free number if they need assistance with these appointments such as scheduling or transportation. See WellVisitIVRScript, WellVisitLetter_EN, WellVisitLetter_SP, and WellVisitTextCampaign. Additionally, HCI's members enrolled in a Text4Baby or Text4Kids campaign may receive timed well visit reminders based on their age (more frequent text for infants aged 0-30 months) and annual reminders for	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	members over three years of age. Our texting vendor is in the process of renovating their texting programs which commenced in June 2024. As a result, they stopped using the messages we used during January – May 2024 and transitioned to temporary campaigns which began in August 2024. See Text4Baby, Text4Baby_TempCampaign, Text4Kids, and Text4Kids_TempCampaign. HCI has a central location to house information about the benefits of preventative 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 at no cost to the member and how to request transportation. Note, information about where services are available for children and youth, how to obtain services, that services are at no cost to the member and how to request transportation is included in our Children and EPSDT: Children & Youth Health Care Services health information sheet. This central location is on our New Member & EPSDT Resources Page on our website. Additionally, we have the following links for members to better understand their benefits: • HCPF's EPSDT link • HCPF's transportation link • Bright Futures Guidelines link • Getting Started Webinar Information	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Getting Started Webinar Information, Spanish • EPSDT: Children and Youth Health Care Services health information sheet • EPSDT: Atencion sanitaria infantile y juvenil (Spanish health information sheet) For the EPSDT: Children and Youth Health Care Services health information sheet, see: EPSDTTipSheet_EN and EPSDTTipSheet_SP. 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-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 and are under 20 years of age. The report contains a breakdown of outreach attempts and the success of each outreach attempt. HCI has also included the result of the quarterly report by HCPF. See R4_EPSDTRpt_FY23-24, R4_EPSDTRpt_Q3FY23-24_Accepted, R4_EPSDTRpt_Q4FY23-24, and R4_EPSDTRpt_Q4FY23-24_Accepted.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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: • Mailed letters, brochures, or pamphlets • Face-to-face interactions • Telephone or automated calls • Video conferencing • Email, text/SMS messages Contract Amendment 17: Exhibit B—7.6.6	**Documents Submitted/Location Within Documents:** 1. R4_EPSDTPln_FY24-25, Entire Document 2. R4_EPSDTPln_FY24-25_Accepted, Entire Document 3. WellVisitLetter_EN, Page 3 4. WellVisitLetter_SP, Page 3 5. Text4Baby, Entire Document 6. Text4Baby_TempCampaign, Entire Document 7. Text4Kids, Entire Document 8. Text4Kids_TempCampaign, Entire Document 9. WelcomeandBenefitTextMessages, Entire Document *Misc 10. WellVisitTextCampaign, Entire Document 11. Email, Entire Document 12. EPSDTTipSheet_EN, Entire Document 13. EPSDTTipSheet_SP, Entire Document 14. WellVisitIVRScript, Entire Document 15. GettingStartedInvite_EN, Entire Document 16. GettingStartedInvite_SP, Entire Document 17. Jan2024WellVisitGettingStarted, Entire Document 18. WellVisitTipSheet_EN, Entire Document 19. WellVisitTipSheet_SP, 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**
	20. Feb2024_DentalGettingStarted, Entire Document 21. DentalTipSheet_EN, Entire Document 22. DentalTipSheet_SP, Entire Document 23. Mar2024HealthyEatingGettingStarted, Entire Document 24. SNAP_WICTipSheet_EN, Entire Document 25. SNAP_WICTipSheet_SP, Entire Document 26. ExerciseTipSheet_EN, Entire Document 27. ExerciseTipSheet_SP, Entire Document 28. HealthyDietTipSheet_EN, Entire Document 29. HealthyDietTipSheet_SP, Entire Document 30. Apr2024BehavioralHealthGettingStarted, Entire Document 31. AlcoholandSubstanceUseTipSheet_EN, Entire Document 32. AlcoholandSubstanceUseTipSheet_SP, Entire Document 33. MentalHealthTipSheet_EN, Entire Document 34. MentalHealthTipSheet_SP, Entire Document 35. May2024FamilyPlanningGettingStarted, Entire Document 36. FamilyPlanningTipSheet_EN, Entire Document 37. FamilyPlanningTipSheet_SP, Entire Document	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	38. June2024MensHealthGettingStarted, Entire Document 39. MensHealthTipSheet_EN, Entire Document 40. MensHealthTipSheet_SP, Entire Document 41. July2024EPSDTGettingStarted, Entire Document 42. ImmunizationsTipSheet_EN, Entire Document 43. ImmunizationsTipSheet_SP, Entire Document 44. Aug2024PrentalGettingStarted, Entire Document 45. Sept2024STIGettingStarted, Entire Document 46. WomensSexualHealthTipSheet_EN, Entire Document 47. WomensSexualHealthTipSheet_SP, Entire Document 48. MensSexualHealthTipSheet_EN, Entire Document 49. MensSexualHealthTipSheet_SP, Entire Document 50. Oct2024WomenCancerScreeningGetting Started, Entire Document 51. WomensCancerScreeningTipSheet_EN, Entire Document 52. WomensCancerScreeningTipSheet_SP, Entire Document	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	53. Nov2024SmokingCessationGettingStarted, Entire Document 54. TeenVapingTipSheet_EN, Entire Document 55. TeenVapingTipSheet_SP, Entire Document 56. ColoradoQuitLineTipSheet_EN, Entire Document 57. ColoradoQuitLineTipSheet_SP, Entire Document 58. Dec2024CrisisServicesGettingStarted, Entire Document 59. CrisisServicesTipSheet_EN, Entire Document 60. CrisisServicesTipSheet_SP, Entire Document **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 visits and understand the benefits available to them for free such as physical health, behavioral health, vision, and dental services. HCI outlined our strategy for EPSDT outreach efforts in our annual plan submitted to HCPF and the accepted annual plan. See R4_EPSDTPln_FY24-25 and R4_EPSDTPln_FY24-25_Accepted. The plan outlines the variety of approaches HCI uses such as:	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Mailed Letters: HCI sends well visit/dental visit reminder letters to EPSDT eligible members who have not had a well visit or dental visit in the previous 12 months. These letters are mailed to members who do not have a valid phone number or members who have opted out of either our texting campaign or IVR campaign. The letters are mailed in either English or Spanish based on members language preference. HCI also includes a tagline sheet in 16 languages for members who may speak another language directing to call our toll-free number to find out more information about the content of the letter. See WellVisitLetter_EN and WellVisitLetter_SP. Face-to-face interactions HCI leverages the relationships our healthcare professionals and stakeholders have with our members. HCI has created materials, such as an EPSDT tip sheet, that provides information about the benefits of preventive healthcare, the services available under EPSDT, and guidance on where and how members can access these services. The tip sheet details the physical and behavioral services that are covered for members at no cost to them. Additionally,	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI has developed numerous health information tip sheets for healthcare professionals that highlight the services and benefits available to Health First Colorado members. These health information tip sheets are distributed to care coordinators, practice transformation coaches, stakeholders, and healthcare professionals. HCI's care coordinators maintain face-to-face contact with our members and ensure they are well-informed. Meanwhile, HCI's practice transformation coaches regularly meet with PCMP practices to distribute the EPSDT tip sheets directly to PCMPs, who then engage with our members face-to-face. HCI also educates healthcare professionals, including care coordinators, behavioral and physical healthcare providers, on EPSDT benefits to maximize the impact of their relationships with our members. HCI's network provider team periodically includes EPSDT information and educates providers at our provider roundtable on EPSDT benefits. All health information tip sheets are located on our website under Prevention & Wellness Resources. For an example of the EPSDT information we have available to distribute to members through face-to-face contact, see EPSDTTipSheet_EN and EPSDTTipSheet_SP.