COLORADO

Department of Health Care Policy & Financing

Fiscal Year 2024–2025 Compliance Review Report

for

Northeast Health Partners

Region 2

May 2025

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

HSAG HEALTH SERVICES ADVISORY GROUP

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

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

Table 1-1—Summary of Scores for Standards

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

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

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

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

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

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

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Credentialing	90	76	76	0	14	100%~
Recredentialing	70	58	58	0	12	100%~
Totals	**160**	**134**	**134**	**0**	**26**	**100%**

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

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

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

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

Standard III—Coordination and Continuity of Care

Evidence of Compliance and Strengths

Northeast Health Partners (NHP) implemented a comprehensive care coordination plan to facilitate the appropriate delivery of physical, behavioral, and social services for its members in Region 2. As the Administrative Service Organization (ASO), Carelon Behavioral Health (Carelon) provided oversight of the care coordination and continuity of care. Care coordination services were provided directly to members through accountable providers: Family Physicians of Greely, The Children's Health Place, Plan Salud del Valle, Inc., and Sunrise Community Health Alliance; and a delegated care coordination entity (CCE): North Colorado Health Alliance. Policies and procedures described that care coordination was accessible to all members attributed to NHP. To ensure coordination and continuity of care, NHP leveraged a team of specialized professionals consisting of registered nurse (RN) care managers, behavioral health professionals, community care coordinators, outreach and navigation coordinators, and transition of care coordinators, who worked to support all different levels of needed care coordination, such as high-risk members with complex needs, transition planning, coordination of services, general care coordination, and member education.

During the interview, staff described that members are engaged with care coordination as a result of the health needs survey from Health First Colorado, risk stratification, self-referrals, provider referrals, utilization management, condition management, and other population triggers. Once outreached by the assigned member of the care coordination team, the care coordinator completed a comprehensive assessment with the member to identify not only clinical needs but also health-related social needs, such as food and housing insecurity, and low health literacy. Then, using information from the assessment, the care coordinator would develop a care plan and act as the primary point of contact for services, ensuring communication with primary and specialty care teams, facilitating service delivery, and making referrals to appropriate agencies or connecting members to resources.

NHP addressed the needs of specific populations, including individuals with intellectual and developmental disabilities, those with substance use disorders, and individuals transitioning from incarceration. Partnering with the Colorado Department of Corrections, NHP provided transitional support, including care coordination, to Medicaid-eligible individuals being released.

Staff members described how assessment results are shared to prevent duplication. With member consent, care coordinators coordinated services and shared treatment information with providers, and other external stakeholders, complying with the Health Insurance Portability and Accountability Act (HIPAA) and Title 42 of the Code of Federal Regulations (42 CFR) Part 2. Coordinators documented all activities, including contact with members, within the care coordination tool, Health Cloud.

NHP described that it monitors its accountable providers and CCEs to ensure they are adequately providing care coordination through audits that occur every six months, wherein NHP reviews policies, procedures, and member records. During the interview, NHP reported that although the entities have met the required 80 percent threshold, NHP continues to identify opportunities for improvement, recommendations, and best practices, which are discussed in monthly care coordination subcommittees.

Recommendations and Opportunities for Improvement

HSAG identified no opportunities for improvement.

Required Actions

HSAG identified no required actions.

Standard IV—Member Rights, Protections, and Confidentiality

Evidence of Compliance and Strengths

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

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

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

The Advance Directive policy described NHP's process for assisting members with advance directives, including establishing training for members, staff, and providers. In addition to trainings, information on advance directives was disseminated to members through welcome outreach, benefit messaging, website resources, and community events. NHP made information on advance directives publicly accessible, enabling community members and other interested parties to readily obtain it.

Recommendations and Opportunities for Improvement

HSAG identified no opportunities for improvement.

Required Actions

HSAG identified no required actions.

Standard VIII—Credentialing and Recredentialing

Evidence of Compliance and Strengths

Carelon, as the ASO, oversaw the activities pertaining to credentialing and recredentialing. NHP demonstrated a comprehensive credentialing and recredentialing process that complied with National Committee for Quality Assurance (NCQA) standards. Staff members provided detailed descriptions of its credentialing department, associated software systems, credentialing committee structure, and the application review process. Throughout the interview, staff members demonstrated that practitioners and organizations were consistently reviewed for credentialing and recredentialing in accordance with established policies and procedures.

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

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

practitioners and organizations through National Practitioner Data Bank (NPDB) continuous query monitoring and DORA.

NHP submitted evidence of a current corrective action plan (CAP) placed on the ASO for failure to meet contractual requirements. NHP reported that Carelon did not meet the 90 percent threshold requirement for contracting credentialed providers within the required 90-day period. Carelon reported mitigations for this required action were implemented which involved a daily triggered event in the system to ensure oversight and monitoring for timeliness. Since incorporating the added feature, Carelon has met the contractual requirements consecutively for three months and the CAP will be closed once Carelon has met the contractual requirement for four months in a row.

Recommendations and Opportunities for Improvement

HSAG identified no opportunities for improvement.

Required Actions

HSAG identified no required actions.

Standard XI—EPSDT Services

Evidence of Compliance and Strengths

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

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

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

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

Recommendations and Opportunities for Improvement

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

Required Actions

HSAG identified no required actions.

3. Background and Overview

Background

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

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

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Mar 14, 2025.

Overview of FY 2024–2025 Compliance Monitoring Activities

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

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

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

Compliance Monitoring Review Methodology

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

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

Objective of the Compliance Review

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

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

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

FY 2023–2024 Corrective Action Methodology

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

Summary of FY 2023–2024 Required Actions

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

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

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

- Update the policy to include language stating Carelon does not "discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification."
- Modify 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.
- Revise the primary care medical provider (PCMP) agreement to include language stating that NHP does not prohibit, or otherwise restrict, healthcare professionals acting within the lawful scope of practice from advising or advocating on behalf of the member who is the provider's patient, for the following:
  - The member's health status, medical care, or treatment options, including any alternative treatments that may be self-administered.
  - Any information the member needs in order to decide among all relevant treatment options.

  - The risks, benefits, and consequences of treatment or non-treatment.
  - The member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment and to express preferences about future treatment decisions.
- Strengthen its documentation of internal NHP compliance monitoring procedures.

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

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

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

Summary of Corrective Action/Document Review

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

Summary of Continued Required Actions

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

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. A. *For the Capitated Behavioral Health Benefit,* the RAE implements procedures to deliver care to and coordinate services for all members. B. *For all RAE members*, the RAE's care coordination activities place emphasis on acute, complex, and high-risk members and ensure active management of high-cost and high-need members. The RAE ensures that care coordination: • Is accessible to members. • Is provided at the point of care whenever possible. • Addresses both short- and long-term health needs. • Is culturally responsive. • Respects member preferences. • Supports regular communication between care coordinators and the practitioners delivering services to members. • Reduces duplication and promotes continuity by collaborating with the member and the member's care team to identify a lead care coordinator for members receiving care coordination from multiple systems. • Addresses potential gaps in meeting the member's interrelated medical, social, developmental, behavioral, educational, informal support system, financial, and spiritual needs. • Is documented, for both medical and non-medical activities.	**Documents Submitted/Location Within Documents:** 1. R2_PopMangPln_FY23-24, Pages 4,9-10,13 2. R2_PopMangPln_FY23-24_HCPF Response_Accepted - 3. R2_PopMangPln_FY24-25_Final, Pages 8-13 4. R2_PopMangPln_FY24-25_HCPF Response_Accepted 5. ComplexCCPlan_SFY24-25, Entire Document 6. GeneralCCPolicy262LR2_SFY24-25, Entire Document 7. CareCoordinationPolicy_262L*Misc, Entire Document 8. ECC_Performance_July2024, Entire Document 9. ECC_Presentation_August2024, Entire Document 10. ECC_Presentation_September2024, Entire Document 11. QM33FHealthEquityProgram, Entire Document 12. CulturalCompetencyTraining, Entire Document 13. Violet Course Catalog_June24, Entire Document 14. Violet Education Engagement Dashboard, Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.208(b) Contract Amendment 17: Exhibit B—11.3.1, 11.3.7	15. Violet Educational Trainings – Filtered, Entire Document 16. Violet Provider Dashboard, Entire Document 17. PrimaryCareProviderHandbook*Misc, Page 17-18 18. BehavioralHealthProviderHandbook, *Misc, Page 64 19. PCMPAgreement,*Misc, Entire Document 20. CareCoordinationPlanSFY24-25, Pages 1,5,6 21. CareCoordinationAuditTool, *Misc, Entire Document **Description of Process:** NHP has implemented robust procedures to deliver care and coordinate services for all members under the Capitated Behavioral Health Benefit. These procedures ensure seamless access to behavioral health services through a comprehensive network of providers. NHP's care delivery model includes: • **Member-Centered Coordination**: NHP ensures care is tailored to individual member needs through assessments and personalized care plans. • **Integration with Primary Care**: Behavioral health services are closely integrated with medical care to promote holistic health outcomes.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• **Community Partnerships**: Collaboration with community resources ensures members have access to non-medical support services that address social determinants of health. This work is demonstrated in the following documents: NHPs Annual Population Management Strategic Plan (R2_PopMangPln_FY23-24 and R2_PopMangPln_FY24-25) includes our region's plan to address and coordinate health care and other needs of members with complex care needs. NHP has created a comprehensive community-based system of care coordination/care management for physical health, mental health, and substance use disorder services. NHP care coordinators/managers address and coordinate care with a central focus on improving member health, preventing disease progression, and reducing unnecessary and/or avoidable utilization and costs. NHP's care coordination model is a member- and family-centered, assessment driven, team-based approach designed to meet the needs of our members. NHP's strategic approach to leverage resources that manage and address the needs of our member population centers on addressing interrelated medical, social, developmental, behavioral, educational, and financial needs to achieve optimal health and	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	wellness outcomes. This is evident in the following ways: NHP stratifies members who may be at higher risk for negative health outcomes, such as hospital readmission or poor treatment outcomes and may benefit from specific interventions and require additional supports like frequent follow-up appointments, medication reconciliation and care coordination between appointments. Through our data analysis, NHP has identified member subpopulations who are more impactable, who have high-cost needs, and struggle with chronic conditions. Our model aims to identify the subset of at-risk members for whom preventive care is expected to be successful as described in detail on page 9-10 of the R2_PopMangPln_FY23-24 and R2_PopMangPln_FY24-25_Final, Pages 8-13 NHP supports the Department's priority subpopulations, including foster care/child welfare, justice- involved, homeless and members with intellectual or developmental disabilities (IDD & non-IDD) through the same care management process we implement for all complex members. These subpopulations are stratified/screened, assessed, carefully planned, and monitored for treatment and outcomes as described in detail on pages 9-10 of the R2_PopMangPln_FY23-24 and pages 8 - 12 of R2_PopMangPln_FY24-25_Final.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	NHP takes a member-centric approach to care coordination, focusing on the following principles: • **Member Preferences**: Care plans respect and align with member preferences, supporting autonomy and engagement in decision-making. • **Regular Communication**: Ongoing communication between care coordinators, primary care providers, and behavioral health specialists ensures members' needs are met comprehensively and efficiently. • **Lead Care Coordinator**: For members receiving services from multiple systems, NHP collaborates with care teams to identify a lead care coordinator. This minimizes duplication, enhances continuity of care, and aligns resources effectively. These elements are represented in our care coordination platform tool, Health Cloud. Health Cloud supports comprehensive care coordination activities to meet contractual and regulatory requirements. Key functionalities include: • **Tracking Outreach and Activities**: Health Cloud records successful and unsuccessful outreach attempts, care coordination activities for over 175 specific tasks (e.g., referrals,	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	health education, care coordination with external entities), and assessments tied to automated tasks based on identified needs. • **Time and Outcome Tracking**: The tool captures time spent on each activity, including travel and documentation, and systematically tracks referral outcomes to ensure closed-loop reporting. • **Social Determinants of Health (SDoH) Integration**: Care managers systematically identify SDoH needs during assessments and incorporate them into care plans. Integration with Aunt Bertha (FindHelp) allows care coordinators to connect members to social care resources, track referral outcomes, and report on closed-loop rates. • **Data Monitoring and Reporting**: Health Cloud captures all member interactions and employs customized logic to generate reports on priority areas and long-term outcomes for specific populations. • **Collaboration Across Departments**: Care coordination staff collaborate with the Quality Improvement department and Practice Transformation Coaches to address care gaps. Nurses adhere to evidence-based guidelines while coordinating care and providing health education. NHP care coordinators demonstrate an evidence-based approach through care	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	management/care planning SMART goals. Developed with the member, SMART goals are Specific, Measurable, Actionable, Realistic, Time-Based and have proven to be a successful care management approach through increased accountability and time-bound objectives, as well as aligning with member preferences. Care plans allow for delineation of a lead care coordinator and the platform supports ongoing documentation of comprehensive coordination to ensure members needs are being addressed. Additionally, there are evidenced based screening and assessment tools available in NHP's designated care coordination tool, Health Cloud (examples: PHQ-9, GAD-7, PRAPARE, ACES, Prenatal Plus Assessments). Members can be automatically stratified and grouped together based on any indicator and "targeted" based on any evidence-based risk score. NHP ensures documentation and gap analysis in the following ways: • **Thorough Documentation**: All care coordination activities, both medical and non- medical, are meticulously documented in the member's care record to ensure transparency and accountability.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• **Gap Identification**: NHP actively identifies and addresses potential gaps in care, focusing on interrelated needs, including medical, social, developmental, behavioral, educational, financial, and spiritual aspects. Health Cloud aggregates member data from multiple sources, creating a holistic view of each member's care journey. This approach enables care teams to identify discrepancies or missing components in care plans and proactively address them to prevent gaps in services. NHP leverages Health Cloud to track care plan adherence and monitor member progress. The platform provides real-time alerts to care coordinators when critical milestones are missed, such as skipped appointments or incomplete tasks, ensuring timely intervention. Health Cloud incorporates SDoH data into the platform to identify non-clinical gaps that impact care, such as transportation barriers, housing instability, or food insecurity. NHP actively monitors care coordination engagement through our comprehensive care coordination dashboard, designed to align with the Department's guidance for evaluating the performance of extended care coordination for complex members. This dashboard leverages data	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	from the quarterly complex care coordination report to assess outreach efforts and member engagement, ensuring care management activities are effective and aligned with performance goals. NHP carefully monitors the percentage of unique complex members engaging in Extended Care Coordination (ECC) through monthly analyses of data, Fiscal Year to Date (FYTD) data, and rolling twelve (12) month data to ensure we were consistently hitting our targets and meeting performance goals. Our quality-of-care team and data analysts review the dashboard monthly with care coordinators to identify trends in the data and realize opportunities for improvement. The documents titled ECC_Performance_July2024, ECC_Presentation_August2024 and ECC_Presentation_September2024 are examples of the data analysis and dashboard presentations provided on a monthly basis to monitor care coordination performance trends. To ensure care coordination services and related activities are aligned with RAE principles, best practices, and evidenced-based contractual obligations, NHP ensures care coordination entities are meeting contractually identified elements through an auditing process. To date, none of our care coordination entities have failed an audit, see page 13 of the	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	R2_PopMangPln_FY23-24 and page 12 of the R2_PopMangPln_FY24-25_Final. NHP's Population Management Strategic Plan ensures alignment across programs and leverages Health Cloud's capabilities to enhance care coordination, track outcomes, and improve quality of care, meeting the requirements of 42 CFR 438.208(b), for more details see pages 13 of the R2_PopMangPln_FY23-24. NHP has established care coordination processes aligned with 42 CFR § 438.208(b) to ensure continuous and coordinated care for members is demonstrated through NHPs policies, ensuring compliance with contract requirements, including the complex CC Plan and the General CC Policy: **ComplexCCPlan_SFY24-25** outlines care coordination processes to ensure the delivery of integrated, member-centered care that meets the interrelated medical, behavioral, social, and developmental needs of individuals with high-risk or complex conditions. This plan promotes the following objectives: comprehensive assessment and care planning; seamless care transitions; collaboration across systems;	

