COLORADO

Department of Health Care Policy & Financing

Fiscal Year 2023–2024 Compliance Review Report

for

Northeast Health Partners

Region 2

June 2024

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Summary of Results

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

Northeast Health Partners (NHP) showed a moderate understanding of federal regulations. While NHP received strong scores for member information and quality requirements, it did not score well for requirements pertaining to the oversight of the delegated entities that perform these tasks.

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

Table 1-1—Summary of Scores for Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
V. Member Information Requirements	18	18	18	0	0	0	100%^
VII. Provider Selection and Program Integrity	16	16	12	4	0	0	75% v
IX. Subcontractual Relationships and Delegation	4	4	2	2	0	0	50% v
X. Quality Assessment and Performance Improvement (QAPI)**	16	16	16	0	0	0	100%~
Totals	**54**	**54**	**48**	**6**	**0**	**0**	**89%**

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

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

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

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

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

Standard V—Member Information Requirements

Evidence of Compliance and Strengths

NHP delegated the administrative and operational processes related to member information to Carelon Behavioral Health (Carelon). Members received information when requested, at no cost, in English and prevalent non-English languages and in alternative formats. Carelon staff members reported that customer service representatives (CSRs) assisted members by providing guidance during calls when members had questions or concerns. Carelon trained CSRs on member benefits via weekly trainings, periodic training, and one-on-one communications. The team lead monitored the CSRs on a bimonthly basis. NHP had reviewed Carelon's customer service outcomes in the call center report.

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

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

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

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

Opportunities for Improvement and Recommendations

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

Required Actions

HSAG identified no required actions for this standard.

Standard VII—Provider Selection and Program Integrity

Evidence of Compliance and Strengths

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

Per policy, Carelon uses several network adequacy tools to identify network needs, including GeoAccess, single case agreements, and "data capturing number" and "type of provider" within the delivery system. Using these tools, Carelon employed different strategies to recruit providers. Regarding retention of providers, Carelon referenced webinars, newsletters, and roundtables as activities that support provider retention. In addition to these activities, Carelon employed community engagement specialists whose role it is to meet with providers on a regular basis and provide support where needed. Carelon also provided specialized trainings to providers across the system, which alleviated an expense for the providers.

Carelon provided a behavioral health compliance program description, compliance workplan summary, risk assessment summary, and myriad compliance-related policies that described a comprehensive and well-rounded compliance program. Carelon had a compliance committee overseen by an experienced and educated compliance lead. NHP's chief executive officer (CEO) also served as NHP's chief compliance officer (CCO); however, the compliance activities described by NHP's CEO/CCO were more akin to a communication and education meeting for delegated provider groups and not

comprehensive compliance oversight. Carelon met with NHP quarterly to provide compliance updates and discuss various compliance-related topics.

Carelon conducted ongoing monitoring of claims data to detect evidence of fraudulent billing. Carelon had a special investigations unit (SIU) that would review any concerns, investigate issues, and determine remediation. Carelon has a process to verify whether services represented to have been delivered by network providers were received by members. This process included mailing 100 members chosen at random an inquiry letter on an annual basis. Carelon reported that there had not been any fraudulent billing practices identified through this activity.

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

Opportunities for Improvement and Recommendations

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

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

Required Actions

Carelon submitted policy CR 226.11 *Prevention and Monitoring of Non-discriminatory Credentialing and Re-Credentialing*. The policy did not include all required language. Carelon must revise its policies to include language that states Carelon does not "discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification."

Carelon submitted a policy titled *Screening Against Exclusion and Ownership and Control Disclosures,* which excluded the term "suspended" from the language within the policy. Carelon must revise its policies to include the terms "excluded, suspended, and debarred" to ensure that Carelon does not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (i.e., an individual owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulations or Executive Order 12549.

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

prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following:

- The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered.
- Any information the member needs in order to decide among all relevant treatment options.
- The risks, benefits, and consequences of treatment or nontreatment.
- The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

NHP delegated a significant operational aspect of its compliance program to Carelon. While Carelon was able to describe the features of the compliance program, NHP did not have sufficient oversight and monitoring of Carelon's compliance activities. While NHP described educational compliance meetings with providers and quarterly compliance meetings between Carelon and NHP, NHP provided no evidence that it maintained strategic oversight of the compliance program or took ownership of developing and implementing policies, procedures, and practices to ensure compliance. For example, the ethics statement was provided through Elevance Health's Code of Conduct (Elevance Health is a parent company of Carelon) and all of the policies and procedures related to program integrity were from Carelon. While aspects of the compliance activities may be delegated, the ongoing strategy, monitoring, and oversight must be managed by NHP. NHP must strengthen its documentation of internal NHP compliance monitoring procedures.

Standard IX—Subcontractual Relationships and Delegation

Evidence of Compliance and Strengths

NHP had a written delegation agreement for care coordination activities with North Colorado Health Alliance (NCHA) as well as a delegated administrative services agreement with Carelon that included, but was not limited to, member management, provider network services, grievances and appeals, utilization management, and compliance. HSAG reviewed the delegation agreement with NCHA and determined that it included almost all federally required language as well as clear performance standards and monitoring protocols that were being evaluated annually. HSAG reviewed the delegation agreement with Carelon and determined the contract included some of the federally required language. During the interview, NHP staff members discussed regularly scheduled meetings that took place with Carelon to review some of the delegated activities. Leadership staff members from NHP demonstrated both knowledge of Carelon's activities and engagement in the delegated activities of its RAE.

Opportunities for Improvement and Recommendations

HSAG identified no opportunities for improvement for this standard.

Required Actions

During the interview, HSAG inquired about NHP's annual audit and oversight of Carelon. While NHP noted that it reviewed the reports and deliverables that Carelon developed for the Department, NHP did not indicate that the oversight included annual monitoring of all delegated activities or assessing Carelon against specific performance standards to ensure compliance with delegated requirements. However, NHP did provide evidence of this for other delegates. For example, in the delegation agreement with NCHA, NHP included specific language identifying key contract performance benchmarks and expectations for satisfactorily adhering to the contract, as well as the periodicity for ongoing review and a set of consequences for not meeting set benchmarks. NHP evidenced this process through policies, audit tools, and results reports. NHP did not have similar language in its agreement with Carelon and was not adhering to its policy to conduct annual monitoring to ensure that its delegate was satisfactorily executing the delegated managed care activities, such as audits of the member call center, network contracting, credentialing, utilization management, information systems, and claims payment. NHP must detail its oversight and monitoring process within its agreement with Carelon, including identifying benchmarks and expectations for the delegated activities. NHP must complete ongoing monitoring of Carelon to ensure that Carelon meets these benchmarks and expectations, and align its delegation agreement with its policies and procedures.

HSAG reviewed the subcontractor agreements with NCHA and Steadman Group and found that the written agreements did not include all required information. NHP must ensure, via revisions or amendments, that its subcontractor agreements include the following required language:

- The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State.
  - The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems related to members.
  - The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
  - If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

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

Evidence of Compliance and Strengths

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

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

Carelon submitted several flowchart diagrams of its health information system, which demonstrated a method for collecting, processing, and reporting data to and receiving data from the State. During the interview, Carelon and NHP staff members described in detail the life cycle of the health information system, including member enrollment, encounter data, auditing for and capturing errors, encounter data processing, and reporting.

Opportunities for Improvement and Recommendations

HSAG identified no recommendations for this standard.

Required Actions

HSAG identified no required actions for this standard.

3. Background and Overview

Background

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

In order to evaluate the RAEs' compliance with federal managed care regulations and State contract requirements, the Department determined that the review period for fiscal year (FY) 2023–2024 was calendar year (CY) January 1, 2023, through December 31, 2023. This report documents results of the FY 2023–2024 compliance review activities for NHP. Section 1 includes the summary of scores for each of the standards reviewed this year. Section 2 contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 3 describes the background and methodology used for the FY 2023–2024 compliance monitoring review. Section 4 describes follow-up on the corrective actions required as a result of the FY 2022–2023 compliance review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B lists HSAG, RAE, and Department personnel who participated in some way in the compliance review process. Appendix C describes the corrective action plan (CAP) process that the RAE will be required to complete for FY 2023–2024 and the required template for doing so. Appendix D contains a detailed description of HSAG's compliance review activities consistent with the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023.[3-1]

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

Overview of FY 2023–2024 Compliance Monitoring Activities

For the FY 2023–2024 compliance review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard V—Member Information Requirements, Standard VII—Provider Selection and Program Integrity, Standard IX—Subcontractual Relationships and Delegation, and Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems. Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the RAE's contract requirements and regulations specified by the federal Medicaid managed care regulations published May 6, 2016. Additional revisions were released in December 2020 and February 2023. HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable.* The Department determined that the review period was CY January 1, 2023, through December 31, 2023. HSAG reviewed materials submitted prior to the compliance review activities, materials requested during the compliance review, and considered interviews with key RAE personnel to determine compliance with applicable federal managed care regulations and contract requirements. Documents consisted of policies and procedures, staff training materials, reports, committee meeting minutes, and member and provider informational materials.

The compliance review processes were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Appendix D contains a detailed description of HSAG's compliance review activities consistent with those outlined in the CMS EQR protocol. The four standards chosen for the FY 2023–2024 compliance reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services; Standard II—Adequate Capacity and Availability of Services; Standard III—Coordination and Continuity of Care; Standard IV—Member Rights, Protections, and Confidentiality; Standard VI—Grievance and Appeal Systems; Standard VIII—Credentialing and Recredentialing; Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT); and Standard XII—Enrollment and Disenrollment,

Objective of the Compliance Review

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

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

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

FY 2022–2023 Corrective Action Methodology

As a follow-up to the FY 2022–2023 compliance review, each RAE that received one or more *Partially Met* or *Not Met* scores was required to submit a CAP to the Department addressing those requirements found not to be fully compliant. If applicable, the RAE was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the RAE and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with NHP until it completed each of the required actions from the FY 2022–2023 compliance monitoring review.

Summary of FY 2022–2023 Required Actions

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

Related to Standard I—Coverage and Authorization of Services, NHP was required to complete two required actions:

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

Related to Standard II—Adequate Capacity and Availability of Services, NHP was required to complete one required action:

- Correct the timely appointment standards in the PCP Practitioner Agreement.

Related to Standard VI—Grievance and Appeal Systems, NHP was required to complete three required actions:

- Monitoring and oversight of NHP's delegates must be enhanced to ensure member letters include the required content.

- Update the following documents to remove the requirement that the member must follow a verbal appeal request with a written request in any way. NHP must also share updated documentation to other staff to ensure all staff are aware of the requirement.
  - Appeal Job Aid, page 2, remove "appeal must be signed by the member."
  - 305L Appeal Policy, page 12 under section J.2, remove the instruction that the coordinator or specialist must attempt to get a signed appeal request from the member.
  - Appeal Form, which can be found online, remove the statement at the bottom of the page, "Please know that we cannot process this appeal until you sign and return this letter."
- Revise 305L Appeal Policy to add that the coordinator will make reasonable efforts to notify the member of the delay if the delay is in the member's best interest.

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

Summary of Corrective Action/Document Review

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

Summary of Continued Required Actions

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

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE provides all required member information to members in a manner and format that may be easily understood and is readily accessible by members. • The RAE ensures that all member materials (for large-scale member communications) have been member tested. *Note: Readily accessible means electronic information which complies with Section 508 guidelines, Section 504 of the Rehabilitation Act, and World Wide Web Consortium Web Content Accessibility Guidelines 2.0 Level AA and successor versions.* *42 CFR 438.10(c)(1)* RAE Contract: Exhibit B-8—7.2.5 and 7.2.7.9	**Documents Submitted:** 1. 307L_MemberInfoReqPolicy, Pages 1, 2 and 3 2. MEACSummary, pages 1-2 3. CoverSheet, entire document 4. IT302.7_ComplianceofExternalWebSitePolicy, entire policy 5. WebsiteComplianceCheck, entire document 6. MemberMaterialReview, entire document 7. SeptMemberMaterialWorkgroup, entire document 8. OctMemberMaterialWorkgroup, entire document 9. NovMemberMaterialWorkgroup, entire document 10. DecMemberMaterialWorkgroup, entire document 11. VoluntaryProductAccessibilityGuide, entire document 12. HealthLiteracyTraining, entire document 13. PlainLanguage_HCPFtraining, entire document **Description of Process:** NHP provides all required member information in a manner and format that may be easily understood	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	changes, which are recommended by our members (page 3). See 307_LMemberInfoReqPolicy, pages 1-3. NHP implemented a monthly Member Material Review Workgroup in September 2023 to review member facing material. Prior to September 2023, NHP reviewed member materials with members at our Member Experience Advisory Council (MEAC) on a quarterly basis. NHP created the member material review workgroup to review materials more frequently. During MEAC or our Member Material Review Workgroup, members were asked to "test" the material and identify concerns with content and/or layout. NHP documents the member materials that have been reviewed with members and may edit based on member feedback (noting there are certain requirements for materials). For evidence of reviewed member material, see MEACSummary, pages 1-2, and MemberMaterialReview. For examples of topics and materials discussed at our Member Material Workgroup, see: • SeptMemberMaterialWorkgroup • OctMemberMaterialWorkgroup • NovMemberMaterialWorkgroup • DecMemberMaterialWorkgroup	

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

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• External websites must adhere and meet 508 compliance standards (page 1). • Under Section 508, agencies must give disabled employees and members of the public access to information that is comparable to the access available to others (page 2). • Information about World Wide Web Consortium (W3C) that leads the website to its full potential is addressed (page 2). • The purpose of the policy is to publish procedures for the development of external websites to ensure that 508 compliance is maintained (page 2). This includes priority checklist items. Priority one (1) items must be addressed and are required to make a site accessible – page 2. Priority two (2) checklist items, which should be addressed to make the site accessible, but these items, are not required – page 4. Priority three (3) checklist items, which could be addressed to improve the accessibility of a site (page 6). See: IT302.7_ComplianceofExternalWebSitesPolicy, pages 1-6. Carelon's website team uses the Voluntary Product Accessibility Guide to conduct periodic reviews for	

