COLORADO

Department of Health Care Policy & Financing

Fiscal Year 2023–2024 Compliance Review Report

for

Health Colorado, Inc.

Region 4

June 2024

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

HSAG HEALTH SERVICES ADVISORY GROUP

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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 moderate understanding of federal regulations. While HCI received strong scores for member information and quality requirements, it did not score well for requirements pertaining to the oversight of the delegated entities that perform these tasks.

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

Table 1-1—Summary of Scores for Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
V. Member Information Requirements	18	18	18	0	0	0	100%^
VII. Provider Selection and Program Integrity	16	16	12	3	1	0	75% v
IX. Subcontractual Relationships and Delegation	4	4	2	1	1	0	50% v
X. Quality Assessment and Performance Improvement (QAPI)**	16	16	16	0	0	0	100%~
Totals	**54**	**54**	**48**	**4**	**2**	**0**	**89%**

*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.

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

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

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

**The full name of Standard X is Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems.

Standard V—Member Information Requirements

Evidence of Compliance and Strengths

HCI delegated the administrative and operational processes related to member information to Carelon Behavioral Health (Carelon). Carelon used a process to provide information to members during their initial enrollment and when requested. Information was provided at no cost, in English and prevalent non-English languages and in alternative formats. Carelon staff members reported that customer service representatives (CSRs) assisted members by providing guidance during calls when members had questions or concerns. Carelon trained CSRs on member benefits via weekly trainings, periodic training, and one-on-one communications. The team lead monitored the CSRs on a bimonthly basis.

Carelon staff members underwent training to ensure that member materials were at or around the sixth-grade reading level by participating in health literacy trainings. Carelon described in detail how member materials were reviewed and tested for reading grade level using the Flesch-Kincaid readability score and through compliance with Section 508 of the Rehabilitation Act (Section 508). Carelon staff members reported using SortSite to ensure compliance with Section 508. When asked how errors were found and addressed, Carelon staff members described the process to identify errors, monitor risk levels, and quickly resolve errors. HSAG used Adobe Acrobat Pro's accessibility testing function to evaluate portable document format (PDF) materials and WebAIM's WAVE accessibility evaluation tool (https://wave.webaim.org/) to evaluate a selection of pages on HCI's website. HSAG found a low number of accessibility errors.

Carelon used monthly member workgroup meeting as a forum to have members test materials for readability and for ease of understanding the end user content. Carelon staff members reported receiving positive member feedback that helped to ensure that members had a better understanding of the materials.

Carelon made health education opportunities available to members through texting, email, and interactive voice response (IVR) modalities designed to increase member understanding about the RAE's benefits and requirements. During the interview, Carelon reported a low number of members opting out of the text messages and a 97 percent retention rate for staying connected. The information sent to the members included member handbook information, website link information, well-child visit reminders, and other relevant information.

The provider directory was available to members electronically and could be searched, downloaded, and printed. Carelon used different approaches to validate directory information to ensure that it remains current.

Opportunities for Improvement and Recommendations

HCI's behavioral health provider directory was managed through Carelon. A list of providers who offered accommodations for people with disabilities could be found by selecting an icon indicating "wheelchair access." During the interview, Carelon stated that providers on the list could offer any facility accommodation described in the Americans with Disabilities Act (ADA). However, the accommodations described in this requirement go beyond the ADA and list specialized medical equipment and exam rooms. HSAG encourages Carelon to determine what that may include in a behavioral health setting and incorporate these accommodations into the provider directory filters. Additionally, HCI should collaborate with Carelon in this discussion to ensure that the revision is completed.

Required Actions

HSAG identified no required actions for this standard.

Standard VII—Provider Selection and Program Integrity

Evidence of Compliance and Strengths

Carelon, as HCI's delegated entity for selection and retention of providers, submitted comprehensive policies and procedures demonstrating compliance with State and federal provider selection requirements. The policies and procedures stated that Carelon maintains an open network and contracts with any provider that meets Medicaid requirements. During the compliance interview, Carelon staff members described the provider selection process from the completion of an enrollment form to the execution of the contract.

Per policy, Carelon uses several network adequacy tools to identify network needs, including GeoAccess, single case agreements, and "data capturing number" and "type of provider" within the delivery system. Using these tools, Carelon employed different strategies to recruit providers. One avenue, highlighted during the compliance interview, was the implementation of "HIT expansion" with the goal of increasing high intensity outpatient services to members by identification of providers that offer HIT services. Additionally, Carelon policies referenced the following as activities that support provider retention: webinars, newsletters, roundtables, and administrative communication tools available on the HCI website.

Carelon provided a behavioral health compliance program description, compliance workplan summary, risk assessment summary, and myriad compliance-related policies that described a comprehensive and well-rounded compliance program. Carelon had a compliance committee overseen by an experienced and educated compliance lead. Carelon conducted ongoing monitoring of claims data to detect evidence of fraudulent billing. Carelon had a special investigations unit (SIU) that would review any concerns, investigate issues, and determine remediation. Carelon has a process to verify whether services

represented to have been delivered by network providers were received by members. This process included mailing 100 members chosen at random an inquiry letter on an annual basis. Carelon reported that there had not been any fraudulent billing practices identified through this activity.

Carelon provided fraud, waste, and abuse (FWA) training for its staff upon hire and annually, as well as an annual "Do the Right Thing" training. Carelon staff members were made aware of and were encouraged to report problems or concerns of noncompliance to the Carelon ethics hotline.

Opportunities for Improvement and Recommendations

HSAG recommends that Carelon revise policy CR 218.14 titled *Credentialing Criteria for Facility/Organizational Providers* to include language stating that Carelon complies with the National Committee for Quality Assurance (NCQA) process for the credentialing and recredentialing of providers.

HSAG recommends that Carelon revise policy CO 029.17 titled *Screening Against Exclusion Lists* to include the terms "excluded, suspended, and debarred" throughout the document to maintain its consistency with the policy statement.

During the interview, Carelon described its role and activities as a delegate of HCI. There were no HCI representatives in attendance during the compliance review to counter or expand on the processes that Carelon described. Following delivery of the draft report, Carelon contacted HSAG and requested a call to discuss some of the findings reported. During the call, HCI provided dashboards as evidence of oversight and described the relationship as more of a partnership. The question remains as to why a delegation agreement was provided as supporting evidence prior to the interview if the relationship between HCI and Carelon is a partnership. The findings in this report describe the conversations between HSAG and Carelon at the time of the compliance review. The additional information HCI provided after the interview that should have been discussed and provided at the time of the interview were not considered for this report. HSAG recommends that HCI strongly consider having key staff members from HCI attend compliance reviews in the future to ensure clarity regarding the functions and activities of the RAE.

Required Actions

Carelon submitted policy CR 226.11 titled *Prevention and Monitoring of Non-discriminatory Credentialing and Re-Credentialing*. The policy did not include all required language. Carelon must revise its policies to include language that states 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."

Carelon submitted policy CR 206.20 titled *Primary Source Verification*, which excluded the terms "excluded, suspended, and debarred" from language within the policy. Carelon must 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 (i.e., an individual 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.

Carelon submitted the behavioral health provider agreement template that included all required language; however, the language was not located within the primary care medical provider (PCMP) agreement. HCI must revise the PCMP agreement to include language stating 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:

- 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 nontreatment.
- 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.

HCI's compliance program was operationally and functionally run by its delegate, Carelon. While Carelon was able to describe the features of its compliance program, including an active compliance committee, no interview attendees from HCI were able to describe HCI's role in leading the compliance program nor in any oversight and monitoring of Carelon's compliance activities. As indicated in its organizational chart, HCI had a designed compliance officer; however, the compliance officer was not present for the interview sessions. While Carelon described quarterly compliance meetings between Carelon and HCI, HCI provided no evidence that HCI or its compliance officer maintained strategic oversight of the compliance program or took ownership of developing and implementing policies, procedures, and practices to ensure compliance. For example, the ethics statement was provided through Elevance Health's Code of Conduct (Elevance Health is a parent company of Carelon) and all policies and procedures related to program integrity were from Carelon.

HCI must 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.

Standard IX—Subcontractual Relationships and Delegation

Evidence of Compliance and Strengths

HCI had a delegated administrative services agreement with Carelon that included, but was not limited to, member management, provider network management, grievances and appeals, quality management, and compliance. HSAG reviewed the delegated agreement and determined that the contract included some of the federally required language. During the interview, Carelon staff members discussed regularly scheduled meetings that took place with HCI to review some of the delegated activities.

Opportunities for Improvement and Recommendations

HSAG identified no opportunities for improvement for this standard.

Required Actions

The delegation agreement between HCI and Carelon did not include the standard to which Carelon was held nor the frequency, methodology, and periodicity for conducting the ongoing monitoring. HCI must have direct oversight and evidence of ongoing monitoring performed by HCI of any delegated activities pertaining to 42 CFR §438. Per State and federal requirements, HCI may choose to delegate a portion of its managed care activities; however, it must maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State and cannot delegate this responsibility.

HSAG reviewed the subcontractor agreements and found that the written agreement did not include all required information. HCI must ensure, via revisions or amendments, that its subcontractor agreements include the following required language:

- The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State.
  - The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems related to 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.

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems

Evidence of Compliance and Strengths

HCI delegated all quality management functions to Carelon. HSAG reviewed the quality report, annual quality plan, and workplan, which demonstrated a comprehensive QAPI program. Within these documents, Carelon described the leadership structure, goals and objectives, and program components encompassing both physical and behavioral health. Carelon maintained an active quality management committee, which identified priority activities and programs, and noted processes related to each component of the QAPI program. Carelon's quality plan addressed key performance indicators (KPIs) and described an improvement initiative for each measure. Progress toward goals was monitored through routine meetings between Carelon and HCI staff members. Mechanisms were in place to detect and address over- and underutilization of services, and processes were established to identify, report, and investigate quality-of-care concerns.

Clinical practice guidelines (CPGs) provided by Carelon were reviewed and discussed by Carelon's scientific review committee every two years or as necessary, then the committee presented the revised CPGs to the corporate medical management committee (CMMC) for approval. HCI made the approved guidelines available on its website, accessible to both providers and members. In addition, CPGs were noted in provider newsletters.

Carelon submitted flowcharts that demonstrated how its health information system processed, collected, analyzed, and reported data. During the interview, Carelon staff members described in detail the life cycle of the health information system, including member enrollment, encounter data, auditing for and capturing errors, encounter data processing, and reporting.

Opportunities for Improvement and Recommendations

HSAG identified no recommendations for this standard.

Required Actions

HSAG identified no required actions for this standard.

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 of Healthcare Policy & Financing (the Department) executed contracts with the Regional Accountable Entities (RAEs) for the Accountable Care Collaborative (ACC) program, effective July 1, 2018. The RAEs are responsible for integrating the administration of physical and behavioral healthcare and managing networks of fee-for-service primary care providers (PCPs) and capitated behavioral health providers to ensure access to care for Medicaid members. Per the Code of Federal Regulations, Title 42 (42 CFR)—RAEs qualify as both Primary Care Case Management (PCCM) entities and Prepaid Inpatient Health Plans (PIHPs). 42 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 and February 2023. The Department has elected to complete this requirement for the RAEs by contracting with an external quality review organization (EQRO), HSAG.

In order 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) 2023–2024 was calendar year (CY) January 1, 2023, through December 31, 2023. This report documents results of the FY 2023–2024 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 2023–2024 compliance monitoring review. Section 4 describes follow-up on the corrective actions required as a result of the FY 2022–2023 compliance review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B lists HSAG, RAE, and Department personnel who participated in some way in the compliance review process. Appendix C describes the corrective action plan (CAP) process that the RAE will be required to complete for FY 2023–2024 and the required template for doing so. Appendix D contains a detailed description of HSAG's compliance review activities consistent with the Centers for Medicare & Medicaid Services (CMS) EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023.[3-1]

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Aug 8, 2023.

Overview of FY 2023–2024 Compliance Monitoring Activities

For the FY 2023–2024 compliance review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard V—Member Information Requirements, Standard VII—Provider Selection and Program Integrity, Standard IX—Subcontractual Relationships and Delegation, and Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems. 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 and February 2023. 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 January 1, 2023, through December 31, 2023. 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 D 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 2023–2024 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 III—Coordination and Continuity of Care; Standard IV—Member Rights, Protections, and Confidentiality; Standard VI—Grievance and Appeal Systems; Standard VIII—Credentialing and Recredentialing; Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT); 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 2022–2023 Corrective Action Methodology

As a follow-up to the FY 2022–2023 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 2022–2023 compliance monitoring review.

Summary of FY 2022–2023 Required Actions

For FY 2022–2023, HSAG reviewed Standard I—Coverage and Authorization of Services, Standard II—Adequate Capacity and Availability of Services, Standard VI—Grievance and Appeal Systems, and Standard XII—Enrollment and Disenrollment.

Related to Standard I—Coverage and Authorization of Services, HCI was required to complete one required action:

- Enhance its procedures and monitoring to ensure that all member notices are sent within time frame requirements. HCI must update its Medical Necessity Determination Timelines policy and any supporting documentation to clarify that the notification time frame is based on the date of the service request until the deadline.

Related to Standard II—Adequate Capacity and Availability of Services, HCI was required to complete two required actions:

- Correct the timely appointment standards in the PCP Practitioner Agreement.
- Develop a way to identify its Region 4 membership and gain an understanding of the membership's cultural norms and practices and how they may affect access to healthcare.

Related to Standard VI—Grievance and Appeal Systems, HCI was required to complete two required actions:

- Update the following documents to remove language that the member must follow a verbal appeal request with a written request. Additionally, HCI must share updated documentation with other staff members to ensure awareness of the updated requirement.
  - Appeal Job Aid, page 2, stated the "appeal must be signed by the member."

  - Appeal Guide, page 4, in the section "What is the Difference between a Quick Appeal and Standard Appeal?" point 2 stated that "You do need to follow up a verbal standard appeal request in writing," which is incorrect.
  - 305L Appeal Policy, page 12, section J.2, inaccurately stated that the coordinator or specialist must attempt to get a signed appeal request from the member.
  - Appeal Form, which can be found online, inaccurately stated at the bottom of the page, "Please know that we cannot process this appeal until you sign and return this letter. We have provided a self-addressed stamped envelope."
- Revise the 305L Appeal Policy to include that the coordinator will make reasonable efforts to notify the member of an extension.

Related to Standard XII—Enrollment and Disenrollment, HSAG identified no required actions.

Summary of Corrective Action/Document Review

HCI submitted a proposed CAP in July 2023. HSAG and the Department reviewed and approved the proposed CAP and responded to HCI. HCI submitted final documentation and completed the CAP in December 2023.

Summary of Continued Required Actions

HCI successfully completed the FY 2022–2023 CAP, resulting in no continued corrective actions.

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE provides all required member information to members in a manner and format that may be easily understood and is readily accessible by members. • The RAE ensures that all member materials (for large-scale member communications) have been member tested. *Note: Readily accessible means electronic information which complies with Section 508 guidelines, Section 504 of the Rehabilitation Act, and World Wide Web Consortium Web Content Accessibility Guidelines 2.0 Level AA and successor versions.* *42 CFR 438.10(c)(1)* RAE Contract: Exhibit B-8—7.2.5 and 7.2.7.9	**Documents Submitted:** 1. 307L_MemberInfoReqPolicy Pages 1, 3 2. MEACSummary, page 3 3. CoverSheet, entire document 4. IT302.7ComplianceofExternalWebSitePolicy, entire document 5. WebsiteComplianceCheck, entire document 6.. MemberMaterialReview, entire document 7. VoluntaryProductAccessibilityGuide, entire document 8. HealthLiteracyTraining 9.PlainLanguage_HCPFtraining, entire document 10. SeptMemberMaterialWorkgroup, entire document 11. OctNovMemberMaterialWorkgroup, entire document 12. DecMemberMaterialWorkgroup, entire document **Description of Process:** HCI provides all required member information in a manner and format that may be easily understood and is readily accessible by members and complies with Section 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's web content accessibility guidelines.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI observes the procedures found in 307L_Member Information Requirement Policy to ensure that the information we provide members is in a format that is easily understood. Some of the highlights from this policy include: • That we will provide member informational materials and instructional materials in a manner and format that are readily accessible, accurate, easily understood, and provide information as required by State, Federal and contractual guidelines (page 1). • Our procedures to ensure that member materials are written at a sixth (6th) grade reading level so that they are clear, concise and understandable to the representative population. HCI runs all member material through the Flesch-Kinkaid readability program, which ascertains the minimum education level required to understand materials (page 3). • Our commitment to have our materials member-tested and make necessary changes, which are recommended by our members (page 3). See 307_LMemberInfoReqPolicy, pages 1-3.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI implemented a monthly Member Material Review Workgroup in September 2023 to review member facing material. Prior to September 2023, HCI reviewed member materials with members at our Member Experience Advisory Council (MEAC) on a quarterly basis. HCI created the member material review workgroup to review materials more frequently. During MEAC or our Member Material Review Workgroup, members were asked to "test" the material and identify concerns with content and/or layout. HCI documents the member materials that have been reviewed with members and may edit based on member feedback (noting there are certain requirements for materials). For evidence of reviewed member material, see MEACSummary and MemberMaterialReview, entire document. For examples of topics and materials discussed at our Member Material Workgroup, see: SeptMemberMaterialWorkgroup, OctNovMemberMaterialWorkgroupand DecMemberMaterialWorkgroup. HCI includes a cover sheet with all member mailings, including any large-scale member communication. The cover sheet is used to protect members' privacy and provides members with information on how to request information in alternative formats, oral interpretation, or written translation for free. The cover sheet is written in	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	large font, has the toll free and TTY/TDD number listed, and is used for any mailings and when a member requests any member material, such as a copy of a member handbook and/or a provider directory. The coversheet information is written in both English and Spanish and includes language assistance information in 16 other non-prominent languages on the second page. To support our members with disabilities or who are in need of interpretation assistance, the coversheet provides necessary information for members to request assistance with services and member materials, while ensuring compliance with Section 504 of the Rehabilitation Act. See CoverSheet, entire document. HCI's electronic information (website) complies with 508 guidelines and W3C's Web Content Accessibility Guidelines. HCI has delegated our website management to Carelon. Carelon uses the IT302.7ComplianceofExternalWebSitesPolicy to ensure compliance with our website being readily accessible. The policy addresses our website being readily accessible as found on the following pages: • External websites must adhere and meet 508 compliance standards (page 1). • Under Section 508, agencies must give disabled employees and members of the public access to information that is	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	comparable to the access available to others (page 2). • Information about World Wide Web Consortium (W3C) that leads the website to its full potential is addressed (page 2). • The purpose of the policy is to publish procedures for the development of external websites to ensure that 508 compliance is maintained (page 2). This includes priority checklist items. Priority one (1) items must be addressed and are required to make a site accessible – page 2. Priority two (2) checklist items, which should be addressed to make the site accessible, but these items, are not required – page 4. Priority three (3) checklist items, which could be addressed to improve the accessibility of a site (page 6). See IT302.7ComplianceofExternalWebSitesPolicy, entire document. Carelon's website team uses the Voluntary Product Accessibility Guide to conduct periodic reviews for 508 compatibility and compliance with the World Wide Web Consortium Web Content Accessibility Guidelines on our website. See VoluntaryProductAccessibilityGuide.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Any detected non-508 compliance related to member material is brought to the attention of HCI's member engagement team for remediation. Carelon's website team corrects the identified accessibility issues, and the member engagement team resolves issues with broken website links or accessing PDF documents. For evidence of this period report, see WebsiteComplianceCheck,. HCI's Non-discrimination Notice can be readily accessed at the bottom of each page of the website, https://www.healthcoloradorae.com/non-discrimination-notice/. Carelon's member engagement team participates in annual training opportunities to improve their health literacy and plain language writing skills. This ensures member materials are developed with an up-to-date approach to Health Literacy and Plain Language. For examples of the training materials, please see HealthLiteracyTraining and PlainLanguage_HCPFtraining.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The RAE has in place a mechanism to help members understand the requirements and benefits of the plan. *42 CFR 438.10(c)(7)* RAE Contract: Exhibit B-8—7.3.8.1	**Documents Submitted:** 1. HCPFWelcomeLetter, entire document 2. HCPFWelcomeLetterEvidence, entire document 3. GettingStartedGuideEN, entire document 4. GettingStartedGuideSP, entire document 5. WelcomeandBenefitTextMessages, entire document 6. TextingReport, entire document 7. CallCenterReport, entire document 8. GettingStartedInvitationEN, entire document 9. GettingStartedInvitationSP, entire document 10. SocialMediaPost, entire document 11. ConstantContactInvitation, entire document 12. CareCoordinationPresentation, slide #8 13. OctProviderNewsletter, pages 2-3 14. DHSMeeting, slide #7 15. GettingStartedPresentation, entire document **Description of Process:** HCI has several mechanisms in place to help members understand the requirements and benefits	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	of the plan. These mechanisms are described below: **New Member Welcome Letter** HCI leverages the welcome letter mailed by Health Care Policy and Financing (HCPF) to all newly enrolled members. The welcome letter has HCI's website information and phone contact information and indicates that the regional organization can help members obtain the health care services they need. HCI confirmed with HCPF via email that the HCPF Welcome Letter submitted in this audit is the most recent template. See HCPFWelcomeLetter, and HCPFWelcomeLetterEvidence **Website - New Member Resources** HCI's website has a tab with New Member Welcome Resources. Members accessing the website will have multiple new member resources in one location. These resources include, but are not limited to the member handbook, HCI's getting started guide, how to find a provider and the PEAK website. HCI's Getting Started Guide has helpful resources for members to start using their benefits. See GettingStartedGuideEN and GettingStartedGuideSP.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Texting Campaigns Newly eligible members are enrolled in a welcome and benefit texting campaign through our vendor, Virgin Pulse. This campaign is designed to help members understand the requirements and benefits of their health plan. The messages include but are not limited to: Welcome message, member handbook information, website link information, well child benefit information, the nurse advice line number, member rights, advance directives, vaccinations, behavioral health, crisis services, and how to get an insurance card. HCI has included the aggregate data from the texting reports to demonstrate the number of texts sent to members and member retention rates in our texting campaigns. Please see WelcomeandBenefitTextMessages and TextingReport. **Automated Calls** HCI uses an Interactive Voice Response (IVR) automated calling system to outreach newly enrolled EPSDT-eligible and newly identified pregnant members within 60 days of their enrollment. The message states “Hi, it’s Health Colorado calling, your Colorado Medicaid health plan. We would like to tell you about your benefit information which includes well visits, dental	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	visits, and vision screens. You can press 1 to be connected to a live person who can tell you about your health benefits. You may also call 1-888-502-4185. Again, that number is 888-502-4185." The IVR calling system provides a bi-directional option for calls to select a number to connect with one of our call center associates. Call center associates identify members calling in response to one of our campaigns in our CONNECTS system and code these calls. HCI has attached a report of members who contacted us following one of our outreach campaigns to obtain additional information. See CallCenterReport. **Constant Contact Emails** HCI uses Constant Contact, an online platform that is utilized to send emails in bulk. HCI sends an invitation to the monthly "getting started" virtual webinar to members who have given consent to receive emails. HCI has included an example of one of the invitations sent to members. See ConstantContactInvitation. **Virtual Platform** HCI hosts a "getting started" virtual webinar on the first Thursday of each month to educate members, family members, or health care professionals about member benefits and requirements of their health	