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Telephonic and automated calls HCI primarily uses automated calls to outreach members to remind them of their well visit or dental visit. 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 has a standardized message in English and Spanish that is used, based on members' language preferences. See WellVisitIVRScript. Emails and Texting HCI has several campaigns it uses to send text messages to our members where members can learn about the services and benefits available to them. These campaigns are our Welcome and Benefits Campaign, Text4Baby, Text4Kids, Text4Health, Well-Visit campaign, as well as ad-hoc campaigns we have utilized to send reminders about dental visits. See WelcomeandBenefitTextMessages, Text4Baby Text messages, Text4Kids, and Well Visit Campaign messages. HCI sends out monthly emails to members who have consented to receive emails to invite them to join our	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	"Getting Started" Webinar. This webinar is described below. See Email. Video conferencing HCI hosts a monthly virtual webinar titled "Getting Started," aimed at educating members, their families, healthcare professionals, and community members about the benefits of preventive healthcare. Scheduled for the first Thursday of every month, the webinar highlights the importance of preventive health, Health First Colorado benefits and services, and how members can effectively utilize these benefits. During these sessions, subject matter experts deliver presentations and engage with attendees, answering questions and providing valuable insights. To extend the reach of the information shared, HCI uploads recordings of these webinars and the accompanying slide decks to its official website under the Calendar and Events section. Members, healthcare professionals, and other interested parties can view or download these resources at their convenience, making it a valuable tool for anyone interested in preventive healthcare. HCI's prevention and wellness strategy is structured to focus on a specific topic or benefit each month. This targeted topic is prominently featured in various	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	meetings we conduct with members, healthcare professionals, our quality team, and care coordination entities. Additionally, HCI disseminates information about the topic via our social media channels and provides health information sheets to healthcare professionals to share with members. Moreover, the identified topic is also addressed in our "Getting Started" webinar presentation. For 2024, the specific "Getting Started" topics that offered education on the benefits of preventive health care include: January 2024 – Well Visits. HCI concentrated on the significance of annual well visits as a cornerstone of preventive care. To support this initiative, HCI provided healthcare professionals with our Well Visit tip sheet. The Well Visit tip sheet included essential details on what to expect during a well visit. See Jan2024WellVisitGettingStarted, WellVisitTipSheet_EN and WellVisitTipSheet_SP. February 2024 – Dental. HCI emphasized the benefits of oral care and obtaining required cleanings. Oral health information was emphasized during the entire month through distribution of our Dental health information sheet to health care professionals. See Feb2024DentalGettingStarted, DentalTipSheet_EN and DentalTipSheet_SP. March 2024 - Healthy Eating. HCI emphasized the significance of healthy eating and exercise in	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	maintaining optimal health and promoting diabetes prevention. To support this initiative, HCI provided resources, including SNAP/WIC resource sheets and health information tip sheets on healthy eating and exercise, for distribution to members. The SNAP/WIC resource sheet details eligibility criteria and application processes for programs such as WIC and SNAP. The healthy eating and exercise tip sheets offer practical advice on maintaining health through wellness practices. See Mar2024HealthyEatingGettingStarted, SNAP_WICTipSheet_EN, SNAP_WICTipSheet_SP, HealthyDietTipSheet_EN, HealthyDietTipSheet_SP ExerciseTipSheet_EN, and ExerciseTipSheet_SP. April 2024 – Behavioral Health. HCI focused on promoting the available behavioral health benefits, which include mental health counseling and substance use disorder (SUD) services and benefits. To disseminate this information, HCI distributed health information sheets detailing SUD and mental health benefits to members, their families, and healthcare professionals. See Apr2024BehavioralHealthGettingStarted, AlcoholandSubstanceUseTipSheet_EN, AlcoholandSubstanceUseTipSheet_SP, MentalHealthTipSheet_EN, and MentalHealthTipSheet_SP.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	May 2024 – Family Planning. HCI detailed the family planning benefit which included resources on sexual health for our EPSDT eligible adolescent members and pregnant members. HCI distributed family planning health information sheets to both members and healthcare professionals for further dissemination. See May2024FamilyPlanningGettingStarted, FamilyPlanningTipSheet_EN, and FamilyPlanningTipSheet_SP. June 2024 – Men's Health. HCI concentrated on men's health, emphasizing preventive measures such as well visits for our male population, particularly those aged 18-20. To support this initiative, HCI distributed a men's health tip sheet to healthcare professionals and members. See June2024MensHealthGettingStarted, MensHealthTipSheet_EN, and MensHealthTipSheet_SP. July 2024 – EPSDT/Bright Futures Screenings. HCI reviewed all the screenings covered by EPSDT at no cost, in accordance with the Bright Futures guidelines. The review included multiple well visits recommended for infants aged 0-30 months and annual visits for individuals aged 3-20 years. HCI outlined specific screenings such as hearing, vision, lead testing, developmental assessments, STI screenings, alcohol and drug evaluations, and	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	behavioral health assessments. To support this initiative, HCI distributed tip sheets on EPSDT, well visits, immunizations, and dental visits to both members and healthcare professionals. See July2024EPSDTGettingStarted, EPSDTTipSheet_EN, EPSDTTipSheet_SP, WellVisitTipSheet_EN, WellVisitTipSheet_SP, DentalTipSheet_EN, DentalTipSheet_SP, ImmunizationsTipSheet_EN, and ImmunizationsTipSheet_SP. August 2024 – Prenatal and Postpartum Care. HCI concentrated on the benefits of prenatal and postpartum care to support our newly pregnant members. HCI distributed our Pregnancy Guide to members and healthcare professionals to help guide members through their maternity benefits. Additional resources, including HCI's "Take Care of Baby and Me" flyer and the "Getting Started Pregnancy" guide, are available under the "Pregnant?" tab on our website. See Aug2024PrenatalGettingStarted. September 2024 – Sexually