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

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The RAE has in place a mechanism to help members understand the requirements and benefits of the plan. *42 CFR 438.10(c)(7)* RAE Contract: Exhibit B-8—7.3.8.1	**Documents Submitted:** 1. HCPFWelcomeLetter, entire document 2. HCPFWelcomeLetterEvidence, entire document 3. GettingStartedGuideEN, entire document 4. GettingStartedGuideSP, entire document 5. WelcomeandBenefitTextMessages, entire document 6. TextingReport, entire document 7. CallCenterReport, entire document 8. GettingStartedInvitationEN, entire document 9. GettingStartedInvitationSP, entire document 10. ConstantContactInvitation, entire document 11. CareCoordinationPresentation, slide #9 12. NovProviderNewsletter, page 3 13. DHSPresentation, Slides 6, 8 14. JanGettingStarted_Transportation, entire document 15. FebGettingStarted_Family Planning, entire document 16. March2023GettingStarted_WIC_SNAP, entire document 17. April2023GettingStarted_SUD, entire document 18. May2023GettingStarted_EPSDT, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	19. June2023GettingStarted_HomeVisiting, entire document 20. July2023GettingStarted_Rights and Responsibilities, entire document 21. Aug2023GettingStarted_Maternity, entire document 22. Sept2023GettingStarted_Dental, entire document 23. Oct2023GettingStarted_WomensHealth, entire document 24. Nov2023GettingStarted_COQuitLine, entire document 25. Dec2023GettingStarted_Immunizations, entire document **Description of Process:** NHP has several mechanisms in place to help members understand the requirements and benefits of the plan. These mechanisms are described below: **New Member Welcome Letter** NHP leverages the welcome letter mailed by Health Care Policy and Financing (HCPF) to all newly enrolled members. The welcome letter has NHP's website information and phone contact information and indicates that the regional organization can help members obtain the health care services they need. NHP confirmed with HCPF via email that the HCPF Welcome Letter	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	submitted in this audit is the most recent template. See HCPFWelcomeLtr and HCPFWelcomeLtrEvidence. **Website - New Member Resources** NHP's website has a tab with New Member Welcome Resources . Members accessing the website will have multiple new member resources in one location. These resources include, but are not limited to the member handbook, NHP's getting started guide, how to find a provider and the PEAK website. NHP's Getting Started Guide has helpful resources for members to start using their benefits. See GettingStartedGuideENt and GettingStartedGuideSP. **Texting Campaigns** Newly eligible members are enrolled in a welcome and benefit texting campaign through our vendor, Virgin Pulse. This campaign is designed to help members understand the requirements and benefits of their health plan. The messages include but are not limited to: Welcome message, member handbook information, website link information, well child benefit information, the nurse advice line number, member rights, advance directives, vaccinations, behavioral health, crisis services, and how to get an insurance card. NHP has included the aggregate data from the texting reports to	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	demonstrate the number of texts sent to members and member retention rates in our texting campaigns. Please see WelcomeandBenefitTextMessages,andTextingReport. **Automated Calls** NHP uses an Interactive Voice Response (IVR) automated calling system to outreach newly enrolled EPSDT-eligible and newly identified pregnant members within 60 days of their enrollment. The message states "Hi, it's Northeast Health Partners calling, your Colorado Medicaid health plan. We would like to tell you about your benefit information which includes well visits, dental visits, and vision screens. You can press 1 to be connected to a live person who can tell you about your health benefits. You may also call 1-888-502-4189. Again, that number is 888-502-4189." The IVR calling system provides a bi-directional option for calls to select a number to connect with one of our call center associates. Call center associates identify members calling in response to one of our campaigns in our CONNECTS system and code these calls. NHP has attached a report of members who contacted us following one of our	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	outreach campaigns to obtain additional information. See CallCenterReport.. **Constant Contact Emails** NHP uses Constant Contact, which is an online platform utilized to send emails in bulk. NHP sends an invitation to the monthly "getting started" virtual webinar to members who have given consent to receive emails. NHP has included an example of one of the invitations sent to members. See ConstantContactInvitation. **Virtual Platform** NHP hosts a "getting started" virtual webinar on the first Thursday of each month to educate members, family members, or health care professionals about member benefits and requirements of their health plan. NHP's getting started webinar focuses on a thorough presentation of one benefit, however, participants are encouraged to ask questions about any of their benefits during the webinar. NHP promotes this webinar through email, social media posts, provider newsletters, and education about this webinar at care coordinator meetings, practice transformation meetings, and other community stakeholder meetings. NHP emails members who have consented to receive emails an invitation to our getting started webinar through constant	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	contact. NHP provides a "getting started" flyer to all health care professionals to distribute to members at the meetings listed above. See: • GettingStartedInvitationEN, • GettingStartedInvitationSP, • ConstantContactInvitation, • CareCoordinationPresentation, • NovProviderNewsletter, • DHSPresentation NHP covered the following benefit topics to help members understand the plan benefits: January: Transportation February: Family Planning March: SNAP/WIC April: Substance Use Disorder Benefits May: EPSDT June: In Home Visiting July: Rights and Responsibilities/Complaints August: Maternity Programs September: Dental Benefits October: Women's Health Screenings November: Smoking Cessation Programs December: Immunizations	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	For evidence of presentation training materials, please see: • JanGettingStarted_Transportation • FebGettingStarted_Family Planning • March2023GettingStarted_WIC_SNAP • April2023GettingStarted_SUD • May2023GettingStarted_EPSDT • June2023GettingStarted_HomeVisiting • July2023GettingStarted_RightsandResponsibilities • Aug2023GettingStarted_Maternity • Sept2023GettingStarted_Dental • Oct2023GettingStarted_WomensHealth • Nov2023GettingStarted_COQuitLine • Dec2023GettingStarted_Immunizations	
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,	**Documents Submitted:** 1. ManagedCareTermsEN, entire document 2. ManagedCareTermsSP, entire document 3. HCPFBrandGuide2023, page 14 4. HCPFCoBranding, entire document 5. MemberMaterialCollaborationNHP, entire document **Description of Process:** To maintain consistency in the information provided to members, NHP uses managed care definitions developed by The Department of	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. • Model member handbooks and member notices. *42 CFR 438.10(c)(4)* RAE Contract: Exhibit B-8—3.6	Healthcare, Policy and Financing (HCPF). NHP created a Managed Care Terms Explained resource for our members after researching managed care definitions found in Health First Colorado's (Colorado's Medicaid Program) member handbook and HCPF's website. The Managed Care Terms Explained document can be found on the Resources tab on our website. To review the managed care terms, please see ManagedCareTermsEnglishand ManagedCareTermsSpanish. NHP uses Health First Colorado's member handbook and does not have an independent member handbook. The English and Spanish member handbooks are displayed on the home page of our website. Our website address is https://www.northeasthealthpartners.org. NHP uses HCPF's branding guide to develop and model our member materials after HCPF and follows their policy transmittal RAE MCO 23-02 to include the Health First Colorado logo on member facing materials. Both the branding guide and policy transmittal give the directive to use Health First Colorado logo with the tagline "In partnership to better serve you" to demonstrate the connection between Health First Colorado and the RAE. NHP has included this logo/tagline on all of our member facing materials. NHP also has this	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	logo on the bottom right-hand corner of our website. The Managed Care Terms document also has the required logo. See: HCPFBrandGuide2023, page 14 and HCPFCoBrandingManagedCareTermsEnglish, ManagedCareTermsSpanish, Additionally, NHP collaborated with Nicky Alden from HCPF on November 16, 2023 to discuss HCPF's branding guide. Specifically, NHP reviewed how we are currently using Health First Colorado (in partnership with) logo on our materials to ensure we are modeling our member materials in alignment with HCPF. Nicky communicated that NHP is following the intent of HCPF's branding guide with our member-facing materials. Additionally, NHP requested for a Spanish version of the Health First Colorado logo to place on our Spanish member materials. See MemberMaterialCollaborationNHP.	
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:	**Documents Submitted:** 1. DATAUSA, entire document 2. AppealGuideEN, entire document 3. AppealGuideSP, entire document 4. ComplaintGuideEN, entire document 5. ComplaintGuideSP, entire document 6. CoverSheet, entire document 7. 307L_MemberInfoReqPolicy, page 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Use easily understood language and format. – Use a font size no smaller than 12-point. – Be available in alternative formats and through provision of auxiliary aids and service that take into consideration the special needs of members with disabilities or limited English proficiency. – Include taglines in large print (conspicuously-visible font size) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDD customer service numbers and availability of materials in alternative formats. – Be member tested. *42 CFR 438.10(d)(2-3) and (d)(6)* RAE Contract: Exhibit B-8—7.2.7.3-9 and 7.3.13.3	8. MEACSummary, pages 1-2 9. SeptMemberMaterialWorkgroup, entire document 10. OctMemberMaterialWorkgroup, entire document 11. NovMemberMaterialWorkgroup, entire document 12. DecMemberMaterialWorkgroup, entire document 13. MemberMaterialReview, entire document **Description of Process:** NHP identified Spanish as the most prevalent non-English language in our region. According to the 2021 Data USA report, there are 16.3% Non-English Speakers in Colorado with the most common non-English language being Spanish. 11.1% of Colorado's overall population are Spanish speakers. For evidence of Spanish as the most prevalent non-English language, see DATAUSA.. NHP makes written information critical to obtain services available in Spanish and English for members, These materials include the following: • Member Handbook – available on the home page of website	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Provider Directory – available on Find A Provider tab • Appeal Guides • Complaint Guides • Cover sheet for grievances, denials, appeals or termination notices. See: • AppealGuideEN, • AppealGuideSP, • ComplaintGuideEN, • ComplaintGuideSP, • CoverSheet,. NHP informs members that they can request information in alternative formats such as large font, Braille other formats or languages, American Sign Language, or to be read aloud. upon their request at no cost to them. This information is communicated in our cover sheet sent with all member correspondence. NHP's cover sheet protects members' privacy and provides members with information on how to request information in alternative formats, oral interpretation or written translation for free. The cover sheet is written in large font and has the toll free and TTY/TDD number listed. NHP also translated the tagline in 16 languages, which is included on the back page of	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	the cover sheet. The cover sheet is used with all correspondence, including grievance, appeal, denials, termination notices and any member material requests, such as a copy of a member handbook or a provider directory. See CoverSheet. NHP added a pop-up message on our website which states in English and Spanish, "If you need any document from our website in large print, Braille, other formats or languages, or read aloud, please contact us. We will send this to you free of charge within five (5) business days. We can also connect to language services or help you find a provider with ADA accommodations. Our number is 888-502-4189. If you have speech or hearing disabilities, there are auxiliary aids you may use (TTY/TDD/American Sign Language at 800-432-9553 or State Relay 711). These services are free." This language is also included on the home page of our website under the Health First Colorado and Member handbook links, near the bottom of the home page. Additionally, NHP has 25 languages accessible through Google Translate available at the lower right hand corner of our website. Members can click on the flag icon to access other languages.	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	NHP follows the procedures found in 307L_MemberInfoReqPolicy to ensure that the information we provide members is in a format that is easily understood. This policy states that member information: • Will use easily understood language and formats (page 3). • Will use a font size no smaller than 12-point (page 3). • Will include taglines in large print (conspicuously-visible font size) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDD customer service numbers and availability of materials in alternative formats (page 3). • Be available in alternative formats and through provision of auxiliary aids and service that take into consideration the special needs of members with disabilities or limited English proficiency (page 3). • Will be member-tested and make necessary changes, which are recommended by our members (page 3). See 307L_MemberInfoReqPolicy, page 3.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	NHP primarily used the platform of our Member Experience Advisory Council (MEAC) during the first three quarters to review member material, NHP identified a need to meet more frequently with members to review: 1) member materials, 2) NHP's website, and 3) our social media posts. As a result, NHP established a member material review committee in September 2023, which meets on a monthly basis. For evidence of member reviewed during a MEAC meeting, please see MEACSummary, pages 1-2. For evidence of our member material work group, please see • SeptMemberMaterialWorkgroup • OctMemberMaterialWorkgroup • NovMemberMaterialWorkgroup • DecMemberMaterialWorkgroup. • For the list of materials reviewed, see MemberMaterialReview.	
5. *If the RAE makes information available electronically:* Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of "readily accessible" above). • The information is placed in a website location that is prominent and readily accessible. • The information can be electronically retained and printed.	**Documents Submitted:** 1. IT302.7_ComplianceofExternalWebSitePolicy, entire document 2. WebsiteUpdatesJobAid, pages 1-2 3. WebsiteComplianceCheck, entire document 4. MemberMaterialRequestJobAid, entire document 5. MemberMaterialsSent, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	simplest language appropriate for a site's content (pages 4 and 6). Carelon's website team uses the Voluntary Product Accessibility Guide to conduct periodic reviews for 508 compatibility and compliance with the World Wide Web Consortium Web Content Accessibility Guidelines on our website. See VoluntaryProductAccessibilityGuide Carelon runs all member-approved PDF documents, which meet content and language requirements through a 508-accessibility scan before uploading the content to the website. This process is outlined in our website updates job aid. Additionally, Carelon runs a periodic website compliance report to identify any priority 1, 2 or 3 checklist items as outlined in the 508 Compliance of External Website Policy and takes action to eliminate these errors. See WebsiteUpdatesJobAid, pages 1-2, See IT302.7_ComplianceofExtrenalWebsite, pages 3-7, and WebsiteComplianceCheck.. NHP has worked with the website team to ensure that information is placed in a prominent position and is readily accessible. For example, NHP identified three crucial elements for members to understand their benefits and obtain care. NHP also	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	wants to ensure that information on our website aligns with Health First Colorado. These are placed on the home page of our website: • Find a Provider link • Member Handbook links in English and Spanish • Health First Colorado link • Nurse Advise Line Link • Crisis Line link • Discrimination Notice on home page which also links to HCPF's non-discrimination policy and non-discrimination notice to address Section 504 of the Rehabilitation Act • Information in two places alerting members how they can request for information to be printed and sent to them within 5 days, free of charge. To ensure that members know that they can request any document from our website to be printed and sent to them free of charge within 5 business days, we have this information in several locations: • Home Page Pop up message: "If you need any document from our website in large print, Braille, other formats or languages,	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	or read aloud, please contact us. We will send this to you free of charge within five (5) business days. We can also connect to language services or help you find a provider with ADA accommodations. Our number is 888-502-4189. If you have speech or hearing disabilities, there are auxiliary aids you may use (TTY/TDD/American Sign Language at 800-432-9553 or State Relay 711). These services are free." • Resources Page • Members Page • Bottom page of home page states "If you want any information on this website sent to you in paper form, please call us at 888-502-4189. We will send it to you for free within five (5) working days. Members can request information to be printed and sent to them free of charge. Members can request this via the RAE's email address, on our "contact us" form found on the website, or by calling the RAE's toll free number. When NHP's call center associate receives a member request for any member material, including but not limited to member handbooks or provider directories to be mailed to them, the call center associate will email and send a call record to the Call Center Team	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Lead. The Call Center Team lead follows the job aid developed to assist with requests for member materials. The job aid outlines the procedures that all staff must follow when a member requests a copy of any document. See MemberMaterialRequestJobAid. NHP developed a report to internally track the number of materials requested by members and to ensure that materials are being sent within five days. See MemberMaterialsSent. 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.	
6. The RAE makes available to members in electronic or paper form information about its formulary: • Which medications are covered (both generic and name brand). • What tier each medication is on. • Formulary drug list must be available on the RAE's website in a machine-readable file and format. *42 CFR 438.10(h)(4)(i)* RAE Contract: Exhibit B-8—None	**Documents Submitted:** 1. HCPFPreferredDrugList, entire document **Description of Process:** NHP makes Health First Colorado's medication formulary drug list available to members electronically on our website, which is in a machine-readable file and format. When/if a member requests this information to be sent to them in a paper form, NHP sends the formulary drug list at no charge to the member within five (5) days. NHP downloaded a copy of the formulary as evidence that this document is in a machine	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	readable file and format. See HCPFPreferredDrugList. The formulary drug list has information on which medications are covered – both generic and name brand as well as which tier each medication is on. NHP has HCPF's medication formulary drug link on our website under Resources – labeled Health First Colorado Prescription Drug List.	
7. The RAE makes interpretation services (for all non-English languages) and use of auxiliary aids such as TTY/TDD and American Sign Language available free of charge, notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and informs about how to access those services. *42 CFR 438.10 (d)(4) and (d)(5)* RAE Contract: Exhibit B-8—7.2.6.2-4	**Documents Submitted:** 1. R2_LangAssistRpt_FY23-24, entire documents 2. R2_LangAssistRpt_FY23-24_Accepted, entire document 3. 311L_RespondingtoMemberswithLEP, entire document . 4. 307L_MemberInfoReqPolicy, Page 3 5. LanguageAssistanceJobAid, entire document 6. CoverSheet, entire document 7. GettingStartedInvitationEN, entire document 8. GettingStartedInvitationSP, entire document 9. AdvanceDirectiveInvitationEN, entire document 10. AdvanceDirectiveInvitationSP, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	11. MEACFactSheetEN, entire document 12. MEACFactSheetSP, entire document 13. CallCenterLanguageServicesTraining, page 1 14. NHP-Behavioral-Health-Medicaid-Provider-Handbook, pages 4, 20, 62*Misc 15. NHP-PCMP-Provider-Handbook, pages 5, 18 *Misc, 16. NovProviderNewsletter, page 3 17. ProviderRoundtable, slide 17 18. Blank ClinicalAuditTool_QM, entire document *Misc. **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 all members. These services could involve the use of oral interpretation for any language including American Sign Language (ASL) and auxiliary aids such as TTY/TDD. Written translation is available for our members in prevalent languages. NHP educates members and health care professionals on members' rights to language services and how to access these services as outlined below. NHP submitted a Language Assistance report to HCPF in September 2023	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	which details our responsibility to ensure that language assistance services are provided to members for all interactions. See R2_LangAssistRpt_FY23-24and R2_LangAssistRpt_FY23-24_Accepted. NHP follows the policy, 311L_Responding to Members with (Limited English Proficiency (LEP) to direct our processes with members who are non-English speakers, LEP, or Deaf/hard of hearing. The policy describes the procedures for handling calls and responding to requests from providers and members for interpretation and or translation services. Embedded in the policy is a guide, "Working with Interpreters," which instructs staff members on how to use an interpreter. Additionally, NHP created a Language Assistance Job Aid for our call center associates to use when working with members needing language assistance. See 311L_RespondingtoMemberswithLEP and LanguageAssistanceJobAid, pages 1-3. NHP also follows the policy, 307L_Member Information Requirements Policy, which outlines on page 3 that member materials are translated into other languages when requested by the member at no charge to the member. The policy states that member materials are available in alternative formats for members who have communication	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	disabilities free of charge. Alternative formats include large type, audio tape, TTY/TDY, and ASL. NHP uses the Language Assistance Job Aid for requests for translation. See 307L_MemberInfoReqPolicy, page 3 and LanguageAssistanceJobAid, pages 3-4. NHP notifies members that oral interpretation is available for any language and written translation is available in prevalent languages. NHP also informs members how to access these services through a variety of channels. **NHP's Website.** NHP includes a pop-up window on our website which has information in English and Spanish about how to ask for interpretation services or materials in alternative formats. Additionally, NHP has a tagline at the bottom of the website, which states, "As our member, you can ask for information in large print, Braille, other formats, or to be read aloud. You can also request American Sign Language for your treatment needs. These services are free. You can call 888-502-4189 to request these services. For TDD/TTY, call 800-432-9553 or the State Relay 711 for help in contacting us. These calls are free. If you want any information on this website sent to you in paper form, please call us at 888-502-4189. We	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	will send it to you for free within five (5) working days." Additionally, if a member uses google translate to change the language of the website, they will have this information about how to request these services in alternative languages. **Written Materials** 1) NHP's cover sheet is attached to all written correspondence mailed to members. Our cover sheet provides members with information in English and Spanish on how to request information in alternative formats, request oral interpretation or written translation at no charge to the member. The cover sheet is written in large font and has the toll free and TTY/TDD numbers listed. The back page of the cover sheet has this information in 16 languages. Please see CoverSheet 2) Member invitations. NHP adds information on how to access reasonable accommodations on member invitations such as our "Getting Started" webinar, Member Experience Advisory Council, or Advance Directives meetings. NHP has contracts with agencies, such as the Colorado Language Connection to provide sign language and/or interpretation services when these services are requested.	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	See: • GettingStartedInvitationEN • GettingStartedInvitationSP • AdvanceDirectiveInvitationEN • AdvanceDirectiveInvitationSP, , • MEACFactSheetEN • MEACFactSheetSP **Education and Training** NHP trains the call center staff on our process to assist members who are non-English speaking, LEP, or Deaf/hard of hearing who contact us and require interpretation or translation. NHP has outlined our procedures in our Language Assistance Job Aid, which is reviewed with call center associates annually and during orientation of new associates. Call center staff are trained on how to access Voiance®, (a CyraCom International company) our language service company to connect members with an interpreter in real time. Voiance® is a leading provider of language interpreting and can serve members in over 150 languages – see language list. The language service is available to our members twenty-four (24) hours a day, seven (7) days a week (24/7) and is free of charge to our members. See	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	LanguageAssistanceJobAidand CallCenterLanguageServicesTraining, page 1. NHP informs providers of their responsibility to offer interpreter services for members in the behavioral health provider handbook pages 4, 20 and 62 and in the physical health provider handbook pages 5 and 18. The handbook explains that providers can contact NHP to receive help with linking providers to these services. NHP also provides language assistance information in the provider newsletter. Please see, NHP-Behavioral-Health-Medicaid-Provider-Handbook, pages 4, 20 and 62 and NHP-PCMP-Provider-Handbook, Pages 5 and 18 . ProviderRoundtable, slide 17, and NovProviderNewsletter, page 3 NHP's Quality Department completes periodic provider chart audits to determine whether a provider used an interpreter to meet the language needs of the member to assess utilization .This information is documented in the chart audit tool. See Blank ClinicalAuditTool_QM line #12.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The RAE ensures that: • Language assistance is provided at all points of contact, in a timely manner and during all hours of operation. • Customer service telephone functions easily access interpreter or bilingual services. RAE Contract: Exhibit B-8—7.2.6.1 and 7.2.6.4	**Documents Submitted:** 1. 311L_RespondingtoMemberswithLEP, entire document 2. ResourceSheet, entire document 3. LanguageAssistanceJobAid, pages 1-2 4. VoianceUseReport, page3 5. NHP-Behavioral-Health-Medicaid-Provider-Handbook, pages 4, 20 and 62 *Misc. 6. NHP-PCMP-Provider-Handbook, Pages 5, 18*Misc. **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. There are several points of contact for our members: • Members calling to access services and/or asking for help to find a provider • Members engaging/attending provider appointments	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• The steps we take when a provider requests an interpreter (page 6). • An educational guide, "working with interpreters" is available for all staff working with members to use (pages 8-10). Please see 311L_RespondingtoMembers with LEP, .NHP's call center staff use the language line number listed on a resource sheet if a member needs interpretation services and also follow the Language Assistance Job Aid. See ResourceSheetand LanguageAssistanceJobAid, pages 1-2. NHP is able to capture the number of calls, which required interpretation services through Voiance. The report show that of the 503 calls needing interpretation services between July 1, 2022 and June 30, 2023, 70.6% of the calls were for Spanish speaking members. The reports outlines the additional languages most frequently requested. See VoianceUseReport, page 3. NHP's 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 we cannot find an in-network provider who is bilingual or	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	signs, we would process a Single Case Agreement (SCA) when an appropriate provider is found. If an appropriate provider cannot be identified, NHP's member engagement team will assist the provider in setting up interpretation services with our member. NHP's call center associates also assist providers who contact us with language interpretation needs for our members by linking them with Colorado Language Connection. Colorado Language Connection has interpreters available for in person, video, remote interpreting and over-the-phone in 75 languages, including American Sign Language. Providers can find out about this language assistance in our behavioral health provider handbook on pages 4, 20, and 62. See NHP-Behavioral-Health-Medicaid-Provider-Handbook, pages 4, 20 and 62 . This information is also in our physical health provider handbook on pages 5 and 18. See NHP-PCMP-Provider-Handbook, pages 5, 18. Additionally, NHP developed a job aid to direct call center associates in assisting members and providers with any language assistance needs. NHP's goal with developing a job aid is to ensure that customer service telephone functions easily access interpreter or bilingual services. See LanguageAssistanceJobAid.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	If interpretation services are needed for an administrative reason, such as a member making a complaint or filing an appeal, the member engagement team will use an interpreter to discuss the complaint or appeal with the member if a bi-lingual staff member is unavailable.	
9. The RAE provides each member with a member handbook within a reasonable time after receiving notification of the member's enrollment. *42 CFR 438.10(g)(1)* RAE Contract: Exhibit B-8—7.3.8.1	**Documents Submitted:** 1. HCPFWelcomeLetter, entire document 2. HCPFWelcomeLetterEvidence entire document 3. WelcomeandBenefitTextMessages, entire document 4. MemberHandbookEN, entire document 5. MemberHandbookSP, entire document **Description of Process:** NHP leverages the letter sent by HCPF for newly enrolled members which has information on how members can obtain a free handbook and also has NHP's website information in the letter. NHP confirmed with HCPF that the HCPF Welcome Letter submitted in this audit is the most recent template. See HCPFWelcomeLetterand HCPFWelcomeLetterEvidence. The member handbook can also be found on our website on the home page and under new member welcome resources. Finally, NHP has the link to Health First	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Colorado on the home page of our website which also has the link to the member handbook. Newly eligible members are enrolled in a welcome and benefit texting campaign through our vendor, Virgin Pulse. This campaign is designed to help members understand the requirements and benefits of their health plan. The message sent on week two states: " Want a copy of your member handbook? Need to find a doctor? Visit www.northeasthealthpartners.org to check out all of the information and tools we offer." Please see WelcomeandBenefitTextMessages, line 10. NHP exclusively uses Health First Colorado's member handbook. See MemberHandbookEN, entire document and MemberHandbookSP, entire document.	
10. The RAE gives members written notice of any significant change (as defined by the State) in the information required at 438.10(g) at least 30 days before the intended effective date of the change. *42 CFR 438.10(g)(4)* RAE Contract: Exhibit B-8—7.3.8.2.2	**Documents Submitted:** 1. PHEUnwindCoordination, page 5 2. R2_PHEContCoverUnwindRpt_12-23, entire document **Description of Process:** NHP will notify members of any significant change communicated by Health Care Policy and Financing (HCPF) at least 30 days before the intended effective date of the change. One example of this was the change in the renewal	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	process with continuous coverage ending for Health First Colorado members related to the end of the Public Health Emergency (PHE). NHP aligned with the state to ensure consistent messaging with members' need to renew their benefit in the timeframe outlined by the state. NHP attached a slide deck from one of the Continuous Coverage Unwind coordination efforts between HCPF and the RAEs in early January 2023 for a significant change identified for May 2023. HCPF outlined the time frames that the RAEs needed to communicate with members the significant change with the renewal process on page 5 of this slide deck. NHP also submitted PHE unwind data to the state which demonstrates when messages about the significant change was sent to the member 30 days in advance of the effective change. See PHEUnwindCoordination and R2_PHEContCoverUnwindRpt_12-23.	
11. For any RAE member handbook or supplement to the member handbook provided to members, the RAE ensures that information is consistent with federal requirements in 42 CFR 438.10(g). • The RAE ensures that its member handbook or supplement includes a link to the online Health First Colorado member handbook. *42 CFR 438.10* RAE Contract: Exhibit B-8—7.3.9.2	**Documents Submitted:** 1. N/A **Description of Process:** NHP exclusively uses Health First Colorado's member handbook, which is found on the home page of our website.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The RAE makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice or 30 days prior to the effective date of the termination, whichever is later, to each member who received their primary care from, or was seen on a regular basis by, the terminated provider. *42 CFR 438.10(f)(1)* RAE Contract: Exhibit B-8—7.3.10.1	**Documents Submitted:** 1. 304L_MemberRandRPolicy, pages 2 and 7 2. PracticeSiteTerminationPolicy, page 1 3. ProviderTerminationForm, entire document 4.NotificationtoMembersofProviderTerminatingJobAid, entire document 5. ProviderTermLetter, page 3 *Misc **Description of Process:** NHP makes a good faith effort to give written notification to impacted members regarding the termination of a contracted provider. Impacted members are members receiving primary care from or are seeing a provider on a regular basis. NHP mails written notification to the member after the receipt or issuance of the termination notice or 30 days prior to the effective date of the termination, whichever is later. NHP's Member Rights and Responsibility policy notes this notification as a member right. Please see 304L_MemberRandRPolicy, pages 2 and 7. NHP follows NWCO 008 Practice Site Termination policy when contracted providers discontinue participation in our network. The policy outlines the timeframes we will follow in notifying members of any provider change. See PracticeSiteTerminationPolicy, page 1.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	NHP's network department will complete the member notification for provider termination request form and email the member engagement team to notify of a provider termination. See ProviderTerminationForm. NHP's member engagement team follows a job aid outlining the procedures for identifying and notifying impacted members of a contracted provider termination from the network. The member engagement team will use the provider termination letter template to develop the member notification letter and will tailor the letter with provider-specific information such as name of provider, address of provider, and termination date. NHP may incorporate any information from correspondence sent to the member by the provider to mirror messaging. The letter informs members of the change in their providers' network status and offers to assist members find a new provider. NHP mails the termination notice to members to addresses in our eligibility files by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice. See NotificationtoMembersofProviderTerminationJob Aidand ProviderTermLetter, page 3.	