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	plan. HCI's getting started webinar was an hour long presentation to help members understand their benefits and provide an overview of their health plan between January 2023 and September 2023. HCI recorded a "getting started" webinar which has information on member benefits and is located on our website under New Member Welcome Resources – Recorded – "Getting Started" Member Orientation to Health First Colorado (Colorado's Medicaid Program benefits). HCI changed the format of the "getting started" webinar in October 2023 from 60 minutes to 30 minutes to increase participation and began focusing on benefits related to prevention and wellness. HCI's getting started webinar focuses on a thorough presentation of a benefit, however, participants are encouraged to ask questions about any of their benefits during the webinar. These webinars and slide decks can be found on Calendar and Events section of our website and included the topics of women's health, immunizations, and smoking cessation between October 2023 and December 2023. HCI promotes this webinar through email, social media posts, provider newsletters, and education about this webinar at care coordinator meetings, practice transformation meetings, and other community stakeholder meetings. HCI emails members who have consented to receive emails an invitation to our getting started webinar through constant contact. HCI provides a "getting started" flyer to	

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	all health care professionals to distribute to members at the meetings listed above. See: • SocialMediaPost • GettingStartedInvitationEN, • GettingStartedInvitationSP • ConstantContactInvitation • CareCoordinationPresentation • OctProviderNewsletter, pages 2-3, DHSMeeting, slide #7, • GettingStartedPresentation	
3. For consistency in the information provided to members, the RAE uses the following as developed by the State, when applicable and when available: • Definitions for managed care terminology, including: appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, participating provider, physician services, plan, preauthorization, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. • Model member handbooks and member notices.	**Documents Submitted:** 1. ManagedCareTermsEN, entire document 2. ManagedCareTermsSP, entire document 3. HCPFBrandGuide2023, page 14 4. HCPFCoBranding, entire document 5. MemberMaterialCollaborationHCI, entire document **Description of Process:** To maintain consistency in the information provided to members, HCI uses managed care definitions developed by Healthcare, Policy and Financing (HCPF). HCI created a Managed Care Terms Explained resource for our members after researching managed care definitions found in Health First Colorado's (Colorado's Medicaid Program) member handbook and HCPF's website.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.10(c)(4) RAE Contract: Exhibit B-8—3.6	The Managed Care Terms Explained document can be found on the resource tab on our website. To review the managed care terms, please see ManagedCareTermsEnglish,and ManagedCareTermsSpanish. HCI uses Health First Colorado's member handbook and does not have an independent member handbook. The English and Spanish member handbooks are displayed on the home page of our website. Our website address is https://www.healthcoloradorae.com. HCI uses HCPF's branding guide to develop and model our member materials after HCPF and follows their policy transmittal RAE MCO 23-02 to include the Health First Colorado logo on member facing materials. Both the branding guide and policy transmittal give the directive to use Health First Colorado logo with the tagline "In partnership to better serve you" to demonstrate the connection between Health First Colorado and the RAE. HCI has included this logo/tagline on all of our member facing materials. HCI also has this logo on the bottom right-hand corner of our website. The Managed Care Terms document also has the required logo. See: • HCPFBrandGuide2023 • HCPFCoBranding, ,	

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	• ManagedCareTermsEnglish, • ManagedCareTermsSpanish Additionally, HCI collaborated with Nicky Alden from HCPF on November 16, 2023 to discuss HCPF's branding guide. Specifically, HCI reviewed how we are currently using Health First Colorado's (in partnership with) logo on our materials to ensure we are modeling our member materials in alignment with HCPF. Nicky communicated that HCI is following the intent of HCPF's branding guide with our member-facing materials. Additionally, HCI requested for a Spanish version of the Health First Colorado logo to place on our Spanish member materials. See MemberMaterialCollaborationHCI.	
4. The RAE makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • Written materials that are critical to obtaining services include, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices. • All written materials for members must: – Use easily understood language and format. – Use a font size no smaller than 12-point. – Be available in alternative formats and through provision of auxiliary aids and service that take into	**Documents Submitted:** 1. DATAUSA, entire document 2. AppealGuideEN, entire document 3. AppealGuideSP, entire document 4. ComplaintGuideEN, entire document 5. ComplaintGuideSP, entire document 6. CoverSheet, entire document 7. 307L_MemberInfoReqPolicy, page 3 8. MEACSummary, page 3 9. MemberMaterialReview, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
consideration the special needs of members with disabilities or limited English proficiency. – Include taglines in large print (conspicuously-visible font size) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDD customer service numbers and availability of materials in alternative formats. – Be member tested. *42 CFR 438.10(d)(2-3) and (d)(6)* RAE Contract: Exhibit B-8—7.2.7.3-9 and 7.3.13.3	10. SeptMemberMaterialWorkgroup, entire document 11. OctNovMemberMaterialWorkgroup, entire document 12. DecMemberMaterialWorkgroup, entire document **Description of Process:** HCI identified Spanish as the most prevalent non-English language in our region. According to the 2021 Data USA report, there are 16.3% Non-English Speakers in Colorado with the most common non-English language being Spanish. 11.1% of Colorado's overall population are Spanish speakers. For evidence of Spanish as the most prevalent non-English language, see DATAUSA. HCI makes written information critical to obtain services available in Spanish and English for members. These materials include the following: • Member Handbook – available on the home page of website • Provider Directory – available on Find A Provider tab • Appeal Guides • Complaint Guides	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Cover sheet for grievances, denials, appeals or termination notices. See: • AppealGuideEN, • AppealGuideSP, • ComplaintGuideEN, • ComplaintGuideSP, and • CoverSheet HCI informs members that they can request information in alternative formats such as large font, Braille other formats or languages, American Sign Language, or to be read aloud. upon their request at no cost to them. This information is communicated in our cover sheet sent with all member correspondence. HCI's cover sheet protects members' privacy and provides members with information on how to request information in alternative formats, oral interpretation or written translation for free. The cover sheet is written in large font and has the toll free and TTY/TDD number listed. HCI also translated the tagline in 16 languages. The cover sheet is used with all correspondence, including grievance, appeal, denials, termination notices and any member material requests, such as a copy of a member handbook or a provider directory. See CoverSheet.	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI added a pop-up message on our website which states in English and Spanish, "If you need any document from our website in large print, Braille, other formats or languages, or read aloud, please contact us. We will send this to you free of charge within five (5) business days. We can also connect to language services or help you find a provider with ADA accommodations. Our number is 888-502-4185. If you have speech or hearing disabilities, there are auxiliary aids you may use (TTY/TDD/American Sign Language at 800-432-9553 or State Relay 711). These services are free." This language is also included on the home page of our website under the Health First Colorado and Member handbook links, near the bottom of the home page. Additionally, HCI has 25 languages accessible through Google Translate available at the lower right-hand corner of our website. Members can click on the flag icon to access other languages. HCI follows the procedures found in 307L_MemberInfoReqPolicy to ensure that the information we provide members is in a format that is easily understood. This policy states that member information:	

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	• Will use easily understood language and formats (page 3). • Will use a font size no smaller than 12-point (page 3). • Will include taglines in large print (conspicuously-visible font size) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDD customer service numbers and availability of materials in alternative formats (page 3). • Be available in alternative formats and through provision of auxiliary aids and service that take into consideration the special needs of members with disabilities or limited English proficiency (page 3). • Will be member-tested and make necessary changes, which are recommended by our members (page 3). See 307L_MemberInfoReqPolicy. HCI primarily used the platform of our Member Experience Advisory Council (MEAC) during the first three quarters to review member material, HCI identified a need to meet more frequently with members to review: 1) member materials, 2) HCI's website, and 3) our social media posts. As a result, HCI established a member material review	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	committee in September 2023, which meets on a monthly basis. For evidence of member reviewed during a MEAC meeting, please see MEACSummary. For evidence of our member material work group, please see SeptMemberMaterialWorkgroup, OctNovMemberMaterialWorkgroup, and DecMemberMaterialWorkgroup for the list of materials reviewed, see MemberMaterialReview.	
5. *If the RAE makes information available electronically:* Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of "readily accessible" above). • The information is placed in a website location that is prominent and readily accessible. • The information can be electronically retained and printed. • The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge upon request and is provided within five business days. • Provide a link to the Department's website on the RAE's website for standardized information such as member rights and handbooks. *42 CFR 438.10(c)(6)*	**Documents Submitted:** 1. IT302.7ComplianceofExternalWebSitePolicy, entire document 2. WebsiteUpdatesJobAid, pages 1-2 3. WebsiteComplianceCheck, entire document 4. MemberMaterialRequestJobAid, entire document 5. MemberMaterialsSent, entire document 6. VoluntaryProductAccessibilityGuide, entire document **Description of Process:** HCI makes information available to members electronically on our website, (https://www.healthcoloradorae.com). HCI's goal	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
RAE Contract: Exhibit B-8—7.3.9.2 and 7.3.14.1	is to utilize technology to centralize information for members, family members, health care professionals, and stakeholders. HCI delegates our website management to Carelon Behavioral Health (Carelon). Carelon uses a policy titled, 508 Compliance of External Website and the VoluntaryProductAccessibilityGuide to guide our process of ensuring compliance with the requirements in this requirement. The policy outlines: • The procedures to be followed to make an external website readily accessible. This includes website compliance checks to ensure that we are meeting readily accessible standards described in 508 guidelines, and W3Cs web content accessibility guidelines (pages 3-6) • The information complies with language and content requirements by ensuring that documents are clear and simple and use the simplest language appropriate for a site's content (pages 4 and 6). See IT302.7_ComplianceofExtrenalWebsite, entire policy and Voluntary Product Accessibility Guide.	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Carelon runs all member-approved PDF documents, which meet content and language requirements through a 508-accessibility scan before uploading the content to the website. This process is outlined in our website updates job aid. Additionally, Carelon runs a periodic website compliance report to identify any priority 1, 2 or 3 checklist items as outlined in the 508 Compliance of External Website Policy and takes action to eliminate these errors. See WebsiteUpdatesJobAid, pages 1-2, See IT302.7_ComplianceofExternalWebsite, pages 3-7, and WebsiteComplianceCheck. HCI has worked with the website team to ensure that information is placed in a prominent position and is readily accessible. For example, HCI identified three crucial elements for members to understand their benefits and obtain care. HCI also wants to ensure that information on our website aligns with Health First Colorado. These are placed on the home page of our website: • Find a Provider link • Member Handbook links in English and Spanish • Health First Colorado link • Nurse Advise Line Link	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Crisis Line link • Discrimination Notice on home page which also links to HCPF's non-discrimination policy and non-discrimination notice to address Section 504 of the Rehabilitation Act • Information in two places alerting members how they can request for information to be printed and sent to them within 5 days, free of charge. To ensure that members know that they can request any document from our website to be printed and sent to them free of charge within 5 business days, we have this information in several locations: • Home Page Pop up message: "If you need any document from our website in large print, Braille, other formats or languages, or read aloud, please contact us. We will send this to you free of charge within five (5) business days. We can also connect to language services or help you find a provider with ADA accommodations. Our number is 888-502-4185. If you have speech or hearing disabilities, there are auxiliary aids you may use (TTY/TDD/American Sign Language at	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	800-432-9553 or State Relay 711). These services are free." • Resources Page • Members Page • Bottom page of home page states "If you want any information on this website sent to you in paper form, please call us at 888-502-4185. We will send it to you for free within five (5) working days. Members can request information to be printed and sent to them free of charge. Members can request this via the RAE's email address, on our "contact us" form found on the website, or by calling the RAE's toll free number. When HCI's call center associate receives a member request for any member material, including but not limited to member handbooks or provider directories to be mailed to them, the call center associate will email and send a call record to the Call Center Team Lead. The Call Center Team lead follows the job aid developed to assist with requests for member materials. The job aid outlines the procedures that all staff must follow when a member requests a copy of any document. See MemberMaterialRequestJobAid. HCI developed a report to internally track the number of materials requested by members and to	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	ensure that materials are being sent within five days. See MemberMaterialsSent. The resources found on our website can be electronically retained and printed for member use. HCI routinely tests this function when a member requests a copy of the member handbook or provider directory.	
6. The RAE makes available to members in electronic or paper form information about its formulary: • Which medications are covered (both generic and name brand). • What tier each medication is on. • Formulary drug list must be available on the RAE's website in a machine-readable file and format. *42 CFR 438.10(h)(4)(i)* RAE Contract: Exhibit B-8—None	**Documents Submitted:** 1. HCPFPreferredDrugList, entire document **Description of Process:** HCI makes Health First Colorado's medication formulary drug list available to members electronically on our website, which is in a machine-readable file and format. When/if a member requests this information to be sent to them in a paper form, HCI sends the formulary drug list at no charge to the member within five (5) days. HCI downloaded a copy of the formulary as evidence that this document is in a machine readable file and format. See HCPFPreferredDrugList. The formulary drug list has information on which medications are covered – both generic and name	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	brand as well as which tier each medication is on. HCI has HCPF's medication formulary drug link on our website under Resources – labeled Health First Colorado Prescription Drug List.	
7. The RAE makes interpretation services (for all non-English languages) and use of auxiliary aids such as TTY/TDD and American Sign Language available free of charge, notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and informs about how to access those services. *42 CFR 438.10 (d)(4) and (d)(5)* RAE Contract: Exhibit B-8—7.2.6.2-4	**Documents Submitted:** 1. R4_LangAssistRpt_FY23-24, entire document 2. 311L_RespondingtoMemberswithLEP, entire document . 3. 307L_MemberInfoReqPolicy, Page 3 4. LanguageAssistanceJobAid, entire document 5. CoverSheet, entire document 6. GettingStartedInvitationEN, entire document 7. GettingStartedInvitationSP, entire document 8. AdvanceDirectiveInvitationEN, entire document 9. AdvanceDirectiveInvitationSP, entire document 10. MEACInformationSheetEN, entire document 11. MEACInformationSheetSP, entire document 12. CallCenterLanguageAssistanceTraining Minutes, page 1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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	13. HCI-Behavioral-Health-Medicaid-Provider-Handbook, pages 10, 20 and 66 *Misc. 14. HCI-PCMP-Provider-Handbook, *Misc., pages 10, 20, 66 15. ProviderRoundtable, slides 14-18 16. OctProviderNewsletter, page 2 17. Blank ClinicalAuditTool_QM, entire document *Misc. **Description of Process:** HCI makes interpretation services and translation services available for all non-English speaking members, members with Limited English Proficiency (LEP), and Deaf/hard of hearing members. These services are available free of charge to all members. These services could involve the use of oral interpretation for any language including American Sign Language (ASL) and auxiliary aids such as TTY/TDD. Written translation is available for our members in prevalent languages. HCI educates members and health care professionals on members' rights to language services and how to access these services as outlined below. HCI submitted a Language Assistance report to HCPF in September 2023 which details our responsibility to ensure that language assistance services are provided to	