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	monitoring and evaluation; privacy and compliance. **GeneralCCPolicy262LR2_SFY24-25** defines the responsibilities of NHP/RAE care coordination activities within ACC2.0 program. Additionally, the **CareCoordinationPolicy_262L** is established with Carelon (the ASO for NHP) to define the responsibilities of Carelon with regard to priority populations, and care coordination activities. Both policies cover the administration of care coordination to NHP's attributed members. NHP's care coordination activities prioritize acute, complex, and high-risk members, particularly those identified as high-cost and high-need. This is achieved through the following strategies: • **Accessible Care Coordination**: NHP ensures care coordination services are easily accessible to members via multiple entry points, including referrals, self-service portals, and direct communication with care coordinators.https://www.northeasthealthpartners.org/members/care-coordination/care-coordination-referral-form/ • **Point-of-Care Delivery**: Whenever feasible, care coordination is provided at the point of	

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	care, ensuring members receive immediate support during provider visits or hospital stays. • **Comprehensive Health Needs Management**: NHP addresses both short- and long-term health goals through personalized care plans, regular follow-ups, and preventive care measures. **Culturally Responsive Care**: Care coordination activities incorporate cultural competence training for staff, ensuring respect for diverse cultural backgrounds, languages, and traditions. This is evidenced in the following documents: Both NHP's Care Coordination Policies, **CareCoordinationPolicy_262L** and **GeneralCCPolicy262LR2_SFY24-25**, define care coordination as the deliberate organization of member care activities between two or more participants (including the member and/or family members/caregivers) to facilitate the appropriate delivery of physical health, behavioral health, functional Long Term Services and Supports (LTSS) supports, oral health, specialty care, and other services. Care Coordination may range from deliberate provider interventions to coordinating with other aspects of the health system to interventions over an extended period of time	

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	by an individual designated to coordinate a member's health and social needs. The policy further details that care coordination will be accessible to all members, is comprised of deliberate interventions as well as extended care coordination, is provided at the point of care whenever possible, is culturally responsive and provided for both short (deliberate) and long-term (extended) healthcare needs. The general care coordination policy, **GeneralCCPolicy262LR2_SFY24-25**, further adheres to the requirements by identifying that the Care Coordinator (CC) is responsible for assessing or arranging for the assessment of the member's need for services including coordinating across provider types including mental, behavioral, and other health and human services agencies and providers. Care Coordinators will share results of their assessments with other providers to prevent duplication of services and reduce the potential for fraud, waste, and abuse. If a member is having difficulty arranging health care, the Care Coordinator will assist and make an appointment for the member, if needed. Care coordination shall be provided in alignment with the following principles:	

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	• Ensuring that physical, behavioral, long-term care, social and other services are continuous and comprehensive, and the service providers communicate with one another in order to effectively coordinate care. • It is documented, for both medical and non-medical activities. • Ensuring that care is coordinated within a practice, as well as between the practice and other providers and organizations serving a member. • Providing services that are not duplicative or other services and that are mutually reinforcing. • Shall not duplicate Care Coordination provided through LTSS and Home & Community Base Services (HCBS) waivers and other programs designed for special populations; rather, will work to link and organize the different Care Coordination activities to promote a holistic approach to a member's care. The document **QM33FHealthEquityProgram** underscores the commitment to developing and implementing policies and procedures that will enhance cultural competency; to breaking down barriers to access and utilization that are faced by many minorities when seeking behavioral health care. These barriers include relevancy of services,	

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	financial, language, transportation, and literacy barriers; to broadening multi-cultural participation in our provider network; to promoting the ethic of cultural competence and educating our staff, providers, partners, members and the community about member's rights to culturally competent services. NHP provides annual cultural competency training to providers, community partners, and in each of our committees we bring the standards forward. NHP and Carelon provide a variety of cultural competency training resources to providers which can be located on the website at NHP Provider Trainings and the Carelon website to assist providers. The provider handbooks (**PrimaryCareProviderHandbook,** page 17-18 and **BehavioralHealthProviderHandbook,** page 64), with which all providers are contractually obligated to comply, contain additional information on cultural competency requirements. NHP leveraged the provider roundtable meetings and provider newsletters to educate providers about the cultural competency training provided by Carelon and resources available on our website under the RAE Roundtables menu. An example of one such training is the slide deck titled **CulturalCompetencyTraining**.	

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	NHP also established a partnership with Violet Health, a Health Equity training platform, in July of 2024. Violet allows regional providers and staff members at contracted organizations to take courses to improve health equity. Violet offers the ability to earn CE/CME credits from the AAPA, the Accreditation Council for Continuing Medical Education, the Accreditation Council for Pharmacy Education, ASWB, ADA, American Nurses Credentialing Center, American Psychological Association, Board of Certification for the Athletic Trainer, National Board for Certified Counselors, the Commission on Dietetic Registration, and COPE. Information on Violet can be found at https://www.joinviolet.com/, and supporting documents include **Violet Educational Trainings – Filtered, Violet Education Engagement Dashboard, Violet Provider Dashboard, and Violet Course Catalog_June24**. Further, we follow the Health Resources and Services Administration (HRSA) National Standards including culturally competent care for members and promoting equal and non- discriminatory services as well as the use of the National Standards for Culturally and Linguistically Appropriate Standards (CLAS) in Health Care. We have shared the	

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	CLAS assessments with providers and on our website. North Colorado Health Alliance (NCHA), our delegated care coordination entity, has received national training on equity, diversity, and inclusion and is working to develop an inclusive workforce. NCHA also utilizes assessment tools with questions to identify a member's cultural preferences regarding language or adaptive assistance aids, i.e., visual, or verbal tools, which are then integrated into the member's care plan. NHP is also responsible for linking all members to multilingual programs and will connect members with these services upon request through the NHP call center, care coordinator, or provider as described in detail on page 4 of the **R2_PopMangPln_FY23-24**. The documents, **PrimaryCareProviderHandbook** (see Cultural Competency Section, Pages 17-18) and **BehavioralHealthProviderHandbook** (see Cultural Competency Section, Page 64), identifies that the regional organization requires that all physical, behavioral health and care coordination services be provided in a culturally competent manner. This includes sensitivity to the member's	

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	particular language needs and their cultural beliefs and values. The document, **PCMPAgreement,** identifies requirements of contracted primary care providers, including: • Identifying member's cultural needs in the Care Plan • Provide services and care in a non-discriminatory and culturally and linguistically appropriate manner to Members in accordance with nationally recognized standards, Health First Colorado and ACC Program rules and requirements, and all applicable state and federal laws, rules and/or regulations • PCMP shall demonstrate commitment to the following principles of the Medical Home model as amended by the Department: o The care provided is Member/family-centered; whole-person oriented and comprehensive; coordinated and integrated; Provided in partnership with the Member and promotes Member self-management; outcomes-focused; consistently provided by the same provider as often as possible so a trusting relationship can develop; and provided in a culturally competent and linguistically sensitive manner.	

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	NHP ensures compliance with contract requirements by enhancing care coordinators' knowledge through ongoing training and monthly care coordination subcommittee meetings with delegated entities across the region. The quality-of-care coordination is closely monitored through established audit and performance improvement procedures, as outlined in the **Care Coordination Plan SFY24-25** and measured using the **CareCoordinationAuditTool.** These efforts demonstrate NHP's commitment to maintaining high standards in care coordination and delivering effective, member-centered services.	
2. The RAE ensures that each behavioral health member has an ongoing source of care appropriate to the member's needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member. • The member must be provided information on how to contact the designated person or entity. *42 CFR 438.208(b)(1)* Contract Amendment 17: Exhibit B—None	**Documents Submitted/Location Within Documents:** 1. CareCoordinationFactSheet_EN *Misc, Entire Document 2. CareCoordinationFactSheet_SP *Misc, Entire Document 3. GeneralCCPolicy262LR2_SFY24-25, Page 3-4 4. CareCoordinationPlanSFY24-25, Entire Document 5. CareCoordinationAuditTool, *Misc, Entire Document 6. Q16.404MonitoringTrtmtRecordReviewGuidelines, Entire Document 7. PrimaryCareProviderHandbook, *Misc, Pages 21-22, 24-25	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	8. BehavioralHealthProviderHandbook, *Misc, Page 4, 21-23, 41 9. CREF105.19MemberRiskAsmtandTriage, Entire Document 10. HCPFWelcomeLetter, *Misc., Entire Document 11. WelcomeLetter_EN, Entire Document 12. WelcomeLetter_SP, Entire Document 13. GettingStartedInvite_EN, *Misc., Entire Document 14. GettingStartedInvite_SP, *Misc., Entire Document 15. WelcomeandBenefitTextMessages, *Misc, Entire Document 16. 307L_MemberInfoReqPolicy, *Misc, Entire Document **Description of Process:** NHP demonstrates its commitment to meeting the requirements of **42 CFR § 438.208(b)(1)** by ensuring every behavioral health member has an ongoing source of care and a designated care coordinator, NHP fosters continuity, accessibility, and a personalized approach to care coordination. These efforts ensure members receive the right care at the right time, improving outcomes and enhancing overall satisfaction.	