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

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

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

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

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

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• The gender of the provider • The number of miles the provider lives from the member's home • If the provider is bilingual, including ASL • The ethnicity of the provider • Provider specialty including SUD specialty • Access for disabilities Members may ask a call center associate if there is specialized equipment for their disability. If this occurs, the call center associate will outreach the provider to ascertain if the provider can accommodate a disability.	
15. Provider directories are made available on the RAE's website in a machine-readable file and format. *42 CFR 438.10(h)(4)* RAE Contract: Exhibit B-8—7.3.9.1.9	**Documents Submitted:** 1. QM37.11_UsabilityTesting, entire document 2. IT302.7_ComplianceofExternalWebSitePolicy, pages 2-7 3. WebsiteComplianceCheck, entire document **Description of Process:** NHP makes electronic provider directories available to members on our website in a machine-readable file and format. The directories are found on our Find A Provider tab.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	NHP has delegated website functions to Carelon Behavioral Health (Carelon). Carelon follows QM37.11 Usability Testing to ensure that our web-based resources are accessible to users and can be applied to their full potential. The policy outlines the process for usability testing. See QM37.11_UsabilityTesting, entire document. Carelon also follows IT302.7_Compliance of External WebSites Policy to ensure that documents are machine-readable. The policy prioritizes any issues, which impede the website from being accessible. Carelon runs 508/WCAG website scans periodically to resolve accessibility issues. The 508/WCAG reports is reviewed by a Carelon associates to resolve and remediate any issues. See IT302.7_ComplianceofExternalWebSitesPolicy, pages 2-7, WebsiteComplianceCheck.	
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.	**Documents Submitted:** 1. HCPFWelcomeLetter, entire document 2. HCPFWelcomeLetterEvidence, entire document 3. GettingStartedGuideEN, entire document 4. GettingStartedGuideSP, entire document 5. CoverSheet, entire document 6. WelcomeandBenefitTextMessages, entire document 7. TextingReport, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The basic features of the RAE's managed care functions as a primary care case management (PCCM) entity and prepaid inpatient health plan (PIHP). • The service area covered by the RAE. • Medicaid benefits, including State Plan benefits and those in the Capitated Behavioral Health Benefit. • Any restrictions on the member's freedom of choice among network providers. • A directory of network providers. • The requirement for the RAE to provide adequate access to behavioral health services included in the Capitated Behavioral Health Benefit, including the network adequacy standards. • The RAE's responsibilities for coordination of member care. • Information about where and how to obtain counseling and referral services that the RAE does not cover because of moral or religious objections. • To the extent possible, quality and performance indicators for the RAE, including member satisfaction. RAE Contract: Exhibit B-8—7.3.6.1	8. ConstantContactInvitation, entire document 9. SocialMediaPost, entire document 10. CAHPS_Summary, entire document 11. MemberMaterialRequestJobAid, entire document 12. MemberMaterialsSent, entire document **Description of Process:** NHP has developed materials to distribute to newly enrolled and existing members assigned to our region. **Written Materials** **New Member Welcome Letter** NHP leverages the welcome letter mailed by Health Care Policy and Financing (HCPF) to all newly enrolled members. The welcome letter has our toll-free customer service phone number and our website address. NHP confirmed with HCPF that the HCPF WelcomeLetter submitted in this audit is the most recent template. See HCPFWelcomeLetter, and HCPFWelcomeLetterEvidence. **Getting Started Guide** NHP's getting started guide is available in a printed trifold brochure and also in an electronic	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	version on our website. The getting started guide has our toll-free number, email address and website address. The guide also has a QR code for our new member resources located on our website. The getting started guide invites members to participate in the "your opinion matters" survey to obtain input about member satisfaction. The guide provides an overview of benefits including member handbook information, finding a provider and care coordination. **Cover Sheet** NHP encloses a cover sheet with all mailed information to members which has our toll-free number, state relay information, and website address. See CoverSheet, entire document. **Electronic Materials** **Website** All of the materials on our website can be printed out and distributed to members. NHP created a New Member Resource page that has multiple member resources in one location, including a welcome letter and a getting started guide.. Additionally, our website has the following information:	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Home Page • Toll-free customer service number • State Relay number • TTY/TDD number • Your Opinion Matter link (survey to measure member satisfaction) • A Directory of Network Providers • Health First Colorado link that has information about coverage physical health and behavioral health coverage Contact Page • Toll-free customer service number • Care Coordination phone number • Email Address • Physical Address • Complaint and appeal address About Page • The functions of the RAE • What Is a Regional Organization? with a service area map of the counties NHP • Serves	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• The basic features of a Primary Case Management Entity (PCCM) and Prepaid Inpatient Health Plan (PIHP). Member Page • Find a Provider • Care Coordination responsibilities • Member Survey Results with the results of member satisfaction surveys • Benefits and Services ➢ Information about services that we do not cover because of moral or religious objections ➢ Freedom of Choice in providers ➢ What behavioral health benefits are covered? ➢ What physical health benefits are covered? Please see CAHPS_Summary, entire document that is also located on our website under member survey results. Members can request for any information from the website to be printed and sent to them free of charge. NHP will send any requested information to a member within five business days. See	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	MemberMaterialRequestJobAidand MemberMaterialsSent. **Texting Campaigns** Newly eligible members are enrolled in a welcome and benefit texting campaign through our vendor, Virgin Pulse. This campaign is designed to help members understand the requirements and benefits of their health plan. The messages include but are not limited to: Welcome message, member handbook information, website link information, well child benefit information, the nurse advice line number, member rights, advance directives, vaccinations, behavioral health, crisis services, and how to get an insurance card. Please see WelcomeandBenefitTextMessages and TextingReport. **Automated Calls** NHP uses an Interactive Voice Response (IVR) automated calling system to outreach newly enrolled EPSDT-eligible and newly identified pregnant members within 60 days of their enrollment. The message states “Hi, it’s Northeast Health Partners calling, your Colorado Medicaid health plan. We would like to tell you about your benefit information which includes well visits, dental visits, and vision screens. You can press 1 to	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	be connected to a live person who can tell you about your health benefits. You may also call 1-888-502-4189. Again, that number is 888-502-4189." **Constant Contact Emails** NHP uses Constant Contact, which is an online platform that is utilized to send emails in bulk. NHP sends an invitation to the monthly "getting started" virtual webinar to members who have given consent to receive emails. NHP has included an example of one of the invitations sent to members. See ConstantContactInvitation. **Social Media Posts** NHP uses social media sites such as Facebook, X (Formerly known as Twitter) and Instagram to post information about upcoming events or health related topics. Our social media sites have our toll free number, email address, and website address. See SocialMediaPost..	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The RAE provides member information by either: • Mailing a printed copy of the information to the member's mailing address. • Providing the information by email after obtaining the member's agreement to receive the information by email. • Posting the information on the website of the RAE and advising the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost. • Providing the information by any other method that can reasonably be expected to result in the member receiving that information. *42 CFR 438.10(g)(3)* RAE Contract: Exhibit B-8—None	**Documents Submitted:** 1. HCPFWelcomeLetter, entire document 2. HCPFWelcomeLetterEvidence, entire document 3. CoverSheet, entire document 4. WelcomeandBenefitTextMessages, line #10 5. GettingStartedGuideEN, entire document 6. GettingStartedGuideSP, entire document 7. NHPOutreachEvents, entire document 8. EmailAddressReport, entire document 9. ConstantContactInvitation, entire document 10. GettingStartedInvitationEN, entire document 11. GettingStartedInvitationSP, entire document 12. DHSPresentation, entire document 13. NovProviderNewsletter, page 3 14. CallCenterContCovTraining, entire document 15. CareCoordinationPresentation, entire document 16. ProviderRoundtable, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Description of Process: NHP provides member information through a variety of platforms, which are outlined below. **Mail** NHP leverages the welcome letter mailed by Health Care Policy and Financing (HCPF) to all newly enrolled members. The welcome letter has NHP's website information and phone contact information and indicates that the regional organization can help members obtain the health care services they need. The welcome letter outlines how members can obtain a member handbook and has NHP's phone number and website information. Additionally, NHP confirmed with HCPF that the HCPF Welcome Letter submitted in this audit is the most recent template. See HCPFWelcomeLetter, and HCPFWelcomeLetterEvidence. Additionally, NHP attaches a cover sheet to all mailed correspondence that provides our website link. The cover sheet has taglines alerting members of the availability of auxiliary aids at no cost to them. See CoverSheet.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Website The predominant method NHP uses to provide member information is through our website at https://www.northeasthealthpartners.org. NHP's website has a pop-up box which states "If you need any document from our website in large print, Braille, other formats or languages, or read aloud, please contact us. We will send this to you free of charge within five (5) business days. We can also connect to language services or help you find a provider with ADA accommodations. Our number is 888-502-4189. If you have speech or hearing disabilities, there are auxiliary aids you may use (TTY/TDD/American Sign Language at 800-432-9553 or State Relay 711). These services are free." NHP has several member materials on our website to help members with their health care needs including, but not limited to Wellness and Prevention Information Sheets, the member handbook, and "getting started" guides. All of these written materials have our contact information, including our website address. NHP promotes our website through a welcome and benefits message, which is sent to new members through our vendor, Virgin Pulse. The message states, "Want a copy of your member handbook?	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Need to find a doctor? Visit www.northeasthealthpartners.org to check out all of the information and tools we offer." Please see WelcomeandBenefitsTextMessages, line 10. NHP participates in several community events throughout the year such as Weld County's chapter of the National Alliance on Mental Illness (NAMI), family festivals and community health forums. NHP brings informational material with our contact information, including our website address to these events to distribute to members. NHP also distributes our "getting started" guide with our website address to members at these events. See GettingStartedGuideEN, GettingStartedGuideSPand NHPOutreachevents. **Email** NHP obtains members' email addresses and consent when they contact our call center. The call center staff informs members that the email is to send them health information. NHP developed a monthly report to document the members that have consented to use their email address. NHP's constant contact email has information about how members can participate in our "getting started" webinar and also includes our email address. For an example of an email sent to members, see a	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	sample of one month of compiled email address in our EmailAddressReportand for a copy of the invitation we sent, see ConstantContactInvitation.. **DHS meetings** NHP identified that the first point of contact for newly enrolled members are the eligibility technicians at the Department of Human Services (DHS) offices. NHP's member engagement team has met with the eligibility technicians in our 10 counties to leverage those relationships. The member engagement team provides eligibility technicians with information that they can give to our members and outlines all of the opportunities for member engagement. This information includes our "getting started" guide and a "getting started" invitation. The "getting started" invitation has our website information, information on how to request help in other languages and a QR code to direct members to the new member welcome packet located on our website. The getting started invitation is also distributed in the provider newsletter. See: GettingStartedInvitationENGettingStartedInvitatio nSPGettingStartedGuideEN GettingStartedGuideSP DHSMeeting, slides 6, 8.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Virtual Webinar NHP hosts a "getting started" virtual webinar on the first Thursday of each month to educate members, family members, or health care professionals about member benefits and requirements of their health plan. Information about the getting started webinar is located in our provider newsletter and announced at care coordination meetings. See NovProviderNewsletter, page 3 and CareCoordinationPresentation, slide 9. **Trainings** NHP understands that our call center associates and our health care professionals have direct member contact either telephonically, in person, or through our email address. NHP meets with the call center leadership and/or team and health care professionals to keep associates and health care professionals informed of member benefit information, wellness and prevention resources, renewal information and other available member materials . NHP encourages associates and health care professionals to verbally communicate member information and distribute member materials to members either in print form or by	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	directing members to our website. For examples of the member information we make available to associates and health care professionals, see slide decks from: • CallCenterContCovTraining • CareCoordinationPresentation • ProviderRoundtable	
18. The RAE must make available to members, upon request, any physician incentive plans in place. *42 CFR 438.10(f)(3)* RAE Contract: Exhibit B-8—None	**Documents Submitted:** **1.** ProviderIncentivePlans, entire document **Description of Process:** NHP incentivizes providers/physicians under our quality performance plans. NHP will make available to members upon their request the physician incentive plans we currently have in place by providing NHP's Physician Incentive Plans document. Members are informed about their right to request any physician incentive plan on our website under our Find a Provider link. The website states, "A member can ask for NHP's physician incentive plans by calling us at 888-502-4189. Members may also email this request to northeasthealthpartners@carelon.com or by completing the contact form on our website." NHP will mail our physician incentive plans to members upon their request. For a copy of our provider incentive plans, see ProviderIncentivePlans.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements written policies and procedures for selection and retention of providers. *42 CFR 438.214(a)* RAE Contract: Exhibit B-8—9.1.6	**Documents Submitted:** 1. NWCO 003 Network Development Access and Availability Standard – Pages 1, 11. 2. R2_GeoAccess Compliance - Entire Document 3. R2_Provider_Support_Newly Contracted Provider – Entire Document 4. R2_ProviderSupport_Webinars_Trainings – Entire Document 5. NHP-Behavioral-Health-Medicaid-Provider-Handbook, page 23 *Misc. **Description of Process:** NHP has policies in place to select providers (NWCO 003 Network Development Access and Availability Standard). This policy stated that NHP will contract with "any willing Community Mental Health Center, Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider" and stipulates that it will recruit Primary Care Medical Providers and Behavioral Health Practitioners who represent racial and ethnic communities and can serve members with limited English proficiency. The policy is based on network monitoring through the review of network adequacy tools at least quarterly. An example of the network adequacy tools used is the	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	GeoAccess analysis generated quarterly (R2_GeoAccess Compliance). For retention of providers NHP maintains "good collaborative relationships with providers through onboarding process and on-going provider supports available through webinars and newsletters." Additionally, we utilize administrative communication tools to foster an open communication for timely response to inquiries and issue resolution. All of these documents are available to providers via the NHP website under the Provider Section. Examples of information available to providers are "R2_Provider_Support_Newly Contracted Provider" which is a dedicated page to assist in the onboarding process, and "R2_ProviderSupport_Webinars_Trainings" which includes historical webinars and newsletters for providers to access as needed. Finally, NHP Behavioral Health Medicaid Provider Handbook outlines how Providers can address Complaints, Grievances, and Appeals to Support issue resolution.	
2. The Contractor follows a documented process for credentialing and recredentialing of providers that complies with the standards of the National Committee for Quality Assurance (NCQA). • The Contractor ensures that all laboratory testing sites providing services under this contract have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration.	**Documents Submitted:** 1. CR 218.14 Credentialing Criteria for Facility, Organizational Providers-Entire Document and Pages 4-5, section VI. **Description of Process:** NHP delegates credentialing and recredentialing of providers to Carelon, following	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.214(b) RAE Contract: Exhibit B-8—9.3.5.2.1 and 9.3.6	Credentialing policy CR 218.14 **(**Credentialing Criteria for Facility, Organizational Providers). This policy outlines the criteria and circumstances for Laboratories or Clinical Laboratories serving in their Behavioral Health network and the requirement for the CLIA certificate for medical services. Carelon ensures that all laboratory testing sites have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration. In policy CR 218.14 Credentialing Criteria for Facility, Organizational Providers - section VI (Page 2) provides a documented process for credentialing and recredentialing of providers that complies with the standards of the National Committee for Quality Assurance (NCQA).	
3. The Contractor's provider selection policies and procedures include provisions that the Contractor does not: • Discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. • Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42 CFR 438.12(a)(1) and (2)* *42 CFR 438.214(c)*	**Documents Submitted:** 1. CR 226.11 Prevention and Monitoring of Non-Discriminatory Credentialing and Re-Credentialing -Page 2 & 3 2. BH_Practitioner_Agreement-Pages 17-18, 27-28, 41, 48 **Description of Process:** NHP does not discriminate against providers for acting within the scope of their license or providing services to Members that require costly treatment, as per the BH_Practitioner_Agreement. The agreement states on Exhibit C-4 section B.5 (pg. 48): "Neither	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
RAE Contract: Exhibit B-8—9.1.6.1-2	Carelon nor Payors will prohibit, or otherwise restrict, Provider, acting within the scope of his/her professional license and scope of practice, from advising or advocating on behalf of a MCD Member who is his or her patient; including providers that serve high risk population or specialized conditions that require costly treatment." Additionally, policy CR 226.11 Prevention and Monitoring of Non-Discriminatory Credentialing and Re-Credentialing, ensures that decisions regarding credentialing are not based on an applicant's race, ethnic/national identity, gender, age, religion, disability, and/or sexual orientation; nor does it discriminate against a health care professional on the basis of licensure, registration, or certification; the type of procedure or patient population being served, or any health care professional who serves high-risk populations or the type of procedure in which the practitioner specializes; or who specializes in the treatment of conditions that require costly treatment.	
Findings: Carelon submitted policy CR 226.11 titled *Prevention and Monitoring of Non-discriminatory Credentialing and Re-Credentialing* (last reviewed/approved on January 12, 2024). The policy did not include language stating the RAE would not "discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification."		
Required Actions: Carelon must revise the policy to include language stating Carelon does not "discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification."		