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	members for all interactions. See R4_LangAssistRpt_FY23-24. HCI follows the policy, 311L_Responding to Members with (Limited English Proficiency (LEP) to direct our processes with members who are non-English speakers, LEP, or Deaf/hard of hearing. The policy describes the procedures for handling calls and responding to requests from providers and members for interpretation and or translation services. Embedded in the policy is a guide, "Working with Interpreters," which instructs staff members on how to use an interpreter. Additionally, HCI created a Language Assistance Job Aid for our call center associates to use when working with members needing language assistance. See 311L_RespondingtoMemberswithLEP document and LanguageAssistanceJobAid. HCI also follows the policy, 307L_Member Information Requirements Policy, which outlines on page 3 that member materials are translated into other languages when requested by the member at no charge to the member. The policy states that member materials are available in alternative formats for members who have communication disabilities free of charge. Alternative formats include large type, audio tape, TTY/TDY, and ASL. HCI uses the Language Assistance Job Aid	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	for requests for translation. See 307L_MemberInfoReqPolicy, page 3 and LanguageAssistanceJobAid, pages 3-4. HCI notifies members that oral interpretation is available for any language and written translation is available in prevalent languages. HCI also informs members how to access these services through a variety of channels. **HCI's Website.** HCI includes a pop-up window on our website which has information in English and Spanish about how to ask for interpretation services or materials in alternative formats. Additionally, HCI has a tagline at the bottom of the website, which states, "As our member, you can ask for information in large print, Braille, other formats, or to be read aloud. You can also request American Sign Language for your treatment needs. These services are free. You can call 888-502-4185 to request these services. For TDD/TTY, call 800-432-9553 or the State Relay 711 for help in contacting us. These calls are free. If you want any information on this website sent to you in paper form, please call us at 888-502-4185. We will send it to you for free within five (5) working days." Additionally, if a member uses google translate to change the language of the website,	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	they will have this information about how to request these services in alternative languages. **Written Materials** 1) HCI's cover sheet is attached to all written correspondence mailed to members. Our cover sheet provides members with information in English and Spanish on how to request information in alternative formats, request oral interpretation or written translation at no charge to the member. The cover sheet is written in large font and has the toll free and TTY/TDD numbers listed. The back page of the cover sheet has this information in 16 languages. Please see CoverSheet. 2) Member invitations. HCI adds information on how to access reasonable accommodations on member invitations such as our "Getting Started" webinar, Member Experience Advisory Council, or Advance Directives meetings. HCI has contracts with agencies, such as the Colorado Language Connection to provide sign language and/or interpretation services when these services are requested. See • GettingStartedInvitationEN • GettingStartedInvitationSP • AdvanceDirectiveInvitationEN • AdvanceDirectiveInvitationSP	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• MEACInformationSheetEN, and • MEACInformationSheetSP **Education and Training** HCI trains the call center staff on our process to assist members who are non-English speaking, LEP, or Deaf/hard of hearing who contact us and require interpretation or translation. HCI has outlined our procedures in our Language Assistance Job Aid, which is reviewed with call center associates annually and during orientation of new associates. Call center staff are trained on how to access Voiance®, (a CyraCom International company) our language service company to connect members with an interpreter in real time. Voiance® is a leading provider of language interpreting and can serve members in over 150 languages – see language list. The language service is available to our members twenty-four (24) hours a day, seven (7) days a week (24/7) and is free of charge to our members. See LanguageAssistanceJobAidand CallCenterLanguageAssistanceTraining, page 1. HCI informs providers of their responsibility to offer interpreter services for members in the behavioral health provider handbook pages 10, 20 and 66 and in the physical health provider	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	handbook page 10, 20, and 66. The handbook explains that providers can contact HCI to receive help with linking providers to these services. HCI also provides language assistance information in the provider newsletter. Please see, HCI-Behavioral-Health-Medicaid-Provider-Handbook, pages 10, 20 and 66, HCI-PCMP-Provider-Handbook,pages 10, 20, 66, OctProviderNewsletter, page 3 and ProviderRoundtable, slides 14-18. HCI's Quality Department completes periodic provider chart audits to determine whether a provider used an interpreter to meet the language needs of the member to assess utilization .This information is documented in the chart audit tool. See Blank ClinicalAuditTool_QM, under the audit tool tab, line #12.	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The RAE ensures that: • Language assistance is provided at all points of contact, in a timely manner and during all hours of operation. • Customer service telephone functions easily access interpreter or bilingual services. RAE Contract: Exhibit B-8—7.2.6.1 and 7.2.6.4	**Documents Submitted:** 1. 311L_RespondingtoMemberswithLEP, entire document 2. ResourceSheet, entire document 3. LanguageAssistanceJobAid, pages 1-3 3. VoianceUseReport, page3 4. HCI-Behavioral-Health-Medicaid-Provider-Handbook,. pages 20 and 66 *Misc. 5. HCI-PCMP-Provider-Handbook, pages 10, 20, 66*Misc. **Description of Process:** HCI ensures that language assistance is provided at all points of contact for a member, in a timely manner, and during all hours of operation. HCI has a 24/7 toll-free customer service number which provides easy access to interpreter or bi-lingual services through Voiance® which has interpreters in over 150 languages. There are several points of contact for our members: • Members calling to access services and/or asking for help to find a provider • Members engaging/attending provider appointments	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Members attending our meetings such as Member Experience Advisory Council (MEAC) or Performance Improvement Advisory Committee (PIAC) • Members needing assistance to make a complaint, file an appeal, or needing help with a state fair hearing. HCI uses the procedures found in our policy 311L_ Responding to Members with LEP. According to this policy, • Language interpretation services are available during all hours of operation (page 1). • The process of using interpretation services if they are needed beyond the initial phone call, such as a request of oral interpretation of written materials (page 1). • Customer service telephone functions with easily accessed interpreters and bilingual services through our call center (page 2). • The process for how to use the language line is outlined (easily accessed interpreters) (pages 3-5). • How to use the relay line of TTY/TDD for members who are Deaf/hard of hearing is explained (pages 5-6). • Interpreter requests for meetings (page 6).	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• The steps we take when a provider requests an interpreter (page 6). • An educational guide, "working with interpreters" is available for all staff working with members to use (pages 8-10). Please see 311L_RespondingtoMembers with LEP, entire document. HCI's call center staff use the language line number listed on a resource sheet if a member needs interpretation services and also follow the Language Assistance Job Aid. See ResourceSheet and LanguageAssistanceJobAid, pages 1-3. HCI is able to capture the number of calls, which required interpretation services through Voiance. The report shows that of the 503 calls needing interpretation services between July 1, 2022 and June 30, 2023, 70.6% of the calls were for Spanish speaking members. The reports outlines the additional languages most frequently requested. See VoianceUseReport, page 3. HCI's call center staff are trained on how to use the referral connect system to identify a bilingual provider for clinical services. HCI uses this process when members request a non-English provider or provider who uses ASL. If we cannot find an in-network provider who is bilingual or signs, we	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	would process a Single Case Agreement (SCA) when an appropriate provider is found. If an appropriate provider cannot be identified, HCI's member engagement team will assist the provider in setting up interpretation services with our member. HCI's call center associates also assist providers who contact us with language interpretation needs for our members by linking them with Colorado Language Connection. Colorado Language Connection has interpreters available for in person, video, remote interpreting and over-the-phone in 75 languages, including American Sign Language. Providers can find out about this language assistance in our behavioral health provider handbook on pages 10, 20, and 66. See HCI-Behavioral-Health-Medicaid-Provider-Handbook, pages 10, 20 and 66. This information is also in our physical health provider handbook. See HCI-PCMP-Provider-Handbook, pages 10, 20, and 66. Additionally, HCI developed a job aid to direct call center associates in assisting members and providers with any language assistance needs. HCI's goal with developing a job aid is to ensure that customer service telephone functions easily access interpreter or bilingual services. See LanguageAssistanceJobAid.	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	If interpretation services are needed for an administrative reason, such as a member making a complaint or filing an appeal, the member engagement team will use an interpreter to discuss the complaint or appeal with the member if a bi-lingual staff member is unavailable.	
9. The RAE provides each member with a member handbook within a reasonable time after receiving notification of the member's enrollment. *42 CFR 438.10(g)(1)* RAE Contract: Exhibit B-8—7.3.8.1	**Documents Submitted:** 1. HCPFWelcomeLetter-entire document 2. HCPFWelcomeLetterEvidence-entire document 3. WelcomeandBenefitTextMessages, entire document **Description of Process:** HCI leverages the letter sent by HCPF for newly enrolled members which has information on how members can obtain a free handbook and also has HCI's website information in the letter. HCI confirmed with HCPF that the HCPF Welcome Letter submitted in this audit is the most recent template. See HCPFWelcomeLetterand HCPFWelcomeLetterEvidence,. The member handbook can also be found on our website on the home page and under New Member Welcome Resources. Finally, HCI has the link to Health First	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Colorado on the home page of our website which also has the link to the member handbook. Newly eligible members are enrolled in a welcome and benefit texting campaign through our vendor, Virgin Pulse. This campaign is designed to help members understand the requirements and benefits of their health plan. The message sent on week two states: "Want a copy of your member handbook? Need to find a doctor? Visit www.healthcoloradorae.com to check out all of the information and tools we offer." Please see WelcomeandBenefitTextMessages, line 10. HCI exclusively uses Health First Colorado's member handbook.	
10. The RAE gives members written notice of any significant change (as defined by the State) in the information required at 438.10(g) at least 30 days before the intended effective date of the change. *42 CFR 438.10(g)(4)* RAE Contract: Exhibit B-8—7.3.8.2.2	**Documents Submitted:** 1. PHEUnwindCoordination, page 5 2. R4_PHEContCoverUnwindRpt_12-23, entire document **Description of Process:** HCI would notify members of any significant change communicated by Health Care Policy and Financing(HCPF) at least 30 days before the intended effective date of the change. One example of this was the change in the renewal	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	process with continuous coverage ending for Health First Colorado members related to the end of the Public Health Emergency (PHE). HCI aligned with the state to ensure consistent messaging with members' need to renew their benefit in the timeframe outlined by the state. HCI attached a slide deck from one of the Continuous Coverage Unwind coordination efforts between HCPF and the RAEs in early January 2023 for a significant change identified for May 2023. HCPF outlined the time frames that the RAEs needed to communicate with members the significant change with the renewal process on page 5 of this slide deck. The target date to message members was the week of April 10th, 2023. HCI also submitted PHE unwind data (R4_PHEContCoverUnwindReport) to the state which demonstrates when messages about the significant change was sent to the member 30 days in advance of the effective change. HCI began to send messaging to members on April 14, 2023, for May 31 renewals, which was at least 30 days before the intended effective date of the change. See PHEUnwindCoordination and R4_PHEContCoverUnwindRpt_12-23.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. For any RAE member handbook or supplement to the member handbook provided to members, the RAE ensures that information is consistent with federal requirements in 42 CFR 438.10(g). • The RAE ensures that its member handbook or supplement includes a link to the online Health First Colorado member handbook. *42 CFR 438.10* RAE Contract: Exhibit B-8—7.3.9.2	**Documents Submitted:** 1. **N/A** **Description of Process:** HCI exclusively uses Health First Colorado's member handbook , which is found on the home page of our website: https://www.healthcoloradorae.com/	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The RAE makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice or 30 days prior to the effective date of the termination, whichever is later, to each member who received their primary care from, or was seen on a regular basis by, the terminated provider. *42 CFR 438.10(f)(1)* RAE Contract: Exhibit B-8—7.3.10.1	**Documents Submitted:** 1. 304L_MemberRandRPolicy, pages 2 and 7 2. NWCO 008PracticeSiteTerminationPolicy, page 1 3. ProviderTerminationForm, entire document 4.NotificationtoMembersofProviderTerminatingJobAid, entire document 5. ProviderTermLetter, page 3*Misc. 6. 2023ProviderTerminationNotices, entire document **Description of Process:** HCI makes a good faith effort to give written notification to impacted members regarding the termination of a contracted provider. Impacted members are members receiving primary care from	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	or are seeing a provider on a regular basis. HCI mails correspondence to members impacted by a provider's termination within fifteen (15) days after the receipt or issuance of the termination notice or 30 days prior to the effective date of the termination, whichever is later. HCI's Member Rights and Responsibility policy notes this notification as a member right. Please see 304L_MemberRandRPolicy, pages 2 and 7. HCI follows NWCO 008 Practice Site Termination policy when contracted providers discontinue participation in our network. The policy outlines the timeframes we will follow in notifying members of any provider change. See PracticeSiteTerminationPolicy, page 1. HCI's network department will complete the member notification for provider termination request form and email the member engagement team to notify of a provider termination. See ProviderTerminationRequestForm. HCI's member engagement team will follow a job aid outlining the procedures for identifying and notifying impacted members of a contracted provider termination from the network. The member engagement team will use the provider termination letter template to develop the member	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	notification letter and will tailor the letter with provider-specific information such as name of provider, address of provider, and termination date. HCI may incorporate any information from correspondence sent to the member by the provider to mirror messaging. The letter informs members of the change in their providers' network status and offers to assist members find a new provider. HCI mails the termination notice to members to addresses in our eligibility files within fifteen (15) days after the receipt or issuance of the termination notice or 30 days prior to the effective date of the termination, whichever is later. See NotificationtoMembersofProviderTerminationJob Aid, entire document and ProviderTermLetter, page 3. During this audit period, HCI identified five providers that terminated their contract. HCI's member engagement team sent member notifications within 15 business days of being notified to the impacted members. See 2023ProviderTerminationNotices.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The RAE shall develop and maintain a customized and comprehensive website that includes: • The RAE's contact information. • Member rights and handbooks. • Grievance and appeal procedures and rights. • General functions of the RAE. • Trainings. • Provider directory. • Access to care standards. • Health First Colorado Nurse Advice Line. • Colorado Crisis Services information. • A link to the Department's website for standardized information such as member rights and handbooks. RAE Contract: Exhibit B-8—7.3.9	**Documents Submitted:** 1. WebsiteRebrandUpdate, entire document 2. WebsiteUpdatesJobAid, entire document 3. WebsiteUpdateRequests, entire document **Description of Process:** HCI has delegated the maintenance of their website to Carelon Behavioral Health (Carelon). Carelon developed a website for HCI when the contract commenced in 2018 and completed a renovation of our website when HCI rebranded in July 2023. As evidence of this, HCI has included the email with the service ticket assigned for the rebranding efforts. See WebsiteRebrandUpdate. Carelon maintains and updates the website as frequently as needed and follows a job aid to complete website updates. The job aid outlines the procedures required to submit a ticket requesting website updates. All of the requested updates are documented in an excel document. See WebsiteUpdatesJobAid and WebsiteUpdateRequests. HCI's website is customized and comprehensive and includes all of the required information in the following sections:	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI's home page has the following information: • HCI's contact information • Health First Colorado's Nurse Advice Line's phone number and link • Colorado Crisis Services information • Health First Colorado's icon and link to website • Member handbook in Spanish and English link • Find a Provider Find a Provider HCI's Member Tab has the following information: • Access to Care Standards • Complaints & Appeals, • Find a Provider • Rights & Responsibilities. HCI's About Tab outlines: • The general functions of the RAE • What is a regional Organization? • Governance Plan • Leadership • Integrated Care	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI's News Tab has: • Trainings for members listed under Calendar & Events. Trainings include "Getting Started Webinar and Advance Directives Trainings. This also has information about our Member Experience Advisory Council (MEAC). Other ad hoc trainings would also be listed in this section.	
14. The RAE makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, pharmacies (and for RAE 1, behavioral health providers): • The provider's name and group affiliation, street address(es), telephone number(s), website URL, specialty (as appropriate), and whether the provider will accept new members. • The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office. • Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment. *Note: Information included in a paper provider directory must be updated at least monthly if the RAE does not have a mobile-enabled,*	**Documents Submitted:** 1. NW006.30_ProviderDatabaseandProvider DirectoryPolicy, entire document. 2. ProviderDirectorySearchOptions, entire document. 3. Provider Directory, entire document **Description of Process:** HCI makes available electronic and mobile enabled provider directories for members on our website under our Find a Provider tab. HCI has three resources to help members find a provider based on their need.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
electronic directory; or quarterly if the RAE has a mobile-enabled, electronic provider directory; and electronic provider directories must be updated no later than 30 calendar days after the contractor receives updated provider information. *42 CFR 438.10(h)(1-3)* RAE Contract: Exhibit B-8—7.3.9.1.6-8	• Find a Primary Care Medical Provider, Hospital, Pharmacy, or Specialist which links to Health First Colorado's site to find a medical provider. • 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 dentist. HCI delegates provider management to Carelon Behavioral Health (Carelon). Carelon follows NW006.30 Provider Database and Provider Directory policy to ensure that the information in Carelon's behavioral health provider database and provider directories is current and accurate, in an easy to understand and usable format and in compliance with current state, federal, accreditation and contractual requirements regarding provider directories, including requirements regarding confidentiality of provider information. Our providers are responsible to update any pertinent information relating to their practice through provider connect. Provider updates could include their availability to see members, change in specialty, updated address and/or phone number. See NW006.30_ProviderDatabaseandProviderDirectoryPolicy.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The Find a Behavioral Health Provider search engine contains: • Provider name and group affiliation • Provider address and telephone number • Provider URL website address • Provider specialty • Provider linguistic capabilities including ASL • Provider cultural competency training • Whether providers are accepting new patients (this can change frequently, and providers are responsible to update their availability) • Accommodations for people with disabilities (ADA). See ProviderDirectorySearchOptions. HCI's provider directory can be viewed and/or printed by a member if they have access to a printer. A member can call and request that a printed copy of one of the provider directories to be mailed to them. For an example of a printed copy of a provider directory, see ProviderDirectory. Many of HCI members choose to contact our call center to request assistance in finding a provider in their vicinity. HCI's call center associates use Carelon Behavioral Health's referral connect	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	system to narrow the search for a provider based on the member preferences. CSAs can search by: • The gender of the provider • The number of miles the provider lives from the member's home • If the provider is bilingual, including ASL • The ethnicity of the provider • Provider specialty including SUD specialty • Access for disabilities Members may ask a 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.	
15. Provider directories are made available on the RAE's website in a machine-readable file and format. *42 CFR 438.10(h)(4)* RAE Contract: Exhibit B-8—7.3.9.1.9	**Documents Submitted:** 1. QM37.11_UsabilityTesting, entire document 2. IT302.7ComplianceofExternalWebSitePolicy, pages 2-7 3. WebsiteComplianceCheck, entire document **Description of Process:** HCI makes electronic provider directories available to members on our website in a machine-readable	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	file and format. The directories are found on our Find a Provider tab. HCI has delegated website functions to Carelon Behavioral Health (Carelon). Carelon follows QM37.11 Usability Testing to ensure that our web-based resources are accessible to users and can be applied to their full potential. The policy outlines the process for usability testing. See QM37.11_UsabilityTesting. Carelon also follows IT302.7_Compliance of External WebSites Policy to ensure that documents are machine-readable. The policy prioritizes any issues, which impede the website from being accessible. Carelon runs 508/WCAG website scans periodically to resolve accessibility issues. The 508/WCAG reports is reviewed by a Carelon associates to resolve and remediate any issues. See IT302.7_ComplianceofExternalWebSitesPolicy, pages 2-3 and WebsiteComplianceCheck.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The RAE shall develop electronic and written materials for distribution to newly enrolled and existing members that include all of the following: • The RAE's single toll-free customer service phone number. • The RAE's email address. • The RAE's website address. • State relay information. • The basic features of the RAE's managed care functions as a primary care case management (PCCM) entity and prepaid inpatient health plan (PIHP). • The service area covered by the RAE. • Medicaid benefits, including State Plan benefits and those in the Capitated Behavioral Health Benefit. • Any restrictions on the member's freedom of choice among network providers. • A directory of network providers. • The requirement for the RAE to provide adequate access to behavioral health services included in the Capitated Behavioral Health Benefit, including the network adequacy standards. • The RAE's responsibilities for coordination of member care. • Information about where and how to obtain counseling and referral services that the RAE does not cover because of moral or religious objections. • To the extent possible, quality and performance indicators for the RAE, including member satisfaction.	**Documents Submitted:** 1. HCPFWelcomeLetter-entire document 2. HCPFWelcomeLetterEvidence-entire document 3. GettingStartedGuideEN, entire document 4. GettingStartedGuideSP, entire document 5. HCIRackCard, entire document 6. WelcomeandBenefitTextMessages, entire document 7. TextingReport, entire document 8. ConstantContactInvitation, entire document 9. SocialMediaPost, entire document 10. MemberMaterialRequestJobAid, entire document 11. MemberMaterialsSent, entire document **Description of Process:** HCI has developed materials to distribute to newly enrolled and existing members assigned to our region. **Written Materials** **New Member Welcome Letter** HCI leverages the welcome letter mailed by Health Care Policy and Financing (HCPF) to all newly	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
RAE Contract: Exhibit B-8—7.3.6.1	enrolled members. The welcome letter has our toll-free customer service phone number and our website address. HCI confirmed with HCPF that the HCPF WelcomeLtr submitted in this audit is the most recent template. See HCPFWelcomeLetter,and HCPFWelcomeLetterEvidence. **Getting Started Guide** HCI's getting started guide is available in a printed trifold brochure and also in an electronic version on our website. The getting started guide has our toll-free number, email address and website address. The guide also has a QR code for our new member resources located on our website. The getting started guide invites members to participate in the "your opinion matters" survey to obtain input about member satisfaction. The guide provides an overview of benefits including member handbook information, finding a provider and care coordination. See GettingStartedGuideEN and GettingStartedGuideSP. **Rack Card** HCI designed a rack card to take to community events. The card has our toll free number, the role of the RAE, including coordinating care, a map of the counties we serve, a QR code to our new	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	member resources, and our social media links. See HCIRackCard. **Electronic Materials** **Website** All of the materials on our website can be printed out and distributed to members. HCI created a New Member Resource page that has multiple member resources in one location, including a welcome letter, a getting started guide and a "getting started" video. Additionally, our website has the following information: Home Page • Toll-free customer service number • State Relay number • TTY/TDD number • Your Opinion Matter link (survey to measure member satisfaction) • Care Coordination • A Directory of Network Providers • Health First Colorado link that has information about coverage physical health and behavioral health coverage	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Contact Page • Toll-free customer service number • Care Coordination phone number • Email Address • Physical Address • Complaint and appeal address Find A Provider • The requirement to provide adequate access to behavioral health services included in the Capitated Behavioral Health Benefit, including the network adequacy standards. About Page • The functions of the RAE • What Is a Regional Organization? with a service area map of the counties HCI serves and the basic features of a Primary Case Management Entity (PCCM) and Prepaid Inpatient Health Plan (PIHP). Member Page • Find a Provider • Care Coordination responsibilities	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Member Survey Results with the results of member satisfaction surveys • Benefits and Services ➢ Information about services that we do not cover because of moral or religious objections ➢ Freedom of Choice in providers ➢ What behavioral health benefits are covered? ➢ What physical health benefits are covered? Members can request for any information from the website to be printed and sent to them free of charge. HCI will send any requested information to a member within five business days. See MemberMaterialRequestJobAid and MemberMaterialsSent. **Texting Campaigns** Newly eligible members are enrolled in a welcome and benefit texting campaign through our vendor, Virgin Pulse. This campaign is designed to help members understand the requirements and benefits of their health plan. The messages include but are not limited to: Welcome message, member handbook information, website link information, well child benefit information, the nurse advice line number, member rights, advance directives,	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	vaccinations, behavioral health, crisis services, and how to get an insurance card. Please see WelcomeandBenefitTextMessages and TextingReport. **Automated Calls** HCI uses an Interactive Voice Response (IVR) automated calling system to outreach newly enrolled EPSDT-eligible and newly identified pregnant members within 60 days of their enrollment. The message states "Hi, it's Health Colorado calling, your Colorado Medicaid health plan. We would like to tell you about your benefit information which includes well visits, dental visits, and vision screens. You can press 1 to be connected to a live person who can tell you about your health benefits. You may also call 1-888-502-4185. Again, that number is 888-502-4185." **Constant Contact Emails** HCI uses Constant Contact, which is an online platform that is utilized to send emails in bulk. HCI sends an invitation to the monthly "getting started" virtual webinar to members who have given consent to receive emails. HCI has included an example of one of the invitations sent to members. See ConstantContactInvitation.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Social Media Posts HCI routinely posts information to our social media sites that includes information such as our website address, toll-free phone number and email address. See SocialMediaPost.	
17. The RAE provides member information by either: • Mailing a printed copy of the information to the member's mailing address. • Providing the information by email after obtaining the member's agreement to receive the information by email. • Posting the information on the website of the RAE and advising the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost. • Providing the information by any other method that can reasonably be expected to result in the member receiving that information. *42 CFR 438.10(g)(3)* RAE Contract: Exhibit B-8—None	**Documents Submitted:** 1. HCPFWelcomeLetter, entire document 2. HCPFWelcomeLetterEvidence, entire document 3. CoverSheet, entire document 4. WelcomeandBenefitTextMessages, entire document 5. GettingStartedGuideEN, entire document 6. GettingStartedGuideSP, entire document 7. EmailAddressReport, entire document 8. ConstantContactInvitation, entire document 9. GettingStartedInvitationEN, entire document 10. GettingStartedInvitationSP, entire document 11. DHSMeeting, slide 7 12. OctProviderNewsletter, pages 2-3 13. CallCenterContCovTraining, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	14. CareCoordinationPresentation, entire document 15. ProviderRoundtable, entire document 16. SWAGPicture, Entire Document **Description of Process:** HCI provides member information through a variety of platforms, which are outlined below. **Mail** HCI leverages the welcome letter mailed by Health Care Policy and Financing (HCPF) to all newly enrolled members. The welcome letter has HCI's website information and phone contact information and indicates that the regional organization can help members obtain the health care services they need. The welcome letter outlines how members can obtain a member handbook and has HCI's phone number and website information. Additionally, HCI confirmed with HCPF that the HCPF Welcome Letter submitted in this audit is the most recent template. See HCPFWelcomeLtr, entire document, and HCPFWelcomeLtrEvidence. Additionally, HCI attaches a cover sheet to all mailed correspondence that provides our website	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	link. The cover sheet has taglines alerting members of the availability of auxiliary aids at no cost to them. See CoverSheet. **Website** The predominant method HCI uses to provide member information is through our website at https://www.healthcoloradorae.com. HCI's website has a pop-up box which states "If you need any document from our website in large print, Braille, other formats or languages, or read aloud, please contact us. We will send this to you free of charge within five (5) business days. We can also connect to language services or help you find a provider with ADA accommodations. Our number is 888-502-4185. If you have speech or hearing disabilities, there are auxiliary aids you may use (TTY/TDD/American Sign Language at 800-432-9553 or State Relay 711). These services are free." HCI has several member materials on our website to help members with their health care needs including, but not limited to Wellness and Prevention Information Sheets, the member handbook, and "getting started" guides. All of these written materials have our contact information, including our website address.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI promotes our website through a welcome and benefits message, which is sent to new members through our vendor, Virgin Pulse. The message states, "Want a copy of your member handbook? Need to find a doctor? Visit www.healthcoloradorae.com to check out all of the information and tools we offer." Please see WelcomeandBenefitsTextMessages, line 10. HCI participates in several community events throughout the year such as Pueblo PRIDE and the Salida HeadStart Health Fair. HCI brings SWAG with our contact information, including our website address to these events to distribute to members. HCI also distributes our "getting started" guide with our website address to members at these events. See GettingStartedGuideEN, GettingStartedGuideSP and SWAGPicture. **Email** HCI obtains members' email addresses and consent when they contact our call center. The call center staff informs members that the email is to send them health information. HCI developed a monthly report to document the members that have consented to use their email address. HCI's constant contact email has information about how members can participate in our "getting started"	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	webinar and also includes our email address. HCI has included data from one month of our email address report as evidence of collecting email consent from our members, see EmailAddressReport. For evidence of an email sent to members, see ConstantContactInvitation. **DHS meetings** HCI identified that the first point of contact for newly enrolled members are the eligibility technicians at the Department of Human Services (DHS) offices. HCI's member engagement team has been meeting with the eligibility technicians in our 19 counties on a quarterly basis to leverage those relationships. The member engagement team provides eligibility technicians with information that they can give to our members and outlines all of the opportunities for member engagement. This information includes our "getting started" guide and a "getting started" invitation. The invitation has our website information, information on how to request help in other languages and a QR code to direct members to the new member welcome packet located on our website. The getting started invitation is also distributed in the provider newsletter. See: • GettingStartedInvitationEN • GettingStartedInvitationSP	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• GettingStartedGuideEN • GettingStartedGuideSP • DHSMeeting **Virtual Webinar** HCI hosts a "getting started" virtual webinar on the first Thursday of each month to educate members, family members, or health care professionals about member benefits and requirements of their health plan. Information about the getting started webinar is located in our provider newsletter and announced at care coordination meetings. See OctProviderNewsletter, pages 2-3 and CareCoordinationPresentation, slide 8. **Trainings** HCI understands that our call center associates, and our health care professionals have direct member contact either telephonically, in person, or through our email address. HCI meets with the call center leadership and/or team and health care professionals to keep associates and health care professionals informed of member benefit information, wellness and prevention resources, renewal information and other available member materials . HCI encourages associates and health care professionals to verbally communicate	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	member information and distribute member materials to members either in print form or by directing members to our website. For examples of the member information, we make available to associates and health care professionals, see slide decks from CallCenterContCovTraining, CareCoordinationPresentation, and ProviderRoundtable.	
18. The RAE must make available to members, upon request, any physician incentive plans in place. *42 CFR 438.10(f)(3)* RAE Contract: Exhibit B-8—None	**Documents Submitted:** 1. ProviderIncentivePlans, entire document **Description of Process:** HCI incentivizes providers/physicians under our quality performance plans. HCI will make available to members upon their request the physician incentive plans we currently have in place by providing HCI's Physician Incentive Plans document. Members are informed about their right to request any physician incentive plan on our website under our Find a Provider link. The website states, "A member can ask for HCI's physician incentive plans by calling us at 888-502-4185. Members may also email this request to healthcolorado@carelon.com or by completing the contact form on our website." HCI will mail	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	our physician incentive plans to members upon their request. See ProviderIncentivePlans.	