Transmitted Infections (STIs). HCI focused on sexually transmitted infections and provided information on resources to obtain testing and treatment. Our women's sexual health and men's sexual health information sheets were distributed to members and health care professionals. This is relevant to our adolescent male	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	and female members. See Sept2024SexualHealthGettingStarted, WomensSexualHealthTipSheet_EN, WomensSexualHealthTipSheet_SP, MensSexualHealthTipSheet_EN, and MensSexualHealthTipSheet_SP. October 2024 – Women's Cancer Screenings. HCI focused on women's cancer screenings in alignment with Breast Cancer Awareness Month. The initiative targeted both cervical and breast cancer screenings, which are particularly relevant for our pregnant members. See Oct2024WomensCancerScreeningGettingStarted, WomensCancerScreeningTipSheet_EN, and WomensCancerScreeningTipSheet_SP. November 2024 – Smoking Cessation. HCI focused our preventative efforts on smoking cessation resources and programs available through the Colorado QuitLine. Some of the available smoke cessation resources applicable to EPSDT members is MyLifeMyQuit for adolescents, the Colorado QuitLine for members 18 and above, and the pregnancy resources for pregnant females. HCI also distributed health information sheets on the Colorado Quit Line to distribute to members as well as teen vaping. See Nov2024SmokingCessationGettingStarted, TeenVapingTipSheet_EN, TeenVapingTipSheet_SP,	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	ColoradoQuitLineTipSheet_EN, and ColoradoQuitLineTipSheet_SP. December 2024 – Crisis Services. HCI focused our educational efforts on crisis services available for all members in our region. HCI distributed health information sheets on crisis services to members and health care providers to educate all about these services. This health information sheet was created by members of our Member Material Work Group. See Dec2024CrisisServicesGettingStarted, CrisisServicesTipSheet_EN and CrisisServicesTipSheet_SP. All health information sheets are located at our Prevention and Wellness Resources on our website.	
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 17: Exhibit B—12.9.2.1, 12.9.3	**Documents Submitted/Location Within Documents:** 1. HCPF_EPSDT_PolicyGuidelines, Entire Document 2. 248L_EPSDTPolicy, Page 6 3. Feb2024ProviderRoundtable, Slides 17-31, *Misc 4. Aug2024ProviderRoundtable, Slides 10-38 5. ProviderDocumentationTraining, Slides 16, 32-33 6. July2024EPSDTGettingStarted, Entire Document 7. BehavioralHealthProviderHandbook, Pages 48, 49, 51-52 *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**
	8. PrimaryCareProviderHandbook, Pages 39-41, 45-46 *Misc **Description of Process:** HCI is committed to ensuring that network providers are well-informed about the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. To achieve this, we leverage materials provided by the Colorado Department of Health Care Policy & Financing (HCPF). Specifically, we utilize the HCPF EPSDT Policy Guidelines in our training sessions aimed at increasing awareness of well-child care and the comprehensive benefits under the EPSDT program. Our training initiatives are structured biannually to maintain a high level of awareness and compliance. In the year 2024, HCI organized two training events. The first was a provider roundtable held in February 2024, followed by another training in August 2024. During these roundtables, we thoroughly reviewed the EPSDT benefit, emphasizing the program's importance and the necessity for consistent implementation of its guidelines. These training sessions are part of our broader strategy to support providers in delivering high-quality care that meets the preventive, diagnostic, and	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	treatment needs of children and adolescents under the EPSDT program. By regularly equipping our network providers with the latest information and guidelines, we aim to ensure that all eligible patients receive timely and appropriate care. To ensure accessibility, HCI has posted recordings of the training sessions on our website. This enables providers who were unable to attend the live sessions to gain the knowledge at their convenience. HCI remains dedicated to continuous education and collaboration with our network providers to promote the best outcomes for the children and adolescents we serve. See HCPF_EPSDT_PolicyGuidelines, Feb2024ProviderRoundtable, and Aug2024ProviderRoundtable. Carelon delivered four training sessions on March 22, 2024, June 27, 2024, September 26, 2024, and December 31, 2024, to educate providers about documentation requirements. During these sessions, network providers were also informed about the EPSDT program. For further information, see ProviderDocumentationTraining. Additionally, HCI sponsored a "Getting Started webinar in July 2024 which focused on EPSDT and Bright Futures Screening Guidelines. This webinar is for members, family members and health care	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	professionals and is posted on Calendar & Events. See July2024EPSDTGettingStarted, Entire Document. HCI adheres to Carelon's 248L_EPSDT Policy, which outlines our procedures for oversight of the EPSDT program, including education for our providers. An integral component of the 248L_EPSDT Policy revolves around facilitating education for health care providers. This covers everything from understanding how the EPSDT program works, the benefits it offers to children, adherence to guidelines, to ways of effectively communicating these benefits to children's parents or caregivers. In following the 248L_EPSDTPolicy, HCI is demonstrating its dedication to provider education, program oversight, and ultimately the health and well-being of children under the EPSDT program. See 248L_EPSDTPolicy, Page 6. HCI has two provider handbooks – one for our behavioral health providers and one for our physical health providers. Information on EPSDT, including state resources and links to provider trainings can be found in our BehavioralHealthProviderHandbook and PrimaryCareProviderHandbook.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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. • 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 17: Exhibit B—14.5.3	**Documents Submitted/Location Within Documents:** 1. 248L_EPSDTPolicy, Pages 1, 5, 6 2. BehavioralHealthProviderHandbook, Pages 51-52*Misc. 3. PrimaryCareProviderHandbook, Pages 41-44 *Misc. 4. ProviderDocumentationTraining, Slides 16, 19-21, 24, 32-34 **Description of Process:** HCI is deeply committed to providing or arranging for the provision of all medically necessary behavioral health benefits for our members under the age of twenty-one (21) as part of our capitated service offerings. This is in accordance with 42 CFR Sections 441.50-441.62 and 10 CCR 2505-10.8280. Our approach ensures that young members receive the comprehensive behavioral health care they need, or when requested, without unnecessary barriers to access. Outpatient and Testing Services: To streamline access to essential mental health services, HCI has established a policy where all Current Procedural Terminology (CPT) codes for outpatient behavioral health services and psychological testing do not require prior authorization. This policy enables quicker and more efficient access to necessary care,	☒ 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**