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This is not construed to: • Require the Contractor to contract with providers beyond the number necessary to meet the needs of its members. • Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. • Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members. *42 CFR 438.12(a-b)* RAE Contract: Exhibit B-8—9.1.6.4, 9.1.9, and 14.4.11	**Documents Submitted:** 1. NWCO 003 Network Development Access and Availability Standard- Page 1, 5, 11 2. N_Practitioner Non-Response Letter – Entire Document 3. Denial Letter-Entire Document **Description of Process:** NHP maintains an open network for Primary Care Medical Providers (PCMPs) and behavioral health providers as stated in NWCO 003 Network Development Access and Availability Standard. This document states that we "will contract with any willing PCMP that meets Medicaid requirements. NHP will contract with any willing Community Mental Health Center, Federally Qualified Center, Rural Health Center and Indian Health Care Provider. NHP also maintains an open network for public and private providers, including independent practitioners, that meet Medicaid and credentialing requirements." Providers who do not respond to requests for documentation to complete contracting and credentialing within 80 days of initial request to join the network will be denied from completing the process. Providers are issued a follow up communication that includes notice of denial should there be no response within established timeframes	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	(N_Practitioner Non-Response Letter). Additional reasons that a provider may be excluded may be if they are applying for Medicaid without a Medicaid enrollment, OIG exclusion, if licensure or education doesn't match the level of care they are applying for. If Carelon determines that the provider does not meet credentialing criteria, providers are notified in writing, of any decision to deny inclusion of practitioners in the network and the reason for the denial (see Denial Letter).	
5. The Contractor has a signed contract or participation agreement with each provider. *42 CFR 438.206(b)(1)* RAE Contract: Exhibit B-8—9.1.13	**Documents Submitted:** 1. BH_Practitioner_Agreement_Executed – Entire Document 2. R2_PCMP Agreement_Executed – Entire Document 3. R2_PCP_ContractStatus – Entire Document **Document Description of Process:** NHP completes and maintains a signed contract or participating agreement with each practitioner in the network. This is evidenced by examples of the signed behavioral health practitioner agreement and the signed primary care provider agreement. See: • BH_Practitioner_Agreement_Executed • R2_PCMP Agreement_Executed R2_PCP_ContractStatus_FY2023 demonstrates a tracking mechanism used to track signed contracts by Physical Health Care Providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor does not employ or contract with providers or other individuals or entities excluded for participation in federal health care programs under either Section 1128 or 1128 A of the Social Security Act. • The Contractor performs monthly monitoring against HHS OIG's List of Excluded Individuals. *(This requirement also requires a policy.)* *42 CFR 438.214(d)* *42 CFR 438.610* RAE Contract: Exhibit B-8—9.1.15 and 17.10.5	**Documents Submitted:** 1. CR 211.15 Ongoing Monitoring of Practitioner and Organizational Provider Sanctions – Entire Document 2. Sanctions Review Log 2023-Entire Document 3. NHP_Compliance_2_ScreeningAgainstExclusionOwnershipAndControlDisclosurePolicy_221220 4. NHP_BackgroudCheck_ExclusionsCheck_Attestation-Entire Document 5. CO 029.17 Screening Against Exclusion Lists_09.24, Pgs. 6-8 **Description of Process:** NHP does not employ or contract with providers or other individuals or entities excluded from participation in federal health programs under section 1128 or 1128 A under the Social Security Act, and has established policies to perform exclusion screening checks as required by federal and state agencies (see NHP_Compliance_2_ScreeningAgainstExclusionPolicy) CO 029.17 Screening Against Exclusion Lists_09.24 includes the list of databases screened prior to hire/contracting and monthly thereafter, includes responsibility and process to complete. It is the policy of Carelon that all credentialed providers or provisionally credentialed practitioners (as available or as required by State or Federal mandate or client request) are monitored between recredentialing cycles for possible sanctions by the Office of the Inspector	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	General (OIG) for Medicare/Medicaid sanctions, the General Service Administration's (GSA) database of Federal Sanctions, the Office of Foreign Assets Control (OFAC) database of individuals and/or entities involved with terrorists and/or terrorist activities, the appropriate state agency, state licensure or certification board, and the Medicare Opt-Out listings for exclusions from Medicare programs, the National Plan & Provider Enumeration System (NPPES) and the Social Security Death Master File (SSDMF/SSDI). Reports of disciplinary/sanction activity are reviewed on a regular basis either monthly or consistent with the reporting entity's publishing cycle if the publishing cycle is greater than monthly. CR 211.15 Ongoing Monitoring of Practitioner and Organizational Provider Sanctions outlines the monthly monitoring process and guidelines NHP follows to performs the monitoring within the Office of the Inspector General (OIG) for sanctions against practitioners and/or providers. These findings are documented on the Sanctions Review Log 2023.	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549. *42 CFR 438.610* RAE Contract: Exhibit B-8—17.9.4.2.3	**Documents Submitted:** 1. N_CR 206.20 Primary Source Verification-Page 6 2. PSV Checks Example – Entire Document 3. NHP_Compliance_2_ScreeningAgainstExclusionOwnershipAndControlDisclosurePolicy_221220-Entire Document **Description of Process:** NHP does not knowingly employ, partner, subcontract, or otherwise partner with any person who is disbarred, suspended, or otherwise excluded from participating in procurement or nonprocurement under federal acquisition regulation. NHP, includes within its credentialing elements a process by which to monitor "any persons defined as disclosing entities with more than 5% ownership or control. Queries are made in the National Practitioner Data Bank within 180 calendar days of the final credentialing decision date to verify if there have been any disciplinary actions against clinical privileges, sanctions or adverse actions enacted against provider by licensure boards, exclusions or disbarments by Medicare, or Medicaid, any reported sanctions, fraudulent activity, professional misconduct, or criminal offenses". Any identified sanctions or exclusions for those individuals are presented to the National Credentialing Committee for appropriate action. Evidence is the policy N_CR 206.20 Primary Source Verification and the sanction	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	checks as seen in the Primary Source Verification PSV Checks Example. The documents cited (see: NHP_Compliance_2_ScreeningAgainstExclusionOwnershipAndControlDisclosurePolicy_221220)demonstrate that NHP does not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549.	
Findings: Carelon submitted a policy titled *Screening Against Exclusion and Ownership and Control Disclosures* (last reviewed/approved on December 12, 2022), which excluded the term "suspended" from the language within the policy.		
Required Actions: Carelon must revise its policies to include the terms "excluded, suspended, and debarred" to ensure that Carelon does not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulations or Executive Order 12549.		
8. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: • The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered. • Any information the member needs in order to decide among all relevant treatment options.	**Documents Submitted:** 1. BH_Practitioner_Agreement-Page 48, 51 2. CR 226.11 Prevention and Monitoring of Non-Discriminatory Credentialing and Re-Credentialing- Page 1 **Description of Process:**	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The risks, benefits, and consequences of treatment or non-treatment. • The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. *42 CFR 438.102(a)(1)* RAE Contract: Exhibit B-8—14.7.3	The BH_Practitioner_Agreement states on Exhibit C-4, B,5: "There will be no prohibiting, or otherwise restrict, Provider, acting within the scope of his/her professional license and scope of practice, from advising or advocating on behalf of a MCD Member who is his or her patient; including providers that serve high risk population or specialized conditions that require costly treatment." Further, Exhibit C-4, I,1 Provider-Member Communication states: "(1) Nothing under this Agreement prohibits, or otherwise restricts, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an MCD Member who is his or her patient, for the following: (a) The MCD Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered. (b) Any information the MCD Member needs in order to decide among all relevant treatment options. (c) The risks, benefits, and consequences of treatment or non-treatment. (d) The MCD Member's right to participate in decisions regarding his or her health are, including the right to refuse treatment, and to express preferences about future treatment decisions." NHP, has supporting documentation referencing Prevention and Monitoring of Non-Discriminatory Credentialing and Re-Credentialing where it states that there is no discrimination against providers who	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	act within the scope of his/her license for advising or acting on the behalf of members.	
Findings: Carelon submitted its behavioral health provider agreement template that included all of the required language; however, the language was not located within NHP's PCMP agreement.		
Required Actions: NHP must revise the PCMP agreement to include language stating that NHP does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: • The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered. • Any information the member needs in order to decide among all relevant treatment options. • The risks, benefits, and consequences of treatment or non-treatment. • The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.		
9. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: • To the State upon contracting or when adopting the policy during the term of the contract. • To members before and during enrollment. • To members 30 days prior to adopting the policy with respect to any particular service. *42 CFR 438.102(a)(2)-(b)* RAE Contract: Exhibit B-8—7.3.6.1.13-14 and 14.4.8	**Documents Submitted:** 1. NHP-Behavioral-Health-Medicaid-Provider-Handbook -Page 16 *Misc. 2. NHP-PCMP-Provider-Handbook-Page 20 and 22 *Misc. 3. 310L_NonDiscrimination Policy - Entire Document **Description of Process:** NHP does not allow discrimination therefore, there is no reason to report to the State. The full policy, 310L_NonDiscrimination, affirms its position on non-discrimination with a clear statement on I.a. (page 1) that it does not "discriminate against Members	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Medicaid provider through the Colorado Department of Health Care Policy and Financing. Under certain circumstances, members may request an out-of-network behavioral health provider." As for a Primary Care Provider, stated in the NHP-PCMP-Provider-Handbook, in accordance with the Department of Health Care Policy & Financing, providers may not dismiss Members based on the Member's gender, race, religion, or sexual orientation. Due to NHP's policy to not discriminate, the Member cannot be dismissed due to moral or religious reasons.	
10. The Contractor has administrative and management arrangements or procedures, including a compliance program to detect and prevent fraud, waste, and abuse and includes: • Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal, State, and contract requirements. • The designation of a compliance officer who is responsible for developing and implementing policies, procedures and practices to ensure compliance with requirements of the contract and reports directly to the Chief Executive Officer and Board of Directors. • The establishment of a Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program.	**Documents Submitted:** 1. 2023 Elevance Code of Conduct-Entire Document 2. R2_CompPln_FY23-24, Pgs. 5-12, Pg. 6 & 7, Pg. 8, Pg. 13, Pg. 17 3. 2023 Carelon Behavioral Health Compliance Program Description-Entire Document 4. CO 101.11 Compliance Program Activities, Pg. 9 5. CO 100.10 Compliance Program Structure_11.24-Entire Document 6. 2023 Carelon Behavioral Health Risk Assessment Summary-Entire Document 7. 2023 Carelon Behavioral Health Compliance Work Plan Summary-Entire Document 8. PRIV 30.12 HIPAA Intake and Investigations, Pg. 3 D.; Pg. 4. E, Pg 6 A.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Training and education of the compliance officer, management, and organization's staff members for the federal and State standards and requirements under the contract. • Effective lines of communication between the compliance officer and the Contractor's employees. • Enforcement of standards through well-publicized disciplinary guidelines. • Implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks. • Procedures for prompt response to compliance issues as they are raised, investigation of potential compliance problems identified in the course of self-evaluation and audits, correction of such problems quickly and thoroughly to reduce the potential for reoccurrence, and ongoing compliance with the requirements under the contract. *42 CFR 438.608(a)(1)* RAE Contract: Exhibit B-8—17.1.3 and 17.1.5.1-7	9. NHP Incident Report_01.01.23_12.31.23-Entire Document 10. PRIV 30D Disciplinary Guidelines for Privacy Violations-Entire Document 11. 2023 Carelon BH Do The Right Thing Course Content 12. CO 102.13 Policy Development Management_10.24-Entire Document 13. 04.19.23 NHP External Compliance Minutes-Protected-Entire Document 14. 05.18.23 NHP Internal Compliance Agenda-Entire Document 15. R2_CompPln_FY23-24_Activities_Grid-Entire Document 16. HCCA Cert KLS-Entire Document 17. NHP_Compliance_ConflictOfInterestAttestationDisclosure_220909-Entire Document **Description of Process:** NHP has robust administrative management arrangements to detect and prevent fraud, waste, and abuse (R2_CompPln_FY23-24). Additionally, the 2023 Elevance Code of Conduct includes a table of contents to confirm the commitment to Behavioral Health's regulatory requirements and business integrity. The 2023 Carelon Behavioral Health Program Description and R2_CompPln_FY23-24 documents include the seven fundamental elements of an effective compliance plan and guidelines for consistent compliance processes identified by the	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Office of the Inspector General for the United States Department of Health and Human Services. Policy CO 101.11 Compliance Program Activities_11.24 provides guidelines for compliance activity processes to ensure consistency throughout the company and CO 100.10 Compliance Program Structure_11.24 explains the roles and responsibilities of the compliance committees and staff members. Element I: Written Policies, Procedures and Standards of Conduct include the commitment to conduct business practices that satisfy all regulatory requirements. This element also includes policies and procedures that are reviewed and updated annually to ensure compliance, demonstrated in CO 102.13 Policy Development Management_10.24. Element II: Confirms the designation of the Compliance Officer with unfettered access to the Board of Directors and functions independently and objectively to oversee the day-to-day activities related to the Compliance Program as shown in R2_CompPln_FY23-24. HCCA Cert KLS Element III supports compliance awareness across all levels of the organization and requires specified new hire training within 90 days of employment and annually thereafter as a condition of employment hire date in CO 101.11 Compliance Program Activities_11.24. All employees complete new hire	

