COLORADO

Department of Health Care Policy & Financing

Fiscal Year 2021–2022 Site Review Report

for

Northeast Health Partners

Region 2

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HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

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

This report documents results of the fiscal year (FY) 2021–2022 site review activities for **Northeast Health Partners (NHP**). For each of the four standard areas reviewed this year, this section contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 2 describes the background and methodology used for the FY 2021–2022 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2020–2021 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B lists HSAG, RAE, and Department personnel who participated in some way in the site review process. Appendix C describes the corrective action plan (CAP) process that the RAE will be required to complete for FY 2021–2022 and the required template for doing so. Appendix D contains a detailed description of HSAG's site review activities consistent with the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[1-1]

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Sep 27, 2021.

Summary of Compliance Results

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

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

Table 1-1—Summary of Scores for Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
III. Coordination and Continuity of Care	10	10	10	0	0	0	100%
IV. Member Rights, Protections, and Confidentiality	6	6	6	0	0	0	100%
V. Member Information Requirements	18	14	12	2	0	4	86%
XI. Early and Periodic Screening, Diagnostic, and Treatment Services	7	7	6	1	0	0	86%
Totals	**41**	**37**	**34**	**3**	**0**	**4**	**92%**

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

Standard III—Coordination and Continuity of Care

Summary of Strengths and Findings as Evidence of Compliance

NHP provided care coordination and continuity of care activities for all members in Region 2 through four Accountable Providers: Family Physicians of Greeley, Peak Vista Community Health Center, Plan De Salud del Valle, and Sunrise Community Health; and one delegated care coordination entity: North Colorado Health Alliance (NCHA). Each Accountable Provider signed the *Primary Care Medical Provider (PCMP) Agreement*, which outlined care coordination responsibilities and requirements as an Accountable Provider. NCHA signed an *Administrative Service Agreement* that outlined NCHA's responsibilities as the delegated care coordination entity. Additionally, Beacon Health Options (Beacon) provided oversight and support to **NHP**'s care coordination program as the administrative service organization (ASO). As the ASO, Beacon is able to support the members with complex and intense case management needs. Through **NHP**'s unique care coordination delegation model, members are able to receive care coordination services where it is convenient to the member and providers are able to reduce duplication of efforts.

NHP's care coordination policies and procedures documented processes for behavioral health and physical health care coordination and continuity of care for all members, including members determined as "complex" who require more intense and prolonged assistance. Each Accountable Provider provided care coordination services to the members directly attributed to them; if the Accountable Provider was unable to offer extensive care coordination to members, NCHA intervened and provided those services to the member. NCHA also provided care coordination services to members attributed to contributing providers in the region.

Members were able to enter care coordination in various ways such as through the call center by speaking to a customer service agent; referrals from community agencies and other RAEs; data workflow through Department-identified members with complex and chronic conditions needing care coordination services; the daily admission, discharge, and transfer (ADT) feed; and the *Health Needs Survey*. **NHP** staff members discussed **NHP**'s utilization of the Department's stratification methodology in the review period to identify members with annual costs of $25,000 or more as complex. Once identified as needing behavioral health and/or physical health care coordination services, the member was connected to a delegated care coordinator who then attempted outreach to the member. Procedures stated that the care coordinator used three bidirectional attempts and two different modalities to contact the member. **NHP** discussed how members may not be receptive to care coordination initially and, therefore, emphasized the importance of establishing a relationship with the member and respecting the member's choices. After the member was contacted and more receptive to care, the care coordinator completed an intake assessment with the member to identify medical and non-medical needs and determine what appropriate resources were needed. The member's answers on the intake assessment triggered any additional assessments that should be completed such as the *Community Prepared Tool*, which identifies social determinants of health (SDOH) or *General Anxiety Disorder 7-Item (GAD-7) Scale*. After being contacted, the member was provided contact information for care coordination including the coordinator's name, phone number, email address, and the 24/7 toll-free number to access

care coordination services. After completing the assessment, a care plan that had appropriate interventions, activities, and short- and long-term goals was developed. Care coordinators were responsible for monitoring, updating, and documenting in the care plan in a timely manner. The Accountable Providers and NCHA reported all care coordination activities they provided to members once a month to **NHP**.

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

NHP provided an overview of the electronic care coordination tool, Health Cloud, that collects and aggregates the member's care coordination information, such as the member's name, age, race, name of care coordinator, care coordination notes, stratification level, and information that can aid in the creation and monitoring of the member's care plan. To monitor documentation for each Accountable Provider and NCHA, **NHP** performed care coordination plan audits to assess the quality of documentation. **NHP** utilized a comprehensive care coordination audit tool to assess compliance with care coordination requirements. During the review, **NHP** discussed common findings in the care plans reviewed and opportunities for improvement. Opportunities for improvement included structuring of goals to include specific, measurable, attainable, realistic, and time-bound (SMART) goals; community and home-based care coordination; and self-management tools.

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

Summary of Findings Resulting in Opportunities for Improvement

NHP's care coordination and continuity of care policies and procedures provided a high-level overview of the comprehensive care coordination services available to Region 2 members. However, HSAG suggests expanding the language in the applicable policies, procedures, and delegate agreements to better illustrate the roles, responsibilities, monitoring in place for all those involved in **NHP**'s multi-tiered care coordination delegation model.

Summary of Required Actions

HSAG identified no required actions for this standard.

Standard IV—Member Rights, Protections, and Confidentiality

Summary of Strengths and Findings as Evidence of Compliance

NHP delegated the administrative responsibility of member rights to Beacon. The *Member Rights and Responsibilities* policy outlined the rights of members and described the various channels used to notify members when there are revisions to **NHP**'s policies. Members were also informed of their rights through the member handbook, member newsletters, periodic informational forums, member mailings, website postings, policy statements, provider manual, notices to providers and practitioners, and required posters at provider office locations. During the interview, staff members discussed the various ways that **NHP** receives feedback and suggestions from members, which included receiving suggestions through the clubhouse webinar, frontier webinar, and other informational forums. Staff members also discussed that members may report complaints via phone calls or in person.

NHP submitted the *PCMP Agreement*, *Privacy Notice*, *Chart Audit Tool*, and other policies to demonstrate how **NHP** complies with applicable federal and State laws. The *Provider Round Table* PowerPoint was used to educate providers on the rights and responsibilities of members, including the laws that pertain to member rights. It also informed providers that members have the right to grieve if they feel that their rights have been violated. Detailed across **NHP**'s documents, members, staff members, and providers were informed that members are free to exercise their rights and the exercise of those rights should not adversely affect the way they are treated. Staff members stated that posters are required in all provider office locations so that members are reminded of their rights.

The *Uses and Disclosure of Protected Health Information* policy described Beacon's procedures and guidelines to employees, contractors, and network providers for the uses and disclosures of protected health information (PHI). Staff members discussed **NHP**'s success regarding upholding HIPAA and protecting member PHI through the transition to telework in the past few years. Staff members discussed providing additional trainings and reminders to employees, and **NHP** purchased the Zoom for

Healthcare platform and obtained HIPAA certificates for Zoom to ensure privacy measures for providers that transitioned to telework.

NHP discussed its approach regarding educating staff members and the community about advance directives. **NHP** offered an advance directive training to staff members, members, families, and the community. Staff members described the various channels through which **NHP** advertises its trainings and discussed the call center associates' responsibilities in assisting and supporting community members with advance directives.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Required Actions

HSAG identified no required actions for this standard.

Standard V—Member Information Requirements

Summary of Strengths and Findings as Evidence of Compliance

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

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

NHP utilized the Department's *Brand Kit Index* and the *Health First Colorado Member Handbook* to ensure consistency in the information provided to members. Staff members stated that when a member is enrolled, the member receives the Department's welcome letter with **NHP**'s information. Staff members described the minimal mailing approach's intent is to reduce the influx of multiple member materials and to ensure consistency in information provided to the member. **NHP** submitted a *Managed Care Terminology* document that is used for consistency in definitions for managed care terminologies. **NHP** contracted with the Voiance® language service company to connect members with an interpreter in real time and with the Asian Pacific Development Center to provide face-to-face, telephonic, or virtual interpretation in approximately 70 languages. Members were informed through the *Getting Started Flyer* and cover sheet that these services are available at no cost to the member.

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

Summary of Findings Resulting in Opportunities for Improvement

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

Summary of Required Actions

The *Member Information Requirements* policy described procedures for ensuring that member informational materials contain taglines that are consistent with the member information requirements. However, critical member materials such as the cover sheet, welcome letter, the newly pregnant member welcome, *Getting Started Pregnancy Guide*, new baby welcome letter, child welcome letter, *Where Do I Start* flyer, *NHP Brochure*, *Care Coordination Fact Sheet*, *EPSDT Tip Sheet*, and provider directory did not include all the required components of a tagline. **NHP** must revise critical member materials to include all required components of a tagline.

During the review, staff members reported that **NHP** received minimal ad hoc printing requests. Although, **NHP** submitted an email as evidence to show how **NHP** communicates internally to fulfill such requests, **NHP** could not provide supporting documents to demonstrate how **NHP** monitors the five-day requirements for such requests. **NHP** also submitted a *Member Information Request Job Aid*; however, staff members stated that there is an opportunity to formalize within a call record, indicating the *Member Information Request Job Aid* was not in place in calendar year (CY) 2021. **NHP** could not provide supporting documents to demonstrate how **NHP** monitors the five-day requirements for such requests. **NHP** must develop and implement a mechanism to monitor that, upon request, members are provided with printed materials within five business days and at no cost. Additionally, **NHP** is required to inform members that information provided electronically is available in paper form without charge upon request and is provided within five business days. While this is noted in the general member webpage and provider directory webpage, the statement in the downloadable provider directory document did not include "within five business days." HSAG recommends that, as best practice, the full statement be placed in prominent locations on the website, particularly where critical documents are linked and/or downloadable (i.e., the *New Member Welcome Packet* page).

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

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

Summary of Strengths and Findings as Evidence of Compliance

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

therapist, specialist, or local agencies as appropriate. Beacon staff members described helping members with transportation frequently.

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

For members who did not utilize EPSDT services in the course of a 12-month period, Beacon deployed text message reminders regarding the importance of well visits to members with mobile phone numbers on record that opted to receive text messages. Members could sign up for additional text messaging programs based on their interests. **NHP** reported efforts to begin collecting email addresses, but had not started sending email communication for non-utilizer outreach in CY 2021. Additionally, staff members reported developing birthday cards for members who had not utilized services in the previous 12-month period but had not yet launched this procedure at the time of the interview.

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

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

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

Summary of Findings Resulting in Opportunities for Improvement

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

Summary of Required Actions

Although **NHP** generally informed the member of general EPSDT information, the *EPSDT Tip Sheet* in use throughout CY 2021 did not follow *Bright Futures Guidelines* timeframes for recommended teen well visits. The tip sheet stated two to three years, which should be annual recommended visits. Additionally, **NHP** did not consistently complete annual outreach for members who had not utilized EPSDT services in the prior 12-month period. Non-utilizer data submitted and staff reports during the interview both indicated that some annual outreach was untimely. Furthermore, the annual outreach process relied solely on text message outreach, which the reports indicated only reached approximately 20 to 50 percent of members according to the submitted non-utilizers report data and FY 2021–2022 second quarter *EPSDT Outreach Quarterly Report*. Staff members did not report using phone or mail outreach for annual outreach purposes in CY 2021. **NHP** must:

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

2. Overview and Background

Overview of FY 2021–2022 Compliance Monitoring Activities

For the FY 2021–2022 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard III—Coordination and Continuity of Care, Standard IV—Member Rights, Protections, and Confidentiality, Standard V—Member Information Requirements, and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services. Compliance with applicable federal managed care regulations and managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the RAE's contract requirements and regulations specified by the federal Medicaid managed care regulations published May 6, 2016. HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable.* The Department determined that the review period was January 1, 2021, through December 31, 2021. HSAG conducted a desk review of materials submitted prior to the site review activities; a review of documents and materials requested during the site review; and interviews of key RAE personnel to determine compliance with applicable federal managed care regulations and contract requirements. Documents submitted for the desk review and site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials.

The site review processes were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Appendix D contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS EQR protocol. The four standards chosen for the FY 2021–2022 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard VI—Grievance and Appeal Systems, Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontractual Relationships and Delegation, and Standard X—Quality Assessment and Performance Improvement.

Objective of the Site Review

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

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

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

FY 2020–2021 Corrective Action Methodology

As a follow-up to the FY 2020–2021 site review, each RAE that received one or more *Partially Met* or *Not Met* scores was required to submit a CAP to the Department addressing those requirements found not to be fully compliant. If applicable, the RAE was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the RAE and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **NHP** until it completed each of the required actions from the FY 2020–2021 compliance monitoring site review.

Summary of FY 2020–2021 Required Actions

For FY 2020–2021, HSAG reviewed Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontractual Relationships and Delegation, and Standard X—Quality Assessment and Performance Improvement.

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

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

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

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

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

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

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

Summary of Corrective Action/Document Review

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

Summary of Continued Required Actions

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

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. A. *For the Capitated Behavioral Health Benefit,* the RAE implements procedures to deliver care to and coordinate services for all members. B. *For all RAE members*, the RAE's care coordination activities place emphasis on acute, complex, and high-risk patients and ensure active management of high-cost and high-need patients. The RAE ensures that care coordination: • Is accessible to members. • Is provided at the point of care whenever possible. • Addresses both short- and long-term health needs. • Is culturally responsive. • Respects member preferences. • Supports regular communication between care coordinators and the practitioners delivering services to members. • Reduces duplication and promotes continuity by collaborating with the member and the member's care team to identify a lead care coordinator for members receiving care coordination from multiple systems. • Is documented, for both medical and non-medical activities. • Addresses potential gaps in meeting the member's interrelated medical, social,	**Documents Submitted/Location Within Documents:** 1. R2_PopMangPln_FY21-22_NHP 2. R2_PopMangPln_FY21-22_HCPF Response_Accepted_NHP 3. ComplexMemberDefinitionProposal_NHP 4. R2_ApprovalLetterforComplexProposal_NHP 5. 262L-R2_CareCoordinationGeneralPolicy_NHP 6. NHP Care Coordination Plan_21-22 7. QM33.9CulturalCompetencyPolicy_NHP 8. PhysicalHealthProviderHandbook_NHP, Pages 20-21, 26-30, *Misc 9. BehavioralHealthProviderHandbook_NHP, Pages 229, 61-62, *Misc 10. PCMPAccountableAgreement_NHP, Exhibit A Pages 1-7, *Misc 11. CareCoordinationAuditTool_NHP, *Misc **Description of Process:** Northeast Health Partners (NHP) implements procedures to deliver care to and coordinate services for all members and demonstrates this in the following documents: NHP developed a Population Health Plan (see R2_PopMangPln_FY21-22_NHP) to support care coordination at the place of care and/or from an existing trusted and local provider, as a critical intervention that is available to all members in Region 2. Care coordination is an intervention that connects members and engages them in the resources available and is a key intervention to managing our population's health overall. Reliably identifying those members most likely to	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
developmental, behavioral, educational, informal support system, financial, and spiritual needs. *42 CFR 438.208(b)* Contract Amendment 7: Exhibit B6—11.3.1, 11.3.7	benefit from specific interventions is paramount to the efficiency of a care management infrastructure. During this audit period, NHP utilized the Health Care Policy and Financing (HCPF) definition of Complex Members, which included members who had $25,000 or more in cost of care over a rolling twelve (12) month period. HCPF classifies members into different strata, which typically results in the following three (3) main categories: • Advanced Illness refers to members who need complex case management • At-risk, Multiple or Poorly Controlled Chronic Conditions refers to members with chronic conditions who may be at risk of developing or progressing into advance illness (complex case) • Healthiest Low Utilizing Members refers to members who do not have any chronic conditions, those that have some acute conditions, or those who may not be utilizing care HCPF's acceptance of NHPs' Population Health Plan is outlined in the document titled R2_PopMangPln_FY21-22_HCPF Response_Accepted_NHP. NHP submitted a proposal (see ComplexMemberDefinitionProposal) during the 2021 calendar year, in alignment with HCPF's support of individual Regional Accountable Entity (RAE) efforts to establish their own innovative and evidence-based risk stratification methodologies for a new Complex Member definition for Region 2. NHP was	

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	granted permission to implement the alternative definition of Complex Members, via the document titled R2_ApprovalLetterforComplexProposal_NHP. This proposal was submitted and approved of during the audit period of 2021 but will not be implemented until 2022. The document titled 262L-R2_CareCoordinationGeneralPolicy_NHP adheres to this requirement and identifies the delegated care coordination entity as responsible for coordinating all aspects of the members care, including the medical treatment team, specialty care and any other health providers involved in the member's care. Care coordination provided at the point of care, whenever possible, is culturally responsive and provided for both short and long-term healthcare needs. Care coordination is accessible to all members, by provider referral, self-referral, or care coordinator referral. Instructions on how to access care coordination are provided by NHP during external meetings, through its call center and website (Northeast Health Partners, Contact), and disseminated by providers, including Primary Care Medical Providers (PCMPs), Community Mental Health Centers (CMHCs) and Federally Qualified Health Centers (FQHCs), etc. Member preferences are respected and regular communication between care coordinators and practitioners delivering services to members is provided. Care coordinators make every effort to provide services that are not duplicative of other services and that are mutually reinforcing. Care coordination activities are documented, for both medical and non-medical activities. Care coordination shall be provided in alignment with RAE principles, which ensure that physical, behavioral, long-term	

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	care, social and other services are integrated, continuous, and comprehensive and the service providers communicate with one another to effectively coordinate care. This policy addresses all components of this requirement, including the following: • Is accessible to members • Is provided at the point of care whenever possible • Addresses both short- and long-term health needs • Is culturally responsive • Respects member preferences • Supports regular communication between care coordinators and the practitioners delivering services to members • Reduces duplication and promotes continuity by collaborating with the member and the member's care team to identify a lead care coordinator for members receiving care coordination from multiple systems • Is documented, for both medical and non-medical activities • Addresses potential gaps in meeting the member's interrelated medical, social, developmental, behavioral, educational, informal support system, financial, and spiritual needs to achieve optimal health, wellness or end-of-life outcomes, according to member preferences The document titled NHP Care Coordination Plan 21-22 provides an overview of comprehensive care coordination services for members of the RAE. RAEs are responsible for providing access to care coordination for all members who need it. Members who have more complex needs may require more	