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)	promoting early intervention and ongoing support. By removing the authorization requirement for these services, we reduce administrative burdens for providers and help ensure timely treatment for our young members. Higher Levels of Care: For more intensive behavioral health services such as inpatient care, residential treatment, and intensive outpatient treatment (IOP), HCI employs a thorough utilization management (UM) process. Our dedicated UM team is responsible for reviewing and approving authorization requests for these higher levels of care. This process is designed to ensure that members are receiving appropriate, medically necessary services while also maintaining quality and cost-effectiveness. The utilization management team follows evidence-based guidelines, EPSDT medical necessity criteria, and best practices in their review process. In situations where a family, provider, or Department of Human Services (DHS) staff member identifies that a member may require residential services, an independent assessment can be requested through HCI. Carelon's utilization management (UM) team is responsible for coordinating these independent assessments, ensuring they are conducted by qualified individuals.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The qualified individual performing the independent assessment must have completed the Behavioral Health Administration's (BHA) training and be certified in the Child and Adolescent Needs and Strengths (CANS) assessment. This certification ensures that the assessment is conducted thoroughly and accurately, focusing on the comprehensive needs and strengths of the child or adolescent. • Assessment and Planning: Should the independent assessment identify a need for residential services or other treatment interventions, our UM team will take the necessary steps to arrange or provide the recommended services. Additionally, the UM team will engage our care coordination team to assist the member and their family throughout the treatment process. This multi-faceted approach ensures a seamless transition to appropriate care settings and supports continuity of care. • Service Provision: If residential services or other treatments are approved under the capitated benefit, the member's treatment team will actively assist in locating suitable treatment facilities. This collaborative effort involves working closely with various providers to ensure that the member can access the necessary services in a timely manner. If a different level of care is recommended by the independent assessment,	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	the treatment team will assist in arranging for this recommended treatment, ensuring that the member's needs are adequately met. • Interim Support Services: In instances where residential services are approved but there is a wait list for available placements, the treatment team will identify and coordinate community-based services. These services are designed to provide necessary community supports to maintain the member's stability while awaiting placement in a residential facility. This approach aims to mitigate risks and ensure that the member receives appropriate interim care, thereby promoting their overall well-being during the waiting period. HCI is dedicated to providing comprehensive and coordinated care, ensuring that all members receive the right services at the right time. Our partnership with Carelon's UM team and the implementation of independent assessments through HCI exemplify our commitment to high-quality, member-centered care. HCI has assisted with 27 completed independent assessments from January 1, 2024 - October 10, 2024. Commitment to Quality Care: HCI's strategy in managing behavioral health benefits reflects our commitment to high-quality, accessible care for young members. By differentiating the authorization	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	requirements based on the type and intensity of the service, we ensure that necessary care is provided efficiently while maintaining oversight for more complex cases requiring intensive interventions. Our processes are designed to support providers in delivering effective treatment, minimize delays in service delivery, and ensure that all behavioral health services are aligned with best practices and regulatory standards. HCI has a written policy and procedure related to the EPSDT program and its requirements, which we follow. See 248L_EPSDTPolicy, Entire Document. The policy outlines: • That eligibility for the EPSDT benefits is for any member enrolled in Health First Colorado who is 20 years old or younger (Page 1) • That we will provide or arrange for the provision of all medically necessary behavioral health services (Page 5) • Ensure the provision of all appropriate mental or behavioral health developmental screenings to members/families who request this information (Page 5) • Ensure screenings are performed by a provider qualified to furnish mental health services (Page 5)	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Ensures that screenings are age appropriate and performed in a culturally and linguistically sensitive manner (Page 5) • That the RAE educates providers to 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 6) • The RAE will provide or arrange for the provision of a diagnostic service in addition to the treatment of a mental illness or condition discovered by any screening or diagnostic procedure (Page 6) HCI has delegated oversight of the provider network to Carelon Behavioral Health. Carelon's credentialing team oversees the process to ensure that providers are qualified to furnish mental health services. Carelon is also responsible for monitoring providers' cultural and linguistic abilities, as well as their cultural competency training, through the ProviderConnect portal. Each provider is tasked with logging their cultural skills and attesting to their cultural competency training via the Council for Affordable Quality Healthcare (CAQH), a healthcare industry alliance that collaborates with payers, providers, and stakeholders to streamline operations, reduce costs, and enhance member experience. By allowing	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	providers to input their information once and share it across all plans, CAQH helps to minimize administrative hassles and errors. This information is then stored and monitored by Carelon in the "Provider Details" section on the ProviderConnect portal. Carelon surveys HCI's providers annually to fulfill the National Committee for Quality Assurance (NCQA) requirement. The survey requires providers to acknowledge whether they have taken cultural humility or competency training courses. HCI and Carelon provide a variety of cultural competency training resources on HCI's website and the Carelon website to assist providers. The provider handbook, with which all providers are contractually obligated to comply, contains essential language service resources that providers may utilize when an interpreter is needed. HCI maintains two comprehensive provider handbooks—one specifically for behavioral health providers and another for primary care medical providers. These handbooks clearly outline all the responsibilities related to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. A significant focus within these handbooks is placed on the critical importance of documenting the results of all screenings and examinations in members' medical records and service coordination. Providers	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	are explicitly instructed on the necessity of thorough documentation to ensure that all aspects of the members' health and well-being are accurately captured and tracked. Furthermore, the handbooks provide detailed guidance on the obligation of providers to either provide or facilitate access to any necessary