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

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Element VII: Procedures and System for Prompt Response to Compliance Issues are responded to and addressed promptly. PRIV 30.12_HIPAA Intake and Investigation outlines the preliminary assessment and immediate response including details of the investigation process to identify, mitigate, and prevent future occurrences and the degree of discipline necessary for the level of violation. Initial and final notification to the client shall be in accordance with the BAA or client contract. The NHP Incident Report_01.01.23_12.31.23 documents the incident date, mitigation steps taken and final determination of one NHP regulatory violations for the reporting period requested. NHP holds both internally and externally-facing quarterly compliance meetings. These meetings cover topics including program integrity, audits, staffing updates, Compliance Hotline reporting, trainings, and any issues surfaced within the last quarter. See 05.18.23 NHP Interrnal Compliance Agenda 04.19.23, NHP External Compliance Minutes, and R2_CompPln_FY23-24_Activities_Grid as supporting documentation. Compliance meetings are chaired by NHP's Chief Compliance Officer, who holds a Certification in Healthcare Compliance (CHC) credential (see HCCA Cert KLS). Additionally, NHP requires staff to complete an annual conflict of interest disclosure to identify compliance	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	risks and to ensure NHP adheres to applicable state, federal, and contractual requirements (see NHP_Compliance_ConflictOfInterestAttestationDisclosure_220909.)	
Findings: NHP delegated a significant operational aspect of its compliance program to Carelon. While Carelon was able to describe the features of the compliance program, NHP did not have sufficient oversight and monitoring of Carelon's compliance activities. While NHP described educational compliance meetings with providers and quarterly compliance meetings between Carelon and NHP, NHP provided no evidence that it held strategic oversight of the compliance program or took ownership of developing and implementing policies, procedures, and practices to ensure compliance. For example, the ethics statement was provided through Elevance Health's Code of Conduct (Elevance Health is a parent company of Carelon) and all of the policies and procedures related to program integrity were from Carelon.		
Required Actions: While aspects of the compliance activities may be delegated, the ongoing strategy, monitoring, and oversight must be overseen by NHP. NHP must strengthen its documentation of internal NHP compliance monitoring procedures.		
11. The Contractor's administrative and management procedures to detect and prevent fraud, waste, and abuse include: • Written policies for all employees, subcontractors or agents that provide detailed information about the False Claims Act, including the right of employees to be protected as whistleblowers. • Provisions for prompt referral of any potential fraud, waste, or abuse to the Department and any potential fraud to the State Medicaid Fraud Control Unit. • Provisions for suspension of payments to a network provider for which the State determines there is credible allegation of fraud (in accordance with 455.23). *42 CFR 438.608(a)(6-8)*	**Documents Submitted:** 1. CO 310.9 Compliance with Fraud Waste and Abuse Laws and Regulations, Pg. 2. A. & B. and Pg. 5, M. 2. R2_CompPln_FY23-24 Pg. 12-23 3. R2_MonthlyFWARpt-Entire Document 4. R2_FWARpt_SemiAnnual-Entire Document 5. SIU 431.3 Provider Payment Suspension Final Draft 2023031-Entire Document 6. 05.18.23 NHP Interrnal Compliance Agenda-Entire Document 7. 04.19.23 NHP External Compliance Minutes-Entire Document 8. R2_CompPln_FY23-24_Activities_Grid - Entire Document **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
RAE Contract: Exhibit B-8—17.1.5.9, 17.1.6, 17.5.1, and 17.7.1 10 CCR 2505-10, Section 8.076	In CO 310.9 Compliance with Fraud Waste and Abuse Laws and Regulations policy provides guidelines to comply with federal and state laws and regulations related to fraud, waste and abuse including the Federal False Claims Act, Deficit Reduction Act and Whistleblower Employee Protection Act. In the R2_CompPln_FY23-24 (pg. 12-23), the Fraud, Waste and Abuse (FWA) Plan Purpose and Scope section states the purpose of NHPs' FWA Plan is to demonstrate the manner in which NHP and affiliated entities comply with the requirements of the Deficit Reduction Act of 2005 and its obligations related to FWA. Any contractor who received or made Medicare/Medicaid payments in the amount of at least five (5) million dollars during the previous Federal Fiscal Year must comply with all federal requirements for employee education regarding Federal False Claims Act, any applicable state False Claims Act, the right of employees to be protected under Qui Tam (whistleblower) provisions and the organization's policies and procedures for detecting and preventing FWA (see Page 13 of R2_CompPln_FY23-24). NHP reports any suspicion or knowledge of fraud and abuse as required by contractual and federal and state regulatory requirements. NHP will submit the Managed Care Suspected Fraud Written Notice within three (3) business days following the initial discovery	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	or suspicion. Within five (5) business days of overpayment identification, NHP will submit information and complete information will be provided within 30 calendar days (see Page 19 of R2_CompPln_FY23-24). Additionally, NHP reports to the Department of Health Care Policy & Financing on a monthly and semi-annual basis any activities regarding FWA, including overpayments (R2_MonthlyFWARpt and R2_ FWARpt_SemiAnnual). When deemed appropriate and approved by HCPF, NHP suspends payments to a provider after NHP, its clients, and/or government agencies determine there is a credible allegation of fraud for which an investigation is pending against the provider, as defined in 42 C.F.R. §455.23 (see Page 17 of R2_CompPln_FY23-24). SIU 431.3 Provider Payment Suspension Final Draft 2023031 outlines the procedure and process Carelon Behavioral Health follows when suspending provider payments. NHP also holds internal and external compliance meetings on a quarterly basis with topics including program integrity, audits, staffing updates, Compliance Hotline reporting, trainings, and any issues surfaced within the previous quarter. See 05.18.23 NHP Interrnal Compliance Agenda, 04.19.23 NHP External Compliance Minutes, and R2_CompPln_FY23-24_Activities_Grid as supporting	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	documentation. Compliance meetings are chaired by NHP's Chief Compliance Officer.	
12. The Contractor's Compliance Program includes: • Provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potential fraud. • Provision for prompt notification to the State about member circumstances that may affect the member's eligibility, including change in residence and member death. • Provision for notification to the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including termination of the provider agreement with the Contractor. • Provision for a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. *42 CFR 438.608 (a)(2-5)* RAE Contract: Exhibit B-8—17.1.5.7.1, 17.1.5.7.2-6, 17.3.1.1.2.3-4, and 17.3.1.3.1.1	**Documents Submitted:** 1. R2_CompPln_FY 23-24 Entire Document and pages 18 and19 2. Member Verification Sample letter_NHP – Entire Document 3. MemberChangeJobAid-Entire Document 4. DeceasedMemberTemplate-Entire Document 5. NHPMemberChangeReport2023_PHIdeidentified-Entire Document 6. R2_MonthlyFWARpt-Entire Document 7. R2_FWARpt_SemiAnnual-Entire Document 8. 05.18.23 NHP Interrnal Compliance Agenda-Entire Document 9. 04.19.23 NHP External Compliance Minutes-Entire Document 10. R2_CompPln_FY23-24_Activities_Grid-Entire Document 11. 2023-9-6-Affiliations Table-Entire Document 12. Region 2 Contract Workbook ACC Phase II Submission- Entire Document **Description of Process:** NHP has a compliance plan in place and reports any suspicion or knowledge of fraud and abuse as required	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	by contractual and federal and state regulatory requirements. NHP will submit the Managed Care Suspected Fraud Written Notice within three (3) business days following the initial discovery or suspicion. Within five (5) business days of overpayment identification, NHP will submit information and complete information will be provided within 30 calendar days (see Page 19 of R2_CompPln_FY23-24). Additionally, NHP reports to the Department of Health Care Policy & Financing on a monthly and semi-annual basis any activities regarding FWA, including overpayments. (R2_MonthlyFWARpt and R2_ FWARpt_SemiAnnual). NHP has processes in place to promptly notify HCPF about any changes in member circumstances that may affect the member's eligibility, including a change in residence and member death. NHP developed a Member Change Job aid which we follow to ensure timely notification to HCPF of any change in member circumstances. The job aid outlines how we may identify a change in a member's circumstance. The four primary ways we would learn about a change in a member's circumstance is through the Quality Team, Call Center Team, Care Coordination Team, and Returned Member Mail. The job aid outlines how member deaths are reported in HCPF's ACC Program External Site and in the member change report. The job aid also outlines who we report a change in	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	members' residence. See MemberChangeJobAid, entire document. NHP developed a form for care coordinators to report a member's death which mirrors the information required in HCPF's ACC Program External Site. Care coordinators send the member death notification for Health First Colorado members template to NHP. NHP records any notification of member death in HCPF's database within five business days. Member death notification is also included in the monthly member change report due to HCPF the fifth day of each month. See DeceasedMemberTemplate, entire document and NHPMemberChangeReport2023, entire document. On an annual basis, Carelon Behavioral Health sends out member verification surveys to a sample of selected RAE members to solicit response confirming that services have been received by members as billed (Member Verification Sample letter_NHP). NHP conducts regular claims sampling, medical record review, and/or data validation of providers (see R2_CompPln FY 23 24). NHP also holds internal and external compliance meetings on a quarterly basis with topics including program integrity, audits, staffing updates, Compliance Hotline reporting, trainings, and any issues surfaced within the previous quarter. See	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	05.18.23 NHP Interrnal Compliance Agenda 04.19.23 NHP External Compliance Minutes, and R2_CompPln_FY23-24_Activities_Grid as supporting documentation. Compliance meetings are chaired by NHP's Chief Compliance Officer. The process for communicating provider changes to the Sate starts with entering changes go into the state database by the 15th of the month. Then the Contract Workbook (Region 2 Contract Workbook ACC Phase II Submission) is sent to the RAE to notify the RAE of any changes. Then the following month by the 10th, Carelon receives an updated Affiliations Table of PCMP providers from HCPF showing the changes have been made.See 2023-9-6-Affiliations Table. Attached is the August 2023 Change Table showing 3 providers that were removed from PCMP and the 9.6.23 Affiliations table showing that they have been removed (by search of NPI).	
13. The Contractor ensures that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure screening, and enrollment requirements of the State. • The Contractor may execute network provider agreements pending the outcome of the State's screening and enrollment process of up to one-hundred and twenty days (120) days, but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of	**Documents Submitted:** 1. N_CR 206.20 Primary Source Verification, page 5 2. Providers_Pending_Disenrollment– Entire Document *Misc. 3. Sanctions Review Log 2023-Entire Document 4. ProviderTermLetter-Entire Document *Misc. **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
one one-hundred and twenty days (120)-day period without enrollment of the provider, and notify affected members. *42 CFR 438.608(b)* RAE Contract: Exhibit B-8—9.2.1.1, 9.3.2, and 17.9.2	As the delegated entity, the Carelon Credentialing team performs primary source state-required verification for Medicaid provider enrollments during credentialing and recredentialing. This includes review of the enrollment using the state-specific Medicaid Management Information System (MMIS). These verifications are performed within 180 days of the credentialing and recredentialing decision date using the state's process as outlined in N_CR 206.20 Primary Source Verification . Regarding disenrollments, the Credentialing team will make recommendations for disenrollment if the provider no longer meets the criteria of an in-network provider including notification from the State. The Disenrollment process is completed by a dedicated team in accordance with NCQA, Federal, State, Client and Organizational guidelines. This team communicates the disenrollment to the providers, and that process triggers member letters to all affected members attached to that provider. Credentialing conducts a weekly meeting with Provider Relations and Contracting associates to review a report of all providers who are on the path to disenrollment, including their claims counts, so that we have additional reinforcement in trying to prevent disenrollment of/retaining high utilization providers. On a weekly basis, Beacon runs a report of providers pending disenrollment and includes reason for the disenrollment. The report is reviewed by staff to confirm disenrollment is accurate. Once confirmed,	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Member Services is notified to send letter to affected members. See ProviderTermLetter. Enclosed is an example of the report and internal communication regarding the termination "Providers_Pend_Disenrollment." Sanctions Review Log 2023 is the record maintained of these monthly sanction checks. On a weekly basis, Careon runs a report of providers pending disenrollment and includes reason for the disenrollment.	
14. The Contractor has procedures to provide to the State: • Written disclosure of any prohibited affiliation (as defined in 438.610). • Written disclosure of ownership and control (as defined in 455.104) • Identification within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract. *42 CFR 438.608(c)* RAE Contract: Exhibit B-8—17.3.1.5.1.1, 17.9.4.3, and 17.10.2.1	**Documents Submitted:** 1. R2_QuarterlyFinInfo_Q4FY22-23 on tab: Admn PMPM Exp. 2. BH_Practitioner_Agreement 22-23-Entire Document 3. BH_Practitioner_Agreement_Executed-Entire Document 4. NHP-Behavioral-Health-Medicaid-Provider-Handbook -Page26-27 *Misc 5. R2_PCMP_Agreement-Page 8 6. R2_PCMP_Agreement_Executed-Entire Document 7. N_CR 206.20 Primary Source Verification-Page 6 8. NHP_Compliance_2_ScreeningAgainstExclusionOwnershipAndControlDisclosurePolicy_221220 9. PSV Checks Example-Entire Document 10. CO 029.17 Screening Against Exclusion Lists_09.24, Pgs. 11&12	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	11. CO 303.2 Conflict of Interest_10.24, Entire Document **Description of Process:** NHP includes within its credentialing elements a process by which to monitor "any persons defined as disclosing entities with more than 5% ownership or control" and "queries the National Practitioner Data Bank within 180 calendar days of the final credentialing decision date to verify if there have been any disciplinary actions against clinical privileges, sanctions or adverse actions enacted against provider by licensure boards, exclusions or disbarments by Medicare, or Medicaid, any reported sanctions, fraudulent activity, professional misconduct, or criminal offenses". Any identified sanctions or exclusions for those individuals are presented to the National Credentialing Committee for appropriate action. Evidence is policy N_CR 206.20 Primary Source Verification and the sanction checks as seen in the Primary Source Verification PSV Checks Example. CO 029.17 Screening Against Exclusion Lists_09_24 addresses disclosure of ownership and control. CO 303.2 Conflict of Interest_10.24 covers the requirements to disclose and report any potential conflicts of interest and provides a list of most common examples to report.	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	For Primary Care Providers, regarding the capitation payments or other payments in excess of the amounts specified in the contract, NHP conducts monthly payments to the Primary Care Providers for the Per Member Per Month (PMPM). These payments are reviewed monthly and approved by Carelon staff as well as NHP management. The amounts paid are based on the Member attribution issued by the Department of Health Care Policy & Financing for the payment month. Should there be an over or underpayment or other error, the payment is automatically adjusted on the subsequent payment to the provider. Additionally, since the month-to-month payments vary, R2_PCMP_Agreement and R2_PCMP_Agreement_Executed states that provider is able to request review of payments when they determine may be incorrect by a margin of ten percent (10%) or more within thirty (30) days of the receipt of the payment. This information is reported to HCPF on the quarterly finance report, as shown in R2_QuarterlyFinInfo_Q4FY22-23 on tab: Admn PMPM Exp. For Behavioral health providers, the BH_Practitioner_Agreement and the BH_Practitioner_Agreement_Executed informs of recoupment, offset, adjustment for overpayments for the "time as required by Applicable Rules" and directs the provider to Provider Manual (aka Provider Handbook) for specifics. The NHP-Behavioral-	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Health-Medicaid-Provider-Handbook specifies the procedures for overpayment recovery.	
15. The Contractor has a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days of identifying the overpayment, and to notify the Contractor in writing of the reason for the overpayment. • The Contractor reports semi-annually to the State on recoveries of overpayments. *42 CFR 438.608 (d)(2) and (3)* RAE Contract: Exhibit B-8—17.1.5.8 and 17.3.1.2.4.4	**Documents Submitted:** 1. BH_Practitioner_Agreement-Page 21-22 2. NHP-Behavioral-Health-Medicaid-Provider-Handbook -Page 32-33 *Misc. 3. R2_PCMP_Agreement -Page 8 4. R2_MonthlyFWARpt- Entire Document 5. R2_FWARpt_SemiAnnual – Entire Document 6. R2_QuarterlyFinInfo_Q4FY22-23 on tab: Admn PMPM Exp. **Document Description of Process:** NHP requires the behavioral health network providers to cooperate with efforts to recover overpayments as per the BH_Practitioner_Agreement . The agreement requires providers to cooperate in the efforts to recover overpayments stating that “any recoupment, improper payment, or overpayment is due from Provider, Provider must refund the amount to Carelon or Payor, as applicable, within thirty (30) days,” and ”if such reimbursement is not received by Carelon or Payor within the thirty (30) days following the date of such notice (or, if a longer period of time is required by Applicable Rules, then within the minimum amount of days required by reason thereof), Carelon or Payor shall be entitled to offset such overpayment	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	against any Claims payments due and payable to Provider under any Plan subject to this Agreement in accordance with Applicable Rules." The NHP-Behavioral-Health-Medicaid-Provider-Handbook specifies the procedures for overpayment recovery. For Primary Care Providers, regarding the capitation payments or other payments in excess of the amounts specified in the contract, NHP conducts monthly payments to the Primary Care Providers for the Per Member Per Month, which are reviewed and approved by NHP management. The amounts paid are based on the Member attribution issued by the Department of Health Care Policy & Financing for the payment month. Should there be an over or underpayment or other error, the payment is automatically adjusted on the subsequent payment to the provider. Since the month-to-month payments vary, R2_PCMP_Agreement states that the provider is able to request review of payments when they determine may be incorrect by a margin of ten percent (10%) or more within thirty (30) days of the receipt of the payment. This information is reported to HCPF on the quarterly finance report, see R2_QuarterlyFinInfo_Q4FY22-23 on tab: Admn PMPM Exp. NHP reports to the Department of Health Care Policy & Financing on a monthly and semi-annual basis any activities regarding FWA, including overpayments. (R2_MonthlyFWARpt and R2_ FWARpt_SemiAnnual).	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The Contractor provides that members are not held liable for: • The Contractor's debts in the event of the Contractor's insolvency. • Covered services provided to the member for which the State does not pay the Contractor. • Covered services provided to the member for which the State or the Contractor does not pay the health care provider that furnishes the services under a contractual, referral, or other arrangement. • Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. *42 CFR 438.106* RAE Contract: Exhibit B-8—14.14.1-2 and 17.13.2-4	**Documents Submitted:** 1. CO 303.2 Conflict of Interest – Entire Document 2. CO 029.17 Screening Against Exclusion – Entire Document 3. BH_Practitioner_Agreement -Page 22-23 4. NHP-Behavioral-Health-Medicaid-Provider-Handbook - Page 24 *Misc 5. BH_Provider Support Call Presentation- Page 29 6. R2_PCMP_Agreement-Page 12 **Description of Process:** Carelon BH, as the delegated entity for NHP, has policy CO 303.2 Conflict of Interest to require individuals to disclose and update Carelon on potential conflict of interest issues and outlines the process for handling any disclosures. Additionally, policy CO 029.17 Screening Against Exclusion,addresses Carelon BH does not employ, contract, conduct business with individuals or entities listed by a federal agency or state law enforcement, regulatory or licensince agency as excluded, suspended, debarred, or otherwise ineligible to participate in federally funded health care programs. Exclusion screens are conducted prior to hire/contracting monthly thereafter against the lists/databases located on pg. 5.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Behavioral Health and Physical Health Providers are required to "not balance bill Members for covered services rendered". This is included in the BH_Practitioner_Agreement, the R2_PCMP_Agrement as well as the NHP-Behavioral-Health-Medicaid-Provider-Handbook. Behavioral Health Providers were informed about this requirement during a provider support call on July 14, 2023 (BH_Provider Support Call Presentation).	

Results for Standard VII—Provider Selection and Program Integrity							
Total	Met	=	12	X	1.00	=	12
	Partially Met	=	4	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	16	**Total Score**		=	12
Total Score ÷ Total Applicable						=	75%

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. Notwithstanding any relationship(s) with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. *42 CFR 438.230(b)(1)* RAE Contract: Exhibit B-8—4.2.13	**Documents Submitted:** 1. NHP_Compliance_1_DelegationOversight Policy_221212 -Entire Document 2. NCHA Administrative Services Agreement Amendment 3 Effective 03.28.22_Executed (pg. 2, Section 2.1 Governance and Oversight, Exhibit A as related to 42 CFR 438.230 C)1)i) 3. NHP Administrative Services Agreement 6.16.2021 (pg. 3, Section 2.1-Governance and Oversight) *Misc. **Description of Process:** NHP possesses the Regional Accountable Entity contract with Health Care Policy and Financing (HCPF) and maintains authority over all delegated functions (NHP_Compliance_1_DelegationOversightPolicy_221212). NHP has delegated contracts with both Northern Colorado Health Alliance (NCHA) (NCHA Administrative Services Agreement Amendment 3 Effective 03.28.22_Executed) and its Administrative Services Agreement (ASA) (NHP Administrative Services Agreement 6.16.2021) with Carelon Behavioral Health (formerly Beacon Health Options).	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: During the compliance interview, HSAG inquired about NHP's annual audit and oversight of Carelon. While NHP noted that it reviewed the reports and deliverables that Carelon developed for the Department, NHP did not indicate that the oversight included ongoing monitoring of all delegated activities nor assessing Carelon against specific performance standards to ensure Carelon's compliance with		

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
delegated requirements. NHP did provide evidence of this for other delegates. For example, in the delegation agreement with NCHA, NHP included specific language identifying benchmarks and expectations for satisfactorily adhering to the contract, as well as the periodicity for ongoing review and a set of consequences for not meeting set benchmarks. NHP evidenced this process through policies, audit tools, and results reports. NHP did not have similar language in its agreement with Carelon and was not adhering to its policy to conduct annual monitoring to ensure that its delegate was satisfactorily executing the delegated managed care activities, such as audits of the member call center, network contracting, credentialing, utilization management, information systems, and claims payment.		
Required Actions: NHP must detail its oversight and monitoring process within its agreement with Carelon, including identifying benchmarks and expectations for the delegated activities. NHP must complete ongoing monitoring of Carelon to ensure that Carelon meets these benchmarks and expectations, and align its delegation agreement with its policies and procedures.		
2. All contracts or written arrangements between the Contractor and any subcontractor specify: • The delegated activities or obligations and related reporting responsibilities. • That the subcontractor agrees to perform the delegated activities and reporting responsibilities. • Provision for revocation of the delegation of activities or obligations or specify other remedies in instances where the Contractor determines that the subcontractor has not performed satisfactorily. *Note: Subcontractor requirements do not apply to network provider agreements. In addition, wholly owned subsidiaries of the RAE are not considered subcontractors.* *42 CFR 438.230(b)(2) and (c)(1)* RAE Contract: Exhibit B-8—4.2.13.6	**Documents Submitted:** 1. NHP Administrative Services Agreement 6.16.2021 (pg. 1 Section 1.1, pg. 8 Section 6.2-6.4, pg. 15-33 Exhibit A: Description of Services) *Misc. 2. NCHA Administrative Services Agreement Amendment 3 Effective 03.28.22_Executed (pg. 1 Section 1.1, pg. 6-7 Section 6.2-6.3, pg. 12-17 Exhibit A: Description of Services) 3. NHP_Beacon_Monitoring Tool_FY22-23_Final-Entire Document 4. NHP_CAP Steadman Response-Entire Document 5. NCHA_AuditResultsLetter_CareCoordination_2023Oct-Entire Document 6. Care Coordination Audit Tool NHP 2022 Revised FINAL-Entire Document 7. NCHA_AuditResultsLetter_CareCoordination_2023Apr-Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Description of Process: Through both NHP's ASA with NCHA and its ASA with Carelon Behavioral Health, formerly Beacon Health Options (NHP Administrative Services Agreement 6.16.2021 and NCHA Administrative Services Agreement Amendment 3 Effective 3.28.22_Executed), Carelon is delegated all non-clinical services required for performance of the Medicaid contract. The ASA goes on to further outline in Exhibit A the specific scope of services and deliverables agreed upon. The ASA in Section 6.2 also provides for corrective actions or revocations for performance concerns. The annual delegation audit results (NHP_CAP Steadman Response) performed by NHP of Carelon are submitted as evidence of such oversight. As to NCHA, the ASA provides comparable evidence of scope of services and oversight in Exhibit A and Section 6.2. On Behalf of NHP, Carelon performs semi-annual audits of the care coordination services delegated to NCHA per the attached audit tool. See NCHA_AuditResultsLetter_CareCoordination_2023 Oct as evidence of oversight as well as the Care Coordination Audit Tool NHP 2022 FINAL and NCHA_AuditResultsLetter_CareCoordination_2023 Apr	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's written agreement with any subcontractor includes: • The subcontractor's agreement to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions. *42 CFR 438.230(c)(2)* RAE Contract: Exhibit B-8—4.2.13.6	**Documents Submitted:** 1. NHP Administrative Services Agreement 6.16.2021 (pg. 1 Purpose of Agreement, pg. 1 Section 1.1-1.2, pg. 2 1.5, pg. 4 Section 4.1, pg. 9 Article 7, pg 10 8.7a pg.12 Section 8.16-8.17) *Misc. 2. NCHA Administrative Services Agreement Amendment 3 Effective 03.28.22_Executed (pg. 1 Purpose of Agreement, pg. 1-2 Section 1.1-1.3, pg. 3, Section 4.1, pg. 6 Section 7.0, pg. 9 Section 8.16-8.17) **Description of Process:** Per the ASA (NHP Administrative Services Agreement 6.16.2021) with Carelon Behavioral Health, formerly Beacon Health Options, and the ASA with NCHA (NCHA Administrative Services Agreement 3 Effective 03.28.22_Executed), the subcontractors agree to comply with all applicable Medicaid laws, including applicable sub-regulatory guidance and contract provisions.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The written agreement with the subcontractor includes: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State. – The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems related to members. – The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. – If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. *42 CFR 438.230(c)(3)* RAE Contract: Exhibit B-8—4.2.13.6	**Documents Submitted:** 1. NCHA Administrative Services Agreement Amendment 3 Effective 03.28.22_Executed (pg. 2 Section 1.3, pg. 4-5 Section 5.1-5.3) 2. NHP Administrative Services Agreement 6.16.2021 (pg. 3 Section 1.6, pg. 6 and 7 Section 5.1-5.3, pg 10 8.7 b-e) *Misc **Description of Process:** Per the ASA with Carelon Behavioral Health, formerly Beacon Health Options, (NHP Administrative Services Agreement 6.16.2021) and the ASA with NCHA (NCHA Administrative Services Agreement Amendment 3 Effective 03.28.22_Executed), the State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate and inspect any and all applicable records.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: HSAG reviewed the subcontractor agreements with North Colorado Health Alliance and Steadman Group, LLC, and found that the written agreements did not include all required information.		

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: NHP must ensure, via revisions or amendments, that its subcontractor agreements include the following language: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State. – The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems related to members. – The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. – If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.		