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	These efforts are demonstrated in the following ways: NHP assigns a care coordinator or care management entity to each behavioral health member based on their level of need and care complexity. For members with complex needs or involvement in multiple systems (e.g., medical, social services), NHP identifies a **lead care coordinator** to centralize coordination efforts and prevent duplication. NHP initiates this process internally by providing each of the delegated care coordination entities in Region 2 with a list of members attributed to them. The member's "Member ID" (Medicaid ID) is bumped up to the 834-member eligibility dataset to confirm that the member is eligible within the RAE. Once complete, a set of queries assigns a care coordinator to members based on Primary Care Medical Provider (PCMP) location. The reports are distributed to care coordinators via secure email or through File Connect. NHP care coordinators work closely with primary care providers, behavioral health specialists, and community resources to align services and ensure a holistic approach to care. Members are involved in the decision to designate a care coordinator, ensuring their preferences and needs are prioritized in care planning and coordination.	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Care coordination information is provided to members via NHPs website, https://www.northeasthealthpartners.org/contact/, which includes a designated, toll free, care coordination phone number listed under the "Contact" tab. To ensure members who exclusively access behavioral health services have a clear and structured care pathway and understand their Medicaid benefits, including care coordination and how to contact their RAE, NHP provides training and education to all behavioral health providers in the region on connecting members to RAE care coordination services. NHP has developed FACT sheets for members and providers explaining care coordination, its benefits, that it comes at no cost, and how to request a care coordinator. These sheets, available in English and Spanish, are shared during training sessions and posted on NHP's website: https://www.northeasthealthpartners.org/care-coordination-fact-sheet-english/. Care coordinators regularly engage with members to establish trust and address any barriers to care. Initial contact is typically made soon after enrollment or at the time of a significant care event (e.g., hospital discharge). The document, **GeneralCCPolicy262LR2_SFY24-25**, pages 3	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	and 4, defines the responsibilities of care coordination activities within the Accountable Care Collaborative (ACC) 2.0 Program. Care coordination will be accessible to all members, provided at the point of care whenever possible, culturally responsive and provided for both short (deliberate) and long-term (extended) health care needs. Members can access their designated care coordinator through multiple channels, including phone, secure messaging, and in-person visits. For high-risk members, care coordinators may provide additional outreach and support. Care coordination delegated entities are monitored on compliance with this requirement using the existing audit procedures outlined in the **CareCoordinationPlanSFY24-25** and documented in the **CareCoordinationAuditTool**. Providers are monitored on compliance with this requirement through existing audit procedures, see **Q16.404 MonitoringTrtmtRecordReviewGuideline.** The document **PrimaryCareProviderHandbook** articulates on pages 21 and 22 that accountable PCMPs/delegated care coordination entities will manage the members physical and behavioral health needs as well as collaboration with social,	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	educational, justice, recreational and housing agencies to foster healthy communities and address complex member needs spanning multiple agencies. The care coordination delegation model allows members to have immediate and continuous access to care coordination staff who are dedicated to providing care coordination services. The document, **BehavioralHealthProviderHandbook,** states on pages 21 and 22 as a part of care coordination activities, participating providers should identify all providers/participating providers involved in the medical and/or behavioral health care and treatment of a member. Care Coordination contact information is listed for providers, see pages 4 and 21- 22. Carelon Behavioral Health care management team, on behalf of NHP, also conducts coordination of care activities in the following situations (see page 41 of **BehavioralHealthProviderHandbook**): • Members and participating behavioral health providers may access the Carelon care management system through any of the following avenues: 24-hour toll-free emergency care/clinical referral line	

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	• Direct registration/certification of care through ProviderConnect for participating providers • Direct authorization/certification of all levels of care through referral by a Carelon Clinical Care Manager (CCM) • Emergency services through freestanding psychiatric hospitals, medical hospitals with psychiatric units, emergency rooms, or crisis response teams If a call is received from a member requesting a referral and/or information about participating behavioral health providers in the member's location, CCMs may conduct a brief screening to assess whether there is a need for urgent or emergent care. Referrals are made to participating behavioral health providers, considering member preferences such as geographic location, hours of service, cultural or language requirements, ethnicity, type of degree the participating behavioral health providers holds and gender. Additionally, the member may require a clinician with a specialty such as treatment of eating disorders. In all cases, where available, the CCM will assist in arranging care for the member. The name, location, and phone number of at least three participating behavioral health providers will be given to the member. The provider manual also captures CCM review process to determine that	

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	the appropriate level of care (LOC) is being provided. All members accessing care through Carelon Behavioral Health's 24-hour Clinical Referral/Direct Line are assessed for risk of self-harm, harm to others, or harm by others and referred to the appropriate level of care in accordance with policy **CREF105.19MemberRiskAsmtandTriage**. Members are provided with information on network providers and delegated care coordination entities, including contact details, to facilitate linkage to needed services. Behavioral health providers are educated on the importance of care coordination, care coordination role with behavioral health providers and how to link members with care coordination (see page 22-23 of **BehavioralHealthProviderHandbook**. The care coordination referral form is also posted on the NHP website at https://www.northeasthealthpartners.org/members/care-coordination/care-coordination-referral-form/. Upon enrollment, members are sent a welcome letter from HCPF which includes a URL link to the NHP website, see **HCPFWelcomeLetter**. On the NHP's website, www.northeasthealthpartners.org/members/new-	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	member-welcome-packet/. NHP ensures that members are informed about their designated care coordinator and know how to contact them through written and verbal communication detailing the name of their care coordinating entity, direct contact information, and instructions on how to seek assistance after hours or in emergencies. Information is communicated in a culturally and linguistically appropriate manner to accommodate diverse member needs. Evidence of these practices are demonstrated in the following documents: NHP's New Member Welcome Packet includes NHPs' welcome letter, see **WelcomeLetter_EN** and **WelcomeLetter_SP**, as well as other onboarding resources. NHP hosts a "Getting Started" webinar, see **GettingStartedInvite_EN** and **GettingStartedInvite_SP**, on the first Thursday of every month to orient members to their benefits, how to use them, and how to get help finding resources. Members identified as having a textable number receive a welcome message from NHP. In accordance with regulations, those members are provided with the option to opt in or opt out of the "Welcome and Benefits" message campaign. Members who do not opt out are subsequently enrolled in the campaign. For more details, see	

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	WelcomeandBenefitTextMessages. This document outlines text messages sent to members enrolled in this campaign covering topics such as how to contact the health plan, accessing the member handbook and member rights, how to get a new ID card; as well as benefit reminders like well visits, immunizations, mental health, and dental services. Through these messages, members are also provided information to access care coordination, connection to community resources and crisis services. The document**, 307L_MemberInfoReqPolicy**, establishes guidelines for the development and distribution of critical member information and mechanisms in place to help members understand the requirements and benefits of their plan in plain language. In summary, NHP adheres to the federal standard by: • Ensuring each behavioral health member has an ongoing and consistent source of care aligned with their assessed needs. • Designating a person or entity responsible for coordinating care, promoting accountability, and enhancing the member experience.	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Providing members with clear and accessible information about how to contact their care coordinator.	
3. The RAE no less than quarterly compares the Department's attribution and assignment list with member claims activity to ensure accurate member attribution and assignment. The RAE conducts follow-up with members who are seeking care from primary care providers other than the attributed primary care medical provider (PCMP) to identify any barriers to accessing the PCMP and, if appropriate, to assist the member in changing the attributed PCMP. Contract Amendment 17: Exhibit B—6.8.1	**Documents Submitted/Location Within Documents:** 1. AttributionClaimsDataValidationProcess, Entire Document 2. PrimaryCareProviderHandbook, *Misc, Page 21-22 3. BehavioralHealthProviderHandbook, *Misc, Page 16 **Description of Process:** NHP compares HCPF's attribution and assignment list with member claims activities to help ensure accurate attribution/assignment. NHP also completes follow-up with members to identify barriers accessing PCMPs within the region and assists with changing the attributed PCMP when appropriate. This is demonstrated in the following supporting documents. • **AttributionClaimsDataValidationProcess** outlines the standard operating procedure to verify the attribution list provided by the Department of Health Care Policy and Financing (HCPF) contains the correct Member to provider with attribution based on claims activity. An attribution list aligned	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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	with claims activity ensures Members are being assigned to providers in which they have an active relationship with. This process is intended to ensure that this alignment exists in the attribution files provided by HCPF. Once this process is complete, NHP provides the list of outliers to the care coordination entities for follow up to assess any barriers, as well as to assist with contacting the enrollment broker for reattribution. • **PrimaryCareProviderHandbook**, pages 21 and 22, and **BehavioralHealthProviderHandbook,** page 16, describes the member attribution process for PCMP providers, as well as how a member can change their PCMP and how PCMPs can check the eligibility of attributed members via the state portal.	
4. The RAE's care coordination activities will comprise: • A range of deliberate activities to organize and facilitate the appropriate delivery of health and social services that support member health and well-being. • Activities targeted to specific members who require more intense and extensive assistance and include appropriate interventions. Contract Amendment 17: Exhibit B—11.3.3	**Documents Submitted/Location Within Documents:** 1. R2_PopMangPln_FY23-24, Page 9, 13 2. CareCoordinationPlanSFY24-25, Page 1-2 3. ComplexCCPlan_SFY24-25, Page 3-4 4. GeneralCCPolicy262LR2_SFY24-25, Page 3-4 5. CareCoordinationAuditTool, *Misc, Entire Document **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	NHP's care coordination framework is designed to integrate and streamline access to a full range of health and social services that promote member health and well-being. NHP ensures care coordination is accessible to all members. Comprehensive assessments are conducted to evaluate members' medical, behavioral, and social needs. This ensures the development of individualized care plans that align with members' goals and circumstances. Care coordination is comprised of deliberate interventions as well as extended care coordination. Deliberate interventions are available to the broader population and include tactics such as medical and social referrals, telephonic/electronic communications, educational resources, etc. Extended care coordination targets specific complex member groups who require more intense and prolonged assistance and include interventions such as care planning and quarterly bidirectional communication between the member and care coordinator. NHP collaborates with healthcare providers, behavioral health specialists, and community organizations to coordinate a cohesive approach to care. NHP conducts multidisciplinary team meetings to ensure that all aspects of a member's care are considered, and service delivery is aligned.	

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	NHP employs a strategic approach to organizing and facilitating the delivery of health and social services to enhance members' health and well-being. Care coordinators actively assist members in navigating complex systems to access appropriate services, including specialty care, mental health resources, and social supports. By stratifying members who may be at higher risk for negative health outcomes such as hospital re-admission or poor treatment results, NHP ensures that specific interventions and additional supports are provided. These supports include frequent follow-up appointments, medication reconciliation, and coordinated care between appointments. Proactive follow-ups ensure members successfully connect with referred services. Factors such as housing, transportation, food security, and employment are addressed to tackle social determinants of health. Our care managers systematically identify influential social determinants of health (SDoH), such as lack of social support, food or housing insecurity, and low health literacy, as part of the assessment and care planning process. These variables are considered markers of upstream drivers of disease exacerbation and healthcare costs. By focusing on	

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	these areas, NHP's care management efforts aim to reduce the intensity and frequency of disease-related symptoms, improve member adherence to treatment plans, and communication between the member, provider, and NHP, all of which contribute to better health outcomes and member satisfaction. Members are engaged through one-on-one consultations, care team meetings, and educational resources to empower them in managing their health and emphasis is placed on ensuring members understand the care process and their role within it. See **R2_PopMangPln_FY23-24**, page 9 for more information. NHP's care coordination model includes tailored interventions for members requiring more intensive and prolonged support. NHP uses predictive analytics, claims data, and clinical assessments to identify members with acute, complex, or chronic conditions who are at risk of adverse outcomes or high costs (**CareCoordinationPlanSFY24-25**, page 1-2). **The ComplexCCPlan_SFY24-25,** pages 3-5 addresses care coordination/care management of priority populations (i.e., complex members) who require more intense and extended assistance and includes appropriate interventions. Target	

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	populations include individuals with multiple comorbidities, frequent emergency room use, hospital re-admissions, or significant behavioral health needs. High-need members are assigned to dedicated care coordinators who provide continuous, personalized support. These care coordinators act as the primary point of contact and advocate for the members, ensuring their needs are consistently met. For these members, we develop targeted care plans that address their specific needs, by providing intensive support and appropriate interventions. Interventions are evidence-based and aligned with the member's unique situation, including close coordination with behavioral health providers to address mental health and substance use challenges; education and support for managing conditions like diabetes, hypertension, and asthma; and immediate intervention for members in crisis, including connection to emergency services and post-crisis follow-up. By focusing on the systematic identification and management of social determinants of health, NHP ensures that interventions address both medical and social risks, optimizing health outcomes. **See R2_PopMangPln_FY23-24**, page 9 for more information. **Extended Support**: For members with long-term needs, NHP develops extended care plans that	

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	include ongoing assessments, regular check-ins, and adaptation of services as circumstances change. Members are connected to durable support systems, such as peer support groups or long-term case management programs. NHP evaluates complex care management through a care coordination dashboard, aligning with the Department's guidance of using the complex care coordination report to evaluate extended care coordination of complex members' performance. NHP developed this dashboard to track care management outreach efforts and care coordination engagement. NHP carefully monitors the percentage of unique complex members engaging in Extended Care Coordination (ECC) through monthly analyses of data, Fiscal Year to Date (FYTD) data, and rolling twelve (12) month data to ensure we were consistently hitting our targets and meeting performance goals. See **R2_PopMangPln_FY23-24**, page 13. The document, **GeneralCCPolicy262LR2_SFY24-25**, section III. c. pages 3-4, supports the framework of the population health plan and addresses all components of this requirement, including: • Care coordination will be accessible to all members. Care coordination is comprised of deliberate interventions as well as extended care coordination. Deliberate interventions are	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	available to the broader population. Extended care coordination is targeted to specific member groups who require more intense and prolonged assistance. • Care coordination is provided at the point of care whenever possible, is culturally responsive and provided for both short (deliberate) and long-term (extended) healthcare needs. • Member preferences will be respected, and care coordinators will maintain regular communication with the practitioners' delivering services to members. The **CareCoordinationAuditTool** serves as the validated source for auditing delegated entities to ensure compliance with established care coordination standards. This tool evaluates documentation demonstrating the development and maintenance of comprehensive knowledge and working relationships with community agencies, health teams, and providers. It ensures these entities provide access to a wide range of care coordination services, including but not limited to medical care, substance use and mental health treatment, legal support, long-term care, dental services, developmental disability services, homeless services, and educational programs for special populations. Additionally, the audit tool	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	verifies that delegated entities facilitate member access to targeted and broad interventions across medical, non-medical, and community-based services. These include transportation, childcare, food assistance, elder support, housing, utility assistance, and other essential resources. This ensures compliance with contract standards and validates that members receive the comprehensive support they need. NHP ensures alignment with contract requirements by: • Delivering deliberate, organized care coordination activities that address the full spectrum of member health and social needs. • Focusing care coordination efforts on members who require more intense and prolonged assistance, ensuring interventions are appropriate, timely, and effective. • Continuously monitoring and improving care coordination practices to achieve optimal outcomes for all members. NHP's care coordination activities are a cornerstone of our commitment to member health and well-being. By organizing and facilitating a range of health and social services and targeting interventions for high-need members, NHP ensures compliance with **Contract Amendment**	