services identified during these screenings. This includes establishing effective referral processes and linking members with appropriate services to address any identified health concerns promptly. By offering clear, comprehensive guidelines, HCI ensures that all providers are well-informed about their roles and responsibilities in delivering EPSDT services. This structured approach supports the consistent and effective coordination of care, enhancing the overall health outcomes for members. See BehavioralHealthProviderHandbook and PrimaryCareProviderHandbook. Carelon conducts quarterly training sessions to ensure providers are well-versed in all documentation requirements. Our training covers the following key areas: • Administrative Chart Elements: Providers receive detailed instruction on necessary administrative chart elements, including EPSDT (Early and Periodic Screening,	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Diagnostic, and Treatment) or Well Child questions and referrals, as detailed on slide 16. • Cultural Considerations: We emphasize the importance of considering cultural factors and their impact on treatment, as outlined on slide 20. • Data Collection: Providers are trained to collect comprehensive data on current and past information, including screening results, medical and dental issues, allergies, current medications, and developmental history for clients under 18, as shown on slides 19 and 21. • Clinical Application: Guidance is provided on using gathered information effectively in clinical formulations and the treatment of a member's diagnosis, as highlighted on slide 24 and reviewing treatment plans on slide 34. • EPSDT Documentation: Providers are instructed to record whether members have had an EPSDT exam in the past year, including the date and provider, as detailed on slide 32, with additional highlights on slide 33. These training sessions were conducted on March 22, 2024, June 27, 2024, September 26, 2024, and December 31, 2024. For further details, please refer to the ProviderDocumentationTraining.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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 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. *42 CFR 441.61–62* Contract Amendment 17: Exhibit B—14.5.3 10 CCR 2505-10 8.280.4.C	**Documents Submitted/Location Within Documents:** 1. 248L_EPSDTPolicy, Pages 2, 5, 6 2. TitleV_Referrals, Entire Document 3. CareCoordinationGeneralPolicy_FY24-25, Pages 5, 6, 8 *Misc 4. Essette_Referrals, Entire Document 5. CallCenterReferralTraining, Slides 7-10 6. CareCoordinationFactSheet_EN, Entire Document *Misc. 7. CareCoordinationFactSheet_SP, Entire Document *Misc. 8. CareCoordinationReferralForm, Entire Document 9. CCM_EPSDTWorkflow, Entire Document 10. CreativeSolutionsFlyer, Entire Document *Misc 11. ComplexSolutionsFlyer, Entire Document *Misc 12. CareCoordinationAuditTools, Lines 25, 29 *Misc. 13. BehavioralHealthProviderHandbook, Pages 49, 50, 51 *Misc 14. PrimaryCareProviderHandbook, Pages 40, 43, 44 *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**
	Description of Process: HCI has a written policy and procedure related to the EPSDT program and its requirements, which we adhere to and outlines the requirements in this section. Specifically, the policy outlines: • The provision of 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 (Page 6) • Assistance with transportation and scheduling appointments for services if requested by the member/family (Pages 2, 5) • Providing referrals to appropriate state health agencies and programs including vocational rehabilitation, maternal and child health, public health, mental health and education programs; Head Start; social service programs, and Women, Infants and Children (WIC) supplemental food program (Page 2) HCI uses this policy to guide our actions with EPSDT. Please see 248L_EPSDTPolicy, Pages 2, 5, 6. HCI's delegated care coordination agencies as well as Carelon's designated Behavioral Care Manager II can provide additional assistance for members who need	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	referral assistance for treatment that is deemed necessary but is not covered under the capitated behavioral health benefit. When a service is deemed medically necessary but isn't included in the capitated behavioral health benefit, Carelon's Behavioral Care Manager will coordinate the member's entire care team to facilitate meetings, ensuring appropriate referrals are made and resources are provided to address any gap in the member's care. HCI provides assistance with transportation and assistance scheduling appointments for services if/when requested by the member or their family. Members can call HCI's toll free number to speak with a call center associate, email or mail HCI, or request help through our contact form located on our website. HCI's call center associates can support or link members or their families with one of HCI's delegated care coordination agencies to further assist with transportation and scheduling assistance. HCI's delegated care coordination agencies are embedded in our communities through shareholder sites and delegated PCMP sites. 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	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	(WIC) supplemental food program. HCI's call center associates can support or link members or their families with one of HCI's delegated care coordination agencies to further assist with appropriate state health agencies as a general function of care coordination. HCI's delegated care coordination agencies are embedded in the communities through the shareholder sites and delegated PCMP sites. Furthermore, HCI and care coordination entities have partnered with social service agencies like Head Start, WIC, SNAP, and Case Management Agencies (community-centered boards and single-entry points) to establish seamless referrals for our members. HCI began tracking our call center associates' referrals for Title V programs such as WIC, SNAP, and Head Start. See TitleV_Referrals, Entire Document. HCI adheres to our Care Coordination Policy which states that when a member is identified as having any care coordination need, the assigned HCI Care Coordinator will complete the following tasks: • Program introduction and/or communication, which includes contact information for the assigned HCI Care Coordinator and instructions on how to access the 24/7 toll free number for care coordination services (Page 8)	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Complete the standardized HCI Intake Assessment. This Intake Assessment guides HCI Care Coordinators in assisting members with SDOH, such as access to healthy food, exercise, transportation, housing, and employment support (Page 8). • Coordinate with other healthcare providers for diagnostics, ambulatory care, hospital, and specialty medical services. The HCI Care Coordinator must have access to the available Colorado statewide health information exchange platform (Contexture) (Page 9) • Care coordination shall be provided in alignment with HCI principles. These principles include: o Identifying and addressing barriers to health and SDOH in HCI's region, such as member transportation issues, food or housing insecurity, or medication management challenges (Page 6). o 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 (Page 6).	