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

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. *42 CFR 438.330(a)(1)* RAE Contract: Exhibit B-8—16.1.1	**Documents Submitted:** 1. NHP_QualityManagementCommittee_Charter_FINAL_20221228-Entire Document 2. NHP Administrative Services Agreement 6.16.2021-Page 28 Quality Management Section *Misc. 3. R2_QualityRpt_FY22-23-Entire Document 4. R2_QualityImprovePln_FY23-24-Entire Document 5. R2_QualityImprovePln_FY23-24_HCPF Response_Accepted-Entire Document 6. R2_QualityRpt_FY22-23_HCPF Response_Accepted-Entire Document 7. SEP2023_QM_Meeting Minutes_FINAL-Entire Document **Description of Process:** NHP's Director of Quality Management over sees the quality management functions of its delegated entity. . Details of NHP's planned quality improvement activities for the year are found in R2_QualityImprovePln_FY23-24 .The R2_QualityRpt_FY22-23 addresses the performance of the NHP QM activities over FY 2022-23. See the Department acceptance of these documents: • R2_QualityImprovePln_FY23-24_HCPF Response_Accepted	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• R2_QualityRpt_FY22-23_HCPF Response_Accepted The NHP Quality Management Committee provides oversite to the NHP Quality Improvement Program, as described in the NHP_QualityManagementCommittee_Charter_FINAL_20221228. The Quality Management Committee is responsible for the monitoring, oversight, and intervention design of NHPs' daily operations specific to quality functions. The Quality Management Committee monitors activities from NHPs' quality improvement, utilization management, provider relations, and member services departments, including (but not limited to): audits, quality of care concerns, critical incidents, over and under-utilization of services, grievances and appeals, performance measurement and improvement, state Performance Improvement Projects (PIPs), Health Equity, and provider network adequacy. Trends are analyzed and interventions are developed and implemented as necessary. Effectiveness of interventions and follow-up activities are also reviewed with this oversight committee.	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor's QAPI Program includes conducting and submitting (to the State) annually performance improvement projects (PIPs) that focus on both clinical and nonclinical areas. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. Each PIP includes the following: • Measurement of performance using objective quality indicators. • Implementation of interventions to achieve improvement in the access to and quality of care. • Evaluation of the effectiveness of the interventions based on the objective quality indicators. • Planning and initiation of activities for increasing or sustaining improvement. *For RAEs two PIPs are required, one administrative and one clinical.* *42 CFR 438.330(b)(1) and (d)(2) and (3)* RAE Contract: Exhibit B-8—16.2.1.1, 16.3.5, and 16.3.8	**Documents Submitted:** 1. NHP SDOH CO2023-24 PIP Submission Form-Entire Document 2. Attachment A. SDOH Denominator Codes-Entire Document 3. Attachment B. SDOH FY23 CCAR User Manual-Entire Document 4. Attachment C. SDOH PRAPARE-English-Entire Document 5. Attachment D. SDOH Prapare.CCAR Crosswalk-Entire Document 6. Attachment E. SDOH Data Completeness Assessment-Entire Document 7. Attachment F. SDOH-key-driver-diagram-Entire Document 8. NHP-R2_CO2023-24_PIP-Val_SDOH_Tool_D1_1223-Entire Document 9. NHP FUA CO2023-24 PIP Submission Form-Entire Document 10. Attachment A. FUA-CH Specifications-Entire Document 11. Attachment B. FUA-AD Specifications-Entire Document 12. Attachment C FUA-AD Value Set-Entire Document 13. Attachment D FUA Medication List-Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	14. Attachment E. FUA-CH Value Set-Entire Document 15. Attachment F. FUA Data Completeness Assessment-Entire Document 16. Attachment G. FUA-key-driver-diagram-Entire Document 17. NHP-R2_ CO2023-24_PIP-Val_FUA_Tool_D1_1223--Entire Document 18. NHP-R2_CO2023-24_PIP-Val_FUA_Tool_F1_0224- Entire Document **Description of Process:** In collaboration with the Department, NHP selected two (2) performance improvement projects (PIP) topics in FY24. HCPF communicated that the next three-year cycle for PIPs will consist of two separate projects. One PIP must focus on a clinical topic while the other will focus on a non-clinical topic. Selecting from the list of potential clinical measures provided by HCPF, NHP elected to pursue performance improvement on the ED SUD Follow-up measure (NHP FUA CO2023-24 PIP Submission Form). This measure was chosen to align with HCPFs Behavioral Health Incentive Pool measure. Baseline data and measure specifications were submitted to HCPF on October 31st, 2023. This submission earned Low Confidence on the Overall Confidence Adherence to Acceptable Methodology from HSAG on initial submission	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	(NHP-R2_ CO2023-24__PIP-Val_FUA_Tool_D1_1223). This document was resubmitted to HSAG in January 2024 to address HSAG notes and NHP earned a High Confidence Rating (NHP-R2_CO2023-24_PIP-Val_FUA_Tool_F1_0224). HCPF directed that the non-clinical PIP target increased performance of Social Determinants of Health (SDOH) screening among behavioral health utilizers in the region, (NHP SDOH CO2023-24 PIP Submission Form). NHP will initiate SDOH PIP efforts by understanding current available data streams on SDOH and will develop further interventions based on the information gathered. Baseline data and measure specifications were submitted to HCPF on October 31st, 2023. This submission earned High Confidence on the Overall Confidence of Adherence to Acceptable Methodology from HSAG (NHP-R2_CO2023-24_PIP-VAL_SDOH_Tool_D1_1223). Attachments A-G are included to provide essential details required for precise Performance Improvement Project documentation. See: • Attachment A. SDOH Denominator Codes • Attachment B. SDOH FY23 CCAR User Manual	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Attachment C. SDOH PRAPARE-English • Attachment D. SDOH Prapare.CCAR Crosswalk • Attachment E. SDOH Data Completeness Assessment • Attachment F. SDOH-key-driver-diagram • Attachment A. FUA-CH Specifications • Attachment B. FUA-AD Specifications • Attachment C FUA-AD Value Set • Attachment D FUA Medication List • Attachment E. FUA-CH Value Set • Attachment F. FUA Data Completeness Assessment • Attachment G. FUA-key-driver-diagram	
3. The Contractor's QAPI Program includes collecting and submitting (to the State): • Annual performance measure data using standard measures identified by the State. • Data, specified by the State, which enables the State to calculate the Contractor's performance using the standard measures identified by the State. • A combination of the above activities. *42 CFR 438.330(b)(2) and (c)* RAE Contract: Exhibit B-8—16.4.1 and 16.4.4	**Documents Submitted:** 1. R2_FlatFile_Q1FY23-24 SFY22 Base Data Statistics Report-Entire Document 2. R2_FlatFile_Q1FY23-24 HCPF Response_Accepted-Entire Document 3. R2_PAD_Mtg_Jan2023-Entire Document 4. R2_PAD_Mtg_Nov2023-Entire Document 5. NHP_CareCoordCompMangRpt_Q3Q4_FY 22-23-Entire Document 6. R2_CondMangRpt_Q3Q4FY22-23-Entire Document 7. R2_CondMangDeliverable_Q3Q4FY22-23-Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Description of Process: The current process for the calculation of the performance measurement data for the Behavioral Health Incentive Program (BHIM) measures and the Key Performance Indicators (KPIs) rests with the State of Colorado. The State currently calculates the performance for the RAEs on these measures. This calculation is based on the submission of claims and encounters through the flat file submission. See, R2_FlatFile_Q1FY23-24 SFY22 Base Data Statistics Report and R2_FlatFile_Q1FY23-24 HCPF Response_Accepted. NHP provides analytics updates to the State on an ad hoc basis during the Program and Data (PAD) meeting as it pertains to specific performance measures. Examples of analysis during CY 2023 include ED Utilization, Oral Evaluation, Immunizations (November 2023) and SUD Engagement, Inpatient Mental Health Follow Up, ED SUD Follow Up, Follow Up After Positive Depression Screening, Foster Care BH Assessment, Preterm Birth Rate, Antidepressant & Asthma Medication Management, and Contraceptive Care for Postpartum Women (January 2023). See R2_PAD_Mtg_Jan2023 and R2_PAD_Mtg_Nov2023.	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	NHP provides quarterly Care Coordination and Complex Care Management Reports to the state that outlines the regions Complex Members and those who need Extended Care Coordination. The report also displays the outreach attempts and contacts made to these populations. (See NHP_CareCoordCompMangRpt_Q3A4_FY22-23). NHP submits the Condition Management Report semi-annually on provider performance data across several national standard measures relevant to the priority conditions identified by the Department (e.g., diabetes, anxiety/depression, substance use disorder) as well as describing performance improvement activities related to these conditions. (See R2_CondMangRpt_Q3Q4FY22-23 and R2_CondMangDeliverable_ Q3Q4FY22-23).	
4. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42 CFR 438.330(b)(3)* RAE Contract: Exhibit B-8—16.6.1	**Documents Submitted:** 1. NHP_COUP Lock-In Process-Entire document 2. COUP.R2.Narratives.Q1-Entire document 3. Blank ClinicalAuditTool_QM-Entire Document *Misc. 4. ClinicalAudTool_SUD-Entire Document 5. Detox_ClinicalAuditTool_SUD_QM-Entire Document 6. TCM_ClinicalAuditTool_UPDATED2022Nov_QM-Entire Document 7. E and M CODING AUDIT FORM_2021March-Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	8. ClinicalAudTool_MAT_SUD-Entire Document 9. Blank ClinicalAuditTool_IOP_UPDATED2022Oct_QM-Entire Document 10. Provider_ClinicalAuditTool_Q1FY24_QM-Entire Document 11. Blank Claims Audit Tool_QM-Entire Document 12. NHP SDOH CO2023-24 PIP Submission Form-Entire Document 13. NHP FUA CO2023-24 PIP Submission Form-Entire Document 14. Care Coordination Audit Tool_NHP_2022_Revised_FINAL_QCAuditTool-Entire Document 15. FPoG_AuditResultsLetter_CareCoordination_2023Aug-Entire Document *Misc. 16. R2_QualityRpt_FY22-23-Entire Document 17. R2_QualityImprovePln_FY23-24-Entire Document 18. Top 50 Report - NHP_2023-12-05-Entire Document 19. CMHC_NHP_QualityMtgMinutes_2023.08.11-Page 2 20. UM Report--RAE 2--8-7-2023-Entire Document 21. RAE2 Penetration Rates by Eligibility 2023-10-05-Entire Document 22. IP Readmissions_NHP-Entire Document	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	23. R2_KPI_BHIP_PerformancePool_Report_06_2023-Entire Document 24. NHP_QI_PH_6.01.2023_FINAL_Meeting_Minutes-Number 4 25. R2_EPSDTRptQ1FY22-23, pages 6-7 26. R2_EPSDTRptQ4FY22-23, pages 6-7 27. R2_EPSDTRptQ3FY22-23, pages 6-7 28. R2_EPSDTRptQ2FY22-23, pages 6-8 29. Text4baby, pages 18, 19, 38-46 30. Text4kids, pages 75-81 31. AdolescentText, entire document 32. WellVisitLetterEN, page 3 33. WellVisitLetterSP, page 3 34. OutreachReports-Entire Document **Description of Process:** NHP ensures mechanisms are in place to detect and evaluate both over-and under-utilization, as noted in the Annual Quality Improvement Report and Plan (See R2_QualityRpt_FY22-23-Entire DocumentR2_QualityImprovePln_FY23-24-Entire Document). Regular audits also take place to assess service utilization. Results of these audits are demonstrated in: Provider_ClinicalAuditTool_Q1FY24_QM. Furthermore, NHP audits network providers over a wide variety of clinical services. The blank audit tools listed below demonstrate the array of audits that NHP conducts on a regular and ongoing basis.	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Blank ClinicalAuditTool_QM • ClinicalAudTool_SUD • Detox_ClinicalAuditTool_SUD_QM • TCM_ClinicalAuditTool_UPDATED2022Nov_QM • E and M CODING AUDIT FORM_2021March • ClinicalAudTool_MAT_SUD • Blank ClinicalAuditTool_IOP_UPDATED2022Oct_QM • Blank Claims Audit Tool_QM NHP audits network providers to ensure that services are appropriately utilized. Furthermore, accountable entities in RAE region 2 are also audited for compliance with care coordination requirements. These audits can provide insight into the way members are being connected to services and utilizing those services. See Care Coordination Audit Tool_NHP_2022_Revised_FINAL_QCAuditTool and FPoG_AuditResultsLetter_CareCoordination_2023Aug. NHP FUA CO2023-24 PIP Submission Form demonstrates to the plan to increase utilization of follow up appointments after a member seeks	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	treatment at an emergency department for an SUD related reason. The NHP SDOH CO2023-24 PIP Submission Form creates connections between social supports and health needs. Another mechanism to detect overutilization of services is observed through Client Overutilization Program (COUP) activities. The COUP program is a collaborative effort between the Department, the Regional Accountable Entities (RAEs), the Department's Utilization Management (UM) vendor, the Department's fiscal agent (Colorado interChange), the Department's Pharmacy Benefit Management System, Pharmacies enrolled in Colorado Medicaid, and the RAEs' contracted network of Primary Care Medical Providers (PCMPs) and behavioral health providers. Together we work to identify, outreach, and intervene with members who meet the Department's criteria for inappropriate overutilization of health care services. Following identification by the Department and initial communication by the UM vendor, the RAEs and their provider networks are responsible for reaching out to identified clients to assess the clients' needs, determine whether the client is inappropriately utilizing services, and to provide additional interventions, supports and/or restrictions to effectively manage the client's health and reduce unnecessary utilization of services. Clients who are determined by the RAE and the client's providers to	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	have not demonstrated a positive change in utilization can be locked-in by the Department to one designated pharmacy, one PCMP, and a physician specialist. This is referred to as COUP Lock-In and prevents payment for services not delivered by or referred by the designated lock-in providers. Through this work, NHP has created a COUP Lock-In Diversion Process that consists of prioritizing outreach for these members, targeting interventions above and beyond standard care coordination. Interventions may include reinforcing education about the appropriate use of the ED; reviewing claims data for specific overutilization information; collaborating with the member's PCMP and the PCMP's ability to meet the member's needs to include behavioral health follow up if needed; collaborating with the ED and other community services where possible to develop a shared plan of care for the member. All outreach attempts and interventions over the course of 6 months are thoroughly documented (following the standard 3 outreach attempts using 2 different modalities per quarter). If the Member remains on the COUP List for 6 more months (12 months total*) in spite of the targeted interventions noted above, the member moves to the Clinical Review List. A multi-disciplinary review will be conducted on members selected by the Care Coordinator. The clinical review team will determine whether or not the	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	member would likely benefit from being locked into one PCMP, one pharmacy, and specialists as needed. As a RAE, we follow guidelines when considering a member for COUP 'lock-in' status, to ensure when members are showing signs of improvement, we continue working with them to access appropriate levels of care. Some of these guidelines include: 1.Demonstrated improvement (enhanced self-management skills; closure of condition specific gaps in care; reduction in ED visits and avoidable hospitalizations), 2.Engaged in services (appropriate health care resource utilization; improved adherence to PCMPs treatment plan, improved communication among member, provider, and RAE), 3.Had appropriate health care resource utilization for disease-related symptoms, Other reasons a member is excluded from lock-in are factors such as: 4.Moved out of the area or, 5.Were unreachable. NHP_COUP Lock-In Process identifies the lock-in process in more detail and COUP.R2.Narratives.Q1-details successes, challenges and plans for improvement as well as anecdotal care coordination summaries regarding working with lock-in members over the last quarter.	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Top 50 Report - NHP_2023-12-05 is a measure of the total cost of care for a member. It combines paid claims and the value of encountered services provided by the CMHC. This report identifies the highest cost utilizers during a specified time period. These reports are distributed to our CMHC partners to review the utilizations patterns and any anomalies. If an anomaly is identified, the Clinical or Quality team can request additional documentation of medical necessity and the rationale for the higher-than-expected utilization. Similarly, the IP Readmissions_NHP.xls report is used to identify 30-day readmissions that result from underutilization or poor follow-up after hospital discharge. Penetration rates (RAE2 Penetration Rates by Eligibility 2023-10-05.xlsx) can be used to identify categories of membership that are not accessing services at the expected frequency. Additional mechanisms in place to monitor both over- and under-utilization include the UM Report--RAE 2--8-7-2023. The document titled CMHC_NHP_QualityMtgMinutes_2023.08.11 Communicates that the membership utilization trends and are reviewed at the NHP Quality Management Committee meeting	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	In addition, as seen in R2_KPI_BHIP_PerformancePool_Report_06_2023, performance in the Key Performance Indicators (KPIs) and Behavioral Health Incentive Program (BHIP) measures are also reviewed monthly for performance trends as several of these measures identify potential under- or over-utilization. See NHP_QI_PH_6.01.2023_FINAL_Meeting_Minutes. for group discussion. NHP monitors EPSDT eligible member's receipt of screenings and examinations in accordance with the American Association of Pediatrics's *Bright Futures* guidelines. NHP has the link to the *Bright Futures* guidelines on our website under "EPSDT resources" located in "New Member Resources" to educate members, family members and health care professionals on the standards set forth by the American Academy of Pediatrics. NHP relies on our Primary Care Medical Providers (PCMPs) to complete a thorough screening for our members under 21 years of age. NHP's goal has been to monitor members who have not had a well visit under the age of 21 and to outreach these members with a reminder that they may be due for their well visit and/or dental visit. These reminders are through text messaging, interactive voice response (IVR) automated calls, or letters. NHP	

<table>
<tr><th colspan="3">Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems</th></tr>
<tr><th>Requirement</th><th>Evidence as Submitted by the Health Plan</th><th>Score</th></tr>
<tr><td></td><td>outreached 21,577 members during FY22-23 with our methods of outreach outlined below.

<table>
<tr><th>Quarter/ FY</th><th>IVR</th><th>Texts</th><th>Birthday Card</th><th>Combo</th></tr>
<tr><td>1FY22-23</td><td>3,161</td><td>1,923</td><td>63</td><td>0</td></tr>
<tr><td>4FY22-23</td><td>3,971</td><td>1,980</td><td>80</td><td>22</td></tr>
<tr><td>3FY22-23</td><td>3,453</td><td>2,397</td><td>92</td><td>140</td></tr>
<tr><td>2FY22-23</td><td>2,798</td><td>1,348</td><td>127</td><td>22</td></tr>
<tr><td>Total</td><td>13,383</td><td>7,648</td><td>362</td><td>184</td></tr>
</table>

For evidence of outreach to non-utilizing members, see R2_EPSDTRptQ1FY22-23, pages 6-7, R2_EPSDTRptQ4FY22-23, pages 6-7, R2_EPSDTRptQ3FY22-23, pages 6-7, and R2_EPSDTRptQ2FY22-23, pages 6-8.