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	7: Exhibit B6—11.3.3 while promoting improved health outcomes and member satisfaction.	
5. The RAE administers the *Capitated Behavioral Health Benefit* in a manner that is fully integrated with the entirety of work outlined in the contract, thereby creating a seamless experience for members and providers. The RAE implements procedures to coordinate services furnished to the member: • Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. • With the services the member receives from any other managed care plan. • With the services the member receives in fee-for-service (FFS) Medicaid. • With the services the member receives from community and social support providers. • Including Medicaid-eligible individuals being released from incarceration to ensure they transition successfully to the community. *Note: Contractor shall ensure that care coordination is provided to members who are transitioning between health care settings and to populations who are served by multiple systems, including, but not limited to, children involved with child welfare; Medicaid-eligible individuals transitioning out of the criminal justice system; members receiving long-term services and supports (LTSS); members transitioning out of inpatient, residential, and institutional settings;*	**Documents Submitted/Location Within Documents:** 1. CareCoordTransitionofCarePolicy_SFY24-25, Page 1, 4 2. R2_PopMangPln_FY23-24, Page 10, 11, 16 3. CareCoordinationPolicy_262L, *Misc, Entire Document 4. GeneralCCPolicy262LR2_SFY24-25, Page 3, 5, 6-7 5. PCMPAgreement, *Misc, Page 1, 7, 8, 17, 19 6. ComplexCCPlan_SFY24-25, Page 4-5 7. CareCoordinationPlanSFY24-25, Page 2 8. DOC_TransitionReferralProcess, Entire Document 9. WelcomeLetter_DOC, Entire Document 10. VisionBenefits, Entire Document 11. DentalBenefit, Entire Document 12. BehavioralHealthProviderHandbook, *Misc, Page 59 13. PrimaryCareProviderHandbook, *Misc, Page 23, 24,25 14. CareCoordinationAuditTool, *Misc, Section P6 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
and members residing in the community who are identified as at-risk for institutionalization. *42 CFR 438.208(b)(2)* Contract Amendment 17: Exhibit B—14.1, 14.3, 11.3.10, 11.3.10.4.2.3, 11.3.20.2.1	NHP administers the Capitated Behavioral Health Benefit as part of a fully integrated approach to ensure seamless experience for members and providers. By aligning our behavioral health program with the broader objectives of the contract, NHP ensures: • **Streamlined Member Experience**: Members access behavioral health and related services through a single point of coordination, reducing complexity and fragmentation. • **Provider Support**: Providers benefit from simplified communication and coordination processes, including shared care plans and accessible support from care coordination teams. NHP is committed to ensuring seamless transitions for members moving from one system of care to another, minimizing any disruption to their health services. This commitment is formalized in the **CareCoordTransitionofCarePolicy**_SFY24-25, page 1, which plays a critical role in upholding contractual requirements for this measure. The policy guarantees that members with special health care needs maintain uninterrupted access to essential services during transitions. Furthermore, it aligns with the federal regulations outlined in 42 CFR 438.62, reinforcing its importance in meeting	

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	both regulatory and contractual obligations while prioritizing member well-being. **Coordination between Care Settings:** NHP implements robust procedures to coordinate services for members transitioning between settings of care, including discharge planning. We address transitions for members entering or leaving the RAE. Our Care Coordinators work closely with providers and related entities to implement effective communication and transition plans. When a member exits the RAE, we promptly identify and notify the receiving Managed Care Entity (MCE). Our team coordinates care, shares necessary information upon request, and makes referrals to appropriate providers, ensuring all transitions are smooth and timely. Clinical information, including medical records and care plans, is transferred within seven business days in compliance with legal standards. For members with special health care needs joining the RAE, we develop tailored care plans and ensure treatment continuity for at least sixty days at a negotiated rate, even if the provider is out-of-network. This may involve single-case agreements or compensating out-of-network providers. These efforts underscore NHP's commitment to providing uninterrupted, high-quality care during transitions (see	

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	CareCoordTransitionofCarePolicy_SFY24-25, *page 4).* In alignment with the Hospital Transformation Program (HTP) requirements, NHP is continuing to work with thirteen hospitals across the region, including seven in the Eastern Plans Healthcare Consortium (EPHC), to establish a technical mechanism in which the hospitals can meet HTP requirements. As the RAE, NHP has worked alongside EPHC hospitals to develop and implement a mutually agreed upon discharge planning notification process for regional members who have a diagnosis of mental illness, substance use disorder (SUD) or test positive for depression while pregnant. Additionally, NHP has begun to receive post-admission reviews through the Inpatient Hospital Transitions (IHT). The goals for the RAE under IHT 2.0 center on member engagement to address acute issues while the member is still at the hospital and identify ongoing/chronic concerns. During this early member engagement/assessment, the RAE care coordinator will connect the member with their PCMP for follow-up support to help prevent readmissions and ensure medication management. Finally, NHP was part of a statewide RAE workgroup focusing on Transitions of Care (TOC) with the goal of creating RAE recommendations for HCPF to consider when developing contract	

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	requirements. This workgroup concentrated on establishing a general agreement among RAEs regarding common language with the complex member definition for this work and specific transition of care activities. *See* **R2_PopMangPln_FY23-24**, page 10. NHP continues to disseminate the Admission, Discharge and Transition (ADT) data and the Daily Census to our care coordination entities for immediate daily outreach. Through these efforts, NHP care coordinators work alongside hospital discharge planners to help members transition to lower levels of care. They review discharge plans, help schedule follow-up appointments, identify transition barriers (such as transportation and prescription medication refills), connect members to community resources, and link members to additional services as needed. See **R2_PopMangPln_FY23-24**, page 16. The document, **CareCoordinationPolicy_262L**, provides guidelines for ensuring assistance members during transitions of care including but not limited to: • Members transitioning between health care settings • Members served by overlapping systems	

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	• Members discharge from inpatient hospitalization, • Members moving to a new provider and/or new area of the state, • Members returning to the community from long-term care and correctional facilities or an episode(s) of acute personal or family destabilization. The **GeneralCCPolicy262LR2_SFY24-25**, page 5, addresses supporting members in need of assistance with medical transitions. If the assigned member is seen in an emergency room or urgent care clinic or is admitted to an inpatient facility, the NHP/RAE Care Coordinator will begin their initial outreach to the facility (if the member is still hospitalized) within 24 hours of notification. NHP care coordinators engage with members, their families, and care teams prior to discharge to ensure post-discharge needs, such as follow-up appointments, medications, and home support, are identified and addressed. The RAE Care Coordinator will follow up with the member within seven (7) business days of discharge from the facility to verify adherence to care plans and address any emerging needs and to assist with transportation and/or scheduling any follow-up appointments. Transitions from inpatient to	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	outpatient behavioral health care are expedited to minimize gaps in service. (Page 6-7). NHP addresses the comprehensive coordination of medical services the members receive under FFS, ensuring seamless integration across care pathways. As outlined on Page 3 of the **GeneralCCPolicy262LR2_SF24-25**, NHP Care Coordinators are committed to ensuring effective collaboration with both medical and behavioral health providers. This ensures that every member receives the holistic care they need. Care Coordinators actively facilitate the delivery of necessary medical services by coordinating with members' healthcare providers. They make reasonable efforts to assist members in obtaining medically necessary services, stepping in to arrange appointments when members face difficulties accessing medical or behavioral healthcare. For members undergoing medical transitions or those with complex behavioral or physical health needs, Care Coordinators offer tailored support to help them navigate these transitions smoothly (**GeneralCCPolicy262LR2_SF24-25**, Page 5). NHP Care Coordinators play a vital role in addressing social determinants of health by facilitating member access to essential resources,	

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	including healthy food, exercise opportunities, transportation, stable housing, and employment support. They collaborate closely with members' providers and caregivers to ensure seamless continuity of care across all services, including for members under the oversight of the Division of Child Welfare /Colorado Department of Human Services (CDHS). Furthermore, Care Coordinators provide support with primary care medical provider (PCMP) referrals and attribution, as needed, to ensure members have access to comprehensive, coordinated, and continuous care. (**GeneralCCPolicy262LR2_SF24-25**, Page 9). The **PCMPAgreement** is a critical component in supporting the coordination of care for special populations and addressing the medical needs of all members. On page 1 of the agreement, "Care Coordination" is defined as the deliberate organization of member care activities across various participants, including family members and caregivers. This coordination is particularly responsive to special populations such as the physically or developmentally disabled, children and foster children, adults, the aged, non-English speakers, and the Health First Colorado Expansion populations. The agreement ensures that members requiring assistance with medical transitions or those with complex health needs	

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	receive targeted and effective care coordination. The agreement emphasizes that PCMPs are required to provide referrals for necessary services outside their scope to other providers within the Health First Colorado network, consistent with program requirements. This ensures members have access to a comprehensive network of care. Additionally, PCMPs are expected to provide input to Carelon regarding medical management and any Care Coordination activities, highlighting issues identified by members, which may necessitate education or community resource intervention (**PCMPAgreement**, Page 7). The expectation set forth mandates that providers and Care Coordination entities involved in a member's care share appropriate treatment records in compliance with professional standards. This facilitates continuity of care, prevents unnecessary re-hospitalizations, and enhances communication among providers, which is vital for optimal health outcomes (**PCMPAgreement**, page 8). Additionally, the **PCMPAgreement** underscores the willingness and capability of PCMPs to collaborate with Carelon on medical management and care coordination, reflecting a commitment to comprehensive case management for members (see **PCMPAgreement,** page 17). Moreover, the agreement reinforces the role of PCMPs in providing Care Coordination tailored to each member's specific needs, aligned with the	

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	RAE program's goals. This involves working collaboratively with interdisciplinary team members addressing a variety of needs, including long-term services and supports (LTSS), behavioral health, pharmacy, housing, employment, foster care, population health, and transitions of care. Such collaboration occurs through various channels, from direct appointments to interdisciplinary meetings and case rounds (**PCMPAgreement**, page 19). The agreement also ensures backup plans are in place for service delivery for members receiving LTSS, those involved in child welfare, or transitioning from incarceration, and confirms the existence of current crisis plans for individuals with behavioral health conditions, thereby providing a robust framework for comprehensive care coordination. NHP is dedicated to supporting members with complex needs within the communities where members reside. NCHA Community Care Coordinators are essential in linking these members to preventive care and treatment services (**ComplexCCPlan_SFY24-25**, pages 4-5). Coordinators focus on promoting member engagement and self-management, reaching out to those referred for enhanced care management and assisting with complex medical, behavioral health, and substance use needs. They play a crucial role in facilitating community re-entry post-	

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	incarceration and support the recovery of members battling substance use and opioid addictions. The program connects priority populations to health, human, and social services by employing effective communication techniques like motivational interviewing and trauma-informed care. Additionally, it ensures LTSS recipients, child welfare-involved members, and those transitioning from incarceration have service delivery backup plans and appropriate behavioral health provider links (**ComplexCCPlan_SFY24-25**, page 5). Support extends to discharge planning, securing community services, offering transportation, and linking housing-unstable members to resources. Coordinators work with community health workers at the Housing Navigation Center, enroll unhoused individuals on the HMIS housing list, and assist in obtaining vital documents such as birth certificates or IDs. Through these efforts, NHP provides comprehensive support to enhance members' well-being and quality of life (**ComplexCCPlan_SFY24-25**, page 5). NHP's Care Coordination approach emphasizes tailored support for special populations by addressing their unique needs and ensuring seamless integration of services. As outlined the **CareCoordinationPolicy_262L** (See page 4), care coordination is designed to be responsive to	

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	various special populations, including people with disabilities (both IDD and Non-IDD), children and foster children, adults, non-English speakers, and populations defined under the Health First Colorado expansion. This also includes members requiring assistance with medical transitions, those with complex health needs, justice-involved individuals, and members experiencing homelessness. Importantly, the policy directs that services provided are not duplicative but rather mutually reinforcing. Care Coordination activities aim to integrate services from different programs like LTSS and HCBS waivers to promote a holistic approach to the member's care without unnecessary overlap. Page 5 of the same document details Carelon's collaboration in assisting these populations through targeted interventions, particularly for those transitioning between healthcare settings or served by overlapping systems such as child welfare and justice. This holistic coordination extends to individuals with intellectual disabilities, mental health, and substance use disorders. Further, as outlined in the **GeneralCCPolicy262LR2_SFY24-25**, (see page 5) care coordination supports special populations by addressing similar needs, emphasizing the provision of services to physically or developmentally disabled individuals, and the	

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	aged, alongside other groups. NHP Care Coordinators are key players in addressing social determinants of health by helping members access vital resources such as food, exercise, transportation, housing, and employment. These coordinators work closely with providers and caregivers, including those involved with the Division of Child Welfare/Colorado Department of Human Services (CDHS), to ensure comprehensive continuity of care (**GeneralCCPolicy262LR2_SFY24-25**, page 9). NHP conducts in-reach programming at seven correctional facilities statewide, supporting outreach and engagement with incarcerated individuals attributed to NHP. Under the Department of Corrections RESTORE program, NHP participates in reentry fairs and plans to expand to additional facilities. NHP collaborates with Judicial Districts to receive referrals and provides training to probation and parole offices on Medicaid benefits, including SUD services, and access to the NHP provider network. Over the past year, NHP partnered with the 18th Judicial Court, Lincoln County jail, and OBH to develop an incentive program for inpatient providers accepting justice-involved members awaiting placement. This finalized process is pending referral implementation. Additionally, NHP collaborates with Colorado Access to educate the	