Results for Standard V—Member Information Requirements							
Total	Met	=	18	X	1.00	=	18
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	18	**Total Score**		=	18
				Total Score ÷ Total Applicable		=	100%

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements written policies and procedures for selection and retention of providers. *42 CFR 438.214(a)* RAE Contract: Exhibit B-8—9.1.6	**Documents Submitted:** 1. NWCO 003 Network Development and Access Standards – Pages 1, 11. 2. R4_GeoAccess Compliance - Entire Document 3. R4_Provider_Support_Newly Contracted Provider- Entire Document 4. R4_ProviderSupport_Webinars&Trainings-Entire Document 5. HCI Behavioral Health Medicaid Provider Handbook, pages 18-19 *Misc. **Description of Process:** Carelon Behavioral Health, as the Administrative Service Organization for HCI, has policies in place to select providers (Network Development and Access Standards). The policy is based on the monitoring of the network through the review of network adequacy tools on a minimum of a quarterly basis. An example of the network adequacy tools used is the GeoAccess analysis generated quarterly (R4_GeoAccess Compliance). For retention of providers Carelon maintains “good collaborative relationships with providers through onboarding process and on-going provider supports available through webinars and newsletters. Additionally, utilize administrative communication	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	tools to foster an open communication for timely response to inquiries and issue resolution." All of these documents are available to providers via the HCI website under the Provider Section. Examples of information available to providers are "R4_Provider_Support_Newly Contracted Provider" which is a dedicated page to assist in the onboarding process, and "R4_ProviderSupport_Webinars&Trainings" which includes historical webinars and newsletters for providers to access as needed. Finally, the HCI Behavioral Health Medicaid Provider Handbook outlines activities related to the credentialing and recrredentialing of the provider network and how these activities go hand in hand with the selection and retention of providers.	
2. The Contractor follows a documented process for credentialing and recredentialing of providers that complies with the standards of the National Committee for Quality Assurance (NCQA). • The Contractor ensures that all laboratory testing sites providing services under this contract have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration. *42 CFR 438.214(b)* RAE Contract: Exhibit B-8—9.3.5.2.1 and 9.3.6	**Documents Submitted:** 1. CR 218.14 Credentialing Criteria for Facility,Organizational Providers, Entire Document and Pages 4-5 and section VI **Description of Process:** Carelon Credentialing policy CR 218.14 outlines the criteria and circumstances of requirement for the CLIA certificate for medical services. Carelon is behavioral health and would not require providers to submit a CLIA certificate for its locations. In policy CR 218.14 Credentialing Criteria for Facility,Organizational Providers section VI	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	provides a documented process for credentialing and recredentialing of providers that complies with the standards of the National Committee for Quality Assurance (NCQA).	
3. The Contractor's provider selection policies and procedures include provisions that the Contractor does not: • Discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. • Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42 CFR 438.12(a)(1) and (2)* *42 CFR 438.214(c)* RAE Contract: Exhibit B-8—9.1.6.1-2	**Documents Submitted:** 1. CR 226.11 Prevention and Monitoring of Non-Discriminatory Credentialing and Re-Credentialing-Page 2 & 3 2. BH_Practitioner_Agreement-Pages 17-18, 27-28, 41, 48 **Description of Process:** Carelon Behavioral Health, as the ASO to the RAE, does not discriminate as per BH_Practitioner_Agreement against providers for acting within the scope of their license or providing services to Members that require costly treatment. The agreement states on Exhibit C-4, B,5: "Neither Carelon nor Payors will prohibit, or otherwise restrict, Provider, acting within the scope of his/her professional license and scope of practice, from advising or advocating on behalf of a MCD Member who is his or her patient; including providers that serve high risk population or specialized conditions that require costly treatment." Additionally, N_CR 226.11_Prevent_Monitor_Non-Discriminatory_CredReCred states that Carelon	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	does not make credentialing decisions based on an applicant's race, ethnic/national identity, gender, age, or sexual orientation; licensure or certification; the type of procedure or patient in which the practitioner specializes; or specializes in the conditions that require costly treatment.	
Findings: Carelon submitted policy CR 226.11 titled *Prevention and Monitoring of Non-discriminatory Credentialing and Re-Credentialing* (last reviewed/approved on January 12, 2024). The policy did not include language stating the RAE would 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."		
Required Actions: Carelon must revise 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."		
4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This is not construed to: • Require the Contractor to contract with providers beyond the number necessary to meet the needs of its members. • Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. • Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members. *42 CFR 438.12(a-b)*	**Documents Submitted:** 1. NWCO 003 Network Development and Access Standards - Page 1, 5, 11 2. N_Practitioner Non-Response Letter – Entire Document 3. Denial Letter-Entire Document – Entire Document **Description of Process:** Carelon, as the delegated entity for HCI, maintains the networks for Primary Care Medical Providers (PCMPs) and behavioral health providers as stated in NWCO 003 Network Development and Access Standards. "Carelon will contract with any willing PCMP that meets Medicaid requirements. Carelon will contract with any willing Community Mental	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
RAE Contract: Exhibit B-8—9.1.6.4, 9.1.9, and 14.4.11	Health Center, Federally Qualified Center, Rural Health Center and Indian Health Care Provider. Carelon will also maintain an open network for public and private providers, including independent practitioners, which meet Medicaid and credentialing requirements." Providers who do not respond to requests for documentation to complete contracting and credentialing within 80 days of initial request to join the network will be denied from completing the process. Providers are issued a follow up communication that includes notice of denial should there be no response within established timeframes (N_Practitioner Non-Response Letter). Additional reasons that a provider may be excluded may be if they are applying for Medicaid without a Medicaid enrollment, OIG exclusion, if licensure or education doesn't match the level of care they are applying for. If Carelon determines that the provider does not meet credentialing criteria, Carelon notifies providers, in writing, of any decision to deny inclusion of practitioners in the network and the reason for the denial. See Denial Letter.	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor has a signed contract or participation agreement with each provider. *42 CFR 438.206(b)(1)* RAE Contract: Exhibit B-8—9.1.13	**Documents Submitted:** 1. BH_Practitioner_Agreement_Executed – Entire Document 2. R4_PCP_Practitioner_Agreement_Executed – Entire Document 3. R4_PCP_ContractStatus_FY2023 – Entire Document **Document Description of Process:** Carelon, as the delegated entity for HCI, completes and maintains a signed contract or participating agreement with each practitioner in the network. This is evidenced by examples of signed behavioral health practitioner agreement and signed primary care provider agreement. See: • BH_Practitioner_Agreement_Executed • R4_PCP_Practitioner_Agreement_Executed • R4_PCP_ContractStatus_FY2023 R4_PCP_ContractStatus_FY2023 demonstrates a tracking mechanism used to track signed contracts by Physical Health Care Providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor does not employ or contract with providers or other individuals or entities excluded for participation in federal health care programs under either Section 1128 or 1128 A of the Social Security Act. • The Contractor performs monthly monitoring against HHS OIG's List of Excluded Individuals. *(This requirement also requires a policy.)* *42 CFR 438.214(d)* *42 CFR 438.610* RAE Contract: Exhibit B-8—9.1.15 and 17.10.5	**Documents Submitted:** 1. CR 211.15 Ongoing Monitoring of Practitioner and Organizational Provider Sanctions – Entire Document 2. Sanctions Review Log 2023-Entire Document 3. CO 029.17 Screening Against Exclusion Lists_09.24, Pgs. 6-8 **Description of Process:** HCI/Carelon does not employ or contract with providers or other individuals or entities excluded from participation in federal health programs under section 1128 or 1128 A under the Social Security Act. CO 029.17 Screening Against Exclusion Lists_09.24 includes the list of databases screened prior to hire/contracting and monthly thereafter, includes responsibility and process to complete. It is the policy of Carelon that all credentialed providers or provisionally credentialed practitioners (as available or as required by State or Federal mandate or client request) are monitored between recredentialing cycles for possible sanctions by the Office of the Inspector General (OIG) for Medicare/Medicaid sanctions, the General Service Administration's (GSA) database of Federal Sanctions, the Office of Foreign Assets Control (OFAC) database of individuals and/or entities involved with terrorists and/or terrorist activities, the appropriate state	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	agency, state licensure or certification board, and the Medicare Opt-Out listings for exclusions from Medicare programs, the National Plan & Provider Enumeration System (NPPES) and the Social Security Death Master File (SSDMF/SSDI). Reports of disciplinary/sanction activity are reviewed on a regular basis either monthly or consistent with the reporting entity's publishing cycle if the publishing cycle is greater than monthly. CR 211.15 Ongoing Monitoring of Practitioner and Organizational Provider Sanctions outline the monthly monitoring Carelon Credentialing performs of the OIG for sanctions against practitioner and/or providers and documents its findings on the Sanctions Review Log 2023.	
7. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549. *42 CFR 438.610* RAE Contract: Exhibit B-8—17.9.4.2.3	**Documents Submitted:** 1. CR 206.20 Primary Source Verification- Page 6 2. PSV Checks Example – Entire Document **Description of Process:** Carelon as the delegated entity, includes within its credentialing elements a process by which to monitor "any persons defined as disclosing entities with more than 5% ownership or control."Carelon "queries the National Practitioner Data Bank within 180 calendar days of the final credentialing decision date to verify if there have been any disciplinary	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	actions against clinical privileges, sanctions or adverse actions enacted against provider by licensure boards, exclusions or disbarments by Medicare, or Medicaid, any reported sanctions, fraudulent activity, professional misconduct, or criminal offenses". Any identified sanctions or exclusions for those individuals are presented to the National Credentialing Committee for appropriate action. Evidence is the policy CR 206.20, and the sanction checks as seen in the Primary Source Verification PSV Checks Example.	
Findings: Carelon submitted policy CR 206.20 titled *Primary Source Verification* (last reviewed/approval date on October 17, 2023) that excluded the terms "excluded, suspended, and debarred" from language within the policy.		
Required Actions: Carelon must 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.		
8. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: • The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered. • Any information the member needs in order to decide among all relevant treatment options. • The risks, benefits, and consequences of treatment or non-treatment.	**Documents Submitted:** 1. BH_Practitioner_Agreement-Page 48, 51 2. CR 226.11 Prevention and Monitoring of Non-Discriminatory Credentialing and Re-Credentialing- Page 1 **Description of Process:** The BH_Practitioner_Agreement states on Exhibit C-4, B,5: "Neither Carelon nor Payors will prohibit, or otherwise restrict, Provider, acting within the	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• 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. *42 CFR 438.102(a)(1)* RAE Contract: Exhibit B-8—14.7.3	scope of his/her professional license and scope of practice, from advising or advocating on behalf of a MCD Member who is his or her patient; including providers that serve high risk population or specialized conditions that require costly treatment." Further, Exhibit C-4, I,1 Provider-Member Communication states: "(1) Nothing under this Agreement prohibits, or otherwise restricts, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an MCD Member who is his or her patient, for the following: (a) The MCD Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered. (b) Any information the MCD Member needs in order to decide among all relevant treatment options. (c) The risks, benefits, and consequences of treatment or non-treatment. (d) The MCD Member's right to participate in decisions regarding his or her health are, including the right to refuse treatment, and to express preferences about future treatment decisions." Carelon, as the delegated entity for NHP, has policy CR 226.11 Prevention and Monitoring of Non-Discriminatory Credentialing and Re-Credentialing ReCred where it states that Carelon does not discriminate against providers who act within the	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	scope of his/her license for advising or acting on the behalf of members.	
Findings: Carelon submitted the behavioral health provider agreement template that included all of the required language; however, the language was not located within the PCMP agreement.		
Required Actions: HCI must revise the PCMP agreement to include language stating that does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: • The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered. • Any information the member needs in order to decide among all relevant treatment options. • The risks, benefits, and consequences of treatment or non-treatment. • The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.		
9. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: • To the State upon contracting or when adopting the policy during the term of the contract. • To members before and during enrollment. • To members 30 days prior to adopting the policy with respect to any particular service. *42 CFR 438.102(a)(2)-(b)* RAE Contract: Exhibit B-8—7.3.6.1.13-14 and 14.4.8	**Documents Submitted:** 1. HCI-Behavioral-Health-Medicaid-Provider-Handbook -Page 21 *Misc. 2. HCI-PCMP-Provider-Handbook-Page 27 * Misc. 3. 310L_NonDiscrimination Policy- Entire Document **Description of Process:** Carelon Behavioral Health does not discriminate which makes the reporting to the State moot. The full policy, 310L_NonDiscrimination, affirms its position on non-discrimination with a clear statement on I.a. (page 1) that it does not "discriminate against Members because of race,	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	religion, gender, age, disability, health status or sexual orientation, in the context of receiving care and services from Carelon Behavioral Health Colorado and its providers". Additionally, should a behavioral health provider not offer services due on moral or religious grounds, Carelon as stated in the HCI-Behavioral-Health-Medicaid-Provider-Handbook, has a process in place to assist the Member to secure a behavioral health provider, including out of network that will offer the services. It states: "Carelon has developed a large provider network for the Health First Colorado program that can provide the types of services needed by Members in convenient locations. Members and families can choose any participating provider who is licensed, credentialed, contracted with Carelon, and enrolled with the Colorado Department of Health Care Policy and Financing for the necessary service(s). A member may request that a behavioral health provider be considered to join the network. In cases of a member already in treatment with a behavioral health provider at the time the member qualifies for Health First Colorado the member's behavioral health provider may request a Single Case Agreement and treatment may be continued for the purpose of continuity of care. In cases involving special needs, Carelon may offer a Single Case Agreement to any other behavioral health provider	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	meeting the specialty or cultural requirement and who meets our credentialing, quality criteria and enrolled as a Medicaid provider through the Colorado Department of Health Care Policy and Financing. Under certain circumstances, members may request an out-of-network behavioral health provider." As for a Primary Care Provider, stated in the HCI-PCMP-Provider-Handbook , in accordance with the Department of Health Care Policy & Financing, providers may not dismiss Members based on the Member's gender, race, religion, or sexual orientation. Due to Carelon's policy to not discriminate, the Member cannot be dismissed due to moral or religious reasons.	
10. The Contractor has administrative and management arrangements or procedures, including a compliance program to detect and prevent fraud, waste, and abuse and includes: • Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal, State, and contract requirements. • The designation of a compliance officer who is responsible for developing and implementing policies, procedures and practices to ensure compliance with requirements of the contract and reports directly to the Chief Executive Officer and Board of Directors. • The establishment of a Compliance Committee on the Board of Directors and at the senior management level	**Documents Submitted:** 1. 2023 Elevance Code of Conduct-Entire Document 2. R4_CompPln_FY23-24, Pg. 9, Pgs. 4-8, Pg. 5 3. 2023 Carelon Behavioral Health Compliance Program Description-Entire Document 4. CO 101.11 Compliance Program Activities, Pg. 9 5. CO 100.10 Compliance Program Structure-Entire Document 6. 2023 Carelon Behavioral Health Risk Assessment Summary-Entire Document	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
charged with overseeing the organization's compliance program. • Training and education of the compliance officer, management, and organization's staff members for the federal and State standards and requirements under the contract. • Effective lines of communication between the compliance officer and the Contractor's employees. • Enforcement of standards through well-publicized disciplinary guidelines. • Implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks. • Procedures for prompt response to compliance issues as they are raised, investigation of potential compliance problems identified in the course of self-evaluation and audits, correction of such problems quickly and thoroughly to reduce the potential for reoccurrence, and ongoing compliance with the requirements under the contract. *42 CFR 438.608(a)(1)* RAE Contract: Exhibit B-8—17.1.3 and 17.1.5.1-7	7. 2023 Carelon Behavioral Health Compliance Work Plan Summary-Entire Document 8. PRIV 30.12 HIPAA Intake and Investigation, Pg.3 D. Pg. 4 E., Pg. 6 A. 9. HCI Incident Report_01.01.23_12.31.23-Entire Document 10. PRIV 30D-Disciplinary Guidelines for Privacy Violations-Entire Document 11. 2023 Carelon BH Do the Right Thing Course Content 12. CO 102.13 Policy Development Management_10.24-Entire Document **Description of Process:** HCI has robust administrative management arrangements to detect and prevent fraud, waste, and abuse (R4_CompPln_FY23-24). Additionally, the 2023 Elevance Code of Conduct includes a table of contents to confirm the commitment to Behavioral Health's regulatory requirements and business integrity. The 2023 Carelon Behavioral Health Program Description and R4_CompPln_FY23-24 documents include the seven fundamental elements of an effective compliance plan and guidelines for consistent compliance processes identified by the Office of the Inspector General for the United States Department of Health and Human Services. Policy CO 101.11	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Compliance Program Activities_11.24 provides guidelines for compliance activity processes to ensure consistency throughout the company and CO 100.10 Compliance Program Structure_11.24 explains the roles and responsibilities of the compliance committees and staff members. Element I: Written Policies, Procedures and Standards of Conduct include the commitment to conduct business practices that satisfy all regulatory requirements. This element also includes policies and procedures that are reviewed and updated annually to ensure compliance, demonstrated in CO 102.13 Policy Development Management_10.24. Element II: Confirms the designation of the Compliance Officer with unfettered access to the Board of Directors and functions independently and objectively to oversee the day-to-day activities related to the Compliance Program as shown in R4_CompPln_FY23-24. Element III supports compliance awareness across all levels of the organization and requires specified new hire training within 90 days of employment and annually thereafter as a condition of employment hire date in CO 101.11 Compliance Program Activities_11.24. All employees complete new hire and annual Do the Right Thing training. Training	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	materials are included for review in 2023 Carelon BH Do the Right Thing Course Content. Element IV: Effective Lines of Communication requires the Compliance Officer to communicate formally with the HCI Board of Directors quarterly and informally when needed. Staff are encouraged to report problems or concerns of non-compliance to the Ethics Hotline. Guidance and contact information is included in CO 101.11 Compliance Program Activities_11.24 Element V: Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks includes internal and external monitoring and auditing to identify compliance risks. The 2023 Carelon Behavioral Health Compliance Work Plan Summary and 2023 Carelon Behavioral Health Risk Assessment Summary are examples of monitoring activities. Element VI: Well-Publicized Disciplinary Standards are consistent in action and contingent with the level of findings. Clear expectations are reviewed during new hire and annual training of potential disciplinary consequences of inappropriate behavior. Violations may be grounds for termination or other disciplinary action. PRIV 30D Disciplinary Guidelines for Privacy Violations.	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Element VII: Procedures and System for Prompt Response to Compliance Issues are responded to and addressed promptly. PRIV 30.12_HIPAA Intake and Investigation outlines the preliminary assessment and immediate response including details of the investigation process to identify, mitigate, and prevent future occurrences and the degree of discipline necessary for the level of violation. Initial and final notification to the client shall be in accordance with the BAA or client contract. The HCI Incident Report_01.01.23_12.31.23 documents the incident date, mitigation steps taken and final determination of one HCI regulatory violations for the reporting period requested.	
Findings: During the interview, Carelon, HCI's delegate, described how the compliance program was operationally and functionally run. While Carelon was able to describe the features of the compliance program, including an active compliance committee, no interview attendees from HCI were able to describe HCI's role in leading the compliance program nor in any oversight and monitoring of Carelon's compliance activities. As indicated in its organizational chart, HCI had a designed compliance officer; however, the compliance officer was not present for the interview sessions. While Carelon described quarterly compliance meetings between Carelon and HCI, HCI provided no evidence that HCI or its compliance officer maintained strategic oversight of the compliance program or took ownership of developing and implementing policies, procedures, and practices to ensure compliance. For example, the ethics statement was provided through Elevance Health's Code of Conduct (Elevance Health is a parent company of Carelon) and all of the policies and procedures related to program integrity were from Carelon.		
Required Actions: HCI must 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.		