IVR automated calls
NHP sends the following message to members who have been identified as not having a well visit in the previous 12 months and who are not enrolled in one of our texting campaigns. This IVR messaging is as follows:</td><td></td></tr>
</table>

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	"Hi, it's Northeast Health Partners calling, your Colorado Medicaid health plan. This is a friendly reminder for you to schedule a well visit or dental check-up for you or your child with your doctor or dentist. If you need help finding or scheduling an appointment with a primary care provider or a dentist, you can press 1 to be connected to a live person who can help you. You may also call 1-888-502-4189. Again, that number is 888-502-4189." Spanish-speaking members are sent the same message in Spanish: *"Hola, soy Northeast Health Partners, su plan de salud Medicaid de Colorado. Este es un recordatorio amistoso para que programe una visita de bienestar o un chequeo dental para usted o su hijo con su médico o dentista. Si necesita ayuda para encontrar o programar una cita con un proveedor de atención primaria o un dentista, puede presionar 1 para conectarse con una persona en vivo que pueda ayudarlo. También puede llamar al 1-888-502-4189. Nuevamente, ese número es 888-502-4189".*	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Text Messages Text4baby is a campaign for pregnant members which supports women throughout their pregnancy and provides prenatal recommendations to promote full-term births. The text4baby messages focusing on preventative baby care begin based on a member's due date or notification that the baby has been delivered. There are new baby protocol messages which encourage new moms to take their child to the doctor at regularly scheduled times. See Text4baby, pages 18, 19 and 38-46. Text4kids is a campaign for parents and guardians of members aged 1-18. The campaign provides educational messages to the parents and/or guardians regarding health-related topics like developmental milestones, child well visits, and dental visits. Reminders are sent at targeted times to encourage parents and/or guardians to complete their child's well visit. See Text4kids, pages 75-81. The adolescent wellness campaign is designed for ages 16-18 years of age to remind members to schedule and attend their well visit and provide education on needed immunizations. See AdolescentText entire document. NHP developed a well visit reminder letter to send to members who have opted out of text messaging and/or IVR automated calls or those members who	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	do not have a valid phone number. NHP began to send these letters to members based on these criteria in Q1 of FY23-24. See WellVisitLetterEN, page 3 and WellVisitLetterSP, page 3. NHP created a report to review the efficacy of our outreach efforts by outreach type. The reports reflect whether a member had a well visit after an outreach campaign, and which outreach campaign related to a member attending an appointment. NHP runs the report 6 months post-outreach to allow for all claims to be processed. During Quarters 2, 3, and 4 of FY22-23 NHP outreached between 22-29% of the members who had a well visit appointment. NHP ran the report for our most recent outreach period, Q1FY23-24 and are currently at 15.88% of members having a visit post outreach, noting that a full six months have not elapsed to review all claims data Please see OutreachReports, entire document.	
5. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. *Note: Persons with special health care needs shall mean persons having ongoing health conditions that have a biological, psychological, or cognitive basis; have lasted or are estimated to last for at least one year; and produce one or more of the following: 1) a significant limitation in areas*	**Documents Submitted:** 1. QOC_AcknowledgementLtr__2023Oct25_QM-Entire Document 2. QOC_ResolutionLtr_2023November15_QM-Entire Document 3. QOC_StateReport_NHP_Q1FY23_QM-Entire Document 4. QOC_MHProvider_ProcessFlow_QM-Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
of physical, cognitive, or emotional function; 2) dependency on medical or assistive devices to minimize limitation of function or activities; 3) for children: significant limitation in social growth or developmental function; need for psychological, educational, medical, or related services over and above the usual for the child's age; or special ongoing treatments such as medications, special diets, interventions, or accommodations at home or at school. *42 CFR 438.330(b)(4)* RAE Contract: Exhibit B-8—16.2.1.4 and 16.5.5 10 CCR 2505-10, Section 8.205.8	5. QOC_PHProvider_ProcessFlow_2021August_QM-Entire Document 6. QOC_NonQuality_ProcessFlow_QM-Entire Document 7. QM 4H Member Safety Program Serious Reportable Event QOC Issues and Outlier Practice Patterns-Entire Policy 8. Blank ClinicalAuditTool_QM-Entire Document *Misc. 9. ClinicalAudTool_SUD-Entire Document 10. Detox_ClinicalAuditTool_SUD_QM-Entire Document 11. TCM_ClinicalAuditTool_UPDATED2022Nov_QM-Entire Document 12. E and M CODING AUDIT FORM_2021March-Entire Document 13. ClinicalAudTool_MAT_SUD-Entire Document 14. Blank ClinicalAuditTool_IOP_UPDATED2022Oct_QM-Entire Document 15. Blank Claims Audit Tool_QM-Entire Document 16. Care Coordination Audit Tool_NHP_2022_Revised_FINAL_QCAuditTool-Entire Document 17. FPoG_AuditResultsLetter_CareCoordination_2023Aug-Entire Document *Misc 18. Documentation Training-Entire Document 19. R2_QualityRpt_FY22-23-Page 19-22	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	20. 248L_EPSDT-Entire Document 21. R2_QOCC_Minutes_2023October10_QM-Entire Document 22. Blank Practice Assessment-Primary Care-Entire Document 23. NHP_Practice Assessment Scores-Entire Document 24. PCMP PT Phase 3 Incentive FINAL47-Entire Document 25. SCL Firestone Hypertension PDSA 2023-24-Entire Document 26. 2023 NHP PT Milestone Program Summary-Entire Document 27. NHP_APM-Entire Document 28. NHP Creative Solutions note example_Redacted-Entire Document 29. 2023-August-ALL-Provider-RAE-Slides-Slide 22 30. UM Program Description_NortheastHealthPartners-Entire Document **Description of Process:** As demonstrated in the documents below, behavioral health providers are audited through a variety of activities and are expected to complete assessments to identify and recommend treatment for individuals with special health care needs. Documents referenced below address the oversight that NHP	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	maintains over its provider network to ensure that the care being delivered is appropriate. • Blank ClinicalAuditTool_QM • ClinicalAudTool_SUD F • Detox_ClinicalAuditTool_SUD_QM • TCM_ClinicalAuditTool_UPDATED2022Nov_QM • E and M CODING AUDIT FORM_2021March • ClinicalAudTool_MAT_SUD • Blank ClinicalAuditTool_IOP_UPDATED2022Oct_QM R2_QualityRpt_FY22-23 demonstrates the various audits that NHP conducts. On a quarterly basis, providers are invited to attend a Mental Health and SUD documentation training session (see Documentation Training). At these sessions, providers learn about documentation standards and the audit requirements. Providers are trained on Early and Periodic Screening, Diagnostic and Treatment (EPSDT) compliance. Information on EPSDT is also shared with network providers through Provider Support Forums (see 2023-August-ALL-Provider-RAE-Slides). In addition, per 248L_EPSDT it is policy to coordinate Early and Periodic Screening, Diagnostic and Treatment	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	(EPSDT) services with other practitioners and agencies for clients aged 20 and under. Members with special needs are supported through case management where care is well-coordinated and constant communication between providers is occurring. See the following supporting documents: • Care Coordination Audit Tool_NHP_2022_Revised_FINAL_QCAuditTool • FPoG_AuditResultsLetter_CareCoordination_2023Aug As indicated in the Quality of Care (QOC) policy (QM 4H Member Safety Program Serious Reportable Event QOC Issues and Outlier Practice Patterns-Entire Policy), an acknowledgement letter is sent (QOC_AcknowledgementLtr_2023Oct25_QM), and an investigation completed when a QOC is reported. Upon receipt, each QOC issue is evaluated to determine the urgency of the issue and assess immediate follow-up actions to assure well-being of the member. Once the QOC is closed, a resolution letter is sent to the parties involved (seeQOC_ResolutionLtr_2023November15_QM). Since adverse incidents may also be quality of care issues, all serious reportable events are evaluated upon receipt to determine whether there are any urgent safety issues to be addressed (see QM 4H	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Member Safety Program Serious Reportable Event QOC Issues and Outlier Practice Patterns-Entire Policy See: QOC_PHProvider_ProcessFlow_2021August_QM and QOC_MHProvider_ProcessFlow_QM and QOC_NonQuality_ProcessFlow_QM for the QOC process flows. The QOC_StateReport_NHP_Q1FY23_QM demonstrates NHP's effort to report QOC issues to the Department on a quarterly basis. R2_QOCC_Minutes_2023October10_QM) makes a determination as to whether the investigation has identified a quality of care issue, and provides direction as to the appropriate follow-up, which may include obtaining more information, developing and monitoring a corrective action plan. As part of the Practice Transformation (PT) program, coaches work with PCMPs on quality improvement efforts based on HCPF's Alternative Payment Models (APM) and the NHP Practice Transformation Milestone Incentive Program. Annually, the Practice Transformation Coach and practice representative(s) engage in performing a practice assessment in which the practice self-assesses their progress in specific areas related to the foundations of high-performing primary care practices. See Blank Practice	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Assessment-Primary Care and NHP_Practice Assessment Scores. Foundational areas of assessment include but are not limited to leadership, team-based care, patient and family engagement, population management, and comprehensiveness of care. The purpose of the assessment is to allow the PCMP to identify areas of potential development and work with the PT coach, set goals in areas that will support the growth of the practice toward better outcomes for members. Support of patients with special health care needs is evidenced in specific questions on the assessment such as: • Practice adopts at least one evidence-based decision aid or self-management support tool for a condition appropriate for their patient population. • Practice uses standardized screening tools to screen patients and has a clear follow-up process for positive screens. • Practice develops a vision for behavioral health integration and chooses a strategy to improve comprehensiveness of behavioral health services. • Practice has awareness of, coordinates care and actively communicates member needs to appropriate care management entities.	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Once the assessment is complete, the PCMP identifies a SMART goal and work ensues over next few months to achieve the goal. The following are examples of quality improvement work being undertaken by some NHP PCMPs to improve the outcomes for special needs populations: • Holyoke Family Medicine- team training on substance use disorder. SBIRT training completed and interested providers looking to attain MAT certification. • Holyoke Family Medicine and Wray Clinic- developing SDoH screening process with care management teams. Includes work on supporting members with positive screens. • Northeast Colorado Family Medicine, Peak Vista Limon Clinic, and Salud Family Medicine- development and implementation of Diabetes standing orders or protocol using 2023 ADA Guidelines. • SCL Firestone Clinic- development and implementation of complex care management team for members with chronic conditions such as diabetes and hypertension Each cycle of the program includes work towards improving clinical measures including diabetes, hypertension and depression screening. (PCMP PT Phase 3 Incentive FINAL47). As part of the quality work performed, PDSA cycles, sample at (SCL	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Firestone Hypertension PDSA 2023-24), are implemented with the PCMP practices, supporting the work of the clinic in serving the needs of populations with chronic conditions. Over the course of a year, clinics set goals and work to achieve forward progress in quality outcomes. A summary of the outcomes for the Phase 3 Milestones is attached (2023 NHP PT Milestone Program Summary), highlighting the outcomes achieved through the Practice Transformation work. The following are examples of quality improvement work supported by Practice Transformation being undertaken by PCMPs to improve the outcomes for special needs populations: • Holyoke Family Medicine- development of Chronic Care Management program to monitor patients with diabetes, hypertension and COPD through the use of educational programming and technology. Clinic has achieved American Diabetes Association certification. Holyoke has also received NHP's Community Reinvestment Grant for the past 3 years to support their work in these areas. As a result of the grant funding, have put into place diabetes management classes, remote monitoring of blood pressure, in-office point of care testing for cholesterol and COPD challenge program. • Peak Vista FQHC used NHP grant funding to develop Registered Dietician role for the	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	clinic in Limon. PDSA efforts focused on workflow starting with provider referrals through in-person counseling with RD. Currently developing clinic protocols for clinic team to implement for all patients with diabetes diagnosis. • SCL Firestone clinic has a focus on the clinical measure to improve blood pressure. The clinic has hired an RN to provide condition management for patients with diabetes and hypertension. They have completed team training on how to properly assess blood pressure. **Practice Transformation Diabetes Work Group** In June 2021, during the Learning Collaborative a creative concept was discussed of developing a Diabetes Work Group. This work group would provide education to patients that have a diagnosis of Type 2 Diabetes.. There was much discussion and a resulting ask was if a Work Group could be convened in order for PCMP's to share best practices. The Diabetes Work Group was developed by the Practice Transformation Team for PCMP's to share best practices, problem solve barriers to care, and learn skills/ techniques to implement. The Practice Transformation team has collaborated with CDPHE Diabetes Management Coordinator to assist with	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Diabetes Self-Management Education & Support (DSMES) and Diabetes Prevention Program (DPP) support. The Diabetes Work Group meets 3-4 times annually and has an average participation of 15-20 PCMP practices from RAE 2. The Work Group has been able to showcase clinics that have been successful in managing their population of patients with diabetes, provide information on programs for clinics and their patients to engage. Highlights of the topics presented are: • Diabetes Self-Management and Support (DSMES), Colorado State Overview • Comprehensive evaluation of members with Type 2 Diabetes • Using Team-based care approach for members with Diabetes • Development of a Registry and using data to drive care • Implementation of Continuous Glucose Monitoring Program • How to set up an evidence-based Diabetes Prevention Program and DSMES program • Emotional Impact of Diabetes	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**

	PCMP outcomes that have evolved from the work of the diabetes work group include:
	• Four practices in RAE 2 are engaged in the Prepare for CGM (Continuous Glucose Monitoring) Program
	  ○ Salud Clinics in Fort Morgan and Sterling
	  ○ Holyoke Family Medicine
	  ○ Yuma Clinic
	  ○ Centura Family Medicine (formerly Colorado Plains Fort Morgan)
	• Holyoke Family Medicine has attained ADA Certification and certification for the Diabetes Prevention Program
	• The Wray Clinic has implemented a CGM program for patients with diabetes
	