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	18th Judicial Court on referral processes, aiming to prevent unnecessary justice system involvement by connecting members to behavioral health services, care coordination, and SDoH resources. Insights gained will inform judicial courts about community networks, support recruitment for service gaps, and enhance cultural and linguistically competent care. See **R2_PopMangPln_FY23-24**, page 11. As outlined in **CareCoordinationPlanSFY24-25**, page 2, NHP has partnered with the Department and the Colorado Department of Corrections (CDOC) to identify and provide services to Medicaid-eligible individuals being released from incarceration to enable them to transition successfully to the community. Services include, but are not limited to, in-reach services, care transition support, and care coordination. Through this work, NHP receives a list of incarcerated members who have recently been released or will be released soon. NHP sends this list to Accountable Providers/Delegated Care Coordination Entities for timely outreach and transitional support. NHP coordinates the transitional support between CDOC and other RAEs for members not assigned to NHP, but in need of coordination. NHP manages all data files using well-established and HIPAA compliant	

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	privacy protocols and safely destroys the CDOC lists to ensure privacy protections. The **DOC_TransitionReferralProcess** outlines the process for identifying and referring members preparing for release from the Department of Corrections (DOC) to the RAE for care coordination, outreach, and support. Justice-involved members contacted through this process receive a welcome letter (**WelcomeLetter_DOC**) that explains their benefits and introduces them to the RAE. Additional materials, such as **VisionBenefits** and **DentalBenefit** documents, are also provided to ensure members are informed about available services. NHP monitors continuity and coordination of care across its behavioral health services, as outlined in the **BehavioralHealthProviderHandbook** (Page 59, Continuity and Coordination of Care). This includes reviewing and auditing treatment records, coordinating discharge planning between inpatient and outpatient providers, and evaluating provider performance on predefined care coordination indicators. Processes are in place to ensure minimal disruption to member care during transitions between treating providers. Additionally, NHP monitors continuity and coordination of care across the contracted primary	

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	care provider network, as outlined in the **PrimaryCareProviderHandbook**, see pages 23,24,25. Care coordination entities are audited on the compliance with the identified policies and procedures through the **CareCoordinationAuditTool**, specifically Section P6 related to compliance in assisting members with transitions.	
6. The RAE uses the results of the health needs survey, provided by the Department, to inform member outreach and care coordination activities. The RAE: • Processes a daily data transfer from the Department containing responses to member health needs surveys. • Reviews the member responses to the health needs survey on a regular basis to identify members who may benefit from timely contact and support from the member's PCMP and/or RAE. *42 CFR 438.208(b)(3)* Contract Amendment 17: Exhibit B—7.5.2–3	**Documents Submitted/Location Within Documents:** 1. HealthNeedsSurveyProcess_NHP, Entire process 2. CareCoordinationPlanSFY24-25, Page 3, 6 3. GeneralCCPolicy262LR2_SFY24-25, Page 2, 5 4. CareCoordinationAuditTool, *Misc, Entire Document **Description of Process:** NHP ensures that we efficiently process and integrate Health Needs Survey (HNS) data provided by the Department into our care coordination workflows through automated data integration, data validation and categorization for prioritization.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	NHP processes daily data transfer from HCPF's enrollment broker Maximus, to retrieve the HNS results for distribution to delegated care coordination entities. This can drive member outreach and care coordination activities. The document, **HealthNeedsSurveyProcess_NHP**, describes the process of intake and distribution of the HNS. The File Utilization Batch System (FUBS) Application runs on an automated schedule to download the Health Needs Surveys. FUBS will look for any new HNS that are made available on the Secure File Transfer Protocol (SFTP) site. Once FUBS finds a new file, the file is downloaded to a file repository on the server. The file is then processed to the Colorado data warehouse under the [RAE2].[dbo].[HealthNeedsSurvey] database structure. All HNS are appended to this database. The member's "MemberID" (Medicaid ID) in the HNS is bumped up to the 834-member eligibility roster dataset to confirm that the member is eligible within the RAE. The HNS does not have the member demographics such as phone and address. This information is pulled from the 834-member eligibility dataset roster and is appended to the HNS database. Once the member's demographics have been included in the HNS dataset, a set of queries assigns a care coordinator to the members based off attribution and care coordination delegation. The reports are then sent	

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	out to the care coordinators via secure email or through FileConnect. Using the insights gained from the Health Needs Survey, NHP conducts targeted outreach and coordinates care to address identified needs. Outreach methods include phone calls, secure messaging, and, when necessary, in-person visits. The document, **CareCoordinationPlanSFY24-25**, page 3 and 6, identifies care coordination interventions are provided in alignment with RAE principles, including using the results of the Health Needs Survey to inform member outreach and care coordination activities. Care coordination activities are customized to align with members' expressed needs and preferences, such as connecting members to behavioral health or substance use treatment providers; addressing social determinants of health, including housing, transportation, and food insecurity; facilitating preventive care visits and chronic disease management. The document, **GeneralCCPolicy262LR2_SFY24-25** pages 2 and 5, reinforces expectations for the delegated care coordination entity to use the results of the Health Needs Survey, to inform member outreach and care coordination activities. NHP shares	

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	relevant survey findings with members' Primary Care Medical Providers (PCMPs) to support coordinated care delivery. NHP employs continuous monitoring and quality improvement processes to optimize our use of health needs survey data, such as response rates, member engagement, and outcomes of outreach efforts. NHP also provides feedback to the department, from insights gained from survey responses to support improvements in survey design and administration. The **CareCoordinationAuditTool** is used to ensure compliance with contractual requirements by assessing and monitoring whether care coordinators are identifying and addressing member needs to guide care coordination activities effectively.	
7. *For the Capitated Behavioral Health Benefit:* The RAE ensures that it has procedures to ensure: • Each member receives an individual intake and assessment appropriate for the level of care needed. • It uses the information gathered in the member's intake and assessment to build a service plan. • It provides continuity of care for members who are involved in multiple systems and experience service	**Documents Submitted/Location Within Documents:** 1. ClinicalAuditTool, *Misc, Sections B & C 2. CareCoordTransitionofCarePolicy_SFY24-25, Entire Document 3. GeneralCCPolicy262LR2_SFY24-25, Page 4, 7 4. BehavioralHealthProviderHandbook, *Misc, Page 37, 59-61	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
transitions from other Medicaid programs and delivery systems. *42 CFR 438.208(c)(2–3)* Contract Amendment 17: Exhibit B—14.7.1	5. PrimaryCareProviderHandbook, *Misc, Page 13, 21, 23- 24 6. Q16.404On the MonitoringTrtmtRecordReviewGuidelines, Entire Document 7. ProviderContract, *Misc, Page 16, 17-18 8. SBHS Billing Manual, Pages 24-25, 86, 87 **Description of Process:** NHP ensures each member receives an individual intake and assessment to identify the appropriate level of care and helps the member identify a person-centered treatment plan based on their diagnosis, level of care, strengths, and ensuring these are reviewed routinely. Providers are monitored on compliance with this requirement through existing audit procedures (see **ClinicalAuditTool**, *Misc, Sections B & C) specifically auditing the intake assessment and treatment planning requirements. NHP implements procedures to maintain continuity of care for members involved in multiple systems or transitioning from other Medicaid programs and delivery systems. NHPs policy, **CareCoordTransitionofCarePolicy_SFY24-25**	

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	(*entire document*) defines the responsibilities for NHP care coordinators to maintain continuity of care for members involved in multiple systems or transitioning from other Medicaid programs and/or delivery systems. This policy highlights cross-system collaboration, transition planning and support for multi-system involvement. This policy is aligned with the requirements of 42 CFR 438.62 and the Colorado Department of Health Care Policy and Financing's Transition of Care Policy. **GeneralCCPolicy262LR2_SFY24-25**, page 4, details that the NHP/RAE Care Coordinator is responsible for assessing or arranging for the assessment of the member's need for services, coordinating mental health services rendered by multiple providers, coordinating behavioral health services with other health care and human service agencies and providers, and referring to other health care and human service agencies and providers, as appropriate. NHP care coordinators complete an initial assessment utilizing evidence-based, standardized assessment tools to evaluate and link members with behavioral, social, and medical providers/entities based on the needs of members. These tools are designed to inform referrals for an appropriate level of care and ensure equitable, effective services. Care coordinators engage members in a culturally	

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	sensitive and trauma-informed manner to ensure the process is inclusive and respectful. The care coordinators facilitate information sharing with relevant entities while adhering to confidentiality and privacy standards. NHP care coordinators will also complete an individualized Care Plan for all members participating in care coordination. Care plans are developed in partnership with the member, their family or caregivers (if applicable), and their care team, to include member preferences, goals and cultural values. Care plans include interventions to address behavioral health needs, physical health conditions, and social support such as housing, transportation, and employment assistance. Plans outline measurable goals, timelines, and assigned responsibilities for members of the care team and are updated regularly or whenever a significant change occurs in the members' health/ circumstances. NHP care coordinators will appropriately share relevant components of the assessment with other providers or agencies serving the member, as outlined on page 7, to prevent duplication of efforts among entities. Carelon complies with audit standards and contract requirements by providing targeted interventions for members transitioning between healthcare settings. The Intensive Case	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Management Team (ICMT) supports members requiring Complex Care Coordination, ensuring they navigate systems effectively and connect to necessary services. Members receiving acute care at higher levels will receive transition services from the Clinical Care Management Team, which facilitates discharges from inpatient hospitalization, transitions to new providers or regions, reintegration into the community from long-term care or correctional facilities, and stabilization after acute personal or family crises. The Clinical Care Management Team also assists with coordination and transitions for residential and day treatment services. For members with particularly complex care needs, the ICMT assumes responsibility for care coordination until their needs stabilize, at which point a regional care coordinator assumes responsibility. The ICMT collaborates with regional care coordinators, the NHP Clinical Director, and other involved parties to ensure seamless transitions and optimal treatment outcomes, see **CareCoordinationPolicy_262L**, page 5. Behavioral health providers/participating behavioral health providers must develop individualized treatment plans that utilize assessment data, address the member's current problems related to the behavioral health	

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	diagnosis, and actively include the member and significant others, as appropriate, in the treatment planning process. See **BehavioralHealthProviderHandbook**, page 37. As outlined in the **BehavioralHealthProviderHandbook**, page 37, the Clinical Care Manager (CCM)s review the treatment plans with the behavioral health providers/participating behavioral health providers to ensure that they include all elements required by the provider agreement, applicable government program, and at a minimum include the following: • Specific measurable goals and objectives • Reflect the use of relevant therapies • Show appropriate involvement of pertinent community agencies • Demonstrate discharge planning from the time of admission • Reflect active involvement of the member and significant others as appropriate Behavioral health providers/participating behavioral health providers are expected to document progress toward meeting goals and objectives in the treatment record and to review and revise treatment plans as appropriate.	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Continuity and coordination of care is monitored through the continuum of behavioral health services, see **BehavioralHealthProviderHandbook**, page 59. Monitoring may include reviews and audits of treatment records, coordination of discharge planning between inpatient and outpatient providers/participating providers, and monitoring provider/participating provider performance on pre-determined coordination of care indicators. Processes are established seeking to avoid disruption of care for the member when there is a change in their treating provider/participating provider. Treatment Record Standards and Guidelines (see **BehavioralHealthProviderHandbook**, page 59-61) outlines how member treatment records should be maintained, as well as what should be included in the progress notes, and record-keeping standards for treatment record reviews and audits. Compliance with these standards of care is monitored through treatment record reviews, audits and associated requests for copies of member records. The "Access to Treatment Records and Treatment" section in the **PrimaryCareProviderHandbook,** Page 14	

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	outlines how member treatment records should be maintained, and shared as appropriate. Additionally, the **PrimaryCareProviderHandbook** page 23, states that optimal care coordination provides timely access to services, enhances continuity of care across providers and care systems, provides support to individual members and their families, and helps them understand and advocate for necessary services. The PCMPs/Delegated Care Coordination Entities are responsible for completing an assessment with the member to determine medical and non-medical needs in order to link members to appropriate resources, see page 24. Following the comprehensive member assessment, care coordination activities are structured by a clinical care plan, a collaborative, living document generated by the member and care coordinator reflecting member's needs, long and short-term goals, associated resources, supports, providers and action steps toward reaching their identified goals. **Q16.404MonitoringTrtmtRecordReviewGuidelines** describes the process in which the Quality Management (QM) Department conducts regular treatment record audits of service providers to ensure compliance with documentation requirements. Assessments of provider	