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	intense levels of care coordination, also referred to as extended care coordination. This is not the only intervention for complex members, but it is a core RAE function that can support members in achieving their physical health, behavioral health, and social determinants of health (SDoH) needs. This plan is intended to provide guidance about the scope of care coordination activities, yet it must be acknowledged that the service needs for individual members can vary widely and members may receive care coordination services through the RAE, or through its partners/providers. Service settings may include individual primary care practices, group medical practices, specialty care settings, behavioral health care settings including CMHCs, FQHCs, and other locations. The RAE works to provide education, monitoring, reporting, training, and communication. This plan identifies the accountable provider/delegated care coordination entity as responsible for coordinating all aspects of the members care to facilitate the appropriate delivery of physical health, behavioral health, functional Long-Term Services and Supports (LTSS), oral health, specialty care, and other services. The document titled QM33.9CulturalCompetencyPolicy_NHP underscores the commitment to developing and implementing policies and procedures that will enhance cultural competency; to breaking down barriers to access and utilization that are faced by many minorities when seeking behavioral health care. These barriers include relevancy of services, financial, language, transportation, and literacy barriers; to broadening multi-cultural participation in our provider network; to promoting the ethic of cultural competence and educating our staff, providers, partners,	

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	members and the community about member's rights to culturally competent services. The document titled PhysicalHealthProviderHandbook_NHP (see Cultural Competency Section, Pages 20-21) identifies that the regional organization requires that all physical, behavioral health and care coordination services be provided in a culturally competent manner. This includes sensitivity to the member's particular language needs and their cultural beliefs and values. Pages 26-30 identify expectations for providers as it relates to care coordination, regional strategy, the care coordination delegation model, provider role as it relates to care coordination and care coordination principles. The document titled BehavioralHealthProviderHandbook_NHP (see Cultural Competency Section, Pages 61-62) identifies that the regional organization requires that all physical, behavioral health and care coordination services be provided in a culturally competent manner. This includes sensitivity to the member's particular language needs and their cultural beliefs and values. Page 22 identifies expectations for providers as it relates to continuity and coordination of care. The document titled PCMPAccountableAgreement_NHP (see Exhibit A, Pages 1-7) identifies requirements of the care coordination delegated entities. NHP works to improve care coordinators knowledge through ongoing trainings/meetings regarding contract requirements. NHP hosts a monthly care coordination subcommittee with	

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	delegated care coordination entities from across the region. Care coordinators are monitored on compliance with this Requirement 1 through existing audit and performance improvement procedures (see CareCoordinationAuditTool_NHP).	
2. The RAE ensures that each *behavioral health member* has an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member. • The member must be provided information on how to contact their designated person or entity. *42 CFR 438.208(b)(1)* Contract Amendment 7: Exhibit B6—None	**Documents Submitted/Location Within Documents:** 1. 262L-R2_CareCoordinationGeneralPolicy_NHP 2. ChartAuditTool_NHP, Section E, *Misc 3. CareCoordinationAuditTool_NHP, Section D. *Misc 4. PhysicalHealthProviderHandbook_NHP, Pages 26-28, *Misc 5. BehavioralHelathProviderHandbook_NHP, Pages 4, 22, & 40-41, *Misc 6. CareCoordandBHProviders_NHP 7. 210L_MemberRoutineRequest_NHP 8. HCPFWelcomeLtr_NHP, *Misc. 9. WelcomeMemberLetter_NHP 10. Getting Started Flyer_NHP, *Misc 11. NHPWelcomeMessage_Acumen Consent 12. NHPWelltokWelcomeBenefitMessages 13. Care Coordination Fact Sheet_NHP, *Misc 14. 307L_MemberInfoReqPolicy_NHP, *Misc **Description of Process:** NHP initiates this process internally by providing each of the delegated care coordination entities in Region 2 with a list of members attributed to them. The member's "Member ID" (Medicaid ID) is bumped up to the 834 member eligibility	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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	dataset to confirm that the member is eligible within the RAE. Once complete, a set of queries assigns a care coordinator to members based on Primary Care Medical Provider (PCMP) location. The reports are distributed to care coordinators via secure email or through File Connect. Care coordination information is provided to members via NHPs website which includes a designated, toll free, care coordination phone number listed under the "Contact" tab (https://www.northeasthealthpartners.org/contact/). Additionally, to ensure that members *who may only be accessing behavioral health services has a well-defined glidepath for care*, understands their Medicaid benefits, including care coordination and how to contact their RAE, NHP provides training/education to all behavioral health providers in the region on how to link members to RAE care coordination. NHP has requested that both CMHCs (North Range Behavioral Health and Centennial Mental Health Center) post NHPs' *Welcome Letter* (see document WelcomeMemberLetter_NHP) in their lobbies and provide a hard copy at the time of enrollment/yearly paperwork updates. Additionally, NHP has created FACT sheets for behavioral health providers to give them the tools to help members access services. This FACT sheet is shared during trainings and is posted to NHPs' website (see CareCoordandBHProviders document and/link below). The document 262L-R2_CareCoordinationGeneralPolicy_NHP defines the responsibilities of care coordination activities within the Accountable Care Collaborative (ACC) 2.0 Program. Care coordination will be accessible to all members, provided at the point of care whenever possible, culturally responsive and	

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	provided for both short (deliberate) and long-term (extended) health care needs. Providers are monitored on compliance with this requirement through existing audit procedures (see ChartAuditTool_NHP,Section E). Care coordination delegated entities are monitored on compliance with this requirement through existing audit procedures (see CareCoordinationAuditTool_NHP, Section D). The document titled PhysicalHealthProviderHandbook_NHP (see Pages 26-28) articulates that accountable PCMPs/delegated care coordination entities will manage the members physical and behavioral health needs as well as collaboration with social, educational, justice, recreational and housing agencies to foster healthy communities and address complex member needs spanning multiple agencies. As well as the care coordination delegation model allowing members to have immediate and continuous access to care coordination staff who are dedicated to providing care coordination services. The document titled BehavioralHealthProviderHandbook (see Page 22**)** states as a part of care coordination activities, participating providers should identify all providers/participating providers involved in the medical and/or behavioral health care and treatment of a member. Care Coordination contact information is listed for providers (see page 4). The importance of behavioral health	

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	providers contacting the RAEs to get their members connected with care coordination is reinforced on page 22 of the handbook. Beacon Health Options care management team, on behalf of NHP, also conducts coordination of care activities in the following situations (see Page 40-41): • Members and participating behavioral health providers may access the Beacon care management system through any of the following avenues: 24-hour toll-free emergency care/clinical referral line • Direct registration/certification of care through ProviderConnect for participating providers • Direct authorization/certification of all levels of care through referral by a Beacon Clinical Care Manager (CCM) • Emergency services through freestanding psychiatric hospitals, medical hospitals with psychiatric units, emergency rooms, or crisis response teams If a call is received from a member requesting a referral and/or information about participating behavioral health providers in the member's location, CCMs may conduct a brief screening to assess whether there is a need for urgent or emergent care. Referrals are made to participating behavioral health providers, considering member preferences such as geographic location, hours of service, cultural or language requirements, ethnicity, type of degree the participating behavioral health providers holds and gender. Additionally, the member may require a clinician with a specialty such as treatment of eating disorders.	

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	In all cases, where available, the CCM will assist in arranging care for the member. The name, location, and phone number of at least three participating behavioral health providers will be given to the member. The provider manual also captures CCM review process to determine that the appropriate level of care (LOC) is being provided. All member requests are handled expeditiously (see 210L_MemberRoutineRequest_NHP). Each member attempting to access care directly or by a representative through any Beacon Health Options 24-hour Clinical Referral/Direct line is assessed for risk of self-harm, harm to others, or harm by others and referred to the appropriate level of care. The members are given information related to network providers and/or delegated care coordination entities, including names, addresses and phone numbers of providers in attempt to link members with services. Behavioral health providers are educated on NHPs' delegated care coordination structure, the importance of care coordination, care coordination role with behavioral health providers and how to link members with care coordination using the CareCoordandBHProviders_NHP document. This information was posted on the NHP website under provider resources (https://www.northeasthealthpartners.org/providers/provider-resources/) Upon enrollment, members are sent a welcome letter from HCPF which includes a URL link to the NHP website (see HCPFWelcomeLtr_NHP). On its website	

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	(www.northeasthealthpartners.org/members/new-member-welcome-packet/), NHP has a New Member Welcome Packet which includes NHPs' welcome letter (see WelcomeMemberLetter_NHP) as well as other onboarding resources. NHP hosts a "Getting Started" webinar (see Getting Started Flyer_NHP) on the first Thursday of every month to orient members to their benefits, how to use them, and how to get help finding resources. Members identified as having a textable number receive a welcome message from NHP (see NHPWelcomeMessage_Acumen Consent) and those who do not opt out are enrolled in the "Welcome and Benefits" message campaign (see NHPWelltokWelcomeBenefitMessages). This document outlines text messages sent to members enrolled in this campaign covering topics such as how to contact the health plan, accessing the member handbook and member rights, how to get a new ID card; as well as benefit reminders such as well visits, immunizations, mental health, and dental services. Through these messages, members are also provided information to access care coordination, connection to community resources and crisis services. Members are provided information regarding what care coordination is, how it works with their care, that it is free and if a member wants a care coordinator how to request one using the Care Coordination Fact Sheet_NHP. The tip sheet was distributed to care coordinators, practice transformation coaches, member advocates and was uploaded to the NHP website	

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	(https://www.northeasthealthpartners.org/members/care-coordination/). The document titled 307L_MemberInfoReqPolicy_NHP establishes guidelines for the development and distribution of critical member information and mechanisms in place to help members understand the requirements and benefits of their plan in plain language.	
3. The RAE no less than quarterly compares the Department's attribution and assignment list with member claims activity to ensure accurate member attribution and assignment. The RAE conducts follow-up with members who are seeking care from primary care providers other than the attributed primary care medical provider (PCMP) to identify any barriers to accessing the PCMP and, if appropriate, to assist the member in changing the attributed PCMP. Contract Amendment 7: Exhibit B6—6.8.1	**Documents Submitted/Location Within Documents:** 1. AttributionClaimsDataValidationProcess_NHP 2. PCMP Data Management Procedure_NHP 3. PhysicalHealthProviderHandbook_NHP, Page 23-24, *Misc **Description of Process:** NHP compares HCPF's attribution and assignment list with member claims activities to help ensure accurate attribution/assignment. NHP also completes follow-up with members to identify barriers accessing PCMPs within the region and assists with changing the attributed PCMP when appropriate. This is demonstrated in the following supporting documents. The document titled AttributionClaimsDataValidationProcess_NHP outlines the standard operating procedure to verify the attribution list provided by HCPF is aligned with claims activity to help ensure members are assigned to providers with which they have an active relationship. Once this process is complete, NHP provides	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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	the list of outliers to the care coordination entities for follow up to assess any barriers, as well as to assist with contacting the enrollment broker for reattribution. The document titled PCMP Data Management Procedure_NHP outlines the standard operating procedure for tracking information necessary to provide network reporting for Primary Care Medical Providers (PCMPs). The described procedure is how NHP accurately documents and tracks the contracted providers to receive member attribution lists. The Provider Relations (PR) Department ensures all contracted PCMPs, by Billing ID, are affiliated with NHP, makes any additions, changes or deletions on monthly basis, as appropriate. This includes closing or opening provider panels for new members or geo attribution. PR also works with internal data analysts to confirm the correct PCMPs by conducting a crosscheck of the attribution and assignment to identify any peculiar attribution (e.g., a non-contracted PCMP has attributed members). PR also works with PCMPs if they report issues with attribution and forward concerns to HCPF for panel analysis and resolution. This can include PCMP reporting members with claims history not being attributed to them. The document titled PhysicalHealthProviderHandbook, (see Pages 23-24) describes the member attribution process for PCMP providers, as well as how a member can change their PCMP and how PCMPs can check the eligibility of attributed members via the state portal.	

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4. The RAE's care coordination activities will comprise: • A range of deliberate activities to organize and facilitate the appropriate delivery of health and social services that support member health and well-being. • Activities targeted to specific members who require more intense and extended assistance and include appropriate interventions. Contract Amendment 7: Exhibit B6—11.3.3	**Documents Submitted/Location Within Documents:** 1. 262L-R2_CareCoordinationGeneralPolicy_NHP, Pages 1-2 2. ComplexCareCoordinationPlan_NHP, Pages 1-2 3. ComplexMemberDefinitionProposal_NHP 4. R2_ApprovalLetterforComplexProposal_NHP 5. CareCoordinationAuditTool_NHP, *Misc **Description of Process:** NHP ensures care coordination is accessible to all members. Care coordination is comprised of deliberate interventions as well as extended care coordination. Deliberate interventions are available to the broader population and include tactics such as medical and social referrals, telephonic/electronic communications, educational resources, etc. Extended care coordination targets specific complex member groups who require more intense and prolonged assistance and includes interventions such as care planning and quarterly bidirectional communication between the member and care coordinator. The document titled 262L-R2_CareCoordinationGeneralPolicy_NHP (see Pages 1-2) addresses all components of this requirement, including the definition of care coordination, including deliberate activities as well as intense/extended assistance and interventions expected from the Accountable Providers/Delegated Care Coordination Entities. The document titled ComplexCareCoordinationPlan_NHP (see Pages 1-2) addresses care coordination/care management of priority populations (i.e., complex members) who require more	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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	intense and extended assistance and includes appropriate interventions. The document titled ComplexMemberDefinitionProposal_NHP submitted the proposal during the 2021 calendar year in alignment with HCPF's support of individual RAE efforts to establish their own innovative and evidence-based risk stratification methodologies for complex members. In alignment with HCPF's timeline, activities targeted for specific members who require more intense and extended assistance and include appropriate interventions aimed at this newly defined complex cohort. NHP requested and was granted permission to implement an alternative definition of complex as outlined in the following brief proposal to the department. HCPF's response can be viewed in the document titled R2_ApprovalLetterforComplexProposal_NHP. This proposal was submitted and approved during the audit period of 2021 but will not be implemented until 2022. The document titled CareCoordinationAuditTool_NHP addresses both short and long-term health needs. It ensures care coordination documentation for developing and maintaining comprehensive knowledge and working relationships with community agencies, health teams and providers that offer a range of deliberate and extended care coordination services including: medical care, substance abuse and mental health treatment, legal services, long-term care, dental services, developmental disability services, homeless services, school and educational programs, and other agencies that serve special populations. This document shows proof of delegating care	

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	coordination for linking members to both deliberate and extended interventions comprised of medical and non-medical, and community-based services such as transportation, child-care, food assistance, elder support services, housing, utilities assistance, and other non-medical supports.	
5. The RAE administers the *Capitated Behavioral Health Benefit* in a manner that is fully integrated with the entirety of work outlined in the contract, thereby creating a seamless experience for members and providers. The RAE implements procedures to coordinate services furnished to the member: • Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. • With the services the member receives from any other managed care plan. • With the services the member receives in fee-for-service (FFS) Medicaid. • With the services the member receives from community and social support providers. *42 CFR 438.208(b)(2)* Contract Amendment 7: Exhibit B6—10.3.2, 10.3.4, 11.3.5, 11.3.7.7, 11.3.10, 14.3	**Documents Submitted/Location Within Documents:** 1. 262L-R2_CareCoordinationGeneralPolicy_NHP 2. 282L_Transitions of Care-BH_FY21-22_NHP 3. 254L_TransitionandContinuityofCare_NHP 4. NHP Care Coordination Plan_21-22, Pages 5-6 5. ComplexCareCoordinationPlan_NHP, Page 3 6. CareCoordinationAuditTool_NHP, *Misc 7. DOCMember Welcome letter_NHP 8. HealthFirstColoradoMemberHandbook_NHP 9. DOC Dental Benefit_NHP 10. BehavioralHelathProviderHandbook_NHP, Page 56-57, *Misc **Description of Process:** NHP administers the Capitated Behavioral Health Benefit in a manner that is fully integrated with the entirety of the work outlined in the contract thereby creating a seamless experience for members and providers, as evidenced by the following documents. The document titled 262L-R2_CareCoordinationGeneralPolicy_NHP provides guidelines for ensuring proper coordination with medical and behavioral providers while ensuring care coordination is accessible to all members, provided at the point of care whenever possible,	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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	member preferences are respected and ensuring that the care is coordinated within a practice as well as between other providers and organizations serving the member. It is the policy of Beacon Health Options (see 282L_Transitions of Care-BH_FY21-22_NHP and 254L_TransitionandContinuityofCare_NHP) to assist members in transitioning from one system of care to another with minimal disruption in their behavioral health services. This policy ensures that members with special health care needs have continued access to services during a transition from one system of care to another. These policies are aligned with the requirements of 42 CFR 438.62 and the HCPF Transition of Care Policy. NHP Care Coordination Plan_21-22 (pages 5-6) identifies outreach expectations during transitions of care to promote continuity of care and to prevent unnecessary re-hospitalizations or services at a higher level of care and to facilitate improved communication about the member among providers, facilities, and others who are involved with the member. The document titled ComplexCareCoordinationPlan_NHP (see Page 3) outlines the expectations of care coordinators with priority/complex members who are undergoing transitions of care between settings of care. If the assigned member is seen in an emergency room or urgent care clinic or is admitted to an inpatient facility, upon notification of this information, the care coordinator follows up with the member within seven (7)	