	The Practice Transformation team supports PCMP practices by helping them to select APM measures for the year and monitor clinical measure performance at least quarterly to ensure forward progress through data sharing and PDSA cycles if necessary. See NHP_APM. The clinical measures in the APM program are related to:
	• Chronic Care Management (Diabetes Hemoglobin A1c Poor Control, Controlling High Blood Pressure, Antidepressant Medication Management)
	• Prevention (Well Child Visits, Immunization Status)	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Screening (Breast, Cervical and Colorectal Cancer Screening) Members with special healthcare needs are additionally supported through Creative Solutions and Complex Solutions meetings. See NHP Creative Solutions note example Redacted. These meetings are multi-disciplinary meetings that bring together various stakeholders who are involved in the Members' lives. For example, a typical Creative Solutions meeting includes the member's family, ~~their~~ behavioral health providers, the Department of Human Services, guardian advocates, school staff, and others. These diverse groups work collaboratively to identify resources and facilitate access to services. The group typically meets weekly until the member has stabilized sufficiently, often for a period of several months. NHP's utilization management (UM) program has an ongoing focus ~~on~~ to ensure access for all members with special needs. Its policies, including those that govern adverse determinations, are audited Thew by HSAG to ensure compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA). For the current fiscal year, NHP's program descriptions, policies, procedures, and documents pertaining to the UM program were reviewed. As part of this desk review, NHP supplied records that	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	included documentation of adverse benefit determinations (ABDs) and communications to members regarding ABDs (denials) of mental health and substance use disorder (SUD) services. See, UM Program Description_NortheastHealthPartners. During this review period, NHP also underwent an audit to review Substance Use Disorder (SUD) Inpatient/Residential Denials Record Review which aimed to review authorizations for inpatient and residential substance use disorder treatment.	
6. The Contractor monitors member perceptions of accessibility and adequacy of services provided. Tools shall include, at a minimum: • Member surveys • Anecdotal information • Grievance and appeals data • Call center data • Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[A-1] survey RAE Contract: Exhibit B-8—16.5.1-3 and 16.5.6	**Documents Submitted:** 1. NHP_CAHPS-Entire Document 2. NHP_YOM_Jan-June 2023-Entire Document 3. NHP YOM_Jul-Dec 2023-Entire Document 4. NOV2023_QM_Meeting Minutes_Final-Page 5, Number 7 5. NHP_QI_PH_10.05.2023_Meeting_Minutes-Page 2-3 6. MEAC-Meeting-Summary-November-15-2023-Page 1-2 7. May2023_MemberEngagement_Quality_NHP-Slide 3 8. R2_GrieveAppealRpt_Q4 FY22-23_No PHI-Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	9. MAY2023_QM_Meeting_Minutes_FINAL-Page 4, Number 8 10. MEAC-Meeting-Summary-August-16-2023-Page 1 11. R2_CallLineStatsRpt-Entire Document **Description of Process:** NHP monitors member's perceptions of well-being and functional status as well as accessibility and adequacy of services through review of various surveys. Two surveys used are the Your Opinion Matters (YOM) Survey and the Consumer Assessment of Healthcare Providers and Systems **(**CAHPS) survey. These reports are reviewed for trends within the RAE as well as comparisons across other RAEs. *Your Opinion Matters Survey* The Your Opinion Matters survey aims to collect information on member interest to improve their healthcare and perceptions of satisfaction and access issues for both physical health and behavioral healthcare services. NHP continues to conduct outreach to members who indicate on the survey that they would like a follow up contact. In FY23, six (6) members have taken the survey and no members indicated that they would like to receive more information about their Health First Colorado Benefits or to speak to someone	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	regarding their questions or concerns. In addition, if there are downward trends detected in the survey responses, these trends are reviewed with the Quality Management Committee, discussions will be held for possible interventions. See: NHP_YOM_Jan-June_2023 and NHP YOM_Jul-Dec 2023 In FY2023-24, NHP has taken the results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) program to better understand patient experience with health care to: • Assess patient experience. • Report survey results. • Help organizations use the results to improve the quality of care. The CAHPS data and low-scoring elements notated in the survey were addressed at the November QM meeting, the October QI/Population Health meeting and at the November MEAC meeting see NHP_CAHPS, NOV2023_QM_Meeting_Minutes_Final-Page 5, NHP_QI_PH_10.05.2023_Meeting_Minutes-Page 2-3 and MEAC-Meeting-Summary-November-15-2023-Page 1-2. Based upon the results of the survey, NHP is exploring partnerships with regional providers to address areas of improvement.	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	During the November MEAC meeting, members were asked what NHP could do to get more people to return the survey and the feedback was to have an incentive see MEAC-Meeting-Summary-November-15-2023-Page 1-2. NHP monitors and reviews Carelon's call center data on a quarterly basis. The average answering speed for each call was eighteen (13) seconds. The call abandonment rate was two and a half (1.7%) percent during the fiscal year. See R2_CallLineStatsRpt. NHP monitors calls for quality to make sure members' needs are met. The call center helps members with access to services by helping them find providers within their search area or to understand their benefits better. If a member calls and shares any information indicating that their needs are not being met, the call center will invite them to talk to Member Engagement and file a grievance. During the grievance process, if it is found that the member is having difficulty accessing the care they need (provider, medication, durable goods, etc.) member engagement will work to get the member's needs met. If a member calls and presents with an issue related to access or accessibility issues, the call will be routed to the appropriate individual for grievance escalation. NHP reviews the grievance and appeal report at the bi-monthly QM committee meeting. See R2_GrieveAppealRpt_Q4 FY22-23_No PHI, May2023_MemberEngagement_Quality_NHP	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	and MAY2023_QM_Meeting_Minutes_FINAL. If a grievance is reported to the Quality Management Department, it will be investigated as a potential a quality of care issue. This investigation process provides direction as to the appropriate follow-up, which may include obtaining more information, developing and monitoring a corrective action, etc. NHP meets quarterly with members at their regional Member Experience Advisory Council (MEAC). The primary objective of this meeting is to listen to members' experience in health care. (see MEAC-Meeting-Summary-August-16-2023). NHP summarizes the MEAC meetings and posts on their website (see https://www.northeasthealthpartners.org/members/join-a-team/member-advisory-council/).	
7. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis. *42 CFR 438.330(e)(2)* RAE Contract: Exhibit B-8—16.2.5	**Documents Submitted:** 1. R2_QualityRpt_FY22-23-Entire Document 2. R2_QualityImprovePln_FY23-24-Entire Document 3. R2_QualityImprovePln_FY23-24_HCPF Response_Accepted-Entire Document 4. R2_QualityRpt_FY22-23_HCPF Response_Accepted-Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Description of Process: NHP Evaluates the impact and the effectiveness of the Quality Improvement Program,annually, NHP completes the annual Quality Improvement Plan (R2_QualityImprovePln_FY23-24) and the annual Quality Report (R2_QualityRpt_FY22-23). Each document addresses the Quality Improvement Program and associated activities and performance on those activities. The annual Quality Report and the Quality Plan are reviewed and approved by the Quality Management Committee. In addition, these documents were accepted by HCPF, see: R2_QualityImprovePln_FY23-24_HCPF Response_Accepted and R2_QualityRpt_FY22-23_HCPF Response_Accepted.	
8. The Contractor adopts practice guidelines that meet the following requirements: • Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. • Consider the needs of the Contractor's members. • Are adopted in consultation with contracted health care professionals. • Are reviewed and updated periodically as appropriate. *42 CFR 438.236(b)*	**Documents Submitted:** 1. CSNT 102.8 Developing and Updating Treatment Guidelines-entire document 2. NHP_Clinical Practice Guidelines_weblink-https://www.carelonbehavioralhealth.com/providers/resources/clinical-practice-guidelines-entire document 3. NHP-Behavioral-Health-Medicaid-Provider-Handbook-Page 40 *Misc.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
RAE Contract: Exhibit B-8—14.8.9.1-3	**Description of Process:** NHP has adopted practice guidelines that meet the following requirements: they are based on valid and reliable clinical evidence, consider the needs of our members and are adopted in consultation with contracted health care professionals. These guidelines are evaluated through a Scientific Review Committee (SRC), responsible for reviewing and/or updating at least every two (2) years, or more often, if national sources publish updates or make changes to the guideline. In addition, relevant new guidelines can be reviewed, adopted, and approved at any time through the committee process. Evidence of these practice guidelines is outlined in CSNT 102.8 *Developing and Updating Treatment Guidelines* policy. Clinical Practice Guidelines are made available to help practitioners and members make decisions about appropriate health care for specific clinical circumstances, ensure the highest quality care for members through use of acceptable standards of care, and reducing undesirable variance in diagnosis and treatment by ensuring compliance with established guidelines. Practice guidelines are available to providers through NHPs website. See NHP_Clinical Practice Guidelines_weblink	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	(https://www.carelonbehavioralhealth.com/providers/resources/clinical-practice-guidelines) Additionally, treatment guidelines and their availability may also be communicated to providers during site visits, and in the context of clinical/peer reviews. Providers are informed of new guidelines and/or edits to existing guidelines through notification in the NHP-Behavioral-Health-Medicaid-Provider-Handbook	
9. The Contractor disseminates the guidelines to all affected providers, and upon request, to members and potential members. *42 CFR 438.236(c)* RAE Contract: Exhibit B-8—14.8.9	**Documents Submitted:** 1. CSNT 102.8 Developing and Updating Treatment Guidelines-entire document 2. NHP_Clinical Practice Guidelines_weblink-Entire Document and https://www.carelonbehavioralhealth.com/providers/resources/clinical-practice-guidelines 3. NHP-Behavioral-Health-Medicaid-Provider-Handbook-p. 40; Clinical Practice Guidelines *Misc 4. https://www.northeasthealthpartners.org/providers/provider-resources/ **Description of Process:** NHP ensures that the practice guidelines are available and disseminated to all affected, providers, upon request, to members and potential members.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Policy "CSNT 102.8 Developing and Updating Treatment Guidelines" provides detail about how clinical practice guidelines are disseminated toNHP's affected providers, members, potential members, and the public. Section VI.B notes that once the guidelines are approved by the Corporate Medical Management Committee (CMMC), the guidelines are posted and linked to NHP's website. NHP's clinical and quality leaders disseminate updates about Clinical Practice Guidelines and Resources to applicable team members and are available to all staff. When necessary, clinical staff may receive additional training through clinical rounds or supervision. Treatment guidelines and their availability may also be communicated to providers during site visits, and in the context of clinical/peer reviews. Additionally, providers are informed of new guidelines and/or edits to existing guidelines through notification in the document titled NHP-Behavioral-Health-Medicaid-Provider-Handbook Practice guidelines are available to providers through NHPs website. NHP_Clinical Practice Guidelines_weblink documents where the guidelines can be seen on the website https://www.carelonbehavioralhealth.com/providers/resources/clinical-practice-guidelines.Guidelines also are noted in the Provider Handbook. See NHP-	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Behavioral-Health-Medicaid-Provider-Handbook.pdf (p. 40; Clinical Practice Guidelines). NHP's members, potential members, and the public have access to the clinical practice guidelines through our website. NHP's Member Engagement Specialist can direct Members to the website to obtain a copy of the clinical practice guidelines upon request. Members can also request a copy of the guidelines be mailed to them free of charge. Additionally, providers are encouraged to communicate with members and their families about the Clinical Practice Guidelines, as appropriate.	
10. The Contractor ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42 CFR 438.236(d)* RAE Contract: Exhibit B-8—14.8.10	**Documents Submitted:** 1. CSNT 102.8 Developing and Updating Treatment Guidelines-entire document 2. NHP_Clinical Practice Guidelines_weblink-https://www.carelonbehavioralhealth.com/providers/resources/clinical-practice-guidelinesEntire Document 3. NHP-Behavioral-Health-Medicaid-Provider-Handbook-p. 40; Clinical Practice Guidelines *Misc **Description of Process:** NHP ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	apply are consistent with the guidelines. Carelon is delegated UM functions on behalf of NHP. The Clinical Practice Guidelines/Treatment Guidelines Policy, CSNT 102.8 provides detail about how clinical practice guidelines are disseminated to NHPs affected providers, members, potential members, and the public. Section VI.B notes that once the guidelines are approved by the Corporate Medical Management Committee (CMMC), the guidelines are postend and linked to NHPs website. NHPs clinical and quality leaders cascade updates about Clinical Practice Guidelines and Resources to applicable team members and are available to all staff. When necessary, clinical staff may receive additional training through clinical rounds or supervision. Treatment guidelines and their availability may also be communicated to providers during site visits, and in the context of clinical/peer reviews. Additionally, providers are informed of new guidelines and/or edits to existing guidelines through notification in NHPs Provider Newsletter. Finally, new providers receive a *Welcome Letter*, which informs them of the Clinical Practice Guidelines. Practice guidelines are available to providers through the NHPs website. See NHP_Clinical Practice Guidelines_weblink	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	https://www.carelonbehavioralhealth.com/providers/resources/clinical-practice-guidelines. Guidelines also are noted in the Provider Handbook. See NHP-Behavioral-Health-Medicaid-Provider-Handbook (p. 40; Clinical Practice Guidelines). NHPs members, potential members, and the public have access to the clinical practice guidelines through our website. NHPs Member Engagement Specialist directs members to the website to obtain a copy of the clinical practice guidelines upon request. Members also may request to be mailed a copy of the guidelines free of charge. Additionally, providers are encouraged to communicate with members and their families about the Clinical Practice Guidelines, as appropriate.	
11. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42 CFR 438.242(a)* RAE Contract: Exhibit B-8—15.1.1	**Documents Submitted:** 1. Carelon_Data_Flows - Entire document 2. Data_Tables_NHP - Entire Document 3. SOP_NHP_Encounter_Data_Submission_Monitoring - Entire Document **Description of Process:** Carelon_Data_Flows document shows the workflow and servers used to collect, integrate, analyze and report data from internal and external sources. Claims and Provider data is received by the CAS system, which is a secure server based in Ashburn,	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Virginia. Applicable parts of this data needed for reporting are downloaded to the Colorado IT Data Warehouse (CO IT DW) also located in Ashburn, Virginia. Unlike claims files, Encounter files are sent to CO IT DW from the community mental health centers (CMHC), processed and loaded into the CO IT DW. Encounters are then submitted to the State of Colorado. The Carelon_Data_Flows document illustrates external data interfaces with Carelon. Data is sent via Secure File Transfer Protocol (SFTP) using an internal gateway process. The encounter data is used as a basis to update the calculation of future capitated payments. The Data_Tables_NHP document shows the name and functional area of tables in the database. The table names are functional; as a result reporting is clear and repeatable. For example, Claim based tables begin with CLM. The data tables listed represent the strategy and storage methods of the data. Finally, the SOP_NHP_Encounter_Data_Submission_Monitoring illustrates in detail the monthly process to ensure all encounter files are processed. Monitoring is necessary so the State of Colorado can get an accurate picture of member care.	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The above mentioned processes, strategies and storage ensure the contractor maintains a health information system that collects, analyzes, integrates, and reports data.	
12. The Contractor's health information system provides information on areas including, but not limited to, utilization, encounters, claims, grievances and appeals, and disenrollment (for reasons other than loss of Medicaid eligibility). *42 CFR 438.242(a)* RAE Contract: Exhibit B-8—8.1, 15.1.1, and 15.1.1.3.2.1	**Documents Submitted:** 1. Data_Tables_NHP - Entire Document 2. Providers_Pending_Disenrollment - Entire Document *Misc. **Description of Process:** If data is required to research issues, IT and Reporting teams use the information in the Data_Tables document. The Data_Tables_NHP document shows the name and functional area of tables in the database. Certification of providers is stored both in Colorado IT Datawarehouse (CO IT-DW) and in the corporate databases at Ashburn, VA. The IT department ensures that the data for these providers is accessible and up to date from the sources of the data (Provider group, State agency, Corporate IT). Colorado IT mirrors all Colorado provider data from the sources and creates interfaces to allow for the updating of data as it changes. The included artifact, Providers_Pending_Disenrollment, shows an	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	example of the updated as dis-enrolled providers**.** This report is from data stored locally. Member disenrollment activity originates from the State data. We maintain activity of members even after they are dis-enrolled, according to State guidelines, so data is ready should the member reenroll.	
13. The Contractor's claims processing and retrieval systems collect data elements necessary to enable the mechanized claims processing and information retrieval systems operated by the State. • Contractor electronically submits encounter claims data in the interchange ANSI X12N 837 format directly to the Department's fiscal agent using the Department's data transfer protocol. The 837-format encounter claims (reflecting claims paid, adjusted, and/or denied by the Contractor) shall be submitted via a regular batch process. *42 CFR 438.242(b)(1)* RAE Contract: Exhibit B-8—15.2.2.3.1-2	**Documents Submitted:** 1. Carelon_Data_Flows -Entire Document 2. SOP_837_HCPF_Build_Instructions -Entire Document 3. Monthly 837 Process Checklist -Entire Document **Description of Process:** Carelon_Data_Flows shows the workflow of loading 837 files into the fully-integrated platform (CAS). This server is the main storage for all data and reporting. Data is sent via Secure web FTP. The document, SOP_837_HCPF_Build_Instructions, describes the monthly 837 build process for CMHC-submitted encounter data. CMHCs submit encounter data in a prescribed flat file format. The data is evaluated for more than one hundred possible errors. Accepted records are stored in the Colorado IT Datawarehouse (CO-IT DW) tables. Perl software programs extract and format data from CO-IT DW tables into the X12-defined 837 format. The	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	document describes in detail the step- by-step process. The Monthly 837 Process Checklist ensures that each of the many steps is completed so that the 837 file is correctly submitted.	
14. The Contractor collects data on member and provider characteristics and on services furnished to members through an encounter data system (or other methods specified by the State). *42 CFR 438.242(b)(2)* RAE Contract: Exhibit B-8—15.2.2	**Documents Submitted:** 1. Encounter_Data_Flow - Entire Document 2. Encounter_Sample_Data - Entire Document 3. Encounter_Schema - Entire Document **Description of Process:** Encounter_Data_Flow is a swim lane document showing data flows between the CMHC, RAE and HCPF. This document illustrates how data moves between these groups and the decision points involved. This document includes both the submission and resubmission process. Encounter_Sample_Data details the header and detail column names and shows an example of what that data looks like. Encounter files are received from the CMHCs for each monthly reporting period. The Encounter Schema shows the layout of the column headers that are sent to the State.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The Contractor ensures that data received from providers are accurate and complete by: • Verifying the accuracy and timeliness of reported data, including data from network providers compensated through capitation payments. • Screening the data for completeness, logic, and consistency. • Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for Medicaid quality improvement and care coordination efforts. • Making all collected data available to the State and upon request to CMS. *42 CFR 438.242(b)(3) and (4)* RAE Contract: Exhibit B-8—15.2.2.3.1 and 15.2.2.3.6.1	**Documents Submitted:** 1. SOP_NHP_Encounter_Data_Submission_Monitoring - Entire document 2. Carelon_Inbound_Encounter_File_Layout- Entire document 3. Provider_Portal_Secure_Login_Screen - Entire document 4. FY24 RAE BH Flat File Specs Version 25 - Entire document 5. Example_CE_CE20231201RAE2_PROD.ENC_err - Entire document 6. Example_CE_CE20231201RAE2_PROD.ENC_log - Entire document 7. Example_CE_CE20231201RAE2_PROD.ENC_mod - Entire document **Description of Process:** The SOP_NHP_Encounter_Data_Submission_Monitoring illustrates in detail the monthly process for ensuring all encounter files are processed. Monitoring is necessary so the State of Colorado gets an accurate picture of Member care. Encounters are combined and converted to a flat file format. The Carelon_Inbound_Encounter_File_Layout file shows the header, detail, data dictionary and layout check for this file. The data is sent to HCPF in 837 format	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	and in Flat File Format and is used as a basis for capitation payments. The Provider Portal is used to collect encounter data. Provider Portal_Secure_Login_Screen shows the login screen for this system. Users log into the portal to transmit documents securely to the Colorado IT department and retrieve documents sent to the user. Encounter files are turned into a flat file which is used by the State. The FY24 RAE BH Flat File Specs Version 25 details the contents of this file. Lastly, log files are produced by the inbound encounter processor; sample logs shown in the examples: • Example_CE_CE20231201RAE2_PROD.ENC_err • Example_CE_CE20231201RAE2_PROD.ENC_log • Example_CE_CE20231201RAE2_PROD.ENC_mod "). The files are returned to the CMHC's to ensure items such as membership are corrected before the monthly final submission. The State receives the Encounter Flat file monthly.	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The Contractor: • Collects and maintains sufficient member encounter data to identify the provider who delivers any items or services to members. • Submits member encounter data to the State in standardized ASC X12N 837 formats as appropriate. • Submits member encounter data to the State at the level of detail and frequency specified by the State (within 120 days of an adjudicated provider claim). *42 CFR 438.242(c)* RAE Contract: Exhibit B-8—15.2.2.1-2, 15.2.2.3.2, and 15.2.2.3.4	**Documents Submitted:** 1. Data_Process_Flows_837 - Entire Document 2. SOP_837_HCPF_Build_Instructions - Entire Document 3. Monthly 837 Process Checklist - Entire Document 4. Carelon_Export_837_export_Example - Entire Document **Description of Process:** Data Process Flows 837 shows the workflow for loading 837 files into the Fully integrated platform (CAS). This server as the main storage for all data and reporting. Data is sent via Secure web ftp. The SOP_837_HCPF_Build_Instructions SOPHCPF_Instructions document describes the monthly build procedure for submitting CMHC encounter data. CMHCs submit encounter data in a prescribed flat file format. The data is evaluated for more than one hundred possible errors. Accepted records are stored in the Colorado Data Warehouse (CO IT DW) tables. Perl software programs will extract data from these tables and format the data into the X12-defined 837 format. The document describes in detail the step- by-step process. The Monthly 837 Process Checklist ensures that each of the many steps are completed so that the 837 file is submitted correctly.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The Carelon_Export_837_export_Example shows example header information in the submitted 837 file.	

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

Appendix B. Compliance Review Participants

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

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

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

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

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

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

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

Table C-1—Corrective Action Plan Process

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

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

The CAP template follows on the next page.

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

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

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

Standard VII—Provider Selection and Program Integrity
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
7. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549. *42 CFR 438.610* RAE Contract: Exhibit B-8—17.9.4.2.3
Findings
Carelon submitted a policy titled *Screening Against Exclusion and Ownership and Control Disclosures* (last reviewed/approved on December 12, 2022), which excluded the term "suspended" from the language within the policy.
Required Actions
Carelon must revise its policies to include the terms "excluded, suspended, and debarred" to ensure that Carelon does not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulations or Executive Order 12549.
Planned Interventions
Person(s)/Committee(s) Responsible

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

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

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

Standard VII—Provider Selection and Program Integrity
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
10. The Contractor has administrative and management arrangements or procedures, including a compliance program to detect and prevent fraud, waste, and abuse and includes: • Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal, State, and contract requirements. • The designation of a compliance officer who is responsible for developing and implementing policies, procedures and practices to ensure compliance with requirements of the contract and reports directly to the Chief Executive Officer and Board of Directors. • The establishment of a Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program. • Training and education of the compliance officer, management, and organization's staff members for the federal and State standards and requirements under the contract. • Effective lines of communication between the compliance officer and the Contractor's employees. • Enforcement of standards through well-publicized disciplinary guidelines. • Implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks. • Procedures for prompt response to compliance issues as they are raised, investigation of potential compliance problems identified in the course of self-evaluation and audits, correction of such problems quickly and thoroughly to reduce the potential for reoccurrence, and ongoing compliance with the requirements under the contract. *42 CFR 438.608(a)(1)* RAE Contract: Exhibit B-8—17.1.3 and 17.1.5.1-7

Standard VII—Provider Selection and Program Integrity
Findings
NHP delegated a significant operational aspect of its compliance program to Carelon. While Carelon was able to describe the features of the compliance program, NHP did not have sufficient oversight and monitoring of Carelon's compliance activities. While NHP described educational compliance meetings with providers and quarterly compliance meetings between Carelon and NHP, NHP provided no evidence that it held strategic oversight of the compliance program or took ownership of developing and implementing policies, procedures, and practices to ensure compliance. For example, the ethics statement was provided through Elevance Health's Code of Conduct (Elevance Health is a parent company of Carelon) and all of the policies and procedures related to program integrity were from Carelon.
Required Actions
While aspects of the compliance activities may be delegated, the ongoing strategy, monitoring, and oversight must be overseen by NHP. NHP must strengthen its documentation of internal NHP compliance monitoring procedures.
Planned Interventions
Person(s)/Committee(s) Responsible
Training Required
Monitoring and Follow-Up Activities Planned

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

Standard IX—Subcontractual Relationships and Delegation
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
1. Notwithstanding any relationship(s) with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. *42 CFR 438.230(b)(1)* RAE Contract: Exhibit B-8—4.2.13
Findings
During the compliance interview, HSAG inquired about NHP's annual audit and oversight of Carelon. While NHP noted that it reviewed the reports and deliverables that Carelon developed for the Department, NHP did not indicate that the oversight included ongoing monitoring of all delegated activities nor assessing Carelon against specific performance standards to ensure Carelon's compliance with delegated requirements. NHP did provide evidence of this for other delegates. For example, in the delegation agreement with NCHA, NHP included specific language identifying benchmarks and expectations for satisfactorily adhering to the contract, as well as the periodicity for ongoing review and a set of consequences for not meeting set benchmarks. NHP evidenced this process through policies, audit tools, and results reports. NHP did not have similar language in its agreement with Carelon and was not adhering to its policy to conduct annual monitoring to ensure that its delegate was satisfactorily executing the delegated managed care activities, such as audits of the member call center, network contracting, credentialing, utilization management, information systems, and claims payment.
Required Actions
NHP must detail its oversight and monitoring process within its agreement with Carelon, including identifying benchmarks and expectations for the delegated activities. NHP must complete ongoing monitoring of Carelon to ensure that Carelon meets these benchmarks and expectations, and align its delegation agreement with its policies and procedures.

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

Standard IX—Subcontractual Relationships and Delegation
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
4. The written agreement with the subcontractor includes: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State. – The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems related to members. – The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. – If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. *42 CFR 438.230(c)(3)* RAE Contract: Exhibit B-8—4.2.13.6
Findings
HSAG reviewed the subcontractor agreements with North Colorado Health Alliance and Steadman Group, LLC, and found that the written agreements did not include all required information.
Required Actions
NHP must ensure, via revisions or amendments, that its subcontractor agreements include the following language: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State.

Standard IX—Subcontractual Relationships and Delegation
– The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems related to members. – The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. – If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.
Planned Interventions
Person(s)/Committee(s) Responsible
Training Required
Monitoring and Follow-Up Activities Planned
Documents to Be Submitted as Evidence of Completion

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

Appendix D. Compliance Monitoring Review Protocol Activities

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

Table D-1—Compliance Monitoring Review Activities Performed

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

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct the Review**
	• During the review, HSAG met with groups of the MCE's key staff members to obtain a complete picture of the MCE's compliance with federal healthcare regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the MCE's performance. • HSAG requested, collected, and reviewed additional documents as needed. • At the close of the review, HSAG provided MCE staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2023–2024 Department-approved Compliance Review Report template to compile the findings and incorporate information from the pre-review and review activities. • HSAG analyzed the findings and calculated final scores based on Department-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the Department**
	• HSAG populated the Department-approved report template. • HSAG submitted the draft Compliance Review Report to the MCE and the Department for review and comment. • HSAG incorporated the MCE and Department comments, as applicable, and finalized the report. • HSAG included a pre-populated CAP template in the final report for all elements determined to be out of compliance with managed care regulations. • HSAG distributed the final report to the MCE and the Department.