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

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	In alignment with the **Provider Contract** (pages 17–18), all services are required to be delivered in accordance with "generally accepted medical standards" and "all Applicable Rules," which explicitly include Medicaid requirements. All activities, including intake, assessment, service planning, and service delivery, adhere to 42 CFR 438.208(c)(2–3), which ensures that Medicaid members receive necessary assessments and care coordination to support continuity of care. This includes specific efforts to address the needs of members involved in multiple systems or transitioning between different Medicaid delivery systems. This is further reinforced by: • Individual Intake and Assessment: each member attempting to access care undergoes an individual intake and assessment to determine the appropriate level of care, as outlined in the **SBHS Billing Manual,** page 86, under H0031 (Mental Health Assessment by a Non-Physician). This process includes a thorough clinical assessment to evaluate behavioral health needs, functional capacity, and factors affecting mental health. The intake assessment also incorporates collateral information when applicable, ensuring a holistic evaluation of the member's condition and circumstances.	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Service Plan Development: The information gathered during the intake and assessment is utilized to create an individualized service plan, as detailed under H0032 (Mental Health Service Plan Development by Non-Physician) in the **SBHS Billing Manual,** page 87. The treatment plan includes clearly defined goals, specific clinical interventions, and progress evaluation criteria tailored to the member's needs. The service plan must be reviewed and updated regularly to reflect changes in the members' condition or progress. • Documentation Standards: The Provider is required to maintain thorough and accurate documentation of the intake and assessment process, service plans, and all clinical encounters, as specified in Section VIII of the **SBHS Billing Manual,** pages 24-25. Documentation must demonstrate the medical necessity and clinical rationale for services provided and establish a direct connection to the member's treatment plan.	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. *For the Capitated Behavioral Health Benefit:* The RAE shares with other entities serving the member the results of its identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR 438.208(b)(4)* Contract Amendment 17: Exhibit B—None	**Documents Submitted/Location Within Documents:** 1. GeneralCCPolicy262LR2_SFY24-25, Page 3, 4,6, 7, 8 2. CareCoordinationPlanSFY24-25, Page 2, 3. CareCoordinationAuditTool, *Misc, Entire Document 4. PCMPAgreement, *Misc, Page 5, 17, 18-19,21-22 **Description of Process:** NHP ensures compliance with 42 CFR 438.208(b)(4) by implementing robust processes to share the results of member identification and assessments with other entities involved in the member's care. NHP has established and strengthened relationships among network providers and the health neighborhood in the region by supporting existing collaborations and facilitating the creation of new connections and improved processes. These processes aim to prevent duplication, foster collaboration, and streamline service delivery for the Capitated Behavioral Health Benefit. Care coordination expectations directly align with this requirement. NHP care coordination entities receive monthly lists (examples: new members, members who need a wellness check, high risk members and other priority populations, etc.), for follow-up. These lists include PCMP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	identification, so that delegated care coordination entities can efficiently engage in two-way communication between care coordinators and PCMPs to ensure member's needs are met. Evidenced in **GeneralCCPolicy262LR2_SFY24-25**, page 7(e): NHP care coordinators share assessment results and service plans with PCMPs to ensure integration of behavioral and physical health care. Additionally, behavioral health providers receive comprehensive information about members' needs, including mental health and substance use disorders, to ensure alignment with treatment plans. Care coordinators continually work on improving bidirectional communication processes with providers/other Medicaid entities. Additionally, NHP employs modern technology and standardized practices to facilitate effective communication across systems. Information is shared through secure platforms that protect member privacy and comply with HIPAA and state-specific confidentiality laws. Whenever possible, NHP shares member information in real-time, particularly during care transitions, to avoid gaps or duplication in services. By sharing assessment results and coordinating care, NHP actively prevents unnecessary	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	duplication of services, benefiting both members and providers. Enhancing these efforts and demonstrated in policy **GeneralCCPolicy262LR2_SFY24-25**, page 8 (g) NHP organizes/leads and participates in multidisciplinary case conferences with care teams (Creative Solutions/Complex Solutions), ensuring alignment and avoiding redundant efforts in addition to targeted follow-up activities including monitoring the implementation of shared care plans to identify and address any overlapping activities. NHP prioritizes sharing assessment results during transitions of care, when members are at heightened risk for service duplication or fragmentation, including during hospital discharges and transfers. As noted in policy **262L-R2**, page 6 (b), NHP care coordinators will respond to care coordination referrals within 24 hours of notification and will coordinate services and share relevant treatment information as detailed on page 5 (f). As detailed in the **CareCoordinationPlanSFY24-25**, additional emphasis on transitions from criminal justice systems as well as support for multi-system populations is prioritized. For Medicaid-eligible individuals re-entering the community, NHP coordinates with justice system	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	caseworkers and community health providers to align on care needs and service plans (page 2). Supporting Multi-System Populations, NHP works closely with child welfare agencies, Colorado Crisis System, waiver service providers and long-term services and support (LTSS) providers to name a few to ensure assessments are shared and used effectively across systems **GeneralCCPolicy262LR2_SFY24-25**, Page6 (f,,i-xii). Finally, NHP ensures that information sharing respects member preferences and is delivered in a culturally competent manner. Member consent is obtained before sharing information, ensuring transparency and trust in the process, and information is communicated to partnering entities in ways that respect members' cultural and linguistic needs **GeneralCCPolicy262LR2_SFY24-25**, Page 3 (b), Page 4 (c. iii & vi-4), Page 6 (f), Page 6 (g). NHP monitors compliance with coordination and continuity of care standards by enhancing care coordinators' knowledge through regular training and meetings focused on contract requirements. Monthly care coordination subcommittee meetings are conducted with delegated care coordination entities across the region to foster	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	collaboration and alignment. Compliance with these standards is systematically monitored through established audit processes and performance improvement initiatives, ensuring adherence to requirements and continuous enhancement of care delivery, see **CareCoordinationAuditTool.** The document titled **PCMPAgreement** (refer to exhibit A starting on page 17) where the document outlines specific requirements for Primary Care Medical Providers (PCMPs) regarding the sharing of member information with other entities to prevent duplication of activities and ensure coordinated care. Under this agreement, PCMPs: • Commit to cooperating with NHP's care coordination, case management, medical management, care management, and disease management activities. • Provide input and recommendations on medical management and care coordination activities, addressing issues identified by members, such as the need for education or community resources. • Adhere to expectations to share member treatment records with other providers or organizations involved in the member's care,	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	as appropriate and in alignment with professional standards. For those PCMPs who are delegated to provide care coordination as an Accountable Provider, NHP outlines additional expectations starting on page 21-22, G: Care Coordination Responsibilities: • Maintain relationships with community organizations such as specialty care, managed service organizations and their networks of substance use disorder providers, hospitals, pharmacists, dental, nonemergency medical transportation, regional health alliances, public health, Area Agencies on Aging, Aging and Disability Resources for Colorado, and other ancillary providers. • Develop and maintain comprehensive knowledge and working relationships with community agencies, health teams and providers that offer a range of services including medical care, substance abuse and mental health treatment, legal services, long-term care, dental services, developmental disability services, homeless services, school and educational programs, and other agencies that serve special populations	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Promote continuity of care, and unnecessary re-hospitalizations or services at a higher level of care and to facilitate improved communication about the member among providers, facilities, and others who are involved with the member. This communication standard fosters continuity of care and reduces the likelihood of unnecessary re-hospitalizations or escalated care, and facilitates improved collaboration among providers, facilities, and organizations serving the members. These practices ensure compliance with the standard to promote seamless care delivery, minimize service duplication, and enhance member outcomes.	
9. *For the Capitated Behavioral Health Benefit:* The RAE ensures that each provider furnishing services to members maintains and shares, as appropriate, member health records, in accordance with professional standards and in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that they are applicable. *42 CFR 438.208(b)(5) and (6)*	1. BehavioralHealthProviderHandbook, *Misc, Page 22 2. PrimaryCareProviderHandbook,*Misc, Page 13-14 3. GeneralCCPolicy262LR2_SFY24-25, Page 6 4. PCMPAgreement*Misc., Page 6, 13 5. ProviderContract, *Misc, Page 23, 26-27, 47 6. ProviderTermProcessNWCO008, Entire Document 7. P05.1B_UseandDisclosureofPHIandPI, *Misc, Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract Amendment 17: Exhibit B—11.3.7.10.6, 15.1.1.5	8. IT201.10HIPAAStandard1_SecurityManagement, Entire Document 9. IT208.11HIPAAStandard 8SecurityEvaluation, Entire Document 10. IT216.9HIPAAComplianceStandard16_Integrity, Entire Document 11. IT217.10HIPAAStandard17_PersonorEntity Authentication, Entire Document 12. PrivacyNotice *Misc, Entire Document **Description of Process:** NHP ensures compliance with 42 CFR 438.208(b)(5) and (6) by implementing robust policies and practices for maintaining, sharing, and protecting member health records. These measures align with professional standards and the privacy requirements established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as codified in 45 CFR Parts 160 and 164, Subparts A and E. NHP prioritizes the protection of member privacy in all activities involving the sharing of health records. All information obtained is used solely for the purposes of utilization management, quality management, disease management, discharge planning, case management, and claims payment.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Both provider handbooks are available and accessible on NHP's website under Provider Handbook and Policies Menu: • Physical Health Provider Handbook:https://s18637.pcdn.co/wp-content/uploads/sites/25/NHP-Primary-Care-Provider-Medicaid-Handbook.pdf • Behavioral Health Provider Handbook: https://s18637.pcdn.co/wp-content/uploads/sites/25/NHP-Behavioral-Health-Medicaid-Provider-Handbook.pdf Provider agreements explicitly outline the obligation to maintain and share member health records according to professional standards and HIPAA requirements. **BehavioralHealthProviderHandbook**, page 22 and **PrimaryCareProviderHandbook** pages 13 and 14 states that providers/participating providers are: • Expected to comply with applicable federal and state privacy, confidentiality, and security laws, rules, and/or regulations, including without limitation the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 C.F.R. Part 2, Health Information Technology for Economic and Clinical Health Act (HITECH Act), and the rules and regulations promulgated thereunder.	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Responsible for meeting their obligations under these laws, rules, and regulations, by implementing such activities as monitoring changes in the laws, implementing appropriate mitigation and corrective actions, and timely distribution of notices to patients(members), government agencies, and the media when applicable. • Responsible for obtaining from members written release of authorizations to share Substance Use Disorder PHI for treatment, payment, or healthcare operations purposes with Carelon. The release should be retained on file. All contracted providers receive the handbook, and it is posted on NHPs' website under provider resources for reference https://www.northeasthealthpartners.org/providers/provider-handbook/. NHP's approach to information sharing strengthens coordination of care while maintaining member privacy. NHP facilitates continuity of care, collaborates with multiple systems (e.g., child welfare, criminal justice), and shares health records to reduce unnecessary duplication of services and assessments. NHP prioritizes the protection of member privacy in all	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	activities involving the sharing of health records. All care coordination entities are required to comply with HIPAA regulations, including safeguarding Protected Health Information (PHI). Privacy practices ensure compliance with 45 CFR Parts 160 and 164, covering the use, disclosure, and storage of member health information. These requirements are illustrated in **GeneralCCPolicy262LR2_SFY24-25**, page 6, indicates that NHP/RAE Care Coordinators will ensure that all communications with other providers are in accord with all applicable Federal and State requirements related to the protection of individually identifiable health information. These requirements include those specifically identified in 45 CFR, parts 160 and 164, subparts A and E (HIPAA), to the extent that they are applicable. When there are questions about whether particular information can be exchanged, consultation with the NHP's Compliance Officer is advised to resolve these questions prior to releasing the information. The **PCMP_Agreement**, page 13, includes provisions for confidentiality. The parties agree to have and implement procedures designed to preserve the privacy and confidentiality of Member records; and maintain, retain, use and/or disclose such Member records and any Protected Health Information in accordance with HIPAA,	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HITECH, 42 C.F.R. Part 2 as related to alcohol and/or substance abuse services and/or records, and all applicable other federal and state laws, rules and regulations regarding the confidentiality, privacy and/or security of Protected Health Information and/or medical/behavioral health/alcohol-substance abuse records and any patient consent required there under. PCMP shall also ensure that any records maintained electronically meet all applicable federal and state laws and regulations related to the storage, transmission and maintenance of such records. Providers are subject to regular audits to ensure record maintenance, sharing protocols, and privacy standards (page 6). The **ProviderContract**, on page 26-27 details the confidentiality of member records including implementation of procedures designed to preserve the privacy and confidentiality of member records. The provisions outlined in the **ProviderContract** illustrate the structured approach taken to ensure network adequacy and continuity of care in the event of provider departure or network termination. On Page 23, the contract specifies whether Carelon's contract with a plan is terminated, or if Carelon ceases business operations, the responsibility for care	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	coordination, authorization, and reimbursement shifts to the plan. This ensures that members continue to receive necessary services without disruption, as providers will recognize the plan as they did Carelon, maintaining continuity of care unless prohibited by applicable regulations such as those involving EOHHS or CMS. Page 47 of the **ProviderContract** further underscores the commitment to continuity of care. If the agreement is terminated without cause by Carelon, and members have not been adequately notified as required by C.R.S. §10-16-705(7), they are allowed to continue receiving covered services from the provider for sixty days post-termination. Additionally, if coverage under a health benefit plan ends for reasons other than nonpayment of premiums, fraud, or abuse, providers are obligated to continue treating members admitted to inpatient facilities until discharge, as mandated by C.R.S. §10-16-705(4). During such continuation periods, providers agree to deliver services in accordance with the existing rates and terms stipulated in the agreement, as per C.R.S. §25-37-111(1). These measures collectively uphold network integrity, assure compliance with regulatory standards, and address potential dissatisfaction by ensuring providers and members experience minimal disruption during transitions.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The Colorado Medicaid Provider Termination Process (ProviderTermProcessNWCO008) policy to notify members of PCMP and behavioral health provider termination from the RAE network within 15 days after the receipt or issuance of the termination notice or 30 days prior to the effective date of the termination. **P05.1B_UseandDisclosureofPHIandPI** states that Carelon Behavioral Health as a wholly owned subsidiary of Elevance Health, has adopted the Elevance Health Corporate Policy and Procedure P-05.1: Use and Disclosure of Protected Health Information (PHI) within Elevance Health Policy and Procedure. Elevance Health Associates may access, use, and share with other Elevance Health Associates the minimum amount of PHI necessary to perform Elevance Health's Treatment, Payment, and Health Care Operations (TPO) without needing Individual Authorization. Elevance Health Associates shall adhere to the guidelines outlined in the applicable Notice of Privacy Practices (Notice Policy) when collecting, using and disclosing PHI. Any collection, Use or Disclosure of PHI not covered in the Notice requires prior approval from the Privacy Department. The Security Management Process outlined in **IT201.10HIPAA**	