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	business days of discharge from the facility. The follow up visit is to ensure that all discharge instructions are being followed and any follow-up appointments have been scheduled. Care coordinators will assist the complex member with moving between service settings to ensure that the member is placed in or remains at the most appropriate, least restrictive setting that meets the member's needs. Care coordinators will assist the member with moving between service settings, for example with the move from the residential treatment setting to Home and Community Based Services (HCBS) setting. The care coordinator will conduct appropriate discharge planning for short-term and long-term hospital and institutional stays. Care coordinators are monitored on compliance with this through existing audit and performance improvement procedures (see CareCoordinationAuditTool_NHP). NHP has excelled with our work supporting our justice-involved members who are transitioning out of a prison facility. The document titled DOCMember Welcome letter_NHP is included in the welcome packet given to members during the face to face in-reach program. Each member is identified 90-days to their release date and with the goal of a face-to-face engagement occurring prior to a member releasing back to the community. The document titled HealthFirstColoradoMemberHandbook_NHP is issued to our members who engage with the NHP in-reach program. Members participate in an educational seminar which goes over each section of the member handbook, while also discussing their criminogenic needs. The Colorado DentaQuest benefit (see	

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	DOC Dental Benefit_NHP) is also shared with our justice involved members prior to their release. The continuity and coordination of care throughout NHPs' continuum of behavioral health services is monitored (see BehavioralHelathProviderHandbook_NHP, Page 56-57, Continuity and Coordination of Care). This may include reviews and audits of treatment records, coordination of discharge planning between inpatient and outpatient providers/participating providers, and monitoring provider/participating provider performance on pre-determined coordination of care indicators. Processes are established seeking to avoid disruption of care for the member when there is a change in their treating provider/participating provider. Such changes may include, but are not limited to the following: • A member requires a change in level of care, necessitating a new participating provider • There are multiple providers/participating providers involved in treatment simultaneously (psychiatrist for medication management, therapist for ongoing treatment) • A change in health plans or benefit plans • Termination of a participating provider • A member is being treated for several (co-morbid) conditions simultaneously with multiple providers/participating providers (both behavioral health specialists, primary care, medical specialists, or providers specializing in developmental disabilities)	

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	• Subject to any member consent or authorization required by applicable state and/or federal laws and/or regulations, participating providers should coordinate care as appropriate, sharing information with other treating providers/participating providers within the context of providing quality care and within the guidelines of protecting a member's privacy and confidentiality.	
6. The RAE uses the results of the health needs survey, provided by the Department, to inform member outreach and care coordination activities. The RAE: • Processes a daily data transfer from the Department containing responses to member health needs surveys. • Reviews the member responses to the health needs survey on a regular basis to identify members who may benefit from timely contact and support from the member's PCMP and/or RAE. *42 CFR 438.208(b)(3)* Contract Amendment 7: Exhibit B6—7.5.2–3	**Documents Submitted/Location Within Documents:** 1. HealthNeedsSurveyProcess_NHP 2. NHP Care Coordination Plan_21-22, Page 6 3. 262L-R2_CareCoordinationGeneralPolicy_NHP, Page 4 4. CareCoordinationAuditTool_NHP, Section D7, *Misc **Description of Process:** NHP uses the results of the Health Needs Survey (HNS), provided by HCPF, to inform member outreach and care coordination activities NHP processes a daily data transfer from HCPF to retrieve the HNS results for distribution to delegated care coordination entities. This can drive member outreach and care coordination activities. The document titled HealthNeedsSurveyProcess_NHP describes the process of intake and distribution of the HNS. The File Utilization Batch System (FUBS) Application runs on an automated schedule to download the Health Needs Surveys. FUBS will look for any new HNS that are made available on the Secure File Transfer Protocol (SFTP) site. Once FUBS finds a	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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	new file, the file is downloaded to a file repository on the server. The file is then processed to the Colorado data warehouse under the [RAE2].[dbo].[HealthNeedsSurvey] database structure. All HNS are appended to this database. The member's "MemberID" (Medicaid ID) in the HNS is bumped up to the 834 member eligibility roster dataset to confirm that the member is eligible within the RAE. The HNS does not have the member demographics such as phone and address. This information is pulled from the 834 member eligibility dataset roster and is appended to the HNS database. Once the member's demographics have been included in the HNS dataset, a set of queries assign a care coordinator to the members based off attribution and care coordination delegation. The reports are then sent out to the care coordinators via secure email or through FileConnect. The document titled NHP Care Coordination Plan_21-22 (see page 6) identifies care coordination interventions are provided in alignment with RAE principles, including using the results of the Health Needs Survey to inform member outreach and care coordination activities. The document titled 262L-R2_CareCoordinationGeneralPolicy_NHP (see Page 4) reinforces expectations for the delegated care coordination entity to use the results of the Health Needs Survey, to inform member outreach and care coordination activities.	

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	The document titled CareCoordinationAuditTool_NHP (see Section D7) identifies where the requirement to use the results of the HNS to inform care coordination activities is being assessed/monitored.	
7. *For the Capitated Behavioral Health Benefit:* The RAE ensures that it has procedures to ensure: • Each member receives an individual intake and assessment appropriate for the level of care needed. • It uses the information gathered in the member's intake and assessment to build a service plan. • It provides continuity of care for members who are involved in multiple systems and experience service transitions from other Medicaid programs and delivery systems *42 CFR 438.208(c)(2-3)* Contract Amendment 7: Exhibit B6—14.7.1	**Documents Submitted/Location Within Documents:** 1. ChartAuditTool_NHP, Sections B & C, *Misc 2. ProviderDocumentationTraining_NHP, *Misc 3. 282L_Transitions of Care-BH_FY21-22_NHP 4. BehavioralHealthProviderHandbook_NHP, Page 37, 56-58, *Misc 5. PhysicalHealthProviderHandbook_NHP, Page 27-28, *Misc 6. QM 16B Provider Treatment Record Review Analysis and Reporting_NHP 7. Audit Policy_QM 16.24_NHP **Description of Process:** Based on the member's needs and level of care required, NHP ensures procedures for the following: each member receives an individual intake and assessment appropriate for the level of care needed, and a service planning system that uses the information gathered in the member's intake and assessment to build a service plan. Providers are monitored on compliance with this requirement through existing audit procedures (see ChartAuditTool_NHP, Sections B & C) specifically auditing the intake assessment and treatment planning requirements. Providers receive training on	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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	these requirements as outlined in the document: titled ProviderDocumentationTraining_NHP. It is the policy of Beacon Health Options to assist members in transitioning from one system of care to another with minimal disruption in their behavioral health services (see 282L_Transitions of Care-BH_FY21-22_NHP). This policy ensures that members with special health care needs have continued access to services during a transition from one system of care to another. This policy is aligned with the requirements of 42 CFR 438.62 and HCPF's Transition of Care Policy. Behavioral health providers/participating behavioral health providers must develop individualized treatment plans that utilize assessment data, address the member's current problems related to the behavioral health diagnosis, and actively include the member and significant others, as appropriate, in the treatment planning process (see BehavioralHealthProviderHandbook_NHP, Page 37). CCMs review the treatment plans with the behavioral health providers/participating behavioral health providers to ensure that they include all elements required by the provider agreement, applicable government program, and at a minimum include the following: • Specific measurable goals and objectives • Reflect the use of relevant therapies • Show appropriate involvement of pertinent community agencies	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Demonstrate discharge planning from the time of admission • Reflect active involvement of the member and significant others as appropriate Behavioral health providers/participating behavioral health providers are expected to document progress toward meeting goals and objectives in the treatment record and to review and revise treatment plans as appropriate. Continuity and coordination of care is monitored through the continuum of behavioral health services (see BehavioralHealthProviderHandbook_NHP, Page 56-57). Monitoring may include reviews and audits of treatment records, coordination of discharge planning between inpatient and outpatient providers/participating providers, and monitoring provider/participating provider performance on pre-determined coordination of care indicators. Processes are established seeking to avoid disruption of care for the member when there is a change in their treating provider/participating provider. Such changes may include, but are not limited to, the following: • A member requires a change in level of care, necessitating a new participating provider • There are multiple providers/participating providers involved in treatment simultaneously (psychiatrist for medication management, therapist for ongoing treatment) • A change in health plans or benefit plans • Termination of a participating provider	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• A member is being treated for several (co-morbid) conditions simultaneously with multiple providers/participating providers (both behavioral health specialists, primary care, medical specialists, or providers specializing in developmental disabilities) The "Treatment Record Standards and Guidelines" section (see BehavioralHealthProviderHandbook_NHP, Pages 57-58) outlines how member treatment records should be maintained, as well as what should be included in the progress notes, and record-keeping standards for treatment record reviews and audits. Compliance with these standards of care is monitored through treatment record reviews, audits and associated requests for copies of member records. Additionally the document titled PhysicalHealthProviderHandbook_NHP states that "All accountable PCMPs/Delegated Care Coordination Entities are responsible for completing an assessment with the member to determine medical and non-medical needs in order to link members to appropriate resources" (see Pages 27-28). Following the comprehensive member assessment, care coordination activities are structured by a clinical care plan, a collaborative, living document generated by the member and care coordinator reflecting member's needs, log and short-term goals, associated resources, supports, providers and action steps toward reaching their identified goals. The document titled QM 16B Provider Treatment Record Review Analysis and Reporting_NHP covers review of	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	behavioral health practitioner treatment records to evaluate compliance with the treatment record documentation standards and to monitor adherence to clinical practice guidelines, as part of continuous quality improvement and/or monitoring activity. All providers are required to maintain records in compliance with standards, and the State of Colorado standards, which require that "member treatment records are maintained in a manner and includes current, comprehensive, detailed, organized, and legible writing and/or electronic organization to promote effective member-care and quality record review process" (see Page 1). Treatment records are subject to audit/reviews by the State of Colorado, Beacon's Clinical and/or Quality Management/Compliance Departments and accrediting bodies. Provider participation is an integral part of NHPs' quality improvement program and is a condition of network participation. The purpose of the document titled Audit Policy_QM16.24_NHP is to have processes in place for treatment record reviews in order to monitor practitioner/provider/facility performance, to determine if this has resulted in positive outcomes for members, and to ensure adherence to the treatment record standards as documented in the provider handbook (see BehavioralHealthProviderHandbook_NHP, Pages 57-58).	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. *For the Capitated Behavioral Health Benefit:* The RAE shares with other entities serving the member the results of its identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR 438.208(b)(4)* Contract Amendment 7: Exhibit B6—None	**Documents Submitted/Location Within Documents:** 1. NHP Care Coordination Plan_21-22, Page 5 2. 262L-R2_CareCoordinationGeneralPolicy_NHP, Pages 2-4 3. CareCoordinationAuditTool_NHP, *Misc 4. PCMPAccountableAgreement_NHP, Pages 5,7 as well as Exhibit A, Pages 2-3 & 6, *Misc 5. R2_narrative_CareCompacts_Q4FY21_NHP 6. R2_CareCompactQ4_FY20-21_NHP 7. Banner_Specialty_Clinics_CareCompact_NHP **Description of Process:** NHP has established and strengthened relationships among network providers and the health neighborhood in the region by supporting existing collaborations and facilitating the creation of new connections and improved processes, while avoiding duplication of existing local and regional efforts. Care coordination expectations directly align with this requirement. Beacon, as the ASO of NHP, sends monthly lists to delegated care coordination entities. These lists include PCMP identification, so that delegated care coordination entities can efficiently engage in two-way communication between care coordinators and PCMPs to ensure member's needs are met. Care coordinators continually work on improving bidirectional communication processes with member PCMPs. The ASO ensures that all care coordination, including interventions provided by network providers and subcontractors meet the needs of the member. Beacon, as the ASO, will provide additional support and guidance when the systems and providers engaged with a member's complex care require leadership and direction.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The document titled NHP Care Coordination Plan_21-22 (see Page 5) highlights that *Accountable Providers/Delegated Care Coordination Entities* provide care coordination for all enrolled members, with care coordination occurring within a practice as well as between the practice and other Health Neighborhood providers and community organizations. This plan also underscores that entities will support regular communication between care coordinators and the practitioners' delivering services to members; reduce duplication and promote continuity by collaborating with the member and the member's care team to identify a lead care coordinator for members receiving care coordination from multiple systems and addresses potential gaps in meeting the member's interrelated medical, social, developmental, behavioral, educational, informal support system, financial and spiritual needs to achieve optimal health, wellness, or end-of-life outcomes, according to member preferences. The plan also identifies that *Accountable Providers/Delegated Care Coordination Entities* reach out and connect with other service providers and communicate information appropriately, consistently and without delay. The document titled 262L-R2_CareCoordinationGeneralPolicy_NHP (see Pages 2-4) addresses all components of this requirement. Care coordinators are required to have proper coordination with all providers working with members. Care coordinators are required to reach out and connect with other service providers not limited to medical and behavioral health providers as well as access to community resources for all members. The goal is to	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	communicate information appropriately, consistently, and without delay. Member preferences will be respected and regular communication between delegated care coordination entities and the practitioners delivering services to members will be provided. The delegated care coordination entity is responsible for assessing or arranging for the assessment of the member's need for services, coordinating mental health services rendered by multiple providers, coordinating behavioral health services with other health care and human service agencies and providers, and referring to other health care and human service agencies and providers, as appropriate. The care coordinator will share the results of their assessment with other providers to prevent duplication of services and reduce the potential for fraud, waste, and abuse. Delegated care coordination entities coordinate with the member's healthcare providers to facilitate delivery of services as appropriate and make reasonable efforts to assist individuals to obtain medically necessary services. If a member is having difficulty arranging for medical/behavioral health care, the delegated care coordination entities assist and make an appointment for the member, if needed. Pages 3-4 outline that care coordination shall be provided in alignment with RAE principles. These principles include the following: • Ensuring that physical, behavioral, long-term care, social and other services are continuous and comprehensive and the service providers communicate with one another in order to effectively coordinate care • Ensuring that care is coordinated within a practice, as well as between the practice and other providers and organizations serving a member	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Provide services that are not duplicative or other services and that are mutually reinforcing. • Shall not duplicate care coordination provided through Healthy Communities, LTSS, HCBS waivers and other programs designed for special populations; rather, will work to link and organize the different care coordination activities to promote a holistic approach to a member's care. Page 4 requires the coordination of services and sharing of relevant treatment information with the following groups or parties, as appropriate, with the consent of the member. This policy does not require the provider to coordinate with all of these groups or to document when or why a particular group is excluded; it only requires the provider to coordinate with the following entities, when it is clinically appropriate to do so: • Providers of primary care • Any other Managed Care Organization • Other behavioral health providers • Other physical health care providers to include specialty care • Long-term supportive services and providers including private duty nursing, long term home health, long term care facilities, and assisted living facilities • Waiver service providers • Pharmacies and pharmacists • County and State agencies • Other provider organizations that provide wraparound services	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• The single-entry point (SEP) organization or care manager • Other parties as required by HCPF • Colorado Crisis System NHP works to improve care coordinators knowledge through ongoing trainings/meetings regarding contract requirements. We have monthly care coordination subcommittee meetings with delegated care coordination entities from across the region. Care coordination providers are monitored on compliance with this requirement through existing audit and performance improvement procedures (see CareCoordinationAuditTool_NHP**).** The document titled PCMPAccountableAgreement_NHP (see Pages 5,7 as well as Exhibit A Pages 2-3 & 6) specifically details the requirements of PCMPs around information sharing with other entities serving the member to prevent duplication of those activities. The PCMP agrees to cooperate with care coordination, case management, medical management, care management and disease management activities and functions of NHP. PCMPs also provide input and recommendations regarding medical management and care coordination activities, issues identified by members as an area for possible education or need for community resources. It is also the expectation that all providers/care coordination entities furnishing services to the member shares, as appropriate, the member treatment record with other providers or organizations involved in the member's care, in accordance with professional standards. This communication expectation promotes continuity of care,	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	prevents unnecessary re-hospitalizations or services at a higher level of care and facilitates improved communication about the member among providers, facilities, and others who are involved with the member. For those PCMPs that are delegated to provide care coordination for NHP, Page 6 of Exhibit A of the PCMPAccountableAgreement_NHP outlines the following expectations: • Maintain relationships with community organizations such as specialty care, managed service organizations and their networks of substance use disorder providers, hospitals, pharmacists, dental, nonemergency medical transportation, regional health alliances, public health, Area Agencies on Aging, Aging and Disability Resources for Colorado, and other ancillary providers • Develop and maintain comprehensive knowledge and working relationships with community agencies, health teams and providers that offer a range of services including: medical care, substance abuse and mental health treatment, legal services, long-term care, dental services, developmental disability services, homeless services, school and educational programs, and other agencies that serve special populations • Promote continuity of care, and unnecessary re-hospitalizations or services at a higher level of care and to facilitate improved communication about the member among providers, facilities, and others who are involved with the member.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The document titled R2_narrative_CareCompacts_Q4FY21_NHP explains NHPs' established process for collecting care compacts and outlines NHPs' transition away from care compacts at the direction of HCPF. The goal of care compacts was to establish a mutual agreement for cooperatively providing health care services as necessary for the health care of members between specialists, PCMPs, and behavioral health providers. The organizations in our region have mutual interest and benefit to work cooperatively in the provision of services and structures how each will work to establish and define the processes and procedures in the provision of services between the parties. The state report submitted by NHP (see R2_CareCompactQ4_FY20-21_NHP) for Fiscal Year 2020-2021, Quarter 4, outlines that there were zero (0) new or renewed care compacts during the quarter to report. An example of a of specialty care/care compact between Sunrise Community Health and Banner Specialty Clinics has been provided (see Banner_Specialty_Clinics_CareCompact_NHP).	
9. *For the Capitated Behavioral Health Benefit:* The RAE ensures that each provider furnishing services to members maintains and shares, as appropriate, member health records, in accordance with professional standards and in the process of coordinating care, each member's privacy is protected in accordance with the privacy	**Documents Submitted/Location Within Documents:** 1. PrivacyNotice_NHP, *Misc 2. NW10.17 Provider Departure and Provider Termination from Network_NHP 3. CO33.8_UsesandDisclosureof PHI_NHP 4. CO400.11MemberPrvacyRights_NHP 5. IT201.8 HIPAACompliance Stnd 1 SecurityMgmtProcess_NHP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
requirements in 45 CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that they are applicable. *42 CFR 438.208(b)(5) and (6)* Contract Amendment 7: Exhibit B6—11.3.7.10.6, 15.1.1.5	6. IT208.9 HIPAA Compliance Stnd 8 Security Evaluation_NHP 7. IT216.7 HIPAA Compliance Stnd 16 Integrity_NHP 8. IT217.7 HIPAACompliance Stnd 17 Person or Entity Authentication_NHP 9. BH_Medical Record Standard_Amendment_NHP 10. PCMPAccountableAgreement_NHP, Page 3 & 7, *Misc 11. BehavioralHealthProviderHandbook_NHP, Page 22, *Misc 12. HIPAAMedicaidProviderPHILetter_NHP 13. OM_DCWHCPF_2021_NHP **Description of Process:** NHP maintain policies and practices to ensure all our members' private healthcare information is protected (see PrivacyNotice_NHP). Utilizing standards, policy, and guidelines, Beacon Health Options compliance department maintains adherence to policies. For our members who are in transition from one provider practice to another, NHP monitors our practices' privacy policies while abiding by our set standards to help with a smooth transition between entities. The document titled NW10.17 Provider Departure and Provider Termination from Network_NHP addresses network adequacy and helps NHP to ensure the continuation of care; to ensure compliance with NCQA; to support the integrity of Beacon's Provider Service Agreements (PSA); to maintain the accuracy of provider database, and to address issues which may cause provider dissatisfaction.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The document titled CO33.8_UsesandDisclosureof PHI_NHP provides guidance to Beacon employees, contractors, and network providers on the proper guidelines for uses and disclosures of PHI. All disclosure referenced in this policy shall be made in compliance with HIPAA, HITECH Final Rule, 42 CFR part 2 and applicable state law. The document titled CO400.11MemberPrvacyRights_NHP ensures that Beacon employees, members and network providers have access to and are knowledgeable about members' rights and responsibilities. The document titled IT201.8 HIPAACompliance Stnd 1 SecurityMgmtProcess_NHP establishes policy governing compliance of HIPAA Security Rule requirements for Administrative Safeguards (Section 164.308) for a Security Management Process. The document titled IT208.9 HIPAA Compliance Stnd 8 Security Evaluation_NHP establishes policy governing compliance to HIPAA Security Rule requirements for Administrative Safeguards (Section 164.308) for a Security Evaluation. The document titled IT216.7 HIPAA Compliance Stnd 16 Integrity_NHP establishes policy and procedures governing compliance to HIPAA Security Rule requirements for Technical Safeguards (see Section 164.312)	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The document titled IT217.7 HIPAACompliance Stnd 17 Person or Entity Authentication_NHP establishes policy and procedures governing compliance to HIPAA Security Rule requirements for Technical Safeguards (see Section 164.312). The document titled BH_Medical Record Standard_Amendment_NHP was sent to providers with existing contracts to include medical record documentation standard. Additionally the language was added to all new provider contracts (see PCMPAccountableAgreement_NHP, Pages 3 & 7). The document titled BehavioralHealthProviderHandbook_NHP (see Page 22) delivers guidance for providers involved in the medical and/or behavioral health care and treatment of a member. All coordination, including PCP coordination, should be documented accordingly in the member treatment record. Behavioral Health providers should contact the RAEs to get their members connected with care coordination. It also gives steps to obtain a release of information and use this to communicate with other providers. All contracted providers receive the handbook and it is posted on NHPs' website under provider resources for reference (https://www.northeasthealthpartners.org/providers/provider-handbook/) The document titled HIPAAMedicaidProviderPHILetter_NHP confirms that a covered entity may disclose PHI without the written consent of the member when it is related to administering the Department's capitated behavioral health benefit; developing a network of PCMPs to serve as medical	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	home providers for their members; developing a contracted statewide network of behavioral health providers; onboarding and activating members; promoting the enrolled population's health and functioning, and coordinating care across disparate providers and social, educational, justice, and other community agencies to address complex member needs that span multiple agencies and jurisdictions. This resource also includes a link to The Office for Civil Rights (OCR) of the Department of Health and Human Services that outlines when, and under what conditions, a covered entity provider may use and disclose PHI without member authorization for the purposes of treatment, payment and health care operations. To address information sharing between the RAE and members specifically served by Departments of Human Services. The document OM_DCWHCPF_2021_NHP, is a memo jointly released by Division of Child Welfare in CDHS and HCPF. The memo serves was confirmation of authority for counties to share data (as listed in the memo) for child welfare populations with RAEs without the use of a Business Associate Agreement. This memo allows the RAEs to better fulfill our contractual obligation to connect foster care children with services in a timely manner. Treatment includes not only the provision of care, but also the coordination or management of healthcare and related services. Currently, the input of information into Trails and the transfer of that data into CBMS and thereby to the RAEs, is slower than is necessary and makes it more difficult for RAEs to timely serve children/youth in the foster care system. The memo was sent out to all Care Coordination Entities shortly after its release in July 2021.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The document titled PrivacyNotice_NHP also addresses how NHP may use and disclose Protected Health Information (PHI) as well as uses of PHI that do not require authorization. The privacy notice is posted on NHPs' website https://www.northeasthealthpartners.org/nhp-privacy-policy-revised-10-12-21/ .	
10. The RAE possesses and maintains an electronic care coordination tool to support communication and coordination among members of the provider network and health neighborhood. The care coordination tool collects and aggregates, at a minimum: • Name and Medicaid ID of member for whom care coordination interventions were provided. • Age. • Gender identity. • Race/ethnicity. • Name of entity or entities providing care coordination, including the member's choice of lead care coordinator if there are multiple coordinators. • Care coordination notes, activities, and member needs. • Stratification level.	**Documents Submitted/Location Within Documents:** 1. CareCoordinationTool_HealthCloudDocumentation **Description of Process:** NHP supports communication and coordination using an electronic care coordination tool, Health Cloud. Health Cloud collects and aggregates data (clinical/EMR data, claims, HIE, ADT data, Daily Census, COUP, attribution/834), to create member profiles, including identifying information required: Name, Medicaid ID, Age, Gender Identity, Race/Ethnicity, Lead Care Coordinator, Notes/Activities, Stratification and Care Planning. The document titled CareCoordinationTool_HealthCloudDocumentation provides the following information: • Member Name: Member name and MCD ID can be found at multiple locations throughout the member profile. The customized member card has MCD ID at the top for quick reference as well as in the member details. The members name can be found throughout the	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Information that can aid in the creation and monitoring of a care plan for the member—such as clinical history, medications, social supports, community resources, and member goals. Contract Amendment 7: Exhibit B6—15.2.1.1, 15.2.1.3-4	member profile and the "tab" feature ensures users can always be sure which member they are viewing (see Slide 1). • Age: Date of birth (and age) is quickly visible upon viewing the member profile. This can be found in the member card and the member details (see Slide 2). • Gender Identity: Gender identity is auto populated into the application based on any relevant data field that CCMCN is instructed to pull (clinical/EMR data, claims, HIE, attribution/834). This information is at the forefront of the member profile to ensure a care manager's approach and outreach is set up to be as successful as possible (see Slide 3). • Race/Ethnicity: Race/ethnicity is auto populated into the application based on any relevant data field that CCMCN is instructed to pull (clinical/EMR data, claims, HIE, attribution/834). This information is at the forefront of the member profile in the detail section to ensure a care manager's approach and outreach is set up to be as successful as possible (see Slide 4). • Care coordination information: Health Cloud has multiple ways of showing the care coordination lead and the entire care team view. The majority of activities are driven by automated assignments based on customized logic, ensuring real time data feeds are actioning the appropriate team members to follow-up relevant to the established need. Health Cloud requires a "lead care manager (aka record owner)" for visibility and "care plan assignments" (aka case) owner. However, tasks within a care plan can be automatically assigned to	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	multiple care team members based on specialty. Both the lead care manager and the care plan owner are visible in multiple places within the member profile. Image 1 shows an example of the "lead care manager" on a member, this person can see all relevant information on a member (with the exception of non-consented part 2 information). Image 2 shows and example of a care plan team which is specific to the care plan (aka case). This layered care team approach enables Health Cloud users to view minimum necessary information based on role within the care team (see Slide 5). • Care coordination notes, activities, and member needs (see Slides 6-10): o Health Cloud has a "rolled up" notes feature that provides RAE care managers the ability to view all notes on a member regardless of care plan/task it is associated with (with the exception of notes on part 2 care plans). o Displays the ability to create and view notes on a care plan (case) level. o Tasks/Activities: Cloud has a "rolled up" task feature that provides RAE care managers the ability to view all open and closed tasks on a member regardless of the care plan/task it is associated with (with the exception of tasks related to part 2 care plans). Tasks can also be viewed on an individual care plan level under "Care Plan Tasks". o Member Needs: social needs/barriers can be automatically imported or manually added to a	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	person's care plan to document the interventions related to the social barrier. Another example of a social determinants of health screener which the RAE care managers complete on individual members. These screeners have customized logic built into them which can automatically trigger follow-up tasks based on identified needs selected (ex: if "yes" to "worried about housing" > auto assign "refer to housing navigation center/resources" is applied to the care manager task list). There are numerous screening and stratification tools that capture member needs (physical, social and behavioral) all utilizing custom logic. • Stratification Level: There are customized assessments (ex: GAD 7 or stratification tool) that can auto sum and trigger additional tasks based on the "total score". Health Cloud utilizes automated data interfaces and specific criteria (indicators) to stratify members into activated care plans which are then auto assigned to relevant care team members. Some examples of these care plans that are stratified are: COVID high risk, high cost, diagnosis / chronic condition, pregnancy. Health Cloud utilizes code sets identified by the RAE and its delegated partner to ensure stratification meets the need of the targeted population. All care plans can be found on a member level which shows a comprehensive view of current and historical stratification driven action has been identified (see Slides11-13).	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• There are moderate and high complexity assessments built into Health Cloud (see Slide 12). • Current NCHA Data Interfaces and Current NCHA Care Plans have information that aides in the creation/monitoring of care plans (see Slide 14).	