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor's administrative and management procedures to detect and prevent fraud, waste, and abuse include: • Written policies for all employees, subcontractors or agents that provide detailed information about the False Claims Act, including the right of employees to be protected as whistleblowers. • Provisions for prompt referral of any potential fraud, waste, or abuse to the Department and any potential fraud to the State Medicaid Fraud Control Unit. • Provisions for suspension of payments to a network provider for which the State determines there is credible allegation of fraud (in accordance with 455.23). *42 CFR 438.608(a)(6-8)* RAE Contract: Exhibit B-8—17.1.5.9, 17.1.6, 17.5.1, and 17.7.1 10 CCR 2505-10, Section 8.076	**Documents Submitted:** 1. CO 310.9 Compliance with Fraud Waste and Abuse Laws and Regulations, Pg. 2. A. & B. and Pg. 5, M. 2. R4_CompPln_FY23-24, Pgs. 9-17, Pg. 10, Pg. 15, Pg. 13, 3. SIU 119.9 Carelon Behavioral Health FWA Plan_03.24 – Entire Document 4. SIU 431.3 Provider Payment Suspension Final Draft 2023031-Entire Document 5. R4_MonthlyFWARpt-Entire Document 6. R4_ FWARpt_SemiAnnual-Entire Document **Description of Process:** CO 310.9 Compliance with Fraud Waste and Abuse Laws and Regulations provides guidelines to comply with federal and state laws and regulations related to fraud, waste and abuse including the Federal False Claims Act, Deficit Reduction Act and Whistleblower Employee Protection Act. In the R4_CompPln_FY23-24 (pg. 9-17), the Fraud, Waste and Abuse (FWA) Plan Purpose and Scope section states the purpose of HCIs' FWA Plan is to demonstrate the manner in which HCI and affiliated entities comply with the requirements of the Deficit Reduction Act of 2005 and its obligations related to FWA. Any contractor who received or made Medicare/Medicaid payments in the amount of at	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	least five (5) million dollars during the previous Federal Fiscal Year must comply with all federal requirements for employee education regarding Federal False Claims Act, any applicable state False Claims Act, the right of employees to be protected under Qui Tam (whistleblower) provisions and the organization's policies and procedures for detecting and preventing FWA (see Page 10 R4_CompPln_FY23-24). HCI reports any suspicion or knowledge of fraud and abuse as required by contractual and federal and state regulatory requirements. (See Page 15 of 2023-R4_CompPln_FY23-24ent of Health Care Policy & Financing on a monthly and semi-annual basis any activities regarding FWA, including overpayments. (R4_MonthlyFWARpt and R4_ FWARpt_SemiAnnual). When deemed appropriate and approved by HCPF, HCI suspends payments to a provider after HCI, its clients, and/or government agencies determine there is a credible allegation of fraud for which an investigation is pending against the provider, as defined in 42 C.F.R. §455.23. (See Page 13 of R4_CompPln_FY23-24. SIU 431.3 Provider Payment Suspension Final Draft 2023031 outlines the procedure and process Carelon Behavioral Health follows when suspending provider payments.	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Any contractor who received or made Medicare/Medicaid payments in the amount of at least five (5) million dollars during the previous Federal Fiscal Year must comply with all federal requirements for employee education regarding Federal False Claims Act, any applicable state False Claims Act, the right of employees to be protected under Qui Tam (whistleblower) provisions and the organization's policies and procedures for detecting and preventing FWA (see Page 10 of R4_CompPln_FY23-24). HCI reports any suspicion or knowledge of fraud and abuse as required by contractual and federal and state regulatory requirements. HCI will submit the Managed Care Suspected Fraud Written Notice within three (3) business days following the initial discovery or suspicion. Within five (5) business days of overpayment identification, HCI will submit information and complete information will be provided within 30 calendar days (see Page 15 of R4_CompPln_FY23-24). Additionally, HCI reports to the Department of Health Care Policy & Financing on a monthly and semi-annual basis any activities regarding FWA, including overpayments. (R4_MonthlyFWARpt and R4_ FWARpt_SemiAnnual).	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	When deemed appropriate and approved by HCPF, HCI suspends payments to a provider after HCI, its clients, and/or government agencies determine there is a credible allegation of fraud for which an investigation is pending against the provider, as defined in 42 C.F.R. §455.23. (see Page 13 of R4_CompPln_FY23-24).	
12. The Contractor's Compliance Program includes: • Provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potential fraud. • Provision for prompt notification to the State about member circumstances that may affect the member's eligibility, including change in residence and member death. • Provision for notification to the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including termination of the provider agreement with the Contractor. • Provision for a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. *42 CFR 438.608 (a)(2-5)* RAE Contract: Exhibit B-8—17.1.5.7.1, 17.1.5.7.2-6, 17.3.1.1.2.3-4, and 17.3.1.3.1.1	**Documents Submitted:** 1. MemberChangeJobAid, Entire Document 2. DeceasedMemberTemplate, Entire Document 3. HCIMemberChange Report2023, Entire Document 4. Member Verification Sample Letter_HCI-Entire Document 5. R4_CompPln_FY23-24, Pgs. 9-19 6. R4_MonthlyFWARpt-Entire Document 7. R4_ FWARpt_SemiAnnual Entire Document 8. 2023-9-6-Affiliations Table-Entire Document 9. Region 4 Contract Workbook ACC Phase II Submission- Entire Document **Description of Process:** HCI reports any suspicion or knowledge of fraud and abuse as required by contractual and federal and state regulatory requirements. (See Page 15 of	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	R4_CompPln_FY23-24. Additionally, HCI reports to the Department of Health Care Policy & Financing on a monthly and semi-annual basis any activities regarding FWA, including overpayments. (R4_MonthlyFWARpt and R4_ FWARpt_SemiAnnual). HCI has processes in place to promptly notify HCPF about any changes in member circumstances that may affect the member's eligibility, including a change in residence and member death. HCI developed a Member Change Job aid which we follow to ensure timely notification to HCPF of any change in member circumstances. The job aid outlines how we may identify a change in a member's circumstance. The four primary ways we would learn about a change in a member's circumstance is through the Quality Team, Call Center Team, Care Coordination Team, and Returned Member Mail. The job aid outlines how member deaths are reported in HCPF's ACC Program External Site and in the member change report. The job aid also outlines who we report a change in members' residence. See MemberChangeJobAid,. HCI developed a form for care coordinators to report a member's death which mirrors the information required in HCPF's ACC Program External Site. Care coordinators send the member	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	death notification for Health First Colorado members template to HCI. HCI records any notification of member death in HCPF's database within five business days. Member death notification is also included in the monthly member change report due to HCPF the fifth day of each month. See DeceasedMemberTemplate, entire document and HCIMemberChangeReport2023, entire document. On an annual basis, Carelon Behavioral Health sends out member verification surveys to a sample of selected RAE members to solicit response confirming that services have been received by members as billed (Member Verification Sample Letter_HCI). The process for communicating provider changes to the Sate starts with entering changes go into the state database by the 15th of the month. Then the Contract Workbook (Region 4 Contract Workbook ACC Phase II Submission) is sent to the RAE to notify the RAE of any changes. Then the following month by the 10th, Carelon receives an updated Affiliations Table of PCMP providers from HCPF showing the changes have been made. See 2023-9-6-Affiliations Table. Attached is the August 2023 Change Table showing providers that were removed from PCMP and the	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	9.6.23 Affiliations table showing that they have been removed (by search of NPI).	
13. The Contractor ensures that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure screening, and enrollment requirements of the State. • The Contractor may execute network provider agreements pending the outcome of the State's screening and enrollment process of up to one-hundred and twenty days (120) days, but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one one-hundred and twenty days (120)-day period without enrollment of the provider, and notify affected members. *42 CFR 438.608(b)* RAE Contract: Exhibit B-8—9.2.1.1, 9.3.2, and 17.9.2	**Documents Submitted:** 1. CR 206.20 Primary Source Verification, page 5 2. Sanctions Review Log 2023_Entire Document 3. Providers_Pending_Disenrollment RAE-Entire Document *MISC. 4. ProviderTermLetter-Entire Document *Misc. **Description of Process:** As the delegated entity, the Carelon Credentialing team performs primary source state-required verification for Medicaid provider enrollments during credentialing and recredentialing. This includes review of the enrollment using the state-specific Medicaid Management Information System (MMIS). These verifications are performed within 180 days of the credentialing and recredentialing decision date using the state's process as outlined in N_CR 206.20 Primary Source Verification . Regarding disenrollments, the Credentialing team will make recommendations for disenrollment if the provider no longer meets the criteria of an in-network provider including notification from the State. The Disenrollment process is completed by a dedicated team in accordance with NCQA, Federal,	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	State, Client and Organizational guidelines. This team communicates the disenrollment to the providers, and that process triggers member letters to all affected members attached to that provider. Credentialing conducts a weekly meeting with Provider Relations and Contracting associates to review a report of all providers who are on the path to disenrollment, including their claims counts, so that we have additional reinforcement in trying to prevent disenrollment of/retaining high utilization providers. On a weekly basis, Beacon runs a report of providers pending disenrollment and includes reason for the disenrollment. The report is reviewed by staff to confirm disenrollment is accurate. Once confirmed, Member Services is notified to send letter to affected members. See ProviderTermLetter. Enclosed is an example of the report and internal communication regarding the termination "Providers_Pend_Disenrollment." Sanctions Review Log 2023 is the record maintained of these monthly sanction checks. On a weekly basis, Carelon runs a report of providers pending disenrollment and includes reason for the disenrollment.	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor has procedures to provide to the State: • Written disclosure of any prohibited affiliation (as defined in 438.610). • Written disclosure of ownership and control (as defined in 455.104) • Identification within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract. *42 CFR 438.608(c)* RAE Contract: Exhibit B-8—17.3.1.5.1.1, 17.9.4.3, and 17.10.2.1	**Documents Submitted:** 1. R4_QuarterlyFinInfo_Q4_FY22-23, on tab: Admn PMPM Exp. 2. BH_Practitioner_Agreement 21-22 3. HCI-Behavioral-Health-Medicaid-Provider-Handbook -Page 32-33 *Misc. 4. R4_PCMP_Agreement-Page 6 5. R4_PCMP_Agreeemnt_Executed-Entire Document 6. CR 206.20 Primary Source Verification-Page 6 **Description of Process:** For Behavioral health providers, the BH_Practitioner_Agreement and R4_PCMP_Agreeemnt_Executed informs of recoupment, offset, adjustment for overpayments for the "time as required by Applicable Rules" and directs the provider to Provider Manual (aka Provider Handbook) for specifics. The HCI-Behavioral-Health-Medicaid-Provider-Handbook specifies the procedures for overpayment recovery. For Primary Care Providers, regarding the capitation payments or other payments in excess of the amounts specified in the contract, HCI conducts monthly payments to the Primary Care Providers for the Per Member Per Month, which are reviewed and	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	approved by Carelon staff as well as RAE management. The amounts paid are based on the Member attribution issued by the Department of Health Care Policy & Financing for the payment month. Should there be an over or underpayment or other error, the payment is automatically adjusted on the subsequent payment to the provider. Additionally, since the month-to-month payments vary, R4_PCMP_Agreement states that provider is able to request review of payments when they determine may be incorrect by a margin of ten percent (10%) or more within thirty (30) days of the receipt of the payment. This information is reported to HCPF on the quarterly finance report, see R4_QuarterlyFinInfo_Q4_FY22-23on tab Admn PMPM Exp. Carelon as the delegated entity, includes within its credentialing elements a process by which to monitor "any persons defined as disclosing entities with more than 5% ownership or control". Carelon "queries the National Practitioner Data Bank within 180 calendar days of the final credentialing decision date to verify if there have been any disciplinary actions against clinical privileges, sanctions or adverse actions enacted against provider by licensure boards, exclusions or disbarments by Medicare, or Medicaid, any reported sanctions, fraudulent activity, professional misconduct, or criminal offenses". Any identified sanctions or	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	exclusions for those individuals are presented to the National Credentialing Committee for appropriate action. Evidence is policy_CR 206.20 Primary Source Verification and the sanction checks as seen in the Primary Source Verification PSV Checks Example.	
15. The Contractor has a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days of identifying the overpayment, and to notify the Contractor in writing of the reason for the overpayment. • The Contractor reports semi-annually to the State on recoveries of overpayments. *42 CFR 438.608 (d)(2) and (3)* RAE Contract: Exhibit B-8—17.1.5.8 and 17.3.1.2.4.4	**Documents Submitted:** 1. BH_Practitioner_Agreement-Page 21-22 2. HCI-Behavioral-Health-Medicaid-Provider-Handbook -Page 32-33 *Misc. 3. R4_PCMP_Agreement -Page 6 4. R4_PCMP_Agreeemnt_Executed 5. R4_MonthlyFWARpt- Entire Document 6. R4_FWARpt_SemiAnnual – Entire Document 7. R4_QuarterlyFinInfo_Q4FY22-23, on tab Admn PMPM Exp. **Document Description of Process:** For Behavioral Health network, BH_Practitioner_Agreement and R4_PCMP_Agreeemnt_Executed requires providers to cooperate in the efforts to recover overpayments including "Upon determination by Carelon or Payor that any recoupment, improper payment, or overpayment is due from Provider, Provider must refund the amount to Carelon or Payor, as applicable, within thirty (30) days of when Carelon	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	or Payor notifies Provider… If such reimbursement is not received by Carelon or Payor within the thirty (30) days following the date of such notice (or, if a longer period of time is required by Applicable Rules, then within the minimum amount of days required by reason thereof), Carelon or Payor shall be entitled to offset such overpayment against any Claims payments due and payable to Provider under any Plan subject to this Agreement in accordance with Applicable Rules." The HCI-Behavioral-Health-Medicaid-Provider-Handbook specifies the procedures for overpayment recovery. For Primary Care Providers, regarding the capitation payments or other payments in excess of the amounts specified in the contract, HCI conducts monthly payments to the Primary Care Providers for the Per Member Per Month, which are reviewed and approved by Carelon staff as well as RAE management. The amounts paid are based on the Member attribution issued by the Department of Health Care Policy & Financing for the payment month. Should there be an over or underpayment or other error, the payment is automatically adjusted on the subsequent payment to the provider. Since the month-to-month payments vary, R4_PCMP_Agreement states that provider is able to request review of payments when they determine may be incorrect by a margin of ten percent (10%) or more within thirty (30) days of the receipt of the	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	payment. This information is reported to HCPF on the quarterly finance report, see R4_QuarterlyFinInfo_Q4_FY22-23on tab Admn PMPM Exp. HCI reports to the Department of Health Care Policy & Financing on a monthly and semi-annual basis any activities regarding Fraud, Waste, and Abuse, including overpayments, please find copies of the monthly reports (R4_MonthlyFWARpt and R4_ FWARpt_SemiAnnual).	
16. The Contractor provides that members are not held liable for: • The Contractor's debts in the event of the Contractor's insolvency. • Covered services provided to the member for which the State does not pay the Contractor. • Covered services provided to the member for which the State or the Contractor does not pay the health care provider that furnishes the services under a contractual, referral, or other arrangement. • Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. *42 CFR 438.106* RAE Contract: Exhibit B-8—14.14.1-2 and 17.13.2-4	**Documents Submitted:** 1. BH_Practitioner_Agreement -Page 21-23 2. BH_Practitioner_Agreement_Executed-Entire Document 3. HCI-Behavioral-Health-Medicaid-Provider-Handbook - Page 30 *Misc. 4. BH_Provider Support Call Presentation-Page 29 5. CO 303.2 Conflict of Interest – Entire Document 6. CO 029.17 Screening Against Exclusion – Entire Document 7. R4_PCMP_Agreement-Page 10 **Description of Process:** Carelon BH, as the delegated entity for HCI, has policy CO 303.2 Conflict of Interest to require	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	individuals to disclose and update Carelon on potential conflict of interest issues and outlines the process for handling any disclosures. Additionally, policy CO 029.17 Screening Against Exclusion, addresses Carelon BH does not employ, contract, conduct business with individuals or entities listed by a federal agency or state law enforcement, regulatory or licensing agency as excluded, suspended, debarred, or otherwise ineligible to participate in federally funded health care programs. Exclusion screens are conducted prior to hire/contracting monthly thereafter against the lists/databases located on pg. 5. Behavioral Health Providers are required to "not balance bill Members for covered services rendered". This is included in the BH_Practitioner_Agreement and BH_Practitioner_Agreement_Executed as well as the HCI-Behavioral-Health-Medicaid-Provider-Handbook. Behavioral Health Providers were informed about this requirement during a provider support call on July 14, 2023 (BH_Provider Support Call Presentation).	

Results for Standard VII—Provider Selection and Program Integrity							
Total	Met	=	12	X	1.00	=	12
	Partially Met	=	3	X	.00	=	0
	Not Met	=	1	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	16	**Total Score**		=	12
				Total Score ÷ Total Applicable		=	75%

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. Notwithstanding any relationship(s) with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. *42 CFR 438.230(b)(1)* RAE Contract: Exhibit B-8—4.2.13	**Documents Submitted:** 1. Administrative Services Agreement Pg 2, Section 2.1 *Misc **Description of Process:** Per the Administrative Services Agreement between HCI and Carelon Behavioral Health formerly Beacon Health Options, Inc. (referred to as Carelon Behavioral Health) HCI maintains ultimate authority over delegated functions.	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: The delegation agreement between HCI and Carelon did not include the standard to which Carelon was held nor the frequency, methodology, and periodicity for conducting the ongoing monitoring.		
Required Actions: HCI must have direct oversight and evidence of ongoing monitoring performed by HCI of any delegated activities pertaining to 42 CFR 438.		

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. All contracts or written arrangements between the Contractor and any subcontractor specify: • The delegated activities or obligations and related reporting responsibilities. • That the subcontractor agrees to perform the delegated activities and reporting responsibilities. • Provision for revocation of the delegation of activities or obligations or specify other remedies in instances where the Contractor determines that the subcontractor has not performed satisfactorily. *Note: Subcontractor requirements do not apply to network provider agreements. In addition, wholly owned subsidiaries of the RAE are not considered subcontractors.* *42 CFR 438.230(b)(2) and (c)(1)* RAE Contract: Exhibit B-8—4.2.13.6	**Documents Submitted:** 1. Administrative Services Agreement Pg 1, Section 1.1, Pg 5 Section 6.2-6.3, pages 10-21 Description of services-*Misc **Description of Process:** Per the HCI Administrative Services Agreement with Carelon Behavioral Health, Carelon is delegated all nonclinical services required for performance of the Medicaid contract. The Administrative Services Agreement goes on to further outline the specific scope of services and deliverables agreed upon. The Agreement also provides for corrective actions or revocations for performance concerns.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's written agreement with any subcontractor includes: • The subcontractor's agreement to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions. *42 CFR 438.230(c)(2)* RAE Contract: Exhibit B-8—4.2.13.6	**Documents Submitted:** 1. Administrative Services Agreement, PG 1 Purpose of Agreement PG 1 Section 1.1, Pg 2 Section 1.2-1.3, Page 3 Section 4.1, PG 6 Section 7.0, Page 8 Section 8.16-8.17, Page 22 *Misc **Description of Process:** Per the HCI Administrative Services Agreement with Carelon Behavioral Health, Carelon as the subcontractor agrees to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The written agreement with the subcontractor includes: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State. – The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems related to members.	**Documents Submitted:** 1. Administrative Services Agreement HCI Page 2 Section1.3-1.4, Page 4 Section 5.1-5.3 *Misc 2. 1st Amendment to the ASA dated 9.22.21-Entire Document **Description of Process:** Per the HCI Administrative Services Agreement and additional 1st Amendment to the Agreement, the State, CMS, HSS Inspector General, the Comptroller General or their designees have the right to audit, evaluate and inspect any and all applicable records.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– 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. *42 CFR 438.230(c)(3)* RAE Contract: Exhibit B-8—4.2.13.6		
Findings: HSAG reviewed the subcontractor agreements and found that the written agreements did not include all required information.		
Required Actions: HCI must ensure, via revisions or amendments, that its subcontractor agreements include the following language: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State. – The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems related to 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.		