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	o HCI Care Coordinators will be member- and family-centered, using motivational interviewing, trauma-informed principles, mental health first aid training, and other evidence-based practices to communicate effectively with members in a culturally and cognitively appropriate manner (Page 6). Additionally, according to our Care Coordination Policy, HCI's Care Coordinators will establish proper coordination with medical and behavioral health providers as well as access to community resources for all members by ensuring: • Care coordination will be accessible to all Health Colorado members. Care coordination can be a compilation of single interventions or multiple interventions, as determined by the member's needs, preference, and agreed upon Care Plan (Page 5). • The HCI Care Coordinator 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	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	service agencies and providers, and referring to other health care and human service agencies and providers as appropriate (Page 5). • The HCI Care Coordinator 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 (Page 5). See CareCoordinationGeneralPolicy_FY24-25. HCI's care coordination teams document referrals to specialty providers and community resources within our electronic health record system, Essette. For visual examples of how our care coordinators generate tasks for these referrals, please refer to Essette_Referrals screenshots. HCI trains our call center associates on EPSDT resources and referrals at least annually through a regularly scheduled call center associate meeting. In July 2024, we discussed the EPSDT information available on our website as well as the reminder that each member call is an opportunity to help link members with services they may need, including care	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	coordination, transportation, and other social service programs. See CallCenterReferralTraining. HCI developed a care coordination fact sheet, which helps members know about care coordination services and is available on our New Member & EPSDT Resources on our website. The care coordination fact sheet has information about how to contact HCI's toll free number to request care coordination for various needs. When members contact HCI's call center, the call center team can make a referral to a care coordinator who assists members with referrals to programs not included in the plan, schedule appointments and transportation, or link a member with a state health agency. See CareCoordinationFactSheet_EN and CareCoordinationFactSheet_SP. HCI's call center staff are available to explain the care coordination benefit and will refer a member identified as needing these services to their assigned care coordination agency. The care coordination referral form includes various reasons for which a member may be referred including EPSDT, Title V programs, transportation, etc. Once the form is completed, it is sent via a secure email system to the care coordination agency. The care coordination agency acknowledges receipt of the form and will contact the member. If the call center associate does	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	not receive a response from the care coordination agency, they will follow up to ensure the referral was received. Additionally, HCI's care coordination referral form can be electronically filled out on-line. See CareCoordinationReferralForm. The Utilization Management Director at HCI created an internal document for our utilization management team to coordinate ESPDT services that are not covered under the capitated benefit. This document outlines the process for care coordination referrals, as well as submitting EPSDT review requests to HCPF or through the Colorado Prior Authorization Review (PAR) site. For further details, refer to the CCM_EPSDTWorkflow. One of our interagency oversight groups (IOGs) requested information on creative and complex solutions meetings. In response to this community request, HCI developed a resource specifically for stakeholders and providers. The Creative Solutions resource sheet has information to assist members 17 years and young and their families to help navigate complex health situations which may include services not covered under the health plan. The complex solutions resource sheet can help EPSDT members who are ages 18-20 navigate complex health needs and services that may not be covered under the health plan. These resource sheets were distributed to	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	partners and stakeholders and are available on the Care Coordination tab on our website. See CreativeSolutionsFlyer and ComplexSolutionsFlyer. HCI conducts chart audits with our delegated care coordination agencies to ensure care coordination activities are occurring. Audit items 4B (line 25) and 5B (line 29) could be scored as met/not met based on if transportation or scheduling assistance needs/goals and, referrals to treatment or state agencies were identified and not met. Following an audit, HCI communicates the results via email to the care coordination agencies, providing specific feedback and highlighting any missing information from a member's chart. There were no care coordination entities that fell below the targeted 80% on these two areas. Additionally, HCI offers support to help these agencies meet Health First Colorado's documentation standards. Refer to CareCoordinationAuditTools. HCI's physical and behavioral health providers are also expected to work with our care coordination entities to assist members and families with referrals, scheduling and transportation issues. See BehavioralHealthProviderHandbook and PrimaryCareProviderHandbook.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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. • Is not primarily for the economic benefit of the provider nor 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 17: Exhibit B—14.5.3	**Documents Submitted/Location Within Documents:** 1. 248L_EPSDTPolicy, Page 4 2. CCM_Training_EPSDT, Entire Document 3. EPSDTDocumentationGuidelines, Entire Document 4. BehavioralHealthProviderHandbook, Pages 48, 50-51 *Misc 5. PrimaryCareProviderHandbook, Pages 39-40, 44-45 *Misc **Description of Process:** HCI outlines the definition of medical necessity for EPSDT services in our 248L_EPSDTPolicy 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 a course of treatment that includes mere observation or no treatment at all (Page 4).	☒ 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**
10 CCR 2505-10 8.076.8; 8.076.8.1; 8.280.4.E	• 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 4). • Is clinically appropriate in terms of type, frequency, extent, site, and duration (Page 4). • Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider (Page 4). • Is delivered in the most appropriate setting(s) required by the client's condition (Page 4). • Provides a safe environment or situation for the child (Page 4) • Is not experimental or investigational (Page 4). • Is not more costly than other equally effective treatment options (Page 4). HCI uses this policy to guide our actions with EPSDT. Please see 248L_EPSDTPolicy. HCI delegates the responsibility for utilization management (UM) to Carelon Behavioral Health. Carelon oversees all aspects of capitated behavioral health utilization management and adheres to the 248L_EPSDTPolicy to define medical necessity for EPSDT services, goods, and programs.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	To ensure consistency and accuracy in the application of these criteria, Carelon's Utilization Management Manager conducts an annual review of the EPSDT medical necessity criteria with the entire UM team. This review process ensures that all team members are up to date with the latest guidelines and standards for determining medical necessity in EPSDT services. For a specific instance of this training, please refer to the CCM_Training_EPSDT session, which took place on October 3, 2024. This training session underscores our commitment to continuous education and adherence to established policies, ultimately ensuring high-quality and appropriate care for our members. See CCM_Training_EPSDT. The HCI Utilization Manager Director has developed a comprehensive document that outlines the guidelines for documenting medical necessity criteria in members' electronic health records. Additionally, this document provides detailed instructions for composing written communications related to the denial of behavioral health services for EPSDT members. Please refer to the complete EPSDTDocumentationGuidelines. Finally, EPSDT medically necessary criteria is outlined in our behavioral health provider handbook and physical health provider handbook. See	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	BehavioralHealthProviderHandbook and PrimaryCareProviderHandbook.	