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

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE has written policies regarding the member rights specified in this standard. *42 CFR 438.100(a)(1)* Contract Amendment 7: Exhibit B6—7.3.7.1–2	**Documents Submitted/Location Within Documents:** 1. 304L_MemberRandRPolicy_NHP, *Misc **Description of Process:** NHP adheres to Beacon's Member Rights and Responsibilities Policy, which guides our position on protecting member rights. The document titled 304L_MemberRandRPolicy_NHP meets all state and federal regulations and contract requirements	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The RAE complies with any applicable federal and State laws that pertain to member rights (e.g., non-discrimination, Americans with Disabilities Act) and ensures that its employees and contracted providers observe and protect those rights. *42 CFR 438.100(a)(2) and (d)* Contract Amendment 7: Exhibit B6—17.10.7.2	**Document Submitted/Location Within Documents:** 1. 304L_MemberRandRPolicy_NHP, Page 10, *Misc 2. Employee AttestationofMemberRights_NHP 3. 310LNonDiscriminationPolicy_NHP 4. Non-Discrimination Notice_NHP 5. Provider Contract_NHP, Pages 8, 28 6. BehavioralHealthProviderHandbook_NHP, Pages 15-16, *Misc 7. PhysicalHealthProviderHandbook_NHP, Page 12, *Misc 8. Provider Roundtable PPT_NHP, Slide 17 9. Feedback Database_NHP, Page 2 10. ChartAuditTool_NHP, Row 14, *Misc 11. Provider Directory_NHP, *Misc **Description of Process:** NHP complies with all applicable federal and state laws that pertain to member rights and ensures that all their	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	employees and contracted providers observe and protect these rights. NHP follows Beacon's policies and procedures, the documents titled 304L_MemberRandRPolicy_NHP and Non-Discrimination Notice_NHP, which outline member rights. NHP requests that all Beacon and NHP staff read and sign a copy of the Member Rights and Responsibility Policy (see Page 10). NHP and Beacon employees must attest that they have read the Members Rights and Responsibilities policy and that they are expected to treat members in a manner that respects their rights. For examples of signed attestations, see the document titled Employee AttestationofMemberRights_NHP. The document titled 310LNon-Discrimination Policy_NHP outlines that NHP will not discriminate against members based on race, color, ethnic or national origin, ancestry, religion, creed, sex, gender, sexual orientation, gender identity and expression, age, disability, handicap, health status (including Acquired Immune Deficiency Syndrome (AIDS) or an AIDS-related condition, the need for health care services, or political beliefs in context of receiving care and services from NHP NHPs' non-discrimination notice is located on the NHP website, https://www.northeasthealthpartners.org/non-discrimination-notice/. NHPs' contracted providers sign a contract stating that members with disabilities will have the same standard of	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	care as other members and will not be discriminated against (see ProviderContract_NHP, Page 8) and that providers will agree to take into account member's rights (see BehavioralHealthProviderHandbook_NHP, Pages 15-16). NHP outlines member rights in the provider handbook (see PhysicalHealthProviderHandbook_NHP, page 12). NHP also uses the document titled Provider Roundtable PPT_NHP (see Slide 17) to educate contracted providers annually about member rights in a provider roundtable forum. If a member believes that their rights have been violated, they or their Designated Client Representative (DCR) can make a complaint at any time by phone, letter, in person, or by sending an email. NHP delegates the oversight of member complaints to Beacon who monitors, documents, and categorizes all member complaints. NHP has a specific category related to the violation of member rights (see Feedback Database_NHP, Page 2). NHP also has information regarding rights/responsibilities, civil rights, the Americans with Disability Act (ADA) on our website, https://www.northeasthealthpartners.org/members/rights-responsibilities/. NHP also posts the document titled Non-Discrimination Notice_NHP on its website as well, https://www.northeasthealthpartners.org/non-discrimination-notice./	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	NHPs' quality team completes chart audits for contracted providers using the document titled ChartAuditTool_NHP. The quality team reviews member charts to ascertain if providers have reviewed rights and responsibilities with members (see Row #14). NHP ensures that providers offer members information about their accommodations for disabilities. The provider directory (see Provider Directory_NHP) has a field entitled ADA Compliant which is answered by a "yes" or "no" by the provider indicating if they have ADA accommodations. Members with disabilities can contact NHPs' call center to find out a provider's specific accommodations. NHPs' call center staff will contact the provider to obtain this information for the member.	
3. The RAE's policies and procedures ensure that each member is guaranteed the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for their dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding their health care, including the right to refuse treatment.	**Documents Submitted/Location Within Documents:** 1. 304L_MemberRandRPolicy_NHP, Pages 1-3, *Misc 2. 307L_MemberInfoReqPolicy_NHP, Page 2, *Misc **Description of Process:** NHP has policies in place to make certain that each member is guaranteed their rights in accordance with federal guidelines. The document titled 304L_MemberRandRPolicy_NHP outlines the following: • Members will receive information in accordance with information requirements (42 CFR 438.10) (see Page 1).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. • Request and receive a copy of their medical records and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210). *42 CFR 438.100(b)(2) and (3)* Contract Amendment 7: Exhibit B6—7.3.7.2.1–6	• Members will be treated with respect and with due consideration for their dignity and privacy (see Page 1). • Members will receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand (see Page 2). • Members can participate in decisions regarding their health care, including the right to refuse treatment (see Page 1). • Members can be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation (see Page 2). • Members can request and receive a copy of their medical records and request that they be amended or corrected (see Page 3). • Members will be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210) (see Page 2). Additionally, NHP follows the document titled 307L_MemberInfoReqPolicy_NHP (see Page 2) to ensure that members are given information in accordance with the requirements stated in 42 CFR438.10.	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The RAE ensures that each member is free to exercise their rights and that the exercise of those rights does not adversely affect the way the RAE, its network providers, or the State Medicaid agency treats the member. *42 CFR 438.100(c)* Contract Amendment 7: Exhibit B6—7.3.7.2.7	**Documents Submitted/Location Within Documents:** 1. RightsandResponsibilities_NHP 2. RightsandResponsibilities_Spanish_NHP 3. RightsandResponsibilitiesPoster_ NHP 4. RightsandResponsibilitiesPosterSpanish_NHP 5. EvidenceofPostersHung_NHP 6. Getting Started PPT_NHP, Pages 16-17, *Misc 7. Complaint Guide_NHP, Pages 1-2 8. 304L_MemberRandRPolicy_NHP, Page 2, *Misc 9. BehavioralHealthProviderHandbook_NHP, Pages 15-16, *Misc 10. PhysicalHealthProviderHandbook_NHP, Page 13, *Misc 11. Provider Roundtable PPT_NHP, Slide 17 12. ChartAuditTool_NHP, Row 14, *Misc **Description of Process:** NHP has a complaint process in place to ensure that members are free to exercise their rights. These processes safeguard members who choose to use their rights to not be adversely treated by NHP, network providers, or Health First Colorado (Colorado's Medicaid Program). NHP delegates the complaint process to Beacon Health Options. Beacon's member engagement team is responsible to educate members and providers about member rights and that members cannot be retaliated against for using their rights. The member engagement team also helps resolve any violation of a member's right and investigates any perceived and/or real retaliation against the member for using their rights.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	NHP educates members about their rights through several platforms, included below: • The documents titled RightsandResponsibilities_NHP and RightsandResponsibilities_Spanish_NHP are available via the NHP website. The documents, in both Spanish and English, explain that members are able to use their rights and file a complaint without fear of being treated poorly (see Page 1, #9). See: https://s18637.pcdn.co/wp-content/uploads/sites/25/Member-Rights-and-Responsibilities.pdf • Provider sites are asked to display the documents titled Rights and RightsandResponsibilitiesPoster_ NHP and RightsandResponsibilitiesPosterSpanish_NHP in prominent locations. NHP outlines in our provider handbook that providers must post or make the rights and responsibility statement available for members. NHP informs providers to contact our member services department to request a poster if they would like to hang one at their practice. The document titled EvidenceofPostersHung_NHP demonstrates these efforts. • The document titled Getting Started PPT_NHP outlines material used in a "Getting Started" webinar offered members. NHP educates members on how	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	they can exercise their rights without retaliation in these forums (see Pages 16-17). • The document titled Complaint Guide_NHP (see Pages 1-2) states how members can use their rights to file a complaint. https://s18637.pcdn.co/wp-content/uploads/sites/25/Complaint-Guide.pdf. The guide states that members will not be treated differently for making a complaint (i.e., exercising their rights). This is available in both English and Spanish. NHP follows Beacon's document titled 304L_MemberRandRPolicy_NHP (see Page 2) to ensure that each member is free to exercise their rights and that they will not be treated adversely by the RAE, network providers, or HCPF. NHP educates providers through two (2) avenues about members' ability to exercise their rights. The first avenue is in the documents titled BehavioralHealthProviderHandbook_NHP (see Pages 15-16) and PhysicalHealthProviderHandbook_NHP (see Page 13). The handbooks describe how members can file a complaint and that members will not lose their Health First Colorado benefits, be treated differently, or be restricted access to services for filing a complaint. The second (2nd) avenue is through an educational forum called Provider Roundtables. NHP used the document titled Provider Roundtable PPT_NHP (see Slide 17) to	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	inform providers that members can file a complaint when they believe their rights have been violated and that they cannot be treated differently for using those rights. NHPs' quality team completes chart audits for contracted providers using the document titled ChartAuditTool_NHP. The quality team reviews member charts to ascertain if there is a signed rights and responsibility form present in the member's chart (see Row #14).	
5. For medical records and any other health and enrollment information that identifies a particular member, the RAE uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42 CFR 438.224* Contract Amendment 7: Exhibit B—11.3.7.10.6, 15.1.1.5	**Documents Submitted/Location Within Documents:** 1. Policy 33.8 Uses and Disclosure of PHI_NHP, Page 1 2. 304L_MemberRandRPolicy_NHP, Pages 2-3, 8-9, *Misc 3. PCMPAccountableAgreement_NHP, Page 10, *Misc 4. ProviderContract_NHP, Pages 13 & 22 5. PrivacyNotice_NHP, *Misc 6. ChartAuditTool_NHP, Row# 15, *Misc **Description of Process:** NHP uses and discloses members' identifiable health information found in medical records and other health and enrollment information that identifies a unique member in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	NHPs' staff comply with Beacon's document titled 33.8 Uses and Disclosure of PHI_NHP(see Page 1) which states that staff may use and disclose PHI only as permitted or required by federal privacy law and relevant state law. The policy states that staff will make reasonable efforts to limit the use and disclosure the "minimum necessary" needed to accomplish the intended purpose. NHP staff adheres to the document titled 304L_MemberRandRPolicy, (see Pages 8-9) which states that the confidentiality policies and procedures must conform to all federal and state confidentiality laws and regulations. In this same policy, it states that members have the right to request, obtain a copy of their PHI, and ask NHP to amend or correct their PHI. NHP posts our privacy notice on our website, https://s18637.pcdn.co/wp-content/uploads/sites/25/NHP-Privacy-Policy-Revised-10-12-21.pdf. The document titled PrivacyNotice_NHP describes how medical information about a member may be used and disclosed and how a member can get access to this information. The privacy notice identifies NHPs' privacy officer as a person to contact if a member believes that their privacy rights have been violated. NHP requires accountable PCMPs to sign the document titled PCMPAccountableAgreement_NHP (see Page 10) stating that they are responsible for compliance with all	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	applicable provisions of state and federal law, which includes a member's medical record. The agreement states that the PCMP is and remains responsible for compliance with all applicable provisions of state and federal law, which includes a member's medical record. NHPs' behavioral health contracted providers also sign the document titled Provider Contract_NHP (see Pages 13 and 22) stating that they will comply with all state and federal laws relating to member's confidentiality rights. NHPs' quality team completes chart audits for contracted providers using the document titled ChartAuditTool_NHP. The quality team reviews member charts to ascertain if providers have reviewed the notice of privacy with members (see Row #15).	
6. The RAE maintains written policies and procedures and provides written information to individuals concerning advance directives with respect to all adult individuals receiving care by or through the RAE. Advance directives policies and procedures include: • Notice that members have the right to request and obtain information about advance directives at least once per year. • A clear statement of limitation if the RAE cannot implement an advance directive as a matter of conscience.	**Documents Submitted/Location Within Documents:** 1. 269L_AdvanceDirectivesPolicy_NHP 2. Advance Directives Training Flyer_NHP 3. AdvanceDirectivesPPT_NHP 4. BehavioralHealthProviderHandbook_NHP, Page 27, *Misc 5. PhysicalHealthProviderHandbook_NHP, Page 14, *Misc 6. ChartAuditTool_NHP, *Misc **Description of Process:** NHP maintains a policy and procedure document titled 269L_AdvanceDirectivesPolicy_NHP concerning advance directives for adult members who may be receiving	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– The difference between institution-wide conscientious objections and those raised by individual physicians. – Identification of the State legal authority permitting such objection. – Description of the range of medical conditions or procedures affected by the conscientious objection. • Provisions: – For providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and is unable to receive information. – For providing advance directive information to the incapacitated member once he or she is no longer incapacitated. – To document in a prominent part of the member's medical record whether the member has executed an advance directive. – That care to a member is not conditioned on whether the member has executed an advance directive, and provision that members are not discriminated against based on whether they have executed an advance directive. – To ensure compliance with State laws regarding advance directives.	treatment through one of NHPs' provider. This policy is located on our website and members can request this information to be printed and sent to them free of charge, https://www.northeasthealthpartners.org/members/advance-directives-living-will/. NHP has links for the advance directive policy, the Colorado Medical Advance Directives, Colorado's Psychiatric Advance Directives, Five Wishes, Achieve Solutions articles, and information on how members, providers, and community members may participate in a training on advance directives the last Thursday of each month. The document titled 269L_AdvanceDirectivesPolicy_NHP contains the following information: • Notice that members have the right to request and obtain information about advance directives at least once per year (see Page 4). • A clear statement of limitation if the RAE cannot implement an advance directive as a matter of conscience (see Page 2) o The difference between institution-wide conscientious objections and those raised by individual physicians. o Identification of the State legal authority permitting such objection. o Description of the range of medical conditions or procedures affected by the conscientious objection.	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– To inform individuals that complaints concerning noncompliance with advance directive requirements may be filed with the Colorado Department of Public Health and Environment. – To inform members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. – To educate of staff concerning its policies and procedures on advance directives. – The components for community education regarding advance directives that include: ▪ What constitutes an advance directive. ▪ Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. ▪ Description of applicable State law concerning advance directives. *The RAE must be able to document its community education efforts.* *42 CFR 438.3(j)* *42 CFR 422.128* Contract Amendment 7: Exhibit B6—7.3.11.2, 7.3.11.3.3	• Provisions: o For providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and is unable to receive information (see Page 3). o For providing advance directive information to the incapacitated member once he or she is no longer incapacitated (see Page 3). o To document in a prominent part of the member's medical record whether the member has executed an advance directive (see Page 3). o That care to a member is not conditioned on whether the member has executed an advance directive, and provision that members are not discriminated against based on whether they have executed an advance directive (see Page 4). o To ensure compliance with State laws regarding advance directives (see Page 1). o To inform individuals that complaints concerning noncompliance with advance directive requirements may be filed with the Colorado Department of Public Health and Environment (see Page 4).	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	o To inform members of changes in State laws regarding advance directives no later than 90 days following the changes in the law (see Page 1). o To educate of staff concerning its policies and procedures on advance directives (see Page 4). o The components for community education regarding advance directives that include the following information are found on Page 4: ▪ What constitutes an advance directive? ▪ Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. ▪ Description of applicable State law concerning advance directives. NHP provides a monthly advance directives training using the document titled Advance Directives Training Flyer_NHP and AdvanceDirectivesPPT_NHP for all members, family members, care coordinators, and providers on the last Thursday of each month. NHPs' member engagement specialist is an advance directives trainer for our members. NHP promotes the monthly advance directives training through the following platforms:	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Social media sites • Care coordination meetings • Department of Human Services (DHS) quarterly meetings • "Getting Started" webinars • Member advocate meetings • Practice transformation coaches • Provider newsletters. NHPs' providers are also made aware of advance directives through provider handbooks (see BehavioralHealthProviderHandbook _NHP, Page 27 and PhysicalHealthProviderHandbook_NHP, Page 14). NHPs' quality team completes chart audits using the document titled ChartAuditTool_NHP for contracted providers. The quality team reviews member charts to ascertain if providers have asked members eighteen (18) years of age and older about advance directives (see Row #72).	