Results for Standard IX—Subcontractual Relationships and Delegation							
Total	Met	=	2	X	1.00	=	2
	Partially Met	=	1	X	.00	=	0
	Not Met	=	1	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	4	**Total Score**		=	2
			Total Score ÷ Total Applicable			=	50%

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. *42 CFR 438.330(a)(1)* RAE Contract: Exhibit B-8—16.1.1	**Documents Submitted:** 1. Administrative Services Agreement-Page 15 Quality Management section *Misc. 2. R4_QualityImprovePln_FY23-24- Entire Document 3. R4_QualityRpt_FY23-24- Entire Document 4. QM WorkPlan FY24_Final- Entire Document 5. QIUM_Region 4_HCI_Minutes__2023June-Page 2, Number 5 6. QIUM_Region 4_HCI_Minutes_Approved-Signed_2023July-Page 2, Number 4 7. R4_PopMangPln_FY23-24 -Entire Document 8. Quality Improvement Utilization Management Committee Charter_Signed_23-24-Entire Document 9. HCI RAE4 Committee Structure_July2023 FINAL – Copy-Entire Document **Description of Process:** HCI delegates all quality management functions to Carelon Behavioral Health. (Administrative Services Agreement). Carelon, along with the HCI Quality Improvement /Utilization Management Committee (QIUM) develops an annual Quality Report, Annual Quality Plan and a Work Plan. See (R4_QualityImprovePln_FY23-24,	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	R4_QualityRpt_FY23-24, QM WorkPlan FY24_Final) The QM WorkPlan documents detail the planned quality improvement activities for the fiscal year. The Annual Report details the completed quality improvement and quality assurance activities that have taken place over the previous fiscal year. The Annual Plan is a detailed report that addresses the quality assurance activities that will occur over the coming fiscal year. The QIUM committee reviews the progress on the work plan quarterly to discuss progress made towards performance improvement. See QIUM_Region 4_HCI_Minutes__2023June and QIUM_Region 4_HCI_Minutes_Approved-Signed_2023July. The HCI RAE4 Committee Structure_July2023 FINAL – Copy demonstrates the oversight of the Quality Management program. In addition, Quality Improvement Utilization Management Committee Charter_Signed_23-24 demonstrates the oversite of the QIUM committee. R4_PopMangPln_FY23-24 details HCIs strategic plan to improve the health of the regions Members. This plan is used to create a framework to guide HCIs activities in order to accomplish the goals of ACC Phase II.	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor's QAPI Program includes conducting and submitting (to the State) annually performance improvement projects (PIPs) that focus on both clinical and nonclinical areas. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. Each PIP includes the following: • Measurement of performance using objective quality indicators. • Implementation of interventions to achieve improvement in the access to and quality of care. • Evaluation of the effectiveness of the interventions based on the objective quality indicators. • Planning and initiation of activities for increasing or sustaining improvement. *For RAEs two PIPs are required, one administrative and one clinical.* *42 CFR 438.330(b)(1) and (d)(2) and (3)* RAE Contract: Exhibit B-8—16.2.1.1, 16.3.5, and 16.3.8	**Documents Submitted:** 1. HCI_2023 PIP Submission Form_ED_SUD_FU-Entire Document 2. HCI_2023 PIP Submission Form_SDoH-Entire Document 3. Attachment A FY2023 Adult HEDIS Codes-Entire Document 4. Attachment B FFY2023 Child HEDIS Codes-Entire Document 5. Attachment C FUA-AD 2023-Entire Document 6. Attachment D FUA-CH 2023-Entire Document 7. Attachment E HCI R4 Data Completeness Calculation-Entire Document 8. Attachment F HCI Key Driver Diagram-FUA-Entire Document 9. Attachment G BHinPC_CodeSet-Entire Document 10. Attachment H PRAPARE-English-Entire Document 11. Attachment I PRAPARE Essette Crosswalk-Entire Document 12. Attachment J HCI Key Driver Diagram-SDoH-Entire Document 13. HCI-R4_CO2023-24_PIP-Val_ED_Visit_Tool_D1_1223	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	14. HCI-R4_CO2023-24_PIP-Val_SDOH_Tool_D1_1223-Entire Document 15. HCI-R4_CO2023-24_PIP-Val_SDOH_Tool_F1_0224- Entire Document **Description of Process:** In collaboration with the Department, HCI selected two (2) performance improvement projects (PIP) topics in FY24. HCPF communicated that the next three-year cycle for PIPs will consist of two separate projects. One PIP must focus on a clinical topic while the other will focus on a non-clinical topic. Selecting from the list of potential clinical measures provided by HCPF, HCI elected to pursue performance improvement on the ED SUD Follow-up measure (HCI_2023 PIP Submission Form_ED_SUD_FU). This measure was chosen due to alignment with the PMAP work that had already commenced with Parkview Medical Center and Health Solutions. The measure specifications for the project will be migrated to the new BHIP measure specification that aligns with the CMS Core Measure: Follow-up After ED Visit for Substance Use (FUA). Baseline data and measure specifications were submitted to HCPF prior to the suspense of October 31, 2023. This submission earned High Confidence on the Overall Confidence of Adherence to Acceptable	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Methodology from HSAG (HCI-R4_CO2023-24_PIP-Val_ED_Visit_Tool_D1_1223). HCPF directed that the non-clinical PIP must initiate performance improvement to target increased performance of Social Determinants of Health (SDOH) screening among behavioral health utilizers in the region, (HCI_2023 PIP Submission Form_SDoH). Following a Technical Assistance (TA) call with HSAG in March 2023, HCI will initiate PIP efforts by understanding current available data streams on SDOH. HCI will develop further interventions based on the information gathered. Potential partners for pilot PIP work will be recruited at the QIUM Committee meeting to refine the process for performing this screening and aggregating this information through impactful and sustainable interventions before RAE-wide implementation is initiated. HCI also plans to incorporate current SDOH screening that is routinely performed by the delegated care coordination entities as part of their intake assessment. This submission earned Moderate Confidence on the Overall Confidence of Adherence to Acceptable Methodology from HSAG on initial submission (HCI-R4_CO2023-24_PIP-Val_SDOH_Tool_D1_1223). This document was be resubmitted to HSAG in January 2024 to address the HSAG notes. This submission earned a High	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Confidence rating (HCI-R4_CO2023-24_PIP-Val_SDOH_Tool_F1_0224). Attachments A-J are included to provide essential details required for precise Performance Improvement Project documentation. See: Attachment A FY2023 Adult HEDIS Codes, Attachment B FFY2023 Child HEDIS Codes, Attachment C FUA-AD 2023, Attachment D FUA-CH 2023, Attachment E HCI R4 Data Completeness Calculation, Attachment F HCI Key Driver Diagram- FUA, Attachment G BHinPC_CodeSet, Attachment H PRAPARE-English, Attachment I PRAPARE Essette Crosswalk, and Attachment J HCI Key Driver Diagram- SDoH.	
3. The Contractor's QAPI Program includes collecting and submitting (to the State): • Annual performance measure data using standard measures identified by the State. • Data, specified by the State, which enables the State to calculate the Contractor's performance using the standard measures identified by the State. • A combination of the above activities. *42 CFR 438.330(b)(2) and (c)* RAE Contract: Exhibit B-8—16.4.1 and 16.4.4	**Documents Submitted:** 1. R4_FlatFileQ1FY23-24 SFY22 Base Data Statistics Report-Entire Document 2. R4_FlatFile_Q1FY23-24 HCPF Response_Accepted-Entire Document 3. Content Available for Mar23 HCI PAD Meeting-Entire Document 4. HCI PAD Meeting_November 2023-Entire Document 5. R4_CondMangRpt_Q3Q4FY22-23-Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	6. R4_CondMangRpt_Q3-Q4 FY 22-23-Entire Document **Description of Process:** The current process for the calculation of the performance measurement data for the Behavioral Health Incentive Program (BHIM) measures and the Key Performance Indicators (KPIs) rests with the State of Colorado. The State currently calculates the performance for the RAEs on these measures. This calculation is based off of the submission of claims and encounters through the flat file submission. See, R4_FlatFileQ1FY23-24 SFY22 Base Data Statistics Report and R4_FlatFile_Q1FY23-24 HCPF Response_Accepted. HCI will provide the State data and analysis on an ad hoc basis during the Program and Data (PAD) meeting as it pertains to specific performance measures. Examples in CY2023 include analysis of Residential SUD Service Utilization (March 2023), High Intensity SUD Service Utilization (March 2023), ED utilization (November 2023). See Content Available for Mar23 HCI PAD Meeting and HCI PAD Meeting_November 2023. HCI submits the Condition Management Report semi-annually to provider performance data on many national standard measures relevant to the priority conditions identified by the Department	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	(e.g., diabetes, anxiety/depression, substance use disorder) as well as to describe performance improvement activities related to these conditions. (See R4_CondMangRpt_Q3Q4FY22-23 and R4_CondMangRpt_Q3-Q4 FY 22-23.)	
4. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42 CFR 438.330(b)(3)* RAE Contract: Exhibit B-8—16.6.1	**Documents Submitted:** 1. QIUM_Region 4_HCI_Agenda_2023October-Number 5-Power Point Presentation 2. QIUM_Region 4_HCI_Minutes_Approved-Signed_2023Oct-Page 5-6 3. Blank ClinicalAuditTool_QM- Entire Document *Misc. 4. ClinicalAudTool_SUD-Entire Document 5. Detox_ClinicalAuditTool_SUD_QM-Entire Document 6. TCM_ClinicalAuditTool_UPDATED2022 Nov_QM-Entire Document 7. E and M CODING AUDIT FORM_2021March-Entire Document 8. ClinicalAudTool_MAT_SUD-Entire Document 9. Blank ClinicalAuditTool_IOP_UPDATED2022Oct_QM-Entire Document 10. ClinicalAuditTool_Q4FY23_Redacted-Entire Document 11. Blank Claims Audit Tool_QM-Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	12. R4_QualityImprovePln_FY23-24-Page 4 through 19 13. CHCI_COUP Data_CY2023Q1-Entire Document 14. Top 50 Report - Health Solutions-Entire Document 15. HCI_2023 PIP Submission Form_ED_SUD_FU-Entire Document 16. HCI_2023 PIP Submission Form_SDoH-Entire Document 17. Care coordination audit results redacted - Entire Document 18. HCI CC Audit Tool FY22-23_FINAL-Entire Document 19. R4_KPI_BHIP_PerformancePool_Executive_Summary_06_2023-Entire Document 20. R4_KPI_BHIP_PerformancePool_Report_2023-01-Entire Document 21. QIUM_Region 4_HCI_Minutes__2023June-Page 5 Section B 22. IP Readmissions_HCI-Entire Document 23. RAE4 Penetration Rates by Eligibility 2023-10-05-Entire Document 24. PMAP- Pueblo DHS Minutes 21Nov23-Entire Document 25. BHO NDA Carelon and Pueblo County DHS August 2023-Entire Document 26. R4_EPSDTRptQ1FY22-23, pages 5-7 27. R4_EPSDTRptQ4FY22-23, pages 4-6	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	28. R4_EPSDTRptQ3FY22-23, pages 5-6 29. R4_EPSDTRptQ2FY22-23, pages 5-6 30. Text4baby, pages 18, 19, 38-46 31. Text4kids, pages 75-81 32. WellVisitTextCampaign-Entire Document 33. WellVisitLetterEN, page 3 34. WellVisitLetterSP, page 3 35. OutreachReports-Entire Document **Description of Process:** HCI ensures mechanisms are in place to detect and evaluate both over-and under-utilization, as noted in the Annual Quality Improvement Plan (R4_QualityImprovePln_FY23-24). Regular audits take place to assess service utilization. Results of these audits are demonstrated in ClinicalAuditTool_Q4FY23_Redacted. Furthermore, HCI audits network providers over a wide variety of clinical services. The blank audit tools listed below demonstrate the wide variety of audits that HCI conducts on a regular and ongoing basis. • Blank ClinicalAuditTool • ClinicalAudTool_SUD • Detox_ClinicalAuditTool_SUD_QM • TCM_ClinicalAuditTool_UPDATED2022 Nov_QM • E and M CODING AUDIT FORM_2021March	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• ClinicalAudTool_MAT_SUD • Blank ClinicalAuditTool_IOP_UPDATED2022Oct_QM • Blank Claims Audit Tool_QM HCI audits network providers to ensure that services are appropriately utilized. Furthermore, accountable entities in RAE region 4 are also audited for compliance with care coordination requirements. These audits can provide insight into the manner in which Members are being connected with and utilizing services. See Care coordination audit results redacted and HCI CC Audit Tool FY22-23. HCI_2023 PIP Submission Form_ED_SUD_FU demonstrates an attempt to increase utilization of follow up appointments after a member seeks treatment at an emergency department for an SUD related reason. The HCI_2023 PIP Submission Form_SDoH attempts to identify Members with non-medical factors that may impact health outcomes and healthcare utilization. It is the hope that by identifying non-medical needs and potentially connecting Members with relevant resources that utilization of medically necessary services will increase. HCI is actively engaged in what is called a COUP lock-in Diversion program. The aim of the lock-in	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Diversion program is for COUP Members to address overutilization of services. The COUP program addresses over utilization of services that would make a member appropriate for lock-in services through the RAE. The CHCI_COUP Data_CY2023Q1 report is used for lock-in status and those requested for lock-in diversion for the quarter. This report uses overutilization data in an attempt to help to reduce pharmacy and Emergency Department over utilization. Mechanisms in place to monitor both over- and under-utilization include: QIUM_Region 4_HCI_Agenda_2023October communicate the Membership utilization trends and are reviewed monthly at the HCI QIUM meeting. If there is a decrease or increase in utilization on a particular level of care these ideas can be addressed at committee meeting. See QIUM_Region 4_HCI_Minutes_Approved-Signed_2023Oct. Additional mechanisms for identifying high and low utilizers include: • Utilization trends and are reviewed monthly at the HCI QIUM meeting. See QIUM_Region 4_HCI_Minutes_Approved-Signed_2023Oct and QIUM_Region 4_HCI_Agenda_2023October. When an	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	area of concern is identified, a specific intervention is then applied. • The Top 50 Report - Health Solutions is a measure of the total cost of care for a member. It combines paid claims and the value of encountered services provided by the CMHC. This report identifies the highest cost utilizers during a specified time period. These reports are distributed to our CMHC partners to review the utilizations patterns and any anomalies. If an anomaly is identified, the Clinical or Quality team can request additional documentation of medical necessity and the rationale for the higher than expected utilization. • Similarly, the IP Readmissions_HCI.xls report is used to identify 30-day readmissions that result from underutilization or poor follow-up after hospital discharge. Penetration rates (RAE4 Penetration Rates by Eligibility 2023-10-05.xls) can be used to identify categories of membership that are not accessing services at the expected frequency. In addition, as seen in R4_KPI_BHIP_PerformancePool_Report_2023-01, and R4_KPI_BHIP_PerformancePool_Executive_Summary_06_2023. Performance in the Key	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Performance Indicators (KPIs) and Behavioral Health Incentive Program (BHIM) measures are also reviewed monthly for performance trends as several of these measures identify potential under- or over-utilization. See QIUM_Region 4_HCI_Minutes_2023June for potential group discussion. Performance on the BHIM measure: Behavioral Health Screening or Assessment for Children in the Foster Care System is the focus of a Performance Measures Action Plan (PMAP) work group to target underutilization of this valuable service for this vulnerable population. Upon final approval of a data-sharing agreement with Pueblo County Department of Human Services (DHS) in late 2023, this group is striving to expedite timely and meaningful notifications of the Community Mental Health Center (CMHC) to initiate outreach and increase engagement in behavioral health services. See: BHO NDA Carelon and Pueblo County DHS August 2023 and PMAP- Pueblo DHS Minutes 21Nov23. HCI monitors EPSDT eligible member's receipt of screenings and examinations in accordance with the American Association of Pediatric's Bright Futures guidelines. HCI has the link to the Bright Futures guidelines on our website under EPSDT resources located in New Member Resources to educate	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	members, family members and health care professionals on the standards set forth by the American Academy of Pediatrics. HCI relies on our Primary Care Medical Providers (PCMPs) to complete a thorough screening for our members under 21 years of age. HCI's goal has been to monitor members who have not had a well visit under the age of 21 and to outreach these members with a reminder that they may be due for their well visit and/or dental visit. These reminders are through text messaging, interactive voice response (IVR) automated calls, or letters. During Q2FY22-23, HCI supported an outreach to all school-aged children who were assigned to Pueblo Community Health Center to inform them of the importance of well visits and link them with school-based health clinics. Some of these members may have already had a well visit in the previous 12 months. HCI sent the following number of messages to members who were identified as not having a well visit in the previous 12 months. Below are the number of outreaches sorted by outreach type from October 1, 2022 – September 30, 2023.	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**

Quarter/ FY	IVR	Texts	Mail	Combo
1FY23-24	1542	2952	60	38
4FY22-23	2334	2993	0	0
3FY22-23	2098	1993	0	7
2FY22-23	2861	2318	1713	250
Total	8,835	10,256	1773	295

For evidence of outreach to non-utilizing members, see R4_EPSDTRptQ1FY22-23, pages 5-7, R4_EPSDTRptQ4FY22-23, pages 4-6, R4_EPSDTRptQ3FY22-23, pages 5-6, and R4_EPSDTRptQ2FY22-23, pages 5-6.

IVR automated calls

HCI sends the following message to members who have been identified as not having a well visit in the previous 12 months and who are not enrolled in one of our texting campaigns.

"Hi, it's Health Colorado calling, your Colorado Medicaid health plan. This is a friendly reminder for you to schedule a well visit or dental check-up for you or your child with your doctor or dentist. If you need help finding or scheduling an appointment