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

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The document, **PrivacyNotice,** also addresses how NHP may use and disclose Protected Health Information (PHI) as well as uses of PHI that do not require authorization. The privacy notice is posted on NHPs' website in English and Spanish https://www.northeasthealthpartners.org/?s=privacy	
10. The RAE possesses and maintains an electronic care coordination tool to support communication and coordination among members of the provider network and health neighborhood. The care coordination tool collects and aggregates, at a minimum: • Name and Medicaid ID of member for whom care coordination interventions were provided. • Age. • Gender identity. • Race/ethnicity. • Name of entity or entities providing care coordination, including the member's choice of lead care coordinator if there are multiple coordinators. • Care coordination notes, activities, and member needs. • Stratification level. • Information that can aid in the creation and monitoring of a care plan for the member—such as clinical history, medications, social supports, community resources, and member goals. The care coordination tool, at a minimum:	**Documents Submitted/Location Within Documents:** 1. R2_PopMangPln_FY23-24, Page 12 2. CC_HealthCloudDocumentation, Entire Document 3. HealthCloudIntakeScreening, Entire Document 4. CareCoordinationAuditTool, *Misc, Section A **Description of Process:** NHP fully complies with the requirement to possess and maintain an electronic care coordination tool, ensuring effective communication and collaboration across the provider network and health neighborhood. Our care coordination tool, Health Cloud, is a cornerstone of NHP's care coordination strategy, designed to enhance member outcomes, reduce duplication of services, and promote whole-person care. Health Cloud collects and aggregates critical information to support member care	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Works on mobile devices. • Supports HIPAA and 42 CFR Part 2 compliant data sharing. • Provides role-based access to providers and care coordinators. *Note: The Contractor shall collect and be able to report the information identified in Section 15.2.1.3 for its entire network. Although network providers and subcontracted care coordinators may use their own data collection tools, the Contractor shall require them to collect and report on the same data.* Contract Amendment 17: Exhibit B—15.2.1.1, 15.2.1.2, 15.2.1.3–5	(clinical/EMR data, claims, HIE, ADT data, Daily Census, COUP, attribution/834), to create member profiles, including identifying information required: Name, Medicaid ID, Age, Gender Identity, Race/Ethnicity, Lead Care Coordinator, Notes/Activities, Stratification and Care Planning. Additionally, there are evidenced based screening and assessment tools available in NHP's designated care coordination tool, Health Cloud (examples: PHQ-9, GAD-7, PRAPARE, ACES, Prenatal Plus Assessments). Members can be automatically stratified and grouped together based on any indicator and "targeted" based on any evidence-based risk score. Health Cloud tracks successful versus unsuccessful outreach attempts and outcomes; ALL care coordination activity for over 175 specific tasks with outcomes (this includes referrals, care coordination with other entities, specific health education activities, etc.), assessments and screenings with automated tasks tied directly to identified needs; member level time tracking tied to each care coordination activity (including travel and documentation time). Moreover, the Health Cloud system captures every touch (activity) that happens within the system and uses customized logic to stage and	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	develop custom reporting for specific priority areas. Health Cloud's activities are closely monitored and can be reported to show any long-term outcome of a specific population or priority. Furthermore, NHP care coordination staff work closely with the Quality Improvement department and Practice Transformation Coaches to assist in quality-of- care gap closure. See, **R2_PopMangPln_FY23-24**, page 12. The documents **CC_HealthCloudDocumentation** and **HealthCloudIntakeScreening** provide the following information: • Member Name: Member name and MCD ID can be found at multiple locations throughout the member profile. The customized member card has MCD ID at the top for quick reference as well as in the member details. The members name can be found throughout the member profile and the "tab" feature ensures users can always be sure which member they are viewing (see Slide 1-2). • Age: Date of birth (and age) is quickly visible upon viewing the member profile. This can be found in the member card and the member details (see Slide 3). • Gender Identity: Gender identity is auto populated into the application based on any relevant data field that CCMCN is instructed	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	to pull (clinical/EMR data, claims, HIE, attribution/834). This information is at the forefront of the member profile to ensure a care manager's approach and outreach is set up to be as successful as possible (see Slide 3). • Race/Ethnicity: Race/ethnicity is auto populated into the application based on any relevant data field that CCMCN is instructed to pull (clinical/EMR data, claims, HIE, attribution/834). This information is at the forefront of the member profile in the detail section to ensure a care manager's approach and outreach is set up to be as successful as possible (see Slide 3). • Care coordination information: Health Cloud has multiple ways of showing care coordination lead and the entire care team view. Most activities are driven by automated assignments based on customized logic, ensuring real time data feeds are actioning the appropriate team members to follow-up relevant to the established need. Health Cloud requires a "lead care manager (aka record owner)" for visibility and "care plan assignments" (aka case) owner. However, tasks within a care plan can be automatically assigned to multiple care team members based on specialty. Both the lead care manager and the care plan owner are visible in multiple	

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

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Member Needs: social needs/barriers can be automatically imported or manually added to a person's care plan to document the interventions related to the social barrier. Another example of a social determinants of health screener which the RAE care managers complete on individual members. These screeners have customized logic built into them which can automatically trigger follow-up tasks based on identified needs selected (ex: if "yes" to "worried about housing" > auto assign "refer to housing navigation center/resources" is applied to the care manager task list). There are numerous screening and stratification tools that capture member needs (physical, social and behavioral) all utilizing custom logic. • Stratification Level: There are customized assessments (ex: GAD 7 or stratification tool) that can auto sum and trigger additional tasks based on the "total score". Health Cloud utilizes automated data interfaces and specific criteria (indicators) to stratify members into activated care plans which are then auto assigned to relevant care team members. Some examples of these care plans that are stratified are: COVID high risk, high cost, diagnosis / chronic condition, pregnancy. Health Cloud utilizes code	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	sets identified by the RAE and its delegated partner to ensure stratification meets the need of the targeted population. All care plans can be found on a member level which shows a comprehensive view of current and historical stratification driven action has been identified (see Slides11-13). • There are moderate and high complexity assessments built into Health Cloud (see Slide 3). Health Cloud is accessible on mobile devices via the Salesforce App. Users must create the appropriate connection between the app and Colorado Community Managed Care Network (CCMCN)'s custom landing Page: https://ccmcn.my.salesforce.com. Once logged in, they can navigate the system via the app, see slide 14 for an example. Health Cloud is fully HIPAA compliant. CCMCN has a BAA with Salesforce that ensures all parties are following appropriate rules and regulations. CCMCN is also HITRUST certified, which required all of NHP's platforms to be fully evaluated prior to certification in October 2023. In addition to HITRUST, CCMCN undergoes an annual HIPAA Security Risk Assessment (SRA) that follows NIST 800-30 Risk Management	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Guide. NHP's last risk assessment was completed on November 27, 2023, through an assessment platform provided by Intraprise Health (aka HIPAA One). Finally, CCMCN also ensures that Health Cloud adheres to any rules and regulations surrounding Part 2 data. This data is locked down from users unless the appropriate consent is obtained, see slide 15. Health Cloud does have role-based access. Whenever a user account is generated, the user must have an assigned role, as well as an assigned profile. Roles determine what a user can see in Salesforce, including which records they can access relative to others in the organization. Profiles determine what a user can do in Salesforce, including which objects, fields, and apps they can access, see slide 16. NHP ensures compliance through audits of the care coordination tool utilizing **CareCoordinationAuditTool**, Section A. NHP's electronic care coordination tool is a vital component of our approach to delivering high-quality, integrated care for members. By aggregating comprehensive member information, facilitating communication across the health neighborhood, and supporting personalized care plans, the tool ensures compliance with the	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	outlined standard. These efforts promote efficient, effective, and member-centered care coordination, aligning with NHP's mission to improve health outcomes and enhance the member experience.	