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

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE provides all required member information to members in a manner and format that may be easily understood and is readily accessible by enrollees. • The RAE ensures that all member materials (for large-scale member communications) have been member tested. *Note: Readily accessible means electronic information which complies with Section 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines.* *42 CFR 438.10(b)(1)* Contract Amendment 7: Exhibit B6—7.2.5, 7.3.6.1	**Documents Submitted/Location Within Documents:** 1. 307L_MemberInfoReqPolicy_NHP, Pages 1 & 3, *Misc 2. MEACSummary_NHP, Page 2 3. CoverSheet_NHP 4. IT302.5_508ComplianceofExternalWebSitesPolicy_NHP 5. WebsiteComplianceCheck_NHP **Description of Process:** NHP 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. NHP observes the procedures found in the document titled 307L_MemberInfoReqPolicy_NHP to ensure that the information we provide members is in a format that is easily understood. Some of the highlights from this policy include the following: • NHP 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 (see Page 1). • NHP procedures ensure member materials are written at a sixth (6th) grade reading level so that they are clear, concise, and understandable to the representative	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	population. NHP runs member material through the Flesch-Kinkaid readability program which ascertains the minimum education level required to understand materials (see Page 3). • NHPs' commitment to have materials member-tested and make necessary changes which are recommended by our members (see Page 3). NHP records the member materials, which are reviewed with members for large-scale member communication at the Member Experience Advisory Council (MEAC) and the member services subcommittee. Members are asked to test the material and identify concerns with content and/or layout. NHP edits the material based on the member feedback. For example, NHPs' health tip sheets were reviewed with members who provided feedback to enhance the readability and layout of the document, which included more member pictures. Member feedback was captured in the document titled MEACSummary_NHP (see Page 2). NHP 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 large font, has the toll free and TTY/TDD number listed, and is used for any mailings and when a member requests a copy of a member handbook and/or a provider directory (see CoverSheet_NHP).	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	NHPs' electronic information (website) complies with 508 guidelines and W3C's Web Content Accessibility Guidelines. NHP delegated website management to Beacon Health Options. To view the website, please see https://www.northeasthealthpartners.org/. Beacon uses the document titled IT302.5_508ComplianceofExternalWebSitesPolicy_NHP to ensure compliance with the NHP website being readily accessible in the following ways: • External websites must adhere to and meet 508 compliance standards (see Page 1). • Under Section 508, agencies must give disabled employees and members of the public access to information that is comparable to the access available to others (see Page 2). • Information about World Wide Web Consortium (W3C) that leads the website to its full potential is addressed (see Page 2). • The purpose of the policy is to publish procedures for the development of external websites to ensure that 508 compliance is maintained (see Page 2). This includes priority checklist items. Priority one (1), items must be addressed and are required to make a site accessible (see Page 2). Priority two (2), checklist items, which should be addressed to make the site accessible, but these items, are not required (see Page 4). Priority three (3), checklist	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	items, which could be addressed to improve the accessibility of a site (see Page 6). Beacon's website team conducts periodic reviews for 508 compatibility of the NHP website and results of a recent review are outlined in the document titled WebsiteComplianceCheck_NHP. Any detected non-508 compliance is brought to the attention of NHPs' member engagement specialist for remediation. Beacon's website team corrects the identified accessibility issues and the member engagement team resolves these issues, such as a broken website link or any difficulty accessing PDF documents.	
2. The RAE has in place a mechanism to help members understand the requirements and benefits of the plan. *42 CFR 438.10(c)(7)* Contract Amendment 7: Exhibit B6—7.38.1	**Documents Submitted/Location Within Documents:** 1. Welltok Monthly Report_NHP 2. Getting Started Flyer_NHP, *Misc 3. Getting Started PPT_NHP, Slides 10-15, *Misc 4. DHS PPT_NHP, Slides 3 & 5 5. Care Coordination Meeting Minutes_NHP, Page 3 6. Provider Newsletter_NHP, Page 7 7. HCPFWelcomeLtr_NHP, *Misc **Description of Process:** NHP has several mechanisms in place to help members understand the requirements and benefits of the plan. The mechanisms are described below: NHP has a texting campaign called Welltok designed to help members understand the requirements and benefits of the plan.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Texting campaigns to help members learn about their benefits are outlined in the document titled Welltok Monthly Report_NHP and include, but are not limited to: welcome message, member handbook information, website link information, well child visits reminders, the nurse advice line number, member rights, advance directives, vaccinations, behavioral health, crisis services, and how to get an insurance card. NHP hosts a "Getting Started" ZOOM webinar on the first Thursday of each month to educate members about their benefits and requirements of their plan. NHP created a "getting started" flyer to inform members about this webinar. NHP distributes the "getting started" flyer for members through care coordinators, DHS eligibility technicians, providers, practice transformation coaches, and social media (see GettingStartedFlyer_NHP). NHP informs care coordinators of the webinar at care coordinator meetings (see Care Coordination Meeting Minutes_NHP, Page 3). NHP informs DHS eligibility technicians of the webinars at our quarterly DHS meeting (see DHS PPT_NHP, Slides 3 & 5). NHP informs providers of the webinar and attaches the "getting started" flyer through their provider newsletter (see Provider Newsletter_NHP, Page 7). NHP distributes the "getting started" flyer to the practice transformation coaches who work with our PCMP offices to make available in PCMP offices. Details of the webinars are provided in the document titled Getting Started PPT_NHP (see Slides 10-15). NHP has a new member information packet located on its website, https://www.northeasthealthpartners.org/members/new-	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	member-welcome-packet/. NHP added a Quick Response (QR) code to the "getting started" flyer to direct members to the new member information packet on our website. The packet has relevant benefit information for members including, but not limited to: the PEAK app, transportation, member handbook, and how to find a provider. NHP worked with HCPF to include the NHP member welcome pack link in the welcome letter that HCPF sends to new members (see HCPFWelcomeLetter_NHP).	
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.	**Documents Submitted/Location Within Documents:** 1. ManagedCareTerms_NHP 2. HCPF Branding Guide_NHP **Description of Process:** NHP uses managed care definitions provided by HCPF to maintain consistency in the information that is provided to our members. NHP developed the document titled ManagedCareTerms_NHP for members after researching managed care definitions provided by HCPF. NHP used the Health First Colorado's (Colorado's Medicaid Program) member handbook and HCPFs website to create this resource. The document can be found on the resource tab on the NHP website, https://www.northeasthealthpartners.org/resources/#mct. NHP does not have an independent member handbook. However, NHP uses the Health First Colorado member handbook developed by HCPF. The member handbook is displayed on the main page of the NHP website. NHP uses HCPF's document titled HCPF Branding Guide_NHP (see Page	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Model member handbooks and member notices. *42 CFR 438.10(c)(4)* Contract Amendment 7: Exhibit B6—3.6, 7.3.4	7) to model member materials and notices. NHP includes the Health First Colorado logo on all member facing materials, including the NHP website.	
4. The RAE makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • Written materials that are critical to obtaining services include, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices. • All written materials for members must: – Use easily understood language and format. – Use a font size no smaller than 12-point. – Be available in alternative formats and through provision of auxiliary aids and service that take into consideration the special needs of members with disabilities or limited English proficiency. – Include taglines in large print (conspicuously-visible font size) and prevalent non-English languages	**Documents Submitted/Location Within Documents:** 1. NonEnglishSpeakingSummary_NHP 2. 307L_MemberInfoReqPolicy_NHP, *Misc 3. CoverSheet_NHP 4. Meeting Minutes_NHP, Page 4 **Description of Process:** NHP makes written information available for members, which are critical to obtain services available in prevalent non-English languages in our ten (10) county region area. NHP informs members that they can request this information in alternative formats upon their request at no cost to them. NHP identified Spanish as the most prevalent non-English language in Region 2 (see NonEnglishSpeakingSummary_NHP). According to the 2019 Data USA report, there are 16.7% Non-English Speakers in Colorado with the most common non-English language being Spanish. 11.4 % of Colorado's overall population are native Spanish speakers, followed by Chinese at .44% and German at .42%. NHP understands that the most common resource for members to understand their services is the member handbook.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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)(3) and (d)(6)* Contract Amendment 7: Exhibit B6—7.2.7.3–9; 7.3.13.3	NHP has the Spanish version of the member handbook on the main page of its website. To see a copy of the handbook, click https://www.northeasthealthpartners.org/. NHP has nineteen (19) languages accessible through Google Translate available on its website. In the lower right-hand corner of the website, click the flag to access additional languages. NHPs'' website notifies members that they can ask for information in large print, Braille other formats or languages, American Sign Language, or to be read aloud. These services are free. See the main page of the NHP website, https://www.northeasthealthpartners.org/, for evidence of Google Translate and information that members can request for alternative languages free. NHP follows the procedures found in the document titled 307L_MemberInfoReqPolicy_NHP to ensure that the information provided to members is in a format that is easily understood. This policy states that member materials include the following aspects: • Easily understood language and formats (see Page 3). • Font size no smaller than 12-point and no smaller than 18-font for large print (see Page 3). • Includes 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	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	and availability of materials in alternative formats (see 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 (see Page 3). • Be member-tested and revised based on changes recommended by members (see Page 3). NHP reviewed the complaint resolution letter with members at the Member Experience Advisory Council (MEAC) to "member-test" the format and language of the letter. NHP members provided excellent feedback, which improved the processes for sending grievance, appeal, provider termination and denial notices. NHP worked with the members to develop a cover sheet that would be attached to members' notices. NHP did not take formal minutes during this MEAC meeting as we were trying to protect the confidentiality of our members. NHP began documenting summaries after this meeting. NHP did incorporate the member feedback from this MEAC meeting and developed a document titled CoverSheet_NHP. 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 large font, has the toll free and TTY/TDD number listed, and is used when a member requests a copy of a member handbook and/or a provider directory. NHP reviewed the reformatted complaint resolution letter, including the cover sheet with the member services subcommittee to	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	ensure that all member advocates were using the new member-approved format (see Meeting Minutes_NHP, Page 4).	
Findings: The *Member Information Requirements* policy described procedures for ensuring that member informational materials contain taglines that are consistent with the member information requirements. However, some critical member materials did not include all required components of a tagline. • The cover sheet, welcome letter, and provider directory had taglines but did not have the entire tagline translated in Spanish. • The newly pregnant member welcome letter, *NHP Brochure*, *Getting Started Pregnancy Guide*, new baby welcome letter, child welcome letter, *Care Coordination Fact Sheet*, *Where Do I Start* flyer, and *EPSDT Tip Sheet* did not have a tagline in English and Spanish.		
Required Actions: NHP must revise critical member materials to include all required components of a tagline.		
5. *If the RAE makes information available electronically:* Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of "readily accessible" above). • The information is placed in a website location that is prominent and readily accessible. • The information can be electronically retained and printed. • The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge	**Documents Submitted/Location Within Documents:** 1. IT302.5_508ComplianceofExternalWebSitesPolicy_NHP 2. WebsiteComplianceCheck_NHP 3. Evidence of Member Handbook Request_NHP **Description of Process:** NHP makes information available to members electronically through its website, https://www.northeasthealthpartners.org/. NHP has delegated website management to Beacon Health Options. Beacon uses the document titled IT302.5_508ComplianceofExternalWebSitesPolicy_NHP to guide the process of ensuring compliance with this requirement. The policy outlines the procedures for website compliance checks to ensure that NHP meets readily accessible standards described in 508 guidelines, Section 504 of the Rehabilitation Act, and W3Cs web content accessibility guidelines. The policy	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
upon request and is provided within five business days. • Provide a link to the Department's website on the RAE's website for standardized information such as member rights and handbooks. *42 CFR 438.10(c)(6)* Contract Amendment 7: Exhibit B6—7.3.14.1, 7.3.9.2	states that documents must use the clearest and simplest language appropriate for the site's content (see Page 4). NHP runs all member-approved PDF documents, which meet content and language requirements through a 508 accessibility scan before uploading the content to the website. The document titled WebsiteComplianaceCheck_NHP provides an example report of this process. NHP identified the two (2) crucial elements for members to obtain services, the member handbook and the provider directory. These two (2) resources can be found in a prominent location on the main page of the website, https://www.northeasthealthpartners.org/. Members can find the member handbook on the middle of the main page and the provider directory embedded in the "find a provider" tab located on the top brown bar or through the member icon. These resources can be electronically retained and printed for member use. NHP routinely tests this function when a member requests a copy of the member handbook or provider directory. NHP informs members that they can request information from the website to be sent to them in paper form within five (5) days free via its website, https://www.northeasthealthpartners.org/members/. When a NHPs' call center associate receives a member request for a handbook or provider directory, the call center associate emails the member's contact information to the member engagement department to send the requested item. (see Evidence of Member Handbook Request_NHP).	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	NHP provides a link to Health First Colorado's website on the front page of its website, https://www.northeasthealthpartners.org/. This ensures that members have standardized information such as member rights and member handbooks.	