7. *For the Capitated Behavioral Health Benefit*, the RAE provides or arranges for the following for children/youth from ages 0 to 21: intensive case management, prevention/early intervention activities, clubhouse and drop-in centers, residential care, assertive community treatment (ACT), recovery services. *Note: All EPSDT services are included in the State Plan or in Non-State Plan 1915(b)(3) Waiver Services (except for respite and vocational rehabilitation).* Contract Amendment 17: Exhibit B—14.5.7.1	**Documents Submitted/Location Within Documents:** 1. 248L_EPSDTPolicy, Page 5 2. October2024_StateBehavioralHealthServicesBillingManual, Pages 173, 194, 195 3. 2024Claims_Encounters, Entire Document **Description of Process:** HCI provides or arranges services for the capitated behavioral health benefit for children and youth ages 20 and under. These services may be in the state plan or in the non-state plan 1915 (b) 3 waiver services. HCI adheres to Carelon's 248L_EPSDTPolicy, which guides our procedures for providing or arranging for the provision of all medically necessary services such as intensive case management, prevention/early intervention activities, clubhouse/drop-in centers, residential care, assertive community treatment, and recovery services. See 248L_EPSDTPolicy. Many of these services may be delivered through our shareholder sites such as the Federally Qualified Health Centers (FQHCs), Comprehensive Safety Net Providers centers (CSNP), or other licensed providers. Below is a description of the services and the CPT codes which may be associated with the service. HCI	☒ 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**
	ran a de-identified report to identify claims and encounters for our EPSDT population between January 1, 2024 – October 14, 2024, to demonstrate services that are being provided. HCI has used the definitions provided by the state behavioral health billing manual for the services below. See October2024_StateBehavioralHealthServicesBillingManual and 2024Claims_Encounters. • Intensive Case Management (ICM). According to the October 2024 State Behavioral Health Services Billing Manual, ICM services describes community-based services which average more than one hour per week to adults with serious behavioral health diagnoses who are at risk of hospitalization, incarceration and/or homelessness due to multiple needs and impaired level of functioning. Services are designed to provide adequate support to ensure community living. Services may include assessments, service plan development, multi-system referrals, assistance with obtaining wrap-around services and supportive living services, monitoring and follow-up (Page 194). There were no specific CPT codes associated with Intensive Case Management. These services are typically provided by our delegated care coordination agencies, CSNPs, or FQHCs	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Prevention/Early Intervention. According to the October 2024 State Behavioral Health Services Billing Manual, these services are proactive efforts to educate and empower individuals to choose and maintain healthy life behaviors and lifestyles that promote positive psychological health. Efforts could include behavioral health screenings and community-based services such as Love and Logic classes, and educational programs. These services are usually provided through our providers or CSNPs. CPT codes could include: H0022, H0023, H0024, H0025, H0027, H0028, H0029, H0038, H1003, s9453, s9454, s9485 (Page 194). HCI identified 2,607 instances of prevention/early intervention services for our members ages 20 and under. • Clubhouse and drop-in centers: According to the October 2024 State Behavioral Health Services Billing Manual, clubhouse and drop-in centers services are peer support services for people who have behavioral disorders, provided in clubhouses and drop-in centers. Clubhouse services are available for members ages 12 and older and are structured community-based services designed to strengthen and or regain the member's interpersonal skills, provide psychosocial support etc. CPT codes include H2030 and	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	H2031. Drop-in centers are for members ages 12 and older and are a form of safe outreach to and engagement with adolescents and adults with mental health conditions (Page 195). The CPT code for drop-in centers is H0046. Both Clubhouse and drop-in center services are available through our community mental health centers within our nineteen (19) counties. HCI identified 38 instances of clubhouse/drop-in services for our members between the ages of 12-20. • Residential Care. According to the October 2024 State Behavioral Health Services Billing Manual, residential services are defined as 24-hour care, excluding room and board (Page 195). There are several CPT codes that are associated with residential care for both mental health and substance use disorders. These services are typically for all ages. CPT codes could include: H0010, H0017, H0018, H0019, H2036 and 0911. These services are provided by contracted behavioral health provider and require prior authorization. HCI identified 564 instances of residential care services for our members ages 20 and under. • Assertive Community Treatment (ACT). According to the October 2024 State Behavioral Health Services Billing Manual, ACT services is a team-based approach to the provision of treatment rehabilitation and	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	support services for members 18 and older (Page 195). The CPT codes usually billed are H0039 and H0040 and are usually provided through our providers or the CSNPs. HCI did not identify any instances of these services being provided to members ages 18-20. • Recovery Services. According to the October 2024 State Behavioral Health Services Billing Manual, recovery services are designed to provide choices and opportunities for adults with serious behavioral health disorders. Recovery-oriented services promote self-management of psychiatric symptoms, focusing on relapse prevention, treatment choices, mutual support, enrichment, and rights protections. Services are peer counseling and support services, peer-run drop-in centers, peer-run employment services, peer mentoring, wellness recovery action planning, advocacy, etc. (Page 173). These services are provided through our providers or CSNPs. CPT codes include: H0043, H0044, H2015, H2016. HCI identified 833 instances of these services provided to our members ages 20 and under. HCI offers our care coordination entities to help connect members with the appropriate Case Management Agency (CMA) or Community Center	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Board (CCB) for the assessment of services under the 1915(b)(3) waiver program.	