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	with a primary care provider or a dentist, you can press 1 to be connected to a live person who can help you. You may also call 1-888-502-4185. Again, that number is 888-502-4185." Spanish-speaking members are sent this message: "Hola, soy Health Colorado, su plan de salud Medicaid de Colorado. Este es un recordatorio amistoso para que programe una visita de bienestar o un chequeo dental para usted o su hijo con su médico o dentista. Si necesita ayuda para encontrar o programar una cita con un proveedor de atención primaria o un dentista, puede presionar 1 para conectarse con una persona en vivo que pueda ayudarlo. También puede llamar al 1-888-502-4185. Nuevamente, ese número es 888-502-4185". **Text Messages** Text4baby is a campaign for pregnant members which supports women throughout their pregnancy and provides prenatal recommendations to promote full-term births. The text4baby messages focusing on preventative baby care begin based on a member's due date or notification that the baby has been delivered. There are new baby protocol messages which encourage new moms to take their child to the doctor at regularly scheduled times. See Text4baby, pages 18, 19 and 38-46.	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Text4kids is a campaign for parents and guardians of members aged 1-18. The campaign provides educational messages to the parents and/or guardians regarding health-related topics like developmental milestones, child well visits, and dental visits. Reminders are sent at targeted times to encourage parents and/or guardians to complete their child's well visit. See Text4kids, pages 75-81. The Well Visit Text Campaign is a campaign designed for all ages over one years of age to remind members to schedule and attend their well visit and provide education on needed immunizations. The target audience for this campaign is for members who have not had a well visit in the previous 12 months. See WellVisitTextCampaign, entire document. HCI developed a well visit reminder letter to send to members who have opted out of text messaging and/or IVR automated calls or those members who do not have a valid phone number. HCI began to send these letters to members based on these criteria in Q1 of FY23-24. See WellVisitLetterEN, page 3 and WellVisitLetterSP, page 3. HCI created a report to review the efficacy of our outreach efforts by outreach type. The reports reflect whether a member had a well visit after an	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	outreach campaign, and which outreach campaign related to a member attending an appointment. HCI runs the report 6 months post outreach to allow for all claims to be processed. During Q2FY22-23, there were 26.85% members who had a well visit appointment post outreach. During Q3FY22-23, there were 23.60% of members who had a well visit post outreach. During Q4FY22-23, there was 18.90% of members had a well visit post outreach. HCI ran the report for our most recent outreach period, Q1FY23-24 and are currently at 11.48% of members having a visit post outreach, noting that a full six months have not elapsed to review all claim data. Please see OutreachReports	
5. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. *Note: Persons with special health care needs shall mean persons having ongoing health conditions that have a biological, psychological, or cognitive basis; have lasted or are estimated to last for at least one year; and produce one or more of the following: 1) a significant limitation in areas of physical, cognitive, or emotional function; 2) dependency on medical or assistive devices to minimize limitation of function or activities; 3) for children: significant limitation in social growth or developmental function; need for psychological, educational, medical, or related services over and above the usual for the child's age; or special ongoing treatments such as medications, special diets, interventions, or accommodations at home or at school.*	**Documents Submitted:** 1. R4_QualityImprovePln_FY23-24-Page 9 through 19 2. R4_QualityRpt_FY23-24-Page 33 3. ClinicalAuditTool_Q4FY23_Redacted-Entite Document 4. Blank ClinicalAuditTool_QM- Entire Document *Misc. 5. ClinicalAudTool_SUD-Entire Document 6. Detox_ClinicalAuditTool_SUD_QM-Entire Document 7. TCM_ClinicalAuditTool_UPDATED2022 Nov_QM-Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.330(b)(4) RAE Contract: Exhibit B-8—16.2.1.4 and 16.5.5 10 CCR 2505-10, Section 8.205.8	8. E and M CODING AUDIT FORM_2021March-Entire Document 9. ClinicalAudTool_MAT_SUD-Entire Document 10. Blank ClinicalAuditTool_IOP_UPDATED2022Oct_QM-Entire Document 11. DocumentationTraining-Entire Document 12. QOC_AcknowledgementLtr_HCI_QM-Entire Document 13. QOC_ResolutionLtr_HCI_QM-Entire Document 14. QOC_MHProvider_ProcessFlow_QM-Entire Document 15. QOC_NonQuality_ProcessFlow_QM-Entire Document 16. QOC_PHProvider_ProcessFlow_2021August_QM-Entire Document 17. R4_QOCC_Minutes_Draft_2023May09_QM-Entire Document 18. R4_QOCC_Agenda_2023May9_QM-Entire Document 19. QM 4H Member Safety Program Serious Reportable Event QOC Issues and Outlier Practice Patterns-Entire Policy 20. Care coordination audit results redacted - Entire Document 21. HCI CC Audit Tool FY22-23_FINAL-Entire Document	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	22. UM Program Description_HealthColoradoInc-Entire Document 23. 248L_EPSDT-Entire Document 24. 2023-August-ALL-Provider-RAE-Slides-Slide 22 25. R4_HealthEquityPln_FY23-24_FINALSUBMITTED-Entire Document 26. Blank Practice Assessment -Primary Care-Entire Document 27. HCI_Practice Assessment Scores-Entire Document 28. PDSA_Hernandez_A1c8-Entire Document 29. 2023 HCI PT Milestone Program Summary-Entire Document 30. HCI_APM-Entire Document 31. HCI Creative Solutions note_Redacted-Entire Document 32. AuditProcessFlow_QM-Entire Document 33. PCMP PT Phase 3 Incentive HCI-Entire Document 34. HCI Health Equity QIUM slides_12_6_23-Entire Document **Description of Process:** HCI, uses several instruments to assess the quality and appropriateness of care provided to all Members.	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI ensures mechanisms are in place to assess the quality and appropriateness of care furnished to members with special health care needs, as noted in the Annual Quality Improvement Plan and Annual Quality Report (R4_QualityImprovePln_FY23-24 and R4_QualityRpt_FY23-24), these demonstrate the various audits that HCI conducts, along with a synopsis of each audit. Behavioral health providers are audited (see AuditProcessFlow_QM) through a variety of activities and are expected to complete assessments to identify and recommend treatment for individuals with special health care needs. Documents referenced below address the oversight that HCI maintains over its provider network to ensure that the care being delivered is appropriate. Results of these audits are demonstrated in ClinicalAuditTool_Q4FY23_Redacted. Furthermore, HCI audits network providers over a wide variety of clinical services. The blank audit tools listed below demonstrate the wide variety of audits that HCI conducts on a regular and ongoing basis. • Blank ClinicalAuditTool • ClinicalAudTool_SUD • Detox_ClinicalAuditTool_SUD_QM • TCM_ClinicalAuditTool_UPDATED2022 Nov_QM	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• E and M CODING AUDIT FORM_2021March • ClinicalAudTool_MAT_SUD • Blank ClinicalAuditTool_IOP On a quarterly basis, providers are invited to attend a Mental Health and SUD documentation training session. See (DocumentationTraining). At these sessions, providers learn about documentation standards and the audit requirements. Information on EPSDT is also shared with network providers through Provider Support Forums (see 2023-August-ALL-Provider-RAE-Slides). In addition, per policy 248L_EPSDT.pdf, it is policy to coordinate Early, Periodic, Diagnostic and Treatment (EPSDT) services with other practitioners and agencies for clients aged 20 and under. As indicated in the Quality of Care (QOC) policy (QM 4H Member Safety Program Serious Reportable Event QOC Issues and Outlier Practice Patterns), an acknowledgement letter is sent (QOC_AcknowledgementLtr_HCI_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	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	letter will be sent to parties involved. See QOC_ResolutionLtr_HCI_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. See (QM 4H Member Safety Program Serious Reportable Event QOC Issues and Outlier Practice Patterns). The QOCC reviews the results of the investigation (R4_QOCC_Minutes_Draft_2023May09_QM and R4_QOCC_Agenda_2023May9_QM) and makes a determination as to whether the investigation has identified a quality of care issue, and provides direction as to the appropriate follow-up, which may include obtaining more information, developing and monitoring a corrective action, etc. The following documents demonstrate the process flow for a Quality of Care incident submission. • QOC_MHProvider_ProcessFlow_QM • QOC_NonQuality_ProcessFlow_QM • QOC_PHProvider_ProcessFlow_2021August_QM Members with special needs are supported through case management where care is well coordinated and constant communication between providers is	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	occurring. See Care coordination audit results redacted and HCI CC Audit Tool FY22-23_FINAL-Entire Document. Members with special healthcare needs are additionally supported through Creative Solutions and Complex Solutions meetings. See HCI Creative Solutions note_Redacted. These meetings are multi-disciplinary meetings that bring together various stakeholders who are involved in the Members' lives. For example, a typical Creative Solutions meeting includes the member's family, their behavioral health providers, the Department of Human Services, guardian advocates, school staff, and others. These diverse groups work collaboratively to identify resources and facilitate access to services. They typically meet weekly until the member has stabilized sufficiently, often for a period of several months. HCI's utilization management (UM) program has an ongoing focus on ensuring access for all members with special needs. Its policies, including those that govern adverse determinations, are audited annually by HSAG to ensure compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA). For the current fiscal year, HCI's program descriptions, policies, procedures, and documents	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	pertaining to the UM program were reviewed. As part of this desk review, HCI supplied records that included documentation of adverse benefit determinations (ABDs) and communications to members regarding ABDs (denials) of mental health and substance use disorder (SUD) services. See, UM Program Description_HealthColoradoInc. During this review period, HCI also underwent an audit to review Substance Use Disorder (SUD) Inpatient/Residential Denials Record Review which aimed to review authorizations for inpatient and residential substance use disorder treatment. As reported in HCI's health equity action plan (see R4_HealthEquityPln_FY23-24_FINALSUBMITTED) for CY 2024, HCI will create a dataset that is intended to be used to evaluate certain health and demographic variables that could potentially be predictors or identifiers to aggregate priority populations experiencing a specific health disparity. Some of the variables we intend to incorporate into our analysis to understand factors that predict or increase risk of certain health disparities include utilization status, disability status, chronic condition status, caregiver status (if caregivers are also Medicaid members), as well as standard demographic data related to individual members. With the data driven aggregation of specific priority populations identified with higher	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	health disparity risk, HCI intends to incorporate programmatic interventions more closely to reach these priority populations and outcome evaluation will include success specific to the priority populations as well. HCI also will be integrating health equity data variables into programmatic interventions, developing, and sharing validated health equity data dashboards for continuous improvement and goal setting, and evaluating outcomes to interventions by demographic variables of respondents to understand the effectiveness of tailored messaging and intervention modalities. Health Equity was also presented at the December QIUM meeting. See HCI Health Equity QIUM slides_12_6_23. As part of the Practice Transformation (PT) program, coaches work with PCMPs on quality improvement efforts based on HCPF's APM and the HCI Practice Transformation Milestone Incentive Program. Annually, the coach and practice representative(s) engage in performing a practice assessment in which the practice self-assesses their progress in specific areas related to the foundations of high-performing primary care practices. See Blank Practice Assessment-Primary Care and HCI_Practice Assessment Scores. Foundational areas of assessment include but are not limited to leadership, team-based care, patient and family engagement, population management,	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	and comprehensiveness of care. The purpose of the assessment is to allow the PCMP to identify areas of potential development and work with the PT coach, set goals in areas that will support the growth of the practice toward better outcomes for members. Support of patients with special health care needs is evidenced in specific questions on the assessment such as: • Practice adopts at least one evidence-based decision aid or self-management support tool for a condition appropriate for their patient population. • Practice uses standardized screening tools to screen patients and has a clear follow-up process for positive screens. • Practice develops a vision for behavioral health integration and chooses a strategy to improve comprehensiveness of behavioral health services. • Practice has awareness of, coordinates care and actively communicates member needs to appropriate care management entities. Once the assessment is complete, the PCMP identifies a SMART goal and work ensues over next few months to achieve the goal. Following are examples of quality improvement work being undertaken by some HCI PCMPs to	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	improve the outcomes for special needs populations: • Sothern Colorado Family Medicine (residency) -Establishing a Patient Family Advisory Counsel (PFAC). Working on setting up and recruiting for their new PFAC. • Mt. San Rafael Rural Health Center - Closing gaps in care. Development and implementation of a health maintenance processes that help care teams more easily identify gaps in care for standard screenings and for patients with diabetes. • Rio Grande Hospital Clinics -After Hours Access to EMR. Working to get appropriate EMR access and training for the ED team who triage and take care of primary patient needs when the clinic is closed at night and on weekends. When after hours and weekend emergencies arise, the ED can see the patients primary care notes. • Steel City Pediatrics – To implement an action plan for 65% of asthmatic patients. Each cycle of the program includes work towards improving clinical measures including diabetes, hypertension and depression screening. (PCMP PT Phase 3 Incentive HCI). As part of the quality work performed, PDSA cycles, sample attached (PDSA_Hernandez_A1c8), are implemented with	

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	the PCMP practices, supporting the work of the clinic in serving the needs of populations with chronic conditions. Over the course of a year, clinics set goals and work to achieve forward progress in quality outcomes. A summary of the outcomes for the Phase 3 Milestones is attached (2023 HCI PT Milestone Program Summary), highlighting the outcomes achieved through the Practice Transformation work. Following are examples of quality improvement work supported by Practice Transformation being undertaken by PCMPs to improve the outcomes for special needs populations: • Rocky Mountain Primary Care -Blood Pressure Control with Patients with Hypertension. Changing their process to include BP re-checks at the end of the visit for patients with elevated blood pressures during the visit. • Colorado Adult Primary Care -A1c Poor control. Focusing in on weight loss education, meds, and self-management with their patients with diabetes to try to bring down their poor control scores. • Southeast Colorado Hospital -A1c Poor Control. -Working their registry from their EMR to call and schedule patients who have not come into the clinic for an A1c check/follow-up visit for 6 or more months.	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• SOCO Primary Care developed Standing Orders for their patients with a diabetes diagnosis **Practice Transformation Diabetes Work Group** In the June 2021 Learning Collaborative the concept of the Diabetes Work Group arose from a Clinic presentation on their PDSA work, which was to provide education to patients that had a diagnosis of Type 2 Diabetes. There was much discussion, and a resulting ask was if a Work Group could be convened in order for PCMP's to share best practices. The Diabetes Work Group was developed by the Practice Transformation Team for PCMP's to share best practices, problem solve barriers to care, and learn skills/ techniques to implement. The Practice Transformation team has collaborated with CDPHE Diabetes Management Coordinator to assist with Diabetes Self-Management Education & Support (DSMES) and Diabetes Prevention Program (DPP) support. The Diabetes Work Group meets 3-4 times annually and has an average participation of 15-20 PCMP practices from RAEs 2 and 4. The Work Group has been able to showcase clinics that have been successful in managing their population of patients with diabetes, provide information on programs for clinics and their patients to engage. Highlight of the topics presented:	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**

	• Diabetes Self-Management and Support (DSMES), Colorado State Overview
	• Comprehensive evaluation of members with Type 2 Diabetes
	• Using Team-based care approach for members with Diabetes
	• Development of a Registry and using data to drive care
	• Implementation of Continuous Glucose Monitoring Program
	• How to set up an evidence-based Diabetes Prevention Program and DSMES program
	• Emotional Impact of Diabetes
	
	PCMP outcomes that have evolved from the work of the diabetes work group include:
	• Six practices in RAE 4 are engaged in the Prepare for CGM program
	  ◦ Castillo Primary Care
	  ◦ Family Care Specialists
	  ◦ SLV Health
	  ◦ Southeast CO Hospital Clinics
	  ◦ Ted Puls MD Primary Care
	  ◦ University Family Medicine
	• Castillo Primary Care was involved in the Prepare for CGM Program and the DSMES Referral Pilot Program and strengthened the workflow for patients with a diagnosis of diabetes.	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Valley Wide: Cesar E. Chavez Medical Center is working towards implementing a Pro CGM program for their patients with diabetes. • Southeast Colorado Hospital's Primary Care clinic joined prepare for CGM after a presentation on CGM at one of our Learning Collaboratives. As a result of adopting the use of CGMs in the clinic, they saw an 8% decrease in their HgA1c poor control in the first year. They went from 36% poorly controlled patients in 2022 to 28% in 2023. They also reported very positive feedback from patients being able to manage the diabetes with the help of frequent CGM feedback. **DSMES Referral Pilot Project:** Purpose: Increase referral to DSMES (Diabetes Self-Management Education and Support) in areas with disproportionately high rates of diabetes and to increase participation in DSMES by high priority populations, including Medicaid/ Health First CO members. Participating Clinics: • Castillo Primary Care • Radiant Healthcare • Valley Wide Health Systems: Cesar E. Chavez Family Medical Center	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Successes: • Team-based approach to engaging patients • MOU resulted in good communication between clinic & program (attendance, outcomes, insurance changes, etc.) • Referrals led to DSMES participation; participants expressed satisfaction in program • Clinic-wide A1c improvements and/or improvements in those referred • Increased awareness of the DSMES Medicare/Medicaid benefit among staff and patients • Identified needs for diabetes care & education in clinic The Practice Transformation team supports PCMP practices by helping them select APM measures for the year and monitor clinical measure performance at least quarterly to ensure forward progress through data sharing and PDSA cycles if necessary. See HCI_APM The clinical measures in the APM program are related to: • Chronic care management (Diabetes Hemoglobin A1c Poor Control, Controlling High Blood Pressure, Antidepressant Medication Management)	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Prevention (Well Child Visits, Immunization Status) • Screening (Breast, Cervical and Colorectal Cancer Screening)	
6. The Contractor monitors member perceptions of accessibility and adequacy of services provided. Tools shall include, at a minimum: • Member surveys • Anecdotal information • Grievance and appeals data • Call center data • Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[A-1] survey RAE Contract: Exhibit B-8—16.5.1-3 and 16.5.6	**Documents Submitted:** 1. HCI_YOM_Survey-Entire Document 2. HCI_CAHPS-Entire Document 3. QIUM_Region 4_HCI_Minutes_Approved Signed_2023Nov-Page 8, Item 9 4. HCI_Jan23_June23_YOM_Results-Entire Document 5. QIUM_Region 4_HCI_Minutes_Approved-Signed_2023July-Page 2, Number 5 6. QM WorkPlan FY24_Final-Rows 34 and 35 7. HCI_YOM_Survey_Popup-found at https://www.healthcoloradorae.com/ 8. R4_QualityRpt_FY23-24-Page 36 through 38 9. R4_QualityImprovePln_FY23-24-Page 37 through 39 10. R4_CallLineStatsRpt-Entire Document 11. YOM Survey Outreach 10012021-Entire Document 12. R4_GrieveAppealRpt_Q3 FY22-23_NO PHI-Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	13. QIUM_Member Engagement Updates_May2023_HCI-Entire Document 14. QIUM_Region 4_HCI_Minutes_Approved-Signed_2023May-Page 2, Section 4A 15. MEAC-Meeting-Summary-August-8-2023-Page 3 16. Member-Experience-Advisory-Council-Meeting-Summary-2023-05-09-Page 1-3 **Description of Process:** HCI monitors Members' perceptions of well-being and functional status as well as accessibility and adequacy of services through review of various Member surveys. Two (2) surveys used are the Your Opinion Matters Survey (YOM) and the Consumer Assessment of Healthcare Providers and Systems **(**CAHPS) survey. These reports are reviewed for trends within the RAE as well as comparisons across other RAEs. **Your Opinion Matters Survey** The Your Opinion Matters survey (HCI_YOM_Survey) aims to collect information on Member interest to improve their healthcare, and perceptions of satisfaction and access issues for both physical health and behavioral healthcare services. HCI continues to conduct outreach members who indicate on the survey that they would like a follow-up contact. See YOM Survey Outreach 10012021. In Q3 and Q4 of FY23, 37	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	members have taken the survey and 19 members have indicated that they would like to receive more information about their Health First Colorado Benefits or to speak to someone regarding their questions or concerns. If we find that there are issues pertaining to access and availability of care, the issues will be relayed to the Provider Relations Department for follow up and will be discussed at the QIUM committee meeting. HCI reviews the results of the YOM survey two times per year at the QIUM Committee meeting (QIUM_Region 4_HCI_Minutes_Approved-Signed_2023July and HCI_Jan23_June23_YOM_Results). Any downward trends detected in the survey responses will be reviewed at QIUM, and discussions will be held for possible interventions. In addition, the HCI workplan (QM WorkPlan_FY24_Final) addresses monitoring of member surveys. HCI places an icon on their webpage for members to easily access the YOM survey. The pop up can be found at: https://www.healthcoloradorae.com/. HCI has also taken the survey to the Member Experience Advisory Council to gain insight into survey access, See MEAC-Meeting-Summary-August-8. HCI reviews the Results of the Your Opinion Matters Survey twice per year. The next review is scheduled for January 2024.	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Survey results are also presented in the HCI Annual Quality Report and Plan. See, R4_QualityRpt_FY23-24 and R4_QualityImprovePln_FY23-24. HCI meets quarterly with Members at their regional Member Experience Advisory Council (MEAC). The primary objective of this meeting is to listen to Members' experience in health care. Members discussed Health Colorado's Member survey – Your Opinion Matters in the August 2023 meeting. The survey was reviewed to evaluate the efficacy of the questions which measure access to services. See MEAC-Meeting-Summary-August-8-2023 HCI summarizes the MEAC meetings and posts on their website. See https://www.healthcoloradorae.com/Members/join-a-team/Member-advisory-council/. At the meeting it was discussed that we would like to make the survey easier to find on the website. As a result, an icon has been added to the home page of the HCI webpage for ease of member access. See https://www.healthcoloradorae.com/ for the added icon.	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) In FY2023-24, HCI has taken the results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) program to better understand patient experience with health care to: • Assess patient experience. • Report survey results. • Help organizations use the results to improve the quality of care. The CAHPS data and low-scoring elements notated in the survey were addressed at the QIUM committee. See HCI_CAHPS and QIUM_Region 4_HCI_Minutes_Approved Signed_2023Nov. Based upon the results of the survey, HCI will be exploring partnerships with regional providers to address areas of improvement. HCI will explore interventions related to providing fliers and reminders at provider locations of after-care options to improve access to care scores. HCI monitors and reviews Carelon's call center data on a quarterly basis. The average answering speed for each call was eighteen (13) seconds. The call abandonment rate was two and a half (1.7%) percent during the fiscal year. See R4_CallLineStatsRpt. HCI monitors calls for	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	quality to make sure that members needs are met. The call center helps members with access to services by helping them find providers within their search area or to understand their benefits better. If a member calls and shares any information indicating that their needs are not being met, the call center will invite them to talk to Member Engagement and file a grievance. During the grievance process, if it is found that the member is having difficulty accessing the care they need (provider, medication, durable goods, etc.) member engagement will work to get the member's needs met. If a member calls and presents with an issue related to access or accessibility issues, the call will be routed to the appropriate individual for grievance escalation. HCI reviews the grievance and appeal report at the bi-annually at the QIUM committee meeting. See R4_GrieveAppealRpt_Q3 FY22-23_NO PHI and QIUM_Member Engagement Updates_May2023_HCI and QIUM_Region 4_HCI_Minutes_Approved-Signed_2023May. If a grievance is reported to the Quality Management Department, it will be investigated as a potential a quality of care issue. This investigation process provides direction as to the appropriate follow-up, which may include obtaining more information, developing and monitoring a corrective action, etc.	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI also takes the member perspective into account when addressing appointment drive times and specialist care in rural areas. These perspectives are valuable as in the MEAC meeting (seeMember-Experience-Advisory-Council-Meeting-Summary-2023-05-09) members discussed their views on specialist access.	
7. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis. *42 CFR 438.330(e)(2)* RAE Contract: Exhibit B-8—16.2.5	**Documents Submitted:** 1. Administrative Services Agreement-Page 15 Quality Management section *Misc. 2. R4_QualityImprovePln_FY23-24-Entire Document 3. R4_QualityRpt_FY23-24- Entire Document 4. QM WorkPlan FY24_Final- Entire Document 5. QIUM_Region 4_HCI_Minutes__2023June-Page 2, Number 5 6. QIUM_Region 4_HCI_Minutes_Approved-Signed_2023July-Page 2, Number 4 7. R4_QualityRpt_FY22-23_HCPF Response_Accepted-Entire Document 8. R4_QualityImprovePln_FY23-24_HCPF Response_Accepted-Entire Document **Description of Process** HCI delegates this function to Carelon (See Administrative Services Agreement) To evaluate the impact and the effectiveness of the Quality	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Improvement Program, annually HCI completes three program documents. Annually, along with the HCI Quality Improvement /Utilization Management Committee (QIUM) HCI develops an Annual Quality Report, Annual Quality Plan, and an annual Work Plan. See (R4_QualityImprovePln_FY23-24, R4_QualityRpt_FY23-24, QM WorkPlan FY24_Final) The QM WorkPlan documents detail the planned quality improvement activities for the fiscal year. The Annual Report details the completed quality improvement and quality assurance activities that have taken place over the previous fiscal year. The Annual Plan is a detail report that addresses the quality assurance activities that will occur over the coming fiscal year. The progress on the work plan is reviewed quarterly for effectiveness and to determine progress on goals. See QIUM_Region 4_HCI_Minutes__2023June and QIUM_Region 4_HCI_Minutes_Approved-Signed_2023July. See R4_QualityRpt_FY22-23_HCPF Response_Accepted and R4_QualityImprovePln_FY23-24_HCPF Response_Accepted for HCPFs acceptance of the annual quality report and plan.	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor adopts practice guidelines that meet the following requirements: • Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. • Consider the needs of the Contractor's members. • Are adopted in consultation with contracted health care professionals. • Are reviewed and updated periodically as appropriate. *42 CFR 438.236(b)* RAE Contract: Exhibit B-8—14.8.9.1-3	**Documents Submitted:** 1. CSNT 102.8 Developing and Updating Treatment Guidelines—Entire Document 2. HCI_Clinical Practice Guidelines_weblink-Entire Document (https://www.carelonbehavioralhealth.com/providers/resources/clinical-practice-guidelines) 3. HCI-Behavioral-Health-Medicaid-Provider-Handbook-Page 45 *Misc.. **Description of Process:** This contract element is delegated to Carelon by the RAE. Carelon policy CSNT 102.8 states that Carelon develops, revises, and/or adopts Clinical Practice Guidelines (CPGs; also known as treatment guidelines) from nationally recognized sources and scientific bodies, including professional organization (e.g., American Psychiatric Association) based on: • Scientific evidence, • Best practice professional standards, and • Expert input from board-certified physicians from appropriate specialties.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Carelon reviews and/or updates CPGs every two (2) years or as necessary. Carelon's Scientific Review Committee (SRC) reviews and/or updates each guideline at least every two (2) years, or more often, if national sources publish updates or make changes to the guideline. In addition, relevant new guidelines can be reviewed, adopted, and approved at any time through the committee process. Updates/changes are then presented to the Corporate Medical Management Committee (CMMC) for final approval. New guidelines can be proposed or developed based on the needs of individual contracts or their members. The clinical practice guidelines for the RAE are available on the RAE's website. See the website excerpt, RAE Website--Clinical Practice Guidelines. Additionally, treatment guidelines and their availability may also be communicated to providers during site visits, and in the context of clinical/peer reviews. Providers are informed of new guidelines and/or edits to existing guidelines through	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	notification in HCI-Behavioral-Health-Medicaid-Provider-Handbook.	
9. The Contractor disseminates the guidelines to all affected providers, and upon request, to members and potential members. *42 CFR 438.236(c)* RAE Contract: Exhibit B-8—14.8.9	**Documents Submitted:** 1. CSNT 102.8 Developing and Updating Treatment Guidelines—entire document 2. HCI_Clinical Practice Guidelines_weblink-Entire Document (https://www.carelonbehavioralhealth.com/providers/resources/clinical-practice-guidelines) 3. HCI-Behavioral-Health-Medicaid-Provider-Handbook (p. 45; Clinical Practice Guidelines) *Misc. **Description of Process:** This audit element is delegated to Carelon by the RAE. Carelon policy CSNT 102.8 provides detail about how clinical practice guidelines are disseminated to the RAE's affected providers, members, potential members, and the public. Section VI.B notes that once the guidelines are approved by the Corporate Medical Management Committee (CMMC), the guidelines are posted to Carelon's external website, which is linked to the RAE's website.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Carelon's clinical and quality leaders cascade updates about Clinical Practice Guidelines and Resources to applicable team Members and are available to all staff. When necessary, clinical staff may receive additional training through clinical rounds or supervision. Practice guidelines are available to providers through the RAE's website. See HCI_Clinical Practice Guidelines_weblink.docx. Guidelines also are noted in the Provider Handbook. See HCI-Behavioral-Health-Medicaid-Provider-Handbook.pdf (p. 45; Clinical Practice Guidelines). The RAE's Members, potential Members, and the public have access to the clinical practice guidelines through the RAE's website. HCI's Member Engagement Specialist can direct Members to the website to obtain a copy of the clinical practice guidelines upon request. Members also may request to be mailed a copy of the guidelines free of charge.	
10. The Contractor ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42 CFR 438.236(d)* RAE Contract: Exhibit B-8—14.8.10	**Documents Submitted:** 1. CSNT 102.8 Developing and Updating Treatment Guidelines—entire document 2. outpatient-treatment-report-form-Entire Document 3. Blank ClinicalAuditTool_QM—Entire Document*Misc	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	4. HCI_Clinical Practice Guidelines_weblink-Entire Document (https://www.carelonbehavioralhealth.com/providers/resources/clinical-practice-guidelines) 5. HCI-Behavioral-Health-Medicaid-Provider-Handbook (p. 45; Clinical Practice Guidelines) *Misc. **Description of Process:** This contract element is delegated from the RAE to Carelon. In Policy CSNT 102.8 Developing and Updating Treatment Guidelines, it is noted that clinical practice guidelines are communicated to internal clinical staff. The guidelines are utilized in the process of care management, especially in the management of complex cases and/or cases that do not demonstrate expected progress or improvement. These guidelines are often the source of recommendations made during peer-to-peer consultations or provider education to help practitioners make decisions about appropriate treatment planning and intervention in specific clinical circumstances. Care management staff are provided training regarding use of the clinical guidelines during their initial orientation, when new guidelines are	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	developed, or when the guidelines are substantially revised. The application of clinical guidelines and level of care criteria is a routine part of case presentations during clinical rounds. Care management staff are tested annually with an inter-rater reliability examination to assess their consistency in applying clinical criteria and relevant practice guidelines in UM determinations. As part of the re-authorization or concurrent review process, providers are asked to attest that they are providing treatment that is consistent with Carelon's clinical practice guidelines and other professional standards of care. See outpatient-treatment-report-form.pdf, page 2. Additionally, provider adherence to guidelines is measured in the audits of clinical records. See Blank ClinicalAuditTool_QM. Practice guidelines are available to providers through HCIs website. HCI_Clinical Practice Guidelines_weblink-Entire Document (https://www.carelonbehavioralhealth.com/providers/resources/clinical-practice-guidelines) Guidelines also are noted in the Provider Handbook. See: HCI-Behavioral-Health-Medicaid-Provider-Handbook.	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42 CFR 438.242(a)* RAE Contract: Exhibit B-8—15.1.1	**Documents Submitted:** 1. Carelon_Data_Flows- Entire document 2. Data_Tables_HCI - Entire document 3. SOP_HCI_Encounter_Data_Submission_Monitoring - Entire document **Description of Process:** Carelon_Data_Flows document shows the workflow and servers used to collect, integrate, analyze and report data from internal and external sources. Claims and Provider data is received by the CAS system, which is a secure server based in Ashburn, Virginia. Applicable parts of this data needed for reporting are downloaded to the Colorado IT Data Warehouse (CO IT DW) also located in Ashburn, Virginia. Unlike claims files, Encounter files are sent to CO IT DW from the community mental health centers (CMHC), processed and loaded into the CO IT DW. Encounters are then submitted to the State of Colorado. The Carelon_Data_Flows document illustrates external data interfaces with Carelon. Data is sent via Secure File Transfer Protocol (SFTP) using an internal gateway process. The encounter data is used as a basis to update the calculation of future capitated payments. The Data_Tables_HCI document shows the name and functional area of tables in the database. The table names are functional; as a result, reporting is	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	clear and repeatable. For example, claim based tables begin with CLM. The data tables listed represent the strategy and storage methods of the data. Finally, the SOP_HCI_Encounter_Data_Submission_Monitoring illustrates in detail the monthly process to ensure all encounter files are processed. Monitoring is necessary so the State of Colorado can get an accurate picture of member care. The above mentioned processes, strategies and storage ensure the contractor maintains a health information system that collects, analyzes, integrates, and reports data.	
12. The Contractor's health information system provides information on areas including, but not limited to, utilization, encounters, claims, grievances and appeals, and disenrollment (for reasons other than loss of Medicaid eligibility). *42 CFR 438.242(a)* RAE Contract: Exhibit B-8—8.1, 15.1.1, and 15.1.1.3.2.1	**Documents Submitted:** 1. Data_Tables_HCI - Entire Document 2. Providers_Pending_Disenrollment RAE-Entire Document *Misc. **Description of Process:** If data is required to research issues, IT and Reporting teams use the information in the Data_Tables_HCI document. The Data_Tables_HCI document shows the name and functional area of tables in the database.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Certification of providers is stored both in Colorado IT Datawarehouse (CO-DW) and in the corporate databases at Ashburn, VA. The IT department ensures that the data for these providers is accessible and up to date from the sources of the data (Provider group, State agency, Corporate IT). Colorado IT mirrors all Colorado provider data from the sources and creates interfaces to allow for the updating of data as it changes. The included artifact, Providers_Pending_Disenrollment, shows an example of the updated as dis-enrolled providers**.** This report is from data stored locally. Member disenrollment activity originates from the State data. We maintain activity of members even after they are dis-enrolled, according to State guidelines, so data is ready should the member reenroll.	
13. The Contractor's claims processing and retrieval systems collect data elements necessary to enable the mechanized claims processing and information retrieval systems operated by the State. • Contractor electronically submits encounter claims data in the interchange ANSI X12N 837 format directly to the Department's fiscal agent using the Department's data transfer protocol. The 837-format encounter claims (reflecting claims paid, adjusted, and/or denied by the Contractor) shall be submitted via a regular batch process.	**Documents Submitted:** 1. Carelon_Data_Flows -Entire Document 2. SOP_837_HCPF_Build_Instructions - Entire Document 3. Monthly 837 Process Checklist-Entire Document **Description of Process:** Carelon_Data_Flows shows the workflow of loading 837 files into the fully integrated platform	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.242(b)(1) RAE Contract: Exhibit B-8—15.2.2.3.1-2	(CAS). This server is the main storage for all data and reporting. Data is sent via Secure web FTP. The document, SOP_837_HCPF_Build_Instructions, describes the monthly 837 build process for CMHC-submitted encounter data. CMHCs submit encounter data in a prescribed flat file format. The data is evaluated for more than one hundred possible errors. Accepted records are stored in the Colorado IT Datawarehouse (CO-IT DW) tables. Perl software programs extract and format data from CO-IT DW tables into the X12-defined 837 format. The document describes in detail the step- by-step process. The Monthly 837 Process Checklist ensures that each of the many steps is completed so that the 837 file is correctly submitted.	
14. The Contractor collects data on member and provider characteristics and on services furnished to members through an encounter data system (or other methods specified by the State). *42 CFR 438.242(b)(2)* RAE Contract: Exhibit B-8—15.2.2	**Documents Submitted:** 1. Encounter_Data_Flow-Entire document 2. Encounter_Sample_Data- Entire document 3. Encounter_Schema- Entire document **Description of Process:** Encounter_Data_Flow is a swim lane document showing data flows between the CMHC, RAE and HCPF. This document illustrates how data moves between these groups and the decision points	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	involved. This document includes both the submission and resubmission process. Encounter_Sample_Data details the header and detail column names and shows an example of what that data looks like. Encounter files are received from the CMHCs for each monthly reporting period. The Encounter Schema shows the layout of the column headers that are sent to the State.	
15. The Contractor ensures that data received from providers are accurate and complete by: • Verifying the accuracy and timeliness of reported data, including data from network providers compensated through capitation payments. • Screening the data for completeness, logic, and consistency. • Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for Medicaid quality improvement and care coordination efforts. • Making all collected data available to the State and upon request to CMS. *42 CFR 438.242(b)(3) and (4)*	**Documents Submitted:** 1. SOP_HCI_Encounter_Data_Submission_Monitoring - Entire document 2. Carelon_Inbound_Encounter_File_Layout- Entire document 3. Provider_Portal_Secure_Login_Screen - Entire document 4. FY24 RAE BH Flat File Specs Version 25 - Entire document 5. Example_WC_WC202312RA4A.ENC_err- Entire document 6. Example_WC_WC202312RA4A.ENC_log- Entire document 7. Example_WC_WC202312RA4A.ENC_mod- Entire document 8. Example_WC_WC202312RA4A.ENC_warnings_log- Entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
RAE Contract: Exhibit B-8—15.2.2.3.1 and 15.2.2.3.6.1	**Description of Process:** The SOP_HCI_Encounter_Data_Submission_Monitoring illustrates in detail the monthly process for ensuring all encounter files are processed. Monitoring is necessary so the State of Colorado gets an accurate picture of Member care. Encounters are combined and converted to a flat file format. The Carelon_Inbound_Encounter_File_Layout file shows the header, detail, data dictionary and layout check for this file. The data is sent to HCPF in 837 format and in Flat File Format and is used as a basis for capitation payments. The Provider Portal is used to collect encounter data. Provider Portal_Secure_Login_Screen shows the login screen for this system. Users log into the portal to transmit documents securely to the Colorado IT department and retrieve documents sent to the user. Encounter files are turned into a flat file which is used by the State. The FY24 RAE BH Flat File Specs Version 25 details the contents of this file.	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Lastly, log files are produced by the inbound encounter processor; sample logs shown in the examples. See: • Example_WC_WC202312RA4A.ENC_err • Example_WC_WC202312RA4A.ENC_log • Example_WC_WC202312RA4A.ENC_mod • Example_WC_WC202312RA4A.ENC_warnings_log The files are returned to the CMHC's to ensure items such as membership are corrected before the monthly final submission. The State receives the Encounter Flat file monthly.	
16. The Contractor: • Collects and maintains sufficient member encounter data to identify the provider who delivers any items or services to members. • Submits member encounter data to the State in standardized ASC X12N 837 formats as appropriate. • Submits member encounter data to the State at the level of detail and frequency specified by the State (within 120 days of an adjudicated provider claim). *42 CFR 438.242(c)* RAE Contract: Exhibit B-8—15.2.2.1-2, 15.2.2.3.2, and 15.2.2.3.4	**Documents Submitted:** 1. Data_Process_Flows_837 - Entire Document 2. SOP_837_HCPF_Build_Instructions - Entire Document 3. Monthly 837 Process Checklist - Entire Document 4. Carelon_Export_837_export_Example - Entire Document **Description of Process:** Data Process Flows 837 shows the workflow for loading 837 files into the Fully integrated platform	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	(CAS). This server as the main storage for all data and reporting. Data is sent via Secure web ftp. The Functional_Design_Document_ENC_837_ Build_Process document describes the monthly build procedure for submitting CMHC encounter data. CMHCs submit encounter data in a prescribed flat file format. The data is evaluated for more than one hundred possible errors. Accepted records are stored in the Colorado Data Warehouse (CO IT DW) tables. Perl software programs will extract data from these tables and format the data into the X12-defined 837 format. The document describes in detail the step- by-step process. The Monthly 837 Process Checklist ensures that each of the many steps are completed so that the 837 file is submitted correctly. The Carelon_Export_837_export_Example shows example header information in the submitted 837 file.	