Findings:

During the review, staff members reported that NHP received minimal ad hoc printing requests. Although NHP submitted an email as evidence to show how NHP communicates internally to fulfill such requests, NHP could not provide supporting documents to demonstrate how NHP monitors the five-day requirements for such requests. NHP also submitted a *Member Information Request Job Aid*; however, staff members stated that there is an opportunity to formalize a documentation process within a call record, indicating the *Member Information Job Aid* was not in place in CY 2021. NHP could not provide supporting documents to demonstrate how NHP monitors the five-day requirements for such requests.

NHP's general member webpage and provider directory webpage included a statement that materials can be printed but did not include "within five business days." HSAG recommends that, as best practice, the full statement be placed in prominent locations on the website, particularly where critical documents are linked and/or downloadable (i.e., the *New Member Welcome Packet* page).

Required Actions:

NHP must develop and implement a mechanism to monitor that, upon request, members are provided with printed materials within five business days and at no cost.

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The RAE makes available to members in electronic or paper form information about its formulary: • Which medications are covered (both generic and name brand). • What tier each medication is on. • Formulary drug list must be available on the RAE's website in a machine-readable file and format. *42 CFR 438.10(i)* Contract Amendment 7: Exhibit B6—None	**Documents Submitted/Location Within Documents:** 1. HCPF Preferred Drug List_NHP **Description of Process:** NHP makes Health First Colorado's medication formulary available to members electronically on its website, which is in a machine-readable format, see pharmacy benefits located at https://www.northeasthealthpartners.org/members/benefits-and-services/. If a member requests this information be sent to them in a paper form, NHP would send the formulary information at no charge to the member within five (5) days (see HCPF Preferred Drug List_NHP). NHP has HCPF's medication formulary link on its website under resources/prescriptions, https://www.northeasthealthpartners.org/resources/#prescription. The preferred drug list has information on which medications are covered – both generic and name brand as well as which tier each medication is on.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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.	**Documents Submitted/Location Within Documents:** 1. CoverSheet_NHP 2. Getting Started Flyer_NHP, *Misc. 3. BehavioralHealthProviderHandbook_NHP, Page 16, *Misc. 4. PhysicalHealthProviderHandbook_NHP, Page 11, *Misc. 5. ChartAuditTool_NHP, Row 63, *Misc. 6. 311L_Responding to Members with LEP_NHP 7. 307L_MemberInfoReqPolicy_NHP, Page 3, *Misc	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.10 (d)(4) and (d)(5) Contract Amendment 7: Exhibit B6—7.2.6.2–4	**Description of Process:** NHP makes interpretation services and translation services available for all non-English speaking members, members with Limited English Proficiency (LEP), and Deaf/hard of hearing members. These services are available free of charge to members. These services could involve the use of oral interpretation for any language including American Sign Language (ASL) and auxiliary aids such as TTY/TDD. Written translation is available in prevalent languages (Spanish) and members are made aware of how to access these services. NHP informs members how to access these services through a variety of mediums indicated below: • NHPs' website. NHP includes information about how to ask for interpretation services on the main page (near the bottom) of its website, https://northeasthealthpartners.org. • The document titled CoverSheet_NHP is attached to all written correspondence sent to members. The cover sheet provides members with information on how to request information in alternative formats, request oral interpretation or written translation at no charge to the member. The cover sheet is written in large font and has the toll free and TTY/TDD numbers listed. • Member invitations. NHP adds language on how to access reasonable accommodations on member invitations as seen in the document titled Getting Started Flyer_NHP. NHP has contracts with agencies to provide	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	sign language and/or interpretation services when these services are needed. • Provider Knowledge. NHP informs providers of their responsibility to offer interpreter services for members in the provider handbooks (see BehavioralHealthProviderHandbook_NHP, Page 16 and PhysicalHealthProviderHandbook_NHP, Page 11). The handbooks explain that providers can contact NHP to receive help with setting these services up. NHPs' quality team completes chart audits for contracted providers using the document titled ChartAuditTool_NHP. The quality team reviews member charts to ascertain if providers have indicated a need for interpretation services (see Row #63). NHP educates the call center staff to assist members who are non-English speaking, LEP, or Deaf/hard of hearing who call NHP to request assistance. Call center staff are trained on how to access Voiance®, our language service company to connect members with an interpreter in real time. Voiance® is a leading provider of language interpreting and can serve members in over 150 languages. The language service is available to our members twenty-four (24) hours a day, seven (7) days a week (24/7) and is free of charge to our members. NHP follows the document titled 311L_Responding to Members with LEP_NHP to direct our practices with members who are non-English speakers, LEP, or Deaf/hard of hearing. The policy describes the procedures for handling calls and responding to	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	requests from providers and members for interpretation and or translation services. Attached to the policy is a guide, "Working with Interpreters," which instructs staff members on how to use an interpreter. NHP follows the document titled 307L_MemberInfoReqPolicy_NHP which outlines that member materials are orally translated into other languages when requested by the member at no charge to the member (see Page 3). The policy states that member materials are available in alternative formats for members who have communication disabilities free of charge. Alternative formats include large type, audio tape, TTY/TDY, and ASL.	
8. The RAE ensures that: • Language assistance is provided at all points of contact, in a timely manner and during all hours of operation. • Customer service telephone functions easily access interpreter or bilingual services. Contract Amendment 7: Exhibit B6—7.2.6.1, 7.2.6.5	**Documents Submitted/Location Within Documents:** 1. 311L_Responding to Members with LEP_NHP 2. Resource Sheet_NHP 3. VoianceUse_NHP 4. BehavioralHealthProviderHandbook_NHP, Page 74, *Misc 5. PhysicalHealthProviderHandbook_NHP, Page 11,*Misc 6. CoverSheet_NHP **Description of Process:** NHP ensures that language assistance is provided at all points of contact for a member, in a timely manner, and during all hours of operation. NHP 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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	There are several points of contact with members to offer language assistance, outlined below: • Members calling to access services and/or asking for help to find a provider • Members engaging/attending provider appointments • 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 NHP uses the procedures found in the document titled 311L_ Responding to Members with LEP_NHP to adhere to the following requirements: • Language interpretation services are available 24 hours per day,7 days per week, and 365 days a year (see Page 1). • The process for how to use the language line is outlined (see Page 2). • How to use the relay line for members who are Deaf/hard of hearing is explained (see Pages 2-3). • The steps we take when a provider and/or PIAC/MEAC committees need an interpreter for a session or meeting (see Page 3). • The process of using interpretation services if they are needed beyond the initial phone call, such as a request of oral interpretation of written materials (see Page 3).	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• An educational guide, "working with interpreters" is available for all staff working with members to use (see Pages 5-6) NHPs' call center staff use the language line number listed on the document titled ResourceSheet_NHP when a member needs interpretation services. NHP is able to capture the number of calls, which required interpretation services through Voiance. The document titled VoianceUse_NHP shows that of the 152 calls needing interpretation services, 96.1% of the calls were for Spanish speaking members. NHPs' call center staff are trained on how to use the referral connect system to identify a bilingual provider for clinical services. NHP uses this process when members request a non-English provider or provider who uses ASL. If staff cannot find an in-network provider who is bilingual or signs, then NHP would process a Single Case Agreement (SCA) when an appropriate provider is found. If an appropriate provider cannot be identified, NHPs' member engagement specialist will schedule interpretation services to assist a provider with service interactions with the member. If interpretation services are needed for an administrative reason, (complaints or appeals) the member engagement specialist will connect with an interpreter and set up a conference call to discuss the complaint or appeal with the member. Providers can	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	contact NHPs' call center if they need language interpretation for a member. NHPs' member engagement specialist will assist the provider in setting up these services. NHP is contracted with the Asian Pacific Development Center. Asian Pacific Development Center has interpreters available for face-to-face, telephonic, or Skype interpretation in approximately seventy (70) languages via their website at https://www.apdc.org/. Providers may also find this resource in the documents titled, BehavioralHealthProviderHandbook_NHP (see Page 74) and PhysicalHealthProviderHandbook_NHP (see Page 11). NHP worked with the members to develop the document titled CoverSheet_NHP to attach to member notices, such as complaint and appeal acknowledgement letters. The cover sheet protects members' privacy and provides members with information on how to request information in alternative formats, oral interpretation or written translation for free. The cover sheet is written in large font and has the toll free and TTY/TDD number listed.	
9. The RAE provides each member with a member handbook within a reasonable time after receiving notification of the member's enrollment. *42 CFR 438.10(g)(1)* Contract Amendment 7: Exhibit B6—7.3.8.1	*Instructions: Unless the RAE has its own handbook or supplement, score this Not Applicable.* NHP exclusively uses Health First Colorado's member handbook	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The RAE gives members written notice of any significant change (as defined by the State) in the information required at 438.10(g) at least 30 days before the intended effective date of the change. *42 CFR 438.10(g)(4)* Contract Amendment 7: Exhibit B6—7.3.8.2	*Instructions: If the RAE does not produce a handbook or supplement, score Not Applicable.* NHP exclusively uses Health First Colorado's member handbook	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
11. For any RAE member handbook or supplement to the member handbook provided to members, the RAE ensures that information is consistent with federal requirements in 42 CFR 438.10(g). • The RAE ensures that its member handbook or supplement references a link to the Health First Colorado member handbook. *42 CFR 438.10* Contract Amendment 7: Exhibit B6—7.3.8.1	*Instructions: If the RAE does not produce a handbook or supplement, score Not Applicable. If the RAE produces its own handbook or supplemental handbook—(a) review for accuracy of any applicable elements and (b) must reference the Department's handbook.* NHP exclusively uses Health First Colorado's member handbook	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
12. The RAE makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice or 30 days prior to the effective date of the termination, whichever is later, to each member who received their primary care from, or was seen on a regular basis by, the terminated provider.	**Documents Submitted/Location Within Documents:** 1. 304L_MemberRandRPolicy_NHP, Page 7, *Misc 2. CUR 140.8 Continued Access when Network Providers Discontinue Participation in Beacons Network_NHP, Page 4 3. Provider Term Template_NHP **Description of Process:** Beacon makes a good faith effort to give written notice to members regarding the termination of a contracted	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.10(f)(1) Contract Amendment 7: Exhibit B6—7.3.10.1	provider. Beacon sends letters to members impacted by a provider's termination within fifteen (15) days after the receipt or issuance of the termination notice or 30 days prior to the effective date of the termination, whichever is later. Beacon has this member right documented in the document titled 304L_MemberRandRPolicy_NHP. Beacon's provider disenrollment process encompasses several departments before a member is sent notification of provider termination. Beacon follows the procedures outlined in the document titled CUR 140.8 Continued Access when Network Providers Discontinue Participation in Beacon's Network_NHP (see Page 4). Beacon sends the document titled Provider Term Template_NHP to impacted members to inform them of the change in their providers' network status and offers to assist members find a new provider.	
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.	**Documents Submitted/Location Within Documents:** 1. WebsiteUpdateRequests_NHP 2. JobAidforWebsiteUpdates_NHP **Description of Process:** NHP has delegated the maintenance of its website to Beacon. Beacon developed a website for NHP when the contract commenced in 2018, https://www.northeasthealthpartners.org/.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• 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. Contract Amendment 7: Exhibit B6—7.3.9.1.1–5; 7.3.9.1.9–11; 7.3.9.2	Beacon maintains and updates the website as frequently as needed using the document titled WebsiteUpdateRequests_NHP. The NHP website is customized and comprehensive and includes all the required information in the following sections: The home page has the following information: • NHPs' contact information • Health First Colorado's Nurse Advice Line's phone number and link • Colorado Crisis Services information • Link to Health First Colorado's website • Link to the Member handbook in both Spanish and English • Find a Provider The Member tab has the following information: • Access to Care Standards • Complaints & Appeals • Find a Provider • Rights & Responsibilities The About tab outlines: • The general functions of the RAE	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The News tab has: • Trainings for members listed under Calendar & Events. Trainings include "Getting Started" Webinar and Advance Directives Trainings. Other ad hoc trainings are also located in this section. NHPs' member engagement team follows the document titled JobAidforWebsiteUpdates_NHP to request website updates for member topics. The member engagement team tracks the requested changes	
14. The RAE makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, pharmacies, behavioral health providers, and long-term services and supports (LTSS) providers: • The provider's name and group affiliation, street address(es), telephone number(s), website URL, specialty (as appropriate), and whether the provider will accept new enrollees. • The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office. • Whether the provider's office has accommodations for people with physical	**Documents Submitted/Location Within Documents:** 1. Provider Directory_NHP, *Misc **Description of Process:** NHP supplies a provider directory for members on its website in a PDF format (see ProviderDirectory_NHP). The directory contains information about NHPs' contracted behavioral and physical providers. NHP also has mobile-enabled electronic resource available on our website under the "find a provider" section, https://www.northeasthealthpartners.org/. NHP delegates provider management to Beacon. The Provider Relations (PR) team has an automated process to update this directory on a monthly basis. Providers are responsible to update any pertinent information relating to their practice through the online portal, Provider Connect. Provider updates could include their availability to see members, change in specialty, updated address and/or phone number. If a provider	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
disabilities, including offices, exam rooms, and equipment. *Note: Information included in a paper provider directory must be updated at least monthly if the RAE does not have a mobile-enabled, electronic directory; or quarterly if the RAE has a mobile-enabled, electronic provider directory; and electronic provider directories must be updated no later than 30 calendar days after the contractor receives updated provider information.* *42 CFR 438.10(h)(1-3)* Contract Amendment 7: Exhibit B6—7.3.9.1.6-7	states they are not currently accepting new members, the PR team requests for a temporary hold to be placed on the provider file so their name does not come up in the directory. Beacon's PR team oversees the process to update the provider directory no later than thirty (30) days from receipt of updated provider information which is captured in the updated provider directory. The provider directory contains: • Provider name and group affiliation • Provider address and telephone number • Provider URL website address • Provider specialty • Provider linguistic capabilities including ASL • Provider cultural competency training • Whether providers are accepting new patients (this can change frequently and providers are responsible to update their availability) • Accommodations for people with disabilities (ADA) The document titled ProviderDirectory_NHP can be viewed and/or printed by a member if they have access to a printer. A member may also call and ask to have a printed copy of the directory to be mailed to them. NHPs' "find a provider" tab located on our website has search engines to help members find health care. Members can select on the "Find a PCP" link to find a doctor, hospital, specialist, pharmacist, or LTSS specialist. Members can select "find a	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	behavioral health provider" to find behavioral health specialists. Members can select "find a dentist" to be linked with Dentaquest, the agency that oversees Health First Colorado's dental benefits. Many of NHP members choose to contact NHPs' call center to request assistance in finding a provider NHPs'' Clinical Service Assistants (CSA) use Beacon's referral connect system to narrow the search for a provider based on the member preferences. CSAs can search by: • The gender of the provider • The number of miles the provider lives from the member's home • If the provider is bilingual, including ASL • The ethnicity of the provider • Provider specialty including SUD specialty • Access for disabilities Members may ask a CSA if there is specialized equipment for their disability. If this occurs, the CSA will outreach the provider to ascertain if the provider can accommodate a disability.	
15. Provider directories are made available on the RAE's website in a machine-readable file and format. *42 CFR 438.10(h)(4)* Contract Amendment 7: Exhibit B6—7.3.9.1.8	**Documents Submitted/Location Within Documents:** 1. Provider Directory_NHP, *Misc 2. IT302.5_508ComplianceofExternalWebSitesPolicy_NHP, Pages 2-3 3. WebsiteComplianceCheck_NHP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Description of Process: The document titled ProviderDirectory_NHP is available to members on NHPs' website in a machine-readable file and format, https://s18637.pcdn.co/wp-content/uploads/sites/25/Provider-Directory-NHP.pdf. NHP has delegated website functions to Beacon. Beacon follows the document titled IT302.5_508ComplianceofExternalWebSitesPolicy_NHP (see Pages 2-3) to ensure that documents are machine-readable. The policy prioritizes any issues, which impede the website being accessible. Beacon runs 508/WCAG website scans monthly to resolve accessibility issues. The 508/WCAG reports is reviewed by a Beacon staff member to resolve and remediate any issues. The PR team completes a 508-accessibility check (see WebsiteComplianceCheck_NHP) on the provider directory before uploading the PDF document to the website.	
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	**Documents Submitted/Location Within Documents:** 1. Brochure_NHP 2. CoverSheet_NHP 3. CAHPS Surveys_NHP **Description of Process:** NHP has developed materials to distribute to newly enrolled and existing members and all the materials are located on the NHP website and can be printed out upon member request free of charge. See	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
management (PCCM) entity and prepaid inpatient health plan (PIHP). • Which populations are subject to mandatory enrollment into the Accountable Care Collaborative. • The service area covered by the RAE. • Medicaid benefits, including State Plan benefits and those in the Capitated Behavioral Health Benefit. • Any restrictions on the member's freedom of choice among network providers. • The requirement for the RAE to provide adequate access to behavioral health services included in the Capitated Behavioral Health Benefit, including the network adequacy standards. • The RAE's responsibilities for coordination of member care. • Information about where and how to obtain counseling and referral services that the RAE does not cover because of moral or religious objections. • To the extent possible, quality and performance indicators for the RAE, including member satisfaction. Contract Amendment 7: Exhibit B6—7.3.6.1	https://www.northeasthealthpartners.org/members/new-member-welcome-packet/. The required elements are identified below: • The document titled Brochure_NHP includes a single toll-free customer service phone number, state relay number and email address and is located on the NHP website. The phone numbers can be found in the top bar of the website – left side. The phone numbers and email address can be found by clicking the contact tab, https://www.northeasthealthpartners.org/contact/. • The document titled Brochure_NHP provides NHPs' website address, as well as the document titled CoverSheet_NHP. • The basic features of a primary care case management (PCCM) entity and prepaid inpatient health plan (PIHP); the service area NHP covers; the requirement of NHP to provide adequate access to behavioral health services included in the plan including network adequacy standards; and NHPs' responsibility for coordination of member care are found on the About tab on the website, https://www.northeasthealthpartners.org/about/what-is-a-rae/. • Which populations are subject to mandatory enrollment into the Accountable Care Collaborative can be found on our website under the News tab, https://www.northeasthealthpartners.org/news/member-attribution/.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Medicaid benefits, including State Plan benefits and those in the Capitated Behavioral Health Benefit; information about where and how to obtain counseling and referral services that NHP does not cover because of moral or religious objections, and if there are any restrictions on the member's freedom of choice among network providers can be found on our website under the Member tab, https://www.northeasthealthpartners.org/members/benefits-and-services/. NHP encourages members to participate in a member satisfaction survey. The Want to Improve Your Health? survey is located on the main page of the website: https://www.northeasthealthpartners.org. The quality team summarizes the member satisfaction survey results and uploads these results as well as other quality and performance indicators on the Provider tab of our website, https://www.northeasthealthpartners.org/providers/quality/. The Your Opinion Matters survey aims to collect information on member interest to improve their healthcare, and perceptions of satisfaction and access issues for both physical health and behavioral healthcare services.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey results (see CAHPS Surveys_NHP) were evaluated and formatted for presentation and review. NHP has identified interventions that can increase satisfaction scores on future survey results by working directly with one of the facilities included in the survey. NHP will continue to look for partnership opportunities to use the results from the survey to create interventions to affect scores on future member satisfaction surveys.	
Findings: NHP used the Department's welcome letter and the *Health First Colorado Member Handbook* to inform newly enrolled members about services and to meet the requirements of 42 CFR §438.10. Although the welcome letter pointed members to *the Health First Colorado Member Handbook*, which included nearly all required information, the welcome letter distributed by the Department during CY 2021 did not contain NHP's website address and neither did the *Health First Colorado Member Handbook*. Based on additional evidence in the form of email communications between NHP and the Department in July and November 2021, NHP was under the impression that the welcome letter used throughout FY 2021 contained website address details for each managed care entity. Based on this information, the requirement is considered met. The Department reported than an updated letter that will include the RAE's website address is estimated to go into production in July 2022; therefore, no required action associated with this finding is needed.		
17. The RAE provides member information by either: • Mailing a printed copy of the information to the member's mailing address. • Providing the information by email after obtaining the member's agreement to receive the information by email. • Posting the information on the website of the RAE and advising the member in paper or electronic form that the information is	**Documents Submitted/Location Within Documents:** 1. HCPFWelcomeLtr_NHP, *Misc 2. Welltok Monthly Report_NHP 3. CoverSheet_NHP 4. Brochure_NHP 5. EmailAddressReport_NHP 6. Getting Started Flyer_NHP,*Misc 7. DHS PPT_NHP, Slide 5	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost. • Providing the information by any other method that can reasonably be expected to result in the member receiving that information. *42 CFR 438.10(g)(3)* Contract Amendment 7: Exhibit B6—None	8. Provider Newsletter_NHP, Page 7 9. Getting Started PPT_NHP, Slide 10, *Misc 10. CallCenterTraining_NHP **Description of Process:** NHP provides member information through a variety of platforms, but the predominant method is through its website, https://www.northeasthealthpartners.org/. The website has information about how members with disabilities can access the information online and explains how members will be provided auxiliary aids at no cost to them. See bottom of the main page of the website and https://www.northeasthealthpartners.org/members/. NHP has worked with HCPF leadership to embed its website URL address into HCPF's welcome letter to new members (see HCPFWelcomeLtr_NHP). NHP employs texting technology through Welltok to alert members of our website address. NHP sends texts with website information through two campaigns, welcome message and website link information. Members would be able to access member information through our website (see Welltok Monthly Report_NHP). NHP attaches the document titled CoverSheet_NHP to all correspondence that provides the NHP website link. The cover sheet has taglines alerting members of the availability of auxiliary aids at no cost to them. NHPs'' website address is also	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	located on the document titled Brochure_NHP where members can access member information on the NHP website. NHP has started to obtain members' email addresses and consent when they call into the call center. Members are made aware by the call center staff that the email is to send them health information. NHP developed a monthly report (see EmailAddressReport_NHP) to document the members that have consented to use their email address. NHP identified that the first point of contact for newly enrolled members are the eligibility technicians at the Department of Human Services (DHS) offices. NHPs' member engagement team has been meeting with the eligibility technicians in our ten (10) 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 (see DHS PPT_NHP, Slide 5). This information includes NHPs' brochure and a document titled Getting Started Flyer_NHP. The flyer has NHP website information, information on how to request help in other languages and a QR code to direct members to the new member welcome packet located on our website. The getting started flyer is also distributed in the provider newsletter (see Provider Newsletter_NHP, Page 7). NHPs' member engagement team reviews member information including benefit updates and services available to the member during the "Getting Started" webinars (see Getting Started PPT_NHP, Slide 10).	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	NHP provides an annual training to the call center team (see CallCenterTraining_NHP) to keep them informed of the information available to members on the website. The call center team can help connect members with the information found on the website.	
18. The RAE must make available to members, upon request, any physician incentive plans in place. *42 CFR 438.10(f)(3)* Contract Amendment 7: Exhibit B6—None	NHP does not have any physician incentive plans currently in place.	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable