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

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2024–2025 External Quality Review
Initial Credentialing Record Review
for Health Colorado, Inc.

Review Period:	January 1, 2024 – December 31, 2024
Completed By:	Elizabeth Yonge
Date of Review:	February 25, 2025
Reviewer:	Crystal Brown
Participating MCE Staff Member During Review:	Elizabeth Yonge

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10
Provider ID #	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****
Provider Type (e.g., MD, PA, NP, LCSW, PsyD, DDS, DMD)	LPC	LPC	LCSW	LPC	LCSW	LCSW	LCSW	LCSW	LPC	LPC
Provider Specialty (e.g., PCP, surgeon, therapist, periodontist)	Licensed Professional Counselor	Licensed Professional Counselor	Licensed Clinical Social Worker	Licensed Professional Counselor	Licensed Clinical Social Worker	Licensed Clinical Social Worker	Licensed Clinical Social Worker	Licensed Clinical Social Worker	Licensed Professional Counselor	Licensed Professional Counselor
Date of Completed Application [MM/DD/YYYY]	10/26/2023	12/22/2023	2/6/2024	3/12/2024	4/23/2024	5/14/2024	6/17/2024	7/5/2024	8/30/2024	10/1/2024
Date of Initial Credentialing [MM/DD/YYYY]	1/16/2024	1/30/2024	2/27/2024	4/2/2024	5/17/2024	6/7/2024	7/19/2024	8/20/2024	10/11/2024	11/25/2024
Completed Application for Appointment Met? [VIII.8]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Verification of Current and Valid License Yes, No, Not Applicable (NA)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Verification of Current and Valid License Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Board Certification Yes, No, NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Evidence of Board Certification Met? [VIII.6]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Evidence of Valid DEA or CDS Certificate (for prescribing providers only) Yes, No, NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Evidence of Valid DEA or CDS Certificate Met? [VIII.6]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Evidence of Education/Training Verification Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Education/Training Verification Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Work History (most recent five years or, if less, from the time of initial licensure) Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Work History Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Malpractice History Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice History Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence Malpractice Insurance/Required Amount (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate) Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice Insurance/Required Amount Met? [VIII.8]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Verification That Provider Is Not Excluded From Federal Participation Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Verification That Provider Is Not Excluded From Federal Participation Met? [VIII.7]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Comments:										

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2024–2025 External Quality Review
Initial Credentialing Record Review
for Health Colorado, Inc.

Scoring	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10
Applicable Elements	7	7	7	7	7	7	7	7	7	7
Compliant (Met) Elements	7	7	7	7	7	7	7	7	7	7
Percent Compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Total Applicable Elements	70									
Total Compliant Elements	70									
Total Percent Compliant	100%									

Notes:

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

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

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

365 Calendar Days
- Signed application/attestation
- Work history

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2024–2025 External Quality Review
Recredentialing Record Review
for Health Colorado, Inc.

Review Period:	January 1, 2024 – December 31, 2024
Completed By:	Elizabeth Yonge
Date of Review:	February 25, 2025
Reviewer:	Crystal Brown
Participating MCE Staff Member During Review:	Elizabeth Yonge

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10
Provider ID #	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****
Provider Type (e.g., MD, PA, NP, LCSW, PsyD, DDS, DMD)	LPC	LCSW	LPC	PsyD	PhD	LPC	LPC	LPC	LPC	LCSW
Provider Specialty (e.g., PCP, surgeon, therapist, periodontist)	Licensed Professional Counselor	Licensed Clinical Social Worker	Licensed Professional Counselor	Licensed Doctor of Psychology	Licensed Doctor of Philosophy	Licensed Professional Counselor	Licensed Professional Counselor	Licensed Professional Counselor	Licensed Professional Counselor	Licensed Clinical Social Worker
Date of Last Credentialing [MM/DD/YYYY]	2/5/2021	3/6/2021	4/28/2021	5/11/2021	9/10/2021	3/1/2022	7/16/2021	8/13/2021	9/17/2021	11/12/2021
Date of Recredentialing [MM/DD/YYYY]	2/2/2024	3/15/2024	3/29/2024	4/26/2024	5/21/2024	7/26/2024	7/31/2024	8/13/2024	10/4/2024	11/25/2024
Months From Initial Credentialing to Recredentialing	35	36	35	35	32	28	36	36	36	36
Time Frame for Recredentialing Met? [VIII.9] Is completed at least every three years (36 months)	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Verification of Current and Valid License Yes, No, Not Applicable (NA)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Verification of Current and Valid License Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Board Certification Yes, No, NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Evidence of Board Certification Met? [VIII.6]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Evidence of Valid DEA or CDS Certificate (for prescribing providers only) Yes, No, NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Evidence of Valid DEA or CDS Certificate Met? [VIII.6]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Evidence of Malpractice History Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice History Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Malpractice Insurance/Required Amount (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate) Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice Insurance/Required Amount Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Ongoing Verification That Provider Is Not Excluded From Federal Participation Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Ongoing Verification That Provider Is Not Excluded From Federal Participation Met? [VIII.10]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Comments:										

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2024–2025 External Quality Review
Recredentialing Record Review
for Health Colorado, Inc.

Scoring	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10
Total Applicable Elements	5	5	5	5	5	5	5	5	5	5
Total Compliant (Met) Elements	5	5	5	5	5	5	5	5	5	5
Total Percent Compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Total Applicable Elements	**50**									
Total Compliant Elements	**50**									
Total Percent Compliant	**100%**									

Notes:

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

   Prior to Credentialing Decision
   - DEA or CDS certificate

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

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

Appendix C. Compliance Review Participants

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

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

HSAG Reviewers	Title
Gina Stepuncik	Associate Director
Sara Dixon	Project Manager III
Crystal Brown	Project Manager I
HCI Participants	**Title**
Michaela Smyth	Behavioral Health Clinical Quality Audit Analyst Senior
Jeremy White	Director, Quality Management/Improvement
Courtney Hernandez	Behavioral Health Clinical Quality Audit Analyst Senior
Elizabeth Yonge	Credentialing Specialist
Christopher Klaric	Credentialing Manager
Lynne Fabian	Manager, Health Promotions Outreach/Services
Dawn Surface	Community Outreach Manager
Marissa Gonzalez Martinez	Clinical Service Assistant
Matthew Wilkins	Manager II, Behavioral Health Services
Christine Anderson	Health Promotion Manager
Madeline Dunn	Director, Network Management
Tiffany Jenkins	Manager, Behavioral Health Services
Jamie Coahran	Account Service Manager Senior
Anna Pittar-Moreno	Behavioral Health Clinical Quality Audit Analyst Senior
Tasha Hughes	Medical Management Specialist II
Jean Gillette	Clinical Service Assistant
Lori Roberts	Chief Executive Officer/Program Officer
Department Observers	**Title**
Russell Kennedy	Quality and Compliance Specialist
Matt Pfeifer	Accountable Care Collaborative Program Specialist
Erin Herman	Accountable Care Collaborative Program Administrator
Angela Ukoha	Accountable Care Collaborative Program Specialist

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

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

Table D-1—CAP Process

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

HSAG identified no required actions; therefore, the CAP template is not included.

Appendix E. Compliance Monitoring Review Protocol Activities

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

Table E-1—Compliance Monitoring Review Activities Performed

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

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