Results for Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems							
Total	Met	=	16	X	1.00	=	16
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	16	**Total Score**		=	16
				Total Score ÷ Total Applicable		=	100%

Appendix B. Compliance Review Participants

Table B-1 lists the participants in the FY 2023–2024 compliance review of HCI.

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

HSAG Review Team	Title
Gina Stepuncik	Associate Director
Cynthia Moreno	Project Manager III
Crystal Brown	Project Manager I
Jenna Curran	Senior Project Manager (Observer)

HCI Participants	Title
Ed Arnold	Senior Behavioral Health Clinical Quality Audit Analyst, Carelon
Laqueda Bell	Director, Behavioral Health Services, Carelon
Michael Clark	Manager, Data Analysis, Carelon
Dr. Steve Coen	Director, Behavioral Health Services, Carelon
Madeline Dunn	Director, Network Management, Carelon
Lynne Fabian	Manager, Health Promotion Outreach Services, Carelon
Courtney Hernandez	Senior Behavioral Health Clinical Quality Audit Analyst, Carelon
Dr. Brian Hill	Medical Director, Carelon
Gretchen Hudson	Director II Technology, Carelon
Tasha Hughes	Medical Management Specialist II, Carelon
Tiffany Jenkins	Manager, Behavioral Health Services, Carelon
John Kearney	Director, Special Investigations Unit, Carelon
Nate Koller	Network Support Consultant, Carelon
Dr. John Mahalik	Director, National Quality Management, Carelon
Angela Manley	Provider Network Senior Manager, Carelon
Marissa Martinez	Clinical Services Assistant, Carelon
Sheree Marzka	Director II, Compliance, Carelon
Stephanie Miller-Olsen	Senior Behavioral Health Clinical Quality Audit Analyst, Carelon
Sarah Nelson	Director, Operations, HCI
Anna Pittar-Moreno	Behavioral Health Clinical Quality Audit Analyst, Carelon
Guy Reese	Manager I, Investigations, Carelon
Hollie Scott	Compliance Consultant, Carelon
Michaela Smyth	Senior Behavioral Health Clinical Quality Audit Analyst, Carelon

HCI Participants	Title
Ryan Sorrel	Regional Vice President I, Provider Solutions, Carelon
Dawn Surface	Community Outreach Manager, Carelon
Steve Thiboutot	Systems Analyst Advisor, Carelon
Jen Wang	Web User Interface Developer, Carelon
Jeremy White	Clinical Quality Program Manager, Carelon
Melissa Wickliffe	Director, State Regional Operations, Carelon
Kristi Williams	Compliance Manager, Carelon
Elizabeth Younge	Credentialing Specialist, Carelon
Department Observers	**Title**
Helen Desta-Fraser	Quality Section Manager
Erin Herman	Accountable Care Collaborative Program Administrator
Russell Kennedy	Quality and Compliance Specialist
Angela Ukoha	Accountable Care Collaborative Program Specialist

Appendix C. Corrective Action Plan Template for FY 2023–2024

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 C-1—Corrective Action Plan Process

Step	Action
Step 1	**Corrective action plans 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 also to proceed with resubmission.	
Step 4	**Documentation substantiating implementation**
Once the MCE has received Department approval of the CAP, the MCE will have a time frame of 90 days (three months) to complete proposed actions and submit documents. The MCE will submit documents as evidence of completion one time only on or before the 90-day deadline for all required actions in the CAP. If any revisions to the planned interventions are deemed necessary by the MCE during the 90 days, the MCE should notify the Department and HSAG. If the MCE is unable to submit documents of completion for any required action on or before the three-month deadline, it must obtain approval in advance from the Department to extend the deadline.	

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

The CAP template follows on the next page.

Table C-2—FY 2023–2024 Corrective Action Plan for HCI

Standard VII—Provider Selection and Program Integrity
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
3. The Contractor's provider selection policies and procedures include provisions that the Contractor does not: • Discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. • Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42 CFR 438.12(a)(1) and (2)* *42 CFR 438.214(c)* RAE Contract: Exhibit B-8—9.1.6.1-2
Findings
Carelon submitted policy CR 226.11 titled *Prevention and Monitoring of Non-discriminatory Credentialing and Re-Credentialing* (last reviewed/approved on January 12, 2024). The policy did not include language stating the RAE would 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."
Required Actions
Carelon must revise 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."
Planned Interventions

Standard VII—Provider Selection and Program Integrity
Person(s)/Committee(s) Responsible
Training Required
Monitoring and Follow-Up Activities Planned
Documents to Be Submitted as Evidence of Completion
HSAG Initial Review:
Documents Included in Final Submission: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***
Date of Final Evidence:

Standard VII—Provider Selection and Program Integrity
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
7. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549. *42 CFR 438.610* RAE Contract: Exhibit B-8—17.9.4.2.3
Findings
Carelon submitted policy CR 206.20 titled *Primary Source Verification* (last reviewed/approval date on October 17, 2023) that excluded the terms "excluded, suspended, and debarred" from language within the policy.
Required Actions
Carelon must 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.
Planned Interventions
Person(s)/Committee(s) Responsible

Standard VII—Provider Selection and Program Integrity
Training Required
Monitoring and Follow-Up Activities Planned
Documents to Be Submitted as Evidence of Completion
HSAG Initial Review:
Documents Included in Final Submission: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***
Date of Final Evidence:

Standard VII—Provider Selection and Program Integrity
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
8. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: • The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered. • Any information the member needs in order to decide among all relevant treatment options. • The risks, benefits, and consequences of treatment or non-treatment. • The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. *42 CFR 438.102(a)(1)* RAE Contract: Exhibit B-8—14.7.3
Findings
Carelon submitted the behavioral health provider agreement template that included all of the required language; however, the language was not located within the PCMP agreement.
Required Actions
HCI must revise the PCMP agreement to include language stating that does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: • The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered. • Any information the member needs in order to decide among all relevant treatment options. • The risks, benefits, and consequences of treatment or non-treatment. • The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Standard VII—Provider Selection and Program Integrity
Planned Interventions
Person(s)/Committee(s) Responsible
Training Required
Monitoring and Follow-Up Activities Planned
Documents to Be Submitted as Evidence of Completion
HSAG Initial Review:
Documents Included in Final Submission: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***
Date of Final Evidence:

Standard VII—Provider Selection and Program Integrity
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
10. The Contractor has administrative and management arrangements or procedures, including a compliance program to detect and prevent fraud, waste, and abuse and includes: • Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal, State, and contract requirements. • The designation of a compliance officer who is responsible for developing and implementing policies, procedures and practices to ensure compliance with requirements of the contract and reports directly to the Chief Executive Officer and Board of Directors. • The establishment of a Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program. • Training and education of the compliance officer, management, and organization's staff members for the federal and State standards and requirements under the contract. • Effective lines of communication between the compliance officer and the Contractor's employees. • Enforcement of standards through well-publicized disciplinary guidelines. • Implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks. • Procedures for prompt response to compliance issues as they are raised, investigation of potential compliance problems identified in the course of self-evaluation and audits, correction of such problems quickly and thoroughly to reduce the potential for reoccurrence, and ongoing compliance with the requirements under the contract. *42 CFR 438.608(a)(1)* RAE Contract: Exhibit B-8—17.1.3 and 17.1.5.1-7
Findings
During the interview, Carelon, HCI's delegate, described how the compliance program was operationally and functionally run. While Carelon was able to describe the features of the compliance program, including an active compliance committee, no interview attendees from HCI were able to describe HCI's role in leading the compliance program nor in any oversight and monitoring of Carelon's compliance activities. As indicated in its organizational

Standard VII—Provider Selection and Program Integrity
chart, HCI had a designed compliance officer; however, the compliance officer was not present for the interview sessions. While Carelon described quarterly compliance meetings between Carelon and HCI, HCI provided no evidence that HCI or its compliance officer maintained strategic oversight of the compliance program or took ownership of developing and implementing policies, procedures, and practices to ensure compliance. For example, the ethics statement was provided through Elevance Health's Code of Conduct (Elevance Health is a parent company of Carelon) and all of the policies and procedures related to program integrity were from Carelon.
Required Actions
HCI must 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.
Planned Interventions
Person(s)/Committee(s) Responsible
Training Required
Monitoring and Follow-Up Activities Planned
Documents to Be Submitted as Evidence of Completion

Standard VII—Provider Selection and Program Integrity
HSAG Initial Review:
Documents Included in Final Submission: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***
Date of Final Evidence:

Standard IX—Subcontractual Relationships and Delegation
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
1. Notwithstanding any relationship(s) with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. *42 CFR 438.230(b)(1)* RAE Contract: Exhibit B-8—4.2.13
Findings
The delegation agreement between HCI and Carelon did not include the standard to which Carelon was held nor the frequency, methodology, and periodicity for conducting the ongoing monitoring.
Required Actions
HCI must have direct oversight and evidence of ongoing monitoring performed by HCI of any delegated activities pertaining to 42 CFR 438.
Planned Interventions
Person(s)/Committee(s) Responsible

Standard IX—Subcontractual Relationships and Delegation
Training Required
Monitoring and Follow-Up Activities Planned
Documents to Be Submitted as Evidence of Completion
HSAG Initial Review:
Documents Included in Final Submission: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***
Date of Final Evidence:

Standard IX—Subcontractual Relationships and Delegation
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
4. The written agreement with the subcontractor includes: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State. – The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems related to 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. *42 CFR 438.230(c)(3)* RAE Contract: Exhibit B-8—4.2.13.6
Findings
HSAG reviewed the subcontractor agreements and found that the written agreements did not include all required information.
Required Actions
HCI must ensure, via revisions or amendments, that its subcontractor agreements include the following language: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State. – The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems related to members.

Standard IX—Subcontractual Relationships and Delegation
– 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.
Planned Interventions
Person(s)/Committee(s) Responsible
Training Required
Monitoring and Follow-Up Activities Planned
Documents to Be Submitted as Evidence of Completion
HSAG Initial Review:
Documents Included in Final Submission: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***

Standard IX—Subcontractual Relationships and Delegation
Date of Final Evidence:

Appendix D. Compliance Monitoring Review Protocol Activities

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

Table D-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the review to assess compliance with federal managed care regulations and Department contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop 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, 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 FY 2023–2024 Department-approved 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.