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

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

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	which is the language for the majority of our members. The DART removes duplicate phone numbers from the list since there may be several members with the same phone number residing in one household. The DART creates and sends a .csv file to NHPs' member engagement team, delegated to Beacon, who is responsible to complete NHPs' first outreach to the member (see EPSDT Weekly.csvlist_NHP). The first outreach is an interactive voice response (IVR) automated call sent within the first sixty (60) days of enrollment. This is considered a bi-directional outreach approach as members have the option to speak to a call center staff member in real time or are provided with NHPs' call back number. NHP also has a texting campaign for newly enrolled members, which has been used to onboard and inform members about their benefits (see Texting Scripts_NHP, pages 2 and 3). NHP developed an automated monthly report to identify non-utilizing EPSDT eligible members that have not had a well visit within the past year (see EPSDT Non-UtilizersReport_NHP). Those identified on this report are sent a text message notifying members that they are due for a well visit if they have opted in for text messaging. Members are instructed to contact NHPs' toll-free number if they need assistance with these appointments such as scheduling or transportation (see Texting Scripts_NHP, pages 5-6). NHP has EPSDT resources on our website with a link to Bright Futures Guidelines. The Bright Futures Guidelines	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	lists the American Academy of Pediatrics recommendations for preventive care. See: https://www.northeasthealthpartners.org/members/new-member-welcome-packet/. NHP developed a well visit tip sheet, which has Bright Future guidelines on how frequently members need a well visit and what members should expect at their well visit (see WellVisitTipSheet_NHP). NHP also developed an EPSDT tip sheet with information about the benefits of preventative health care, the services available under EPSDT, including where and how members can obtain services (see EPSDT Tip Sheet_NHP). The tip sheet includes links to the American Association of Pediatrics' Bright Futures Guidelines. The EPSDT tip sheet includes a statement indicating that services are without cost to the member and provides a phone number for when members have questions or need to request transportation. Both tip sheets are located on our website (see https://www.northeasthealthpartners.org/members/my-health-matters-menu/; https://www.northeasthealthpartners.org/members/new-member-welcome-packet/). NHP submits an EPSDT quarterly report to HCPF to reflect the work we have done in the previous quarter with outreaching newly eligible members and non-utilizing EPSDT members. Newly eligible members are those under 21 years of age or pregnant females. Non-utilizing members are those who have not had a well visit in the previous	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	twelve (12) months (see EPSDT QuarterlyPlan_NHP). The report contains a breakdown of outreach attempts and the success of each outreach attempt. The report is accompanied by a .csv file with the specific members who were outreached.	
Findings: Although NHP generally informed the member of general EPSDT information, the *EPSDT Tip Sheet* in use throughout CY 2021 did not follow *Bright Futures Guidelines* timeframes for recommended teen well visits. The tip sheet stated two to three years, which should be annual recommended visits. Additionally, NHP did not consistently complete annual outreach for members who had not utilized EPSDT services in the prior 12-month period. Non-utilizer data submitted and staff reports during the interview both indicated that some annual outreach was untimely. Furthermore, the annual outreach process relied solely on text message outreach, which the reports indicated only reached approximately 20 to 50 percent of members according to the submitted non-utilizers report data and FY 2021–2022 second quarter *EPSDT Outreach Quarterly Report*. Staff members did not report using phone or mail outreach for annual outreach purposes in CY 2021.		
Required Actions: NHP must: • Update the *EPSDT Tip Sheet* and any associated documents to include the correct *Bright Futures Guidelines* timeframe for annual well visits. • Enhance annual non-utilizer outreach to ensure that it is timely and has a reasonable chance of reaching the member.		
2. The EPSDT informational materials use a combination of oral and written approaches to outreach EPSDT eligible members to ensure members receive regularly scheduled examinations, including physical and mental health services: • Mailed letters, brochures, or pamphlets • Face-to-face interactions • Telephone or automated calls	**Documents Submitted/Location with Documents** 1. EPSDT AnnualPlan_NHP 2. HCPFWelcomeLtr_NHP, *Misc 3. EPSDT Tip Sheet_NHP 4. ProviderDocumentationTraining_NHP, Slide 18, *Misc 5. ProviderDecNewsletter_NHP 6. Texting Scripts_NHP, Pages 2-4 7. Getting Started Flyer_NHP, *Misc	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Video conferencing • Email, text/SMS messages Contract Amendment 7: Exhibit B6—7.6.3.2	8. Getting Started PPT_NHP, Slide 11 *Misc **Description of Process:** NHP employs various methods of communication to outreach members who are eligible for the EPSDT program. NHPs' goal is to ensure that our members receive regularly scheduled well visits and understand the benefits available to them for free such as physical health, behavioral health, vision, and dental services. NHP outlined their strategy for EPSDT outreach efforts in its annual plan submitted and accepted by HCPF (see EPSDT AnnualPlan_NHP). The plan outlines a variety of outreach methods which are described below. <u>Mailed letters</u> NHP worked with HCPF to include our new member welcome packet link in the welcome letter that HCPF sends to new members (see HCPFWelcomeLtr_NHP). HCPF lists the RAE's phone number and NHPs' website link, which would direct a member to NHPs' new member welcome packet (see: https://www.northeasthealthpartners.org/members/new-member-welcome-packet/). The purpose of this collaboration with NHP and HCPF was to consolidate information being sent to members.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Face-to-face interactions NHP developed an EPSDT tip sheet with information about the benefits of preventive health care and the services available under EPSDT, including where and how members can obtain services (see EPSDT Tip Sheet_NHP). The tip sheet explains the available physical and behavioral services, which are covered for members at no charge to them. NHP distributes this tip sheet to practice transformation coaches, care coordinators, and DHS eligibility technicians. NHPs' care coordinators and DHS eligibility technicians have face-to-face contact with our members. NHPs' practice transformation coaches meet regularly with PCMP practices and distribute the EPSDT tip sheets to PCMPs who meet face-to-face with our members. NHP educates delegated care coordination entities on EPSDT benefits to leverage the relationships they have with our members. These delegated staff members are usually meeting face-to-face with our members. The Provider Relations team includes EPSDT information in the provider newsletters and educates providers at either roundtable or documentation trainings about EPSDT benefits (see ProviderDocumentationTraining_NHP, slide 18; ProviderDecNewsletter_NHP). The tip sheet is located on our website (see https://www.northeasthealthpartners.org/members/new-member-welcome-packet/).	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Telephone or automated calls; Email, text/SMS messages NHP uses both telephonic and automated calls to outreach members. When a member receives an automated call through our Interactive Voice Response (IVR) system, they have the option to speak with an NHP call center associate who can help answer any questions related to their health or EPSDT benefits or they can choose to call back at a time convenient for them. NHP sends text messages to new members and invites them to join our text messaging service to learn about their health benefits (see Texting Scripts_NHP, Pages 2-4). Video conferencing NHP hosts a getting started webinar on the first Thursday of each month and uses ZOOM technology to explain benefits (including EPSDT) available to members (see Slide 11 of the Getting Started PPT_NHP and Getting Started Flyer_NHP).	
3. The RAE makes network providers aware of the Colorado Medicaid EPSDT program information by: • Using Department materials to inform network providers about the benefits of well-child care and EPSDT. • Ensuring that trainings and updates on EPSDT are made available to network providers every six months.	**Documents Submitted/Location Within Documents** 1. 248L_EPSDTPolicy_NHP, Page 5 2. Provider Documentation Training Invite_NHP 3. ProviderDocumentationTraining_NHP_, Slide 18, *Misc 4. Provider Welcome Letter_NHP, Page 2 5. BehavioralHealthProviderHandbook_NHP, Pages 41-43, *Misc	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract Amendment 7: Exhibit B6—7.6.2.3, 12.8.3.4; 12.9.3.4	6. PhysicalHealthProviderHandbook_NHP, Pages 31-33, *Misc 7. ChartAuditTool_NHP, Row 73, *Misc **Description of Process:** NHP offers training for network providers to increase awareness of Health First Colorado's EPSDT program information. NHP follows its 248L_EPSDTPolicy (see Page 5; delegated function to Beacon), which outlines procedures for oversight of the EPSDT program including education for our providers. NHP provides documentation training for providers on a quarterly basis. The training reviews the EPSDT benefit and documentation requirements for providers. Dates of training were March 11, 2021, June 21, 2021, September 30, 2021 and December 10, 2021 (see ProviderDocumentationTrainingInvite_NHP; ProviderDocumentationTraining_NHP, Slide 18). NHP offered a PCMP Roundtable in August 2021 and reviewed EPSDT benefits. The presentation (see Slides 13-22) can be found on our website at https://www.northeasthealthpartners.org/august-primary-care-provider-support-call/. NHP outlines EPSDT benefits and includes HCPF's information in its provider handbook (see Pages 41-43 of BehavioralHealthProviderHandbook_NHP and Pages 31 to	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	33 of PhysicalHealthProviderHandbook_NHP). Providers are sent a welcome letter which provides both the provider handbook and the link to the website where NHPs' provider handbook is located (see Provider Welcome Letter_NHP, Page 2). The Behavioral Health Provider Handbook outlines providers' responsibility for the following: 1. Assess new members to determine that EPSDT screenings have been occurring (see Page 67). 2. Refer members to their PCP, if screenings are not being conducted (see Page 67). 3. Provide behavioral health assessment/treatment upon referral from a PCP who desires additional behavioral health services, and for which medical necessity has been determined (see Page 67). 4. Communicate with the PCP regarding any pertinent findings/actions (see Page 67). 5. Document all actions in the member's clinical record (see Page 68). The Physical Health Providers Handbook outlines the following: 1. The ages of the members that qualify for EPSDT services (see Page 31). 2. That an EPSDT is conducted by a PCMP or Pediatrician to screen for behavioral health needs or other health care issues (see Page 31). 3. The types of medically necessary care available (see Pages 31-32).	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	4. When EPSDT eligible members should have their well-child visits (see Page 32). 5. The definition of medical necessity for EPSDT (see Page 32) 6. The link to HCPF's website for EPSDT benefits (see Page 33). 7. All medically necessary health care services must be made available for the treatment of all physical and mental illness discovered by any screening or diagnostic procedure (see Page 33). 8. EPSDT services must be performed by or under the supervision of a certified Health First Colorado provider (see Page 33). The provider handbooks can be found on our website via the following link: https://www.northeasthealthpartners.org/providers/provider-handbook/. NHPs' quality team completes chart audits for our contracted providers. The quality team reviews member charts to ascertain if providers have documented evidence that they educated the child/parent about EPSDT services needed (see Row 73 of ChartAuditTool_NHP). NHPs' quality team sends a letter with chart audit results to the provider, noting any missing documentation and offers assistance to help providers meet Health First Colorado's standards for documentation.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. For children under the age of 21, the RAE provides or arranges for the provision of all medically necessary *Capitated Behavioral Health Benefit* covered services in accordance with 42 CFR Sections 441.50 to 441.62 and 10 CCR 2505-10 8.280 (EPSDT program). For the *Capitated Behavioral Health Benefit*, the RAE: • Has written policies and procedures for providing EPSDT services to members ages 20 and under. • Ensures provision of all appropriate mental/behavioral health developmental screenings to EPSDT beneficiaries who request it. • Ensures screenings are performed by a provider qualified to furnish mental health services. • Ensures screenings are age appropriate and performed in a culturally and linguistically sensitive manner. • Ensures results of screenings and examinations are recorded in the child's medical record and include, at a minimum, identified problems, negative findings, and further diagnostic studies and/or treatments needed and the date ordered. • Provides diagnostic services in addition to treatment of mental illnesses or conditions discovered by any screening or diagnostic procedure. *42 CFR 441.55; 441.56(c)*	**Documents Submitted/Location Within Documents:** 1. 248L_EPSDTPolicy_NHP 2. BehavioralHealthProviderHandbook_NHP, Pages 41-43, *Misc 3. PhysicalHealthProviderHandbook_NHP, Pages 31-33, *Misc 4. ProviderDocumentationTraining_NHP, Slide 18, *Misc 5. Provider Documentation Training Invite_NHP 6. ChartAuditTool_NHP, Row 74, *Misc **Description of Process:** NHP provides or arranges for the provision of all medically necessary capitated behavioral health benefit coverage for members under the age of twenty-one (21). NHP has a written policy and procedure related to the EPSDT program and its requirements (see Policy 248L_EPSDTPolicy_NHP). The policy outlines the following: • That eligibility for EPSDT benefits is for any member enrolled in the Health First Colorado who is 20 years old or younger (see Page 2) • Behavioral health providers must record the results of all screenings and examinations in the child's medical record. Documentation shall include, at a minimum, identified problem(s) and negative findings and further diagnostic studies and/or treatments needed, and the date(s) ordered (see Page 5).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract Amendment 7: Exhibit B6—14.5.3 10 CCR 2505-10 8.280.8.A, 8.280.4.A (3)(d), 8.280.4.A (4), 8.280.4.A (5), 8.280.4.C (1–3)	• NHP authorizes all medically necessary services covered by the capitated benefit program (see Page 6). • The RAE reviews all requests for mental and behavioral health developmental screenings to eligible EPSDT members or family members who request it. The RAE will ensure these screenings are performed by a provider qualified (correct licensure) to furnish mental health screenings in a culturally and linguistically sensitive manner (see Page 6). • The RAE shall authorize diagnostic services and treat any identified diagnostic or treatment service needs, including substance abuse needs, which are medically necessary (see Page 6). NHPs' contracted network providers are instructed about documentation requirements through the provider handbook and the documentation trainings provided by NHPs' quality department (see Pages 41-43 of BehavioralHealthProviderHandbook_NHP; Pages 31 to 33 of PhysicalHealthProviderHandbook_NHP; Slide 18 of ProviderDocumentationTraining_NHP and Provider Documentation Training Invite_NHP). NHPs' quality team also completes chart audits of our contracted providers to ensure that they are documenting that providers have discussed EPSDT services with members (see Row 74 of ChartAuditTool_NHP). NHP sends a letter to providers following an audit which outlines any missing information	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	from a member's chart and offers assistance to help providers meet Health First Colorado's standards for documentation.	
5. *For the Capitated Behavioral Health Benefit,* the RAE: • Provides referral assistance for treatment not covered by the plan but found to be needed as a result of conditions disclosed during screening and diagnosis. • Provides assistance with transportation and assistance scheduling appointments for services if requested by the member/family. • Makes use of appropriate State health agencies and programs including: vocational rehabilitation; maternal and child health; public health, mental health, and education programs; Head Start; social services programs; and Women, Infants and Children (WIC) supplemental food program. *42 CFR 441.61–62* Contract Amendment 7: Exhibit B6—14.5.3 10 CCR 2505-10 8.280.4.C	**Documents Submitted/Location Within Documents:** 1. BehavioralHealthProviderHandbook_NHP, Pages 41-43, *Misc 2. PhysicalHealthProviderHandbook_NHP, Pages 31-33, *Misc 3. 248L_EPSDTPolicy_NHP, Pages 2 and 7 4. CareCoordinationAuditTool_NHP, Rows 36-43, *Misc 5. Care Coordination Fact Sheet_NHP, *Misc 6. Care Coordination Referral Form_NHP 7. ChartAuditTool_NHP, Row 75, *Misc **Description of Process:** NHP provides referral assistance for treatment not covered by the plan but is found to be needed as of a result of conditions disclosed during screening and diagnosis. This is outlined in its policy titled 248L_EPSDTPolicy_NHP, page 2. This policy also explains that NHP will help members and their families schedule transportation or appointments for any EPSDT related services (see 248L_EPSDTPolicy_NHP, Page 2). NHP provides assistance for transportation and/or assistance scheduling an appointment when requested by a member or a family member. NHPs' delegated care coordination agencies assist families and members with	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

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

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	handbook, specifically offering the member and family referral assistance, appointment scheduling and transportation services (see Pages 41-43 of BehavioralHealthProviderHandbook_NHP and Pages 31 to 33 of PhysicalHealthProviderHandbook_NHP). NHPs' quality team completes chart audits with contracted providers and looks for evidence that there is coordination with non-medical providers (see Row 75 of ChartAuditTool_NHP).	
6. *For the Capitated Behavioral Health Benefit*, the RAE defines medical necessity for EPSDT services as a program, good, or service that: • Will or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all. • Assists the member to achieve or maintain maximum functional capacity. • Is provided in accordance with generally accepted professional standards for health care in the United States. • Is clinically appropriate in terms of type, frequency, extent, site, and duration.	**Documents Submitted/Location Within Documents**: 1. 248L_EPSDTPolicy_NHP 2. CCMAgenda_NHP **Description of Process:** NHP outlines the definition of medical necessity for EPSDT services in its policy titled 248L_EPSDTPolicy_NHP for the capitated behavioral health benefit. The medical necessity definition is for a program, good, or service that: • Will or is reasonably be expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all (see Page 4). • Assists the member to achieve or maintain maximum functional capacity (see Page 4).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider. • Is delivered in the most appropriate setting(s) required by the client's condition. • Provides a safe environment or situation for the child. • Is not experimental or investigational. • Is not more costly than other equally effective treatment options. Contract Amendment 7: Exhibit B6—14.5.3 10 CCR 2505-10 8.076.8; 8.076.8.1; 8.280.4.E	• Is provided in accordance with generally accepted professional standards for health care in the United States (see Page 6). • Is clinically appropriate in terms of type, frequency, extent, site, and duration (see Page 6). • Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider (see Page 6). • Is delivered in the most appropriate setting(s) required by the client's condition (see Page 6). • Provides a safe environment or situation for the child (see Page 6) • Is not experimental or investigational (see Page 6). • Is not more costly than other equally effective treatment options (see Page 4). NHP delegates utilization management to Beacon Health Options. Beacon oversees all capitated behavioral health utilization and follows the policy titled 248L_EPSDTPolicy_NHP for definitions of medical necessity for EPSDT services, goods or programs. The utilization management team reviews the EPSDT medical necessity criteria at least annually (see CCMAgenda_NHP).	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. *For the Capitated Behavioral Health Benefit*, the RAE provides or arranges for the following for children/youth from ages 0 to 21: vocational services, intensive case management, prevention/early intervention activities, clubhouse and drop-in centers, residential care, assertive community treatment (ACT), recovery services, respite services. *Note: All EPSDT services are included in the State Plan or in Non-State Plan 1915(b)(3) Waiver Services (respite and vocational rehabilitation).* Contract Amendment 7: Exhibit B6—14.5.7.1, 2.1.1	**Documents Submitted/Location Within Documents:** 1. RTCReport_NHP 2. EncounterandClaimReport_NHP 3. Evidence of ICMandCreativeSolutions Meeting_NHP **Description of Process:** NHP provides or arranges the following services for the capitated behavioral health benefit for children and youth ages 0-21: • Vocational Services. These services are usually arranged through NHPs' community mental health centers who have vocational programs. Members may also be connected with county-specific vocation rehab programs. • Intensive Case Management. These services are provided by an assigned intensive case manager or a care coordinator. ICMs attend HCPF-run Creative Solutions meetings. • Prevention/Early Intervention. These services are usually provided through our providers or the CMHCs. CPT codes include the following: S9453 S9454, H0022, H0023, H0024, H0025, H0027, H0028, H0029. • Club house and drop-in centers: These services are available through our community mental health centers within our ten (10) counties. CPT codes include the following: CPT codes H0029, H2030, H2031	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Residential Care. These services are provided by contracted behavioral health providers when medically necessary. • Assertive Community Treatment (ACT). These services are usually provided through our providers or the CMHCs. CPT codes include the following: CPT codes H0039 and H0040. • Recovery Services. These services are provided through our providers or CMHCs. CPT codes include the following: H0043, H0044, H2015, H2016. • Respite Services. These services are usually provided through our providers or the CMHCs. CPT codes include the following: CPT codes T1005, T1006, H0045. NHP offers vocational services through their partner CMHCs. One example is through North Range Behavioral Health's accredited clubhouse, The Frontier House. The Frontier House offers vocational services and highlights this in their monthly newsletter. See one of the 2021 newsletters from Frontier Press at https://www.northeasthealthpartners.org/news/newsletters/ for information on Employment and Education. NHP would also arrange or refer a member to vocational programs through the CMHCs or connect them with county-specific vocational rehab programs if a member called in to request vocational services.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	NHP pulled a report for the above-listed services, which we provide or arrange for under the capitated behavioral health benefit (see RTCReport_NHP and EncounterandClaimReport_NHP). NHP participates in HCPF's Creative Solutions meetings to provide intensive case management and help arrange services for EPSDT-eligible members when appropriate (see Evidence of ICMandCreativeSolutions Meeting_NHP). NHP refers members to Community Center Boards for assessment of services provided in the 1915 (b) (3) waiver services. NHPs' Member Services Director attends both the Children's Disability Advisory Committee (CDAC) and HCPF's Children's Services Steering Committee. The goal of NHPs' participation in these meetings is to inform committee members who work with EPSDT eligible members about the services NHP can provide and/or arrange.	

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

Appendix B. Site Review Participants

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

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

HSAG Review Team	Title
Sarah Lambie	Project Manager III
Evarista Ogbon	Project Manager I
Sara Dixon	Project Manager II
Lauren Gomez	Project Manager I
Crystal Brown	Project Coordinator III
NHP Participants	**Title**
Kari Snelson	Northeast Health Partners: Chief Executive Officer
Alicia Williams	Beacon Health Options: Chief Operating Officer
Alma Mejorado	Beacon Health Options: Director, Contracting Development
Ashley Clement	Northeast Health Partners: Regional Care Coordination Manager
Brian Robertson	Northeast Health Partners: Director of Quality Improvement
Charlotte Blakely-Frazier	Beacon Health Options: Privacy and Security Consultant
Courtney Hernandez	Beacon Health Options: Behavioral Health Clinical Quality Analyst, Senior
Dawn Surface	Beacon Health Options: Member Engagement Specialist
Dr. Brian Hill	Beacon Health Options: Chief Clinical Officer
Ed Arnold	Beacon Health Options: Performance Improvement Analyst
Frank Merrill	Northeast Health Partners: Chief Financial Officer
Jamie Coahran	Beacon Health Options: Contract Development Manager
Jen Hale-Coulson	Northeast Health Partners: Clinical Director
Jen Wang	Beacon Health Options: Web User Interface Developer
Jeremy White	Beacon Health Options: Quality Program Manager
John Mahalik	Beacon Health Options: Director of Quality Management
Kara Doone	Colorado Community Managed Care Network: Care Coordination Director

NHP Participants	Title
Karen Talone	Beacon Health Options: Colorado Provider Relations Manager
Leah Agee	Beacon Health Options: Clinical Service Assistant
Lori Sealock	Beacon Health Options: Call Center Manager
Lynne Bakalyan	Beacon Health Options: Director, Member Services
Mandi Strickland	Northeast Health Partners: Chief Operating Officer
Michael Clark	Beacon Health Options: Director of Health Information Systems
Myron Unruh	Beacon Health Options: Beacon Market President
Natasha Lawless	Northeast Health Partners: Contract Manager
Ron Botten	Beacon Health Options: Director of Information Technology
Dr. Steve Coen	Beacon Health Options: Director of Utilization Management
Tina Gonzalez	Beacon Health Options: Health Promotion Consult Senior
Wayne Watkins	Northeast Health Partners: Director, Health Information & Technology
Department Observers	**Title**
Angela Ukoha	Accountable Care Collaborative Program Specialist
Brooke Powers	Accountable Care Collaborative Program Specialist
Curt Curnow	Quality Improvement Section Manager
Erin Herman	Health Programs Office, Program Administrator
Jeff Helm	Program Design and Policy
Russell Kennedy	Quality and Compliance Specialist

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

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

Table C-1—Corrective Action Plan Process

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

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

The CAP template follows.

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

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

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
services, including written translation or oral interpretation and the toll-free and TTY/TDD customer service numbers and availability of materials in alternative formats. – Be member tested. *42 CFR 438.10(d)(3) and (d)(6)* Contract Amendment 7: Exhibit B6—7.2.7.3–9; 7.3.13.3		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to Be Submitted as Evidence of Completion:		
HSAG Initial Review:		

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

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
5. *If the RAE makes information available electronically:* Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of "readily accessible" above). • The information is placed in a website location that is prominent and readily accessible. • The information can be electronically retained and printed. • The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge upon request and is provided within five business days. • Provide a link to the Department's website on the RAE's website for standardized information such as member rights and handbooks. *42 CFR 438.10(c)(6)* Contract Amendment 7: Exhibit B6—7.3.14.1, 7.3.9.2	During the review, staff members reported that NHP received minimal ad hoc printing requests. Although NHP submitted an email as evidence to show how NHP communicates internally to fulfill such requests, NHP could not provide supporting documents to demonstrate how NHP monitors the five-day requirements for such requests. NHP also submitted a *Member Information Request Job Aid*; however, staff members stated that there is an opportunity to formalize a documentation process within a call record, indicating the *Member Information Job Aid* was not in place in CY 2021. NHP could not provide supporting documents to demonstrate how NHP monitors the five-day requirements for such requests. NHP's general member webpage and provider directory webpage included a statement that materials can be printed but did not include "within five business days." HSAG recommends that, as best practice, the full statement be placed in prominent locations on the website, particularly where critical documents are linked and/or downloadable (i.e., the *New Member Welcome Packet* page).	NHP must develop and implement a mechanism to monitor that, upon request, members are provided with printed materials within five business days and at no cost.

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to Be Submitted as Evidence of Completion:		
HSAG Initial Review:		
Documents for Final Submission:		
Date of Final Evidence:		

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Findings**	**Required Action**
1. The RAE onboards and informs members and their families regarding the services provided by Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). This includes: • Informing the member about the EPSDT program generally within 60 days of the member's initial Medicaid eligibility determination, or after a member regains eligibility following a greater than 12-month period of ineligibility, or within 60 days of identification of the member being pregnant. • At least one time annually, the RAE outreaches members who have not utilized EPSDT services in the previous 12 months in accordance with the American Association of Pediatrics (AAP) "Bright Futures Guidelines" and "Recommendations for Preventive Pediatric Health Care." • Information about benefits of preventive health care, including the American Association of Pediatrics "Bright Futures Guidelines," services available under EPSDT, where services are available, how to obtain services, that services are without cost	Although NHP generally informed the member of general EPSDT information, the *EPSDT Tip Sheet* in use throughout CY 2021 did not follow *Bright Futures Guidelines* timeframes for recommended teen well visits. The tip sheet stated two to three years, which should be annual recommended visits. Additionally, NHP did not consistently complete annual outreach for members who had not utilized EPSDT services in the prior 12-month period. Non-utilizer data submitted, and staff reports during the interview both indicated that some annual outreach was untimely. Furthermore, the annual outreach process relied solely on text message outreach, which the reports indicated only reached approximately 20 to 50 percent of members according to the submitted non-utilizers report data and FY 2021–2022 second quarter *EPSDT Outreach Quarterly Report*. Staff members did not report using phone or mail outreach for annual outreach purposes in CY 2021.	NHP must: • Update the *EPSDT Tip Sheet* and any associated documents to include the correct *Bright Futures Guidelines* timeframe for annual well visits. • Enhance annual non-utilizer outreach to ensure that it is timely and has a reasonable chance of reaching the member.

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Findings**	**Required Action**
to the member, and how to request transportation. Contract Amendment 7: Exhibit B6—7.3.12.1, 7.6.2		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to Be Submitted as Evidence of Completion:		
HSAG Initial Review:		
Documents for Final Submission:		
Date of Final Evidence:		

Appendix D. Compliance Monitoring Review Protocol Activities

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

Table D-1—Compliance Monitoring Review Activities Performed

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

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct the Review**
	• During the review, HSAG met with groups of the RAE's key staff members to obtain a complete picture of the RAE's compliance with federal healthcare regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the RAE's performance. • HSAG requested, collected, and reviewed additional documents as needed. • At the close of the review, HSAG provided RAE staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2021–2022 Department-approved Site Review Report template to compile the findings and incorporate information from the pre-review and review activities. • HSAG analyzed the findings and calculated final scores based on Department-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the Department**
	• HSAG populated the Department-approved report template. • HSAG submitted the draft Site Review Report to the RAE and the Department for review and comment. • HSAG incorporated the RAE and Department comments, as applicable, and finalized the report. • HSAG included a pre-populated CAP template in the final report for all elements determined to be out of compliance with managed care regulations. • HSAG distributed the final report to the RAE and the Department.