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

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE has written policies regarding the member rights specified in this standard. *42 CFR 438.100(a)(1)* Contract Amendment 17: Exhibit B—7.3.7.1–2	**Documents Submitted/Location Within Documents:** 1. 304L_MemberRandRPolicy, Entire Policy **Description of Process:** Northeast Health Partners (NHP) follows Carelon's Member Rights and Responsibilities Policy, underscoring our commitment to safeguarding member rights and ensuring every member is treated with respect and dignity. NHP ensures that members are informed about their rights as stipulated in 42 CFR 438.100. This policy is fully compliant with applicable state and federal laws, as well as contractual requirements. To review the complete policy, refer to document **304L_MemberRandRPolicy** in its entirety.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The RAE complies with any applicable federal and State laws that pertain to member rights (e.g., non-discrimination, Americans with Disabilities Act) and ensures that its employees and contracted providers observe and protect those rights. *42 CFR 438.100(a)(2) and (d)* Contract Amendment 17: Exhibit B—17.10.7.2	**Documents Submitted/Location Within Documents:** 1. 304L_MemberRandRPolicy, Pages 1,11 2. RAEAttestationofMemberRights, Entire Document 3. 310L_NonDiscriminationPolicy, Entire Document 4. NonDiscriminationNotice, EntireDocument 5. ProviderContract, Pages 15, 17 *Misc 6. BehavioralHealthProviderHandbook, Page 15, Page 18 *Misc.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	7. PrimaryCareProviderHandbook, Pages 10, 14 *Misc 8. Feb2024ProviderRoundtable, Slides 36-38 *Misc 9. July2024ProviderRoundtable, Slides 10-13 10. FeedbackDatabase, Page 2 11. ChartAuditTool, Line A3 12. IT206.13_HIPAACompliance_SecurityIncidentProceduresPolicy, Entire Document 13. ProviderDirectorySearchOptions, Entire Document **Description of Process:** NHP strictly adheres to all pertinent federal and state laws regarding member rights, ensuring that both our employees and contracted providers respect and protect these rights. NHP follows two key policies and procedures focused on member rights: • **304L_Member Rights and Responsibilities Policy** • **310L_Non-Discrimination Policy** NHP mandates that all employees read and sign the **304L_Member Rights and Responsibilities Policy**, confirming their understanding and commitment to treating members with respect. See **304L_MemberRandRPolicy**, Page 11 and for examples of employee attestation, see **RAEAttestationofMemberRights**, Entire Document. Moreover, NHP adheres to the	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	310L_Non-Discrimination Policy, ensuring that no member faces discrimination based on race, color, ethnic or national origin, ancestry, religion, creed, sex, gender, sexual orientation, gender identity and expression, age, disability, handicap, health status (including AIDS or an AIDS-related condition), the need for health care services, or political beliefs in the context of receiving care and services from NHP. For full details, refer to the **310L_NonDiscriminationPolicy**, Entire Policy. Additionally, the non-discrimination notice is available on the NHP website at https://www.northeasthealthpartners.org/non-discrimination-notice/See **NonDiscriminationNotice**, Entire Document. NHP also provides information regarding rights and responsibilities, disenrollment rights, civil rights, the Americans with Disabilities Act, and transgender equality on our website. These resources are available in both English and Spanish at https://www.northeasthealthpartners.org/members/rights-responsibilities/. NHP requires its contracted providers to sign an agreement ensuring that members with disabilities receive the same standard of care as other members without facing discrimination and respect and uphold members' rights. NHP educates contracted providers	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	about member rights and responsibilities twice a year during the provider roundtable forums. For evidence refer to **ProviderContract**, pages 15 and 17, **BehavioralHealthProviderHandbook**, pages 19 and 22 **PrimaryCareProviderHandbook,** pages 10 and 14**, Feb2024ProviderRoundtable**, slides 36-38, and **July2024ProviderRoundtable**, slides 10-13. NHP is committed to keeping members informed about available disability accommodations. We offer electronic and mobile-enabled provider directories accessible through the Find a Provider tab on our website. 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. • Find a Behavioral Health Provider which links to Carelon Behavioral Health to find a behavioral health provider. • Find a Dentist which links to DentaQuest to find a dental provider. See **ProviderDirectorySearchOptions**, Entire Document.. Members can view and print NHP's provider directory if they have access to a printer.	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Additionally, they may call and request that a printed copy of the provider directory be mailed to them. Many NHP members opt to contact our call center for assistance in finding a local provider. Our call center associates use these provider search tools to help members locate providers based on their preferences. Clinical Service Assistants (CSAs) can perform searches by: • The gender of the provider • The number of miles the provider lives from the member's home • If the provider is bilingual, including ASL • The ethnicity of the provider • Provider specialty including SUD specialty • Access for disabilities • Telehealth Members may ask a call center associate if there is specialized equipment for their disability. If this occurs, the call center associate will outreach the provider to ascertain if the provider can accommodate a disability. In cases where a member believes their rights have been violated, they or their designated client representative (DCR) can file a complaint via phone,	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	letter, in person, or email at any time. NHP delegates the oversight of member complaints to Carelon, who monitors, documents, and categorizes all complaints, particularly those related to the violation of member rights. See **FeedbackDatabase**, page 2. NHP's quality team at Carelon performs chart audits for our contracted providers to ensure compliance with reviewing rights and responsibilities with members. This information is documented in the chart audit tool. See **ChartAuditTool**, Line A3. In the event of a data security breach, NHP follows the **IT206.13_HIPAA Compliance – HIPAA Standard 6: Security Incident Procedures Policy**, ensuring violations are prevented, detected, contained, and corrected in line with federal **HIPAA Security Regulations**. See **IT206.13_HIPAACompliance_SecurityIncidentProceduresPolicy**, Entire Document.	
3. The RAE's policies and procedures ensure that each member is guaranteed the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for the member's dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.	**Documents Submitted/Location Within Documents:** 1. 304L_MemberRandRPolicy, Entire Document 2. 307L_MemberInfoReqPolicy, Pages 1-3 *Misc **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Participate in decisions regarding their health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. • Request and receive a copy of their medical records and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210). *42 CFR 438.100(b)(2) and (3)* Contract Amendment 17: Exhibit B—7.3.7.2.1–6	NHP has implemented policies to ensure each member's rights are protected according to federal guidelines. The "Rights and Responsibilities Policy" includes the following provisions, refer to **304L_MemberRandRPolicy**, pages 2-3: • Members will receive information in compliance with the information requirements (42 CFR 438.10) (Section V.f). • Members will be treated with respect and due consideration for their culture, dignity, and privacy (Section II.a.v). • Members will be informed about available treatment options and alternatives in a manner appropriate to their condition and understanding (Section II.a.xxii). • Members have the right to participate in decisions regarding their healthcare, including the right to refuse treatment (Section II.a.viii). • Members have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation as specified in other Federal regulations on the use of restraints and seclusion (Section II.a.xxiii). • Members can request and receive a copy of their medical records and request amendments or corrections (Section II.a.xxxii).	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Members will receive healthcare services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210) (Section II.a.xiii). Refer to **304L_MemberRandRPolicy**, Entire Document for details. Additionally, NHP adheres to the "Member Information Requirements Policy and Procedures" to ensure compliance with the information requirements outlined in 42 CFR 438.10. Refer to **307L_MemberInfoReqPolicy**, pages 1- 3.	
4. The RAE ensures that each member is free to exercise their rights and that the exercise of those rights does not adversely affect how the RAE, its network providers, or the Department treat(s) the member. *42 CFR 438.100(c)* Contract Amendment 17: Exhibit B—7.3.7.2.7	**Documents Submitted/Location Within Documents:** 1. Rights&Responsibilities, Entire Document 2. Rights&ResponsibilitiesSpanish, Entire Document 3. RightsandResponsibilitiesPoster, Entire Document 4. RightsandResponsibilitiesPosterSpanish, Entire Document 5. EvidenceofDisplay, Entire Document 6. GettingStarted, Slide 3 7. ComplaintGuide, Page 2 8. ComplaintGuideSpanish, Page 2 9. MEACMeeting, Slide 6 10. 304L_MemberRandRPolicy, Page 7, Section V.b.iii.1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	11. BehavioralHealthProviderHandbook, Pages 16-17 *Misc 12. PrimaryCareProviderHandbook, Page 11 *Misc 13. Feb2024ProviderRoundtable, Slides 36-38 *Misc 14. July2024ProviderRoundtable, Slides 10-13 15. AdvocateMeetingPresentation, Slides 16-17 16. CallCenterMemberEngagementMeeting, Slides 2-5 17. CareCoordinationPresentation, Slides 6-7 18. WelcomeandBenefitTextMessages, Line 14*Misc 19. Chart Audit Tool, Entire Document **Description of Process:** NHP has established a comprehensive complaint process to ensure that each member can freely exercise their rights without fear of adverse treatment by NHP, network providers, or Health First Colorado (Colorado's Medicaid Program). This process is managed by Carelon, which handles complaints, but a complaint can come through anyone and any venue (face to face, providers, state, email, call). The member engagement team is responsible for educating both members and providers about member rights, emphasizing that members cannot face retaliation for exercising these rights. Additionally, the team assists in resolving any	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	violations of members' rights and investigates any instances of perceived or actual retaliation. NHP educates members about their rights through several platforms: • Website: Our member rights and responsibilities statement is available as both a PDF document and as a poster for providers to display in their practices. The documents and posters are available in both Spanish and English and outline that members can exercise their rights and file a complaint without fear of adverse treatment. Both formats are accessible on the RAEs website https://www.northeasthealthpartners.org/members/rights-responsibilities/ and is included in the evidence section. See **Rights&Responsibilities**, Entire Document, **Rights&ResponsibilitiesSpanish**, Entire Document, **RightsandResponsibilitiesPoster**, Entire Document , and **RightsandResponsibilitiesPosterSpanish**, Entire Document. • Provider Locations: Member rights and responsibilities are prominently displayed at provider locations. See **EvidenceofDisplay**, Entire Document.	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Monthly Webinars: NHP conducts a monthly "Getting Started" webinar for members, family members, and staff, which provides an opportunity to discuss member rights, for members to ask questions about their rights, and to discuss how to exercise these rights without retaliation. Refer to **GettingStarted**, slide 3. • Complaint Guide: The complaint guide, available in both English and Spanish, states that members can file a complaint without being treated differently. This guide is accessible at **Complaint Guide English** and **Complaint Guide Spanish**, see **ComplaintGuide**, page 2 and **ComplaintGuideSpanis**h, page 2. • Member Meetings: Rights and responsibilities are reviewed during Member Experience Advisory Council Meetings. Refer to **MEACMeeting**, slide 6. • Member Advocate Meetings: NHP partners with member advocates at partner sites to research grievances. NHP educates member advocates on our member rights and responsibilities statements to ensure that member rights are upheld and protected, see **AdvocateMeetingPresentation**, slides 16-17.	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Staff Meetings: The NHP call center and care coordinators are educated on our Member Rights and Responsibilities statements, see **CallCenterMemberEngagementTraining**, slides 2-5, **CareCoordinationPresentation**, slides 6-7. • Text Messaging: Members receive a text message that states, "As a Northeast Health Partners member, you have rights and responsibilities! Read about them in your handbook online at www.northeasthealthpartners.org.", see **WelcomeandBenefitTextMessage**, line 14*Misc. Northeast Health Partners adheres to the Member Rights and Responsibilities Policy to ensure that each member is free to exercise their rights without adverse treatment by the RAE, network providers, or Health First Colorado, see **304L_MemberRandRPolicy**, page 7. NHP educates providers about members' rights through two avenues: • Provider Handbook: The handbook describes how members can file a complaint and ensures that members will not lose their Health First Colorado benefits, be treated differently, or face restricted access to services for filing a complaint, refer to the	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	BehavioralHealthProviderHandbook, pages 16 and 17 and the **PrimaryCareProviderHandbook**, page 11 • Provider Roundtables: These bi-annual education forums teach providers that members can file a complaint if they believe their rights have been violated and reassure providers that members cannot be treated differently for exercising these rights, see **Feb2024ProviderRoundtable**, slides 36-38 and **July2024ProviderRoundtable**, slides 10-13. The quality team at NHP completes chart audits for contracted providers using the document titled **ChartAuditTool NHP**.	
5. For medical records and any other health and enrollment information that identify a particular member, the RAE uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42 CFR 438.224* Contract Amendment 17: Exhibit B—11.3.7.10.6, 15.1.1.5	**Documents Submitted/Location Within Documents:** 1. P05.1B_UseandDisclosureofPHIandPI, Entire Document, *Misc. 2. 304L_MemberRandRPolicy, Pages 8-9 Section V.d 3. LC400_MemberPrivacyRightsPolicy, Page 5, Section c,1-2. Page 7. Section D.1-2, and Page 10, Section G 4. PCMPAgreement, Page 10, Page 13 *Misc 5. ProviderContract, Page 26-27, Page 54 *Misc 6. BehavioralHealthProviderHandbook, Page 18,*Misc 7. PrimaryCareProviderHandbook, Pages 13-14*Misc	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	8. PrivacyNotice, Entire Document *Misc 9. ChartAuditTool, Page1 Line A4 10. CareCoordinationPolicy_262L, Page 6-7 *Misc **Description of Process:** NHP uses and discloses members' health information in strict accordance with HIPAA privacy requirements (45 CFR parts 160 and 164, subparts A and E) when applicable. All NHP staff adheres to the policy P05.1B_Uses and Disclosure of PHI and PI regarding the use and disclosure of Protected Health Information (PHI) and Personally Identifiable Information (PI). This policy mandates compliance with federal and state privacy laws and ensures that only the "minimum necessary" information is used or disclosed for the required purpose, see **P05.1B_UsesandDisclosureofPHIandPI**, Entire Document. Additionally, NHP staff follow the policy 304L Member Rights and Responsibilities Policy, which stipulates that confidentiality procedures must conform to all relevant laws. Members have the right to access, obtain copies, and request amendments to their PHI, see **304L_MemberRandRPolicy**, Pages 8-9 and supporting policy	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	LC400_MemberPrivacyRightsPolicy, Page 5, Section c,1-2. Page 7. Section D.1-2, and Page 10, Section G NHP Notice of Privacy Practices is available on our website, details how medical information may be used and disclosed, as well as how members can access this information. The privacy notice also provides contact information for the privacy officer in case of any privacy concerns. The document can be accessed at NHP Notice of Privacy Practices. The notice is included as evidence, see **PrivacyNotice**, entire document. Primary Care Medical Providers (PCMPs) must sign an agreement to comply with all applicable laws regarding members' medical records. Additionally, behavioral health providers sign contracts to uphold state and federal confidentiality laws. These requirements are also outlined in both the Behavioral Health Provider Handbook and the Primary Care Provider Handbook. For evidence of both, see **PCMPAgreement**, page 13, **ProviderContract**, pages 26 and 54, **BehavioralHealthProviderHandbook**, page 18, and **PrimaryCareProviderHandbook**, pages 13 and 14. The Quality Department at NHP conducts chart audits to ensure providers review privacy notices	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	with members, as documented in the chart audit tool, see **ChartAuditTool**, Line A4. Care Coordinators follow Policy 262L-R2_Care Coordination to ensure that all communications with other providers are in accordance with all applicable Federal and State requirements related to protected individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable, see **CareCoordinationPolicy_262L**, page 6.	
6. The RAE maintains written policies and procedures and provides written information to individuals concerning advance directives with respect to all adult individuals receiving care by or through the RAE. Advance directives policies and procedures include: • Notice that members have the right to request and obtain information about advance directives at least once per year. • A clear statement of limitation if the RAE cannot implement an advance directive as a matter of conscience. – The difference between institution-wide conscientious objections and those raised by individual physicians. – Identification of the State legal authority permitting such objection.	**Documents Submitted/Location Within Documents:** 1. 269L_AdvanceDirectivesPolicy, Entire Document 2. AdvanceDirectivesTrainingFlyer, Entire Document 3. AdvanceDirectivesTrainingFlyerSpanish, Entire Document 4. AdvanceDirectivesTraining, Entire Document 5. AdvanceDirectives_SocialMedia, Entire Document 6. CareCoordinationPresentation, Slides 10, 11 7. GettingStarted, Slide 22 8. AdvocateMeetingPresentation, Slides 22, 23 9. PTLearningCollaborative, Slides 23-34 10. July2024ProviderRoundtable, Slides 30-31	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Description of the range of medical conditions or procedures affected by the conscientious objection. • Provisions: – For providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and is unable to receive information. – For providing advance directive information to the incapacitated member once he or she is no longer incapacitated. – To document in a prominent part of the member's medical record whether the member has executed an advance directive. – That care to a member is not conditioned on whether the member has executed an advance directive, and provision that members are not discriminated against based on whether they have executed an advance directive. – To ensure compliance with State laws regarding advance directives. – To inform individuals that complaints concerning noncompliance with advance directive requirements may be filed with the Colorado Department of Public Health and Environment.	11. ProviderNewsletter, Page 3 12. AdvanceDirectives-NCHA, Entire Document 13. BehavioralHealthProviderHandbook, Pages 17-18 *Misc.doc 14. PrimaryCareProviderHandbook, Pages 12-13 *Misc. 15. ChartAuditTool, Line A6 **Description of Process:** NHP has a comprehensive policy and procedure in place regarding advance directives for adult members receiving treatment from our providers. This policy is accessible online, and members may request a free printed copy by visiting Advance Directives and Living Will. The website includes links to: • Advance Directives policy • Colorado Medical Advance Directives • Colorado Psychiatric Advance Directives • Five Wishes • Information on quarterly Life Care Planning/Advance Directives training sessions for members, providers, and community members Northeast Health Partners Advanced Directive policy, **269L_AdvanceDirectivesPolicy**, contains the following key points:	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– To inform members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. – To educate staff concerning its policies and procedures on advance directives. – The components for community education regarding advance directives that include: ▪ What constitutes an advance directive. ▪ Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. ▪ Description of applicable State law concerning advance directives. *Note: The RAE must be able to document its community education efforts.* *42 CFR 438.3(j)* *42 CFR 422.128* Contract Amendment 17: Exhibit B—7.3.11.2, 7.3.11.3.3	• Annual Information: Members have the right to request and obtain information about advance directives at least once per year (Page 5, Section V.H). • Conscientious Objections: Clear statements regarding limitations if the RAE cannot implement an advance directive as a matter of conscience, and details on both institution-wide and individual physician objections, including State legal authority (Page 3, Section IV). • Medical Conditions: Description of the range of medical conditions or procedures affected by conscientious objections (Page 3, Section IV). • Family or Surrogate Information: Provisions for providing advance directive information to the member's family or surrogate if the member is incapacitated at the time of initial enrollment (Page 4, Section V.D.4). • Incapacitated Member Information: Provisions for providing advance directive information to the incapacitated member once they are no longer incapacitated (Page 4, Section V.D.5). • Medical Record Documentation: Documentation in a prominent part of the member's medical record indicating whether	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	the member has executed an advance directive (Pages 3-4, Section V.A). • Non-Discrimination: Assurance that care is not conditioned on whether the member has executed an advance directive, and members are not discriminated against based on whether they have executed an advance directive (Page 2, Section II.D and Page 6, Section V.K). • State Law Compliance: Ensuring compliance with State laws regarding advance directives (Page 1, Section II.A). • Complaint Information: Informing individuals that complaints concerning noncompliance with advance directive requirements may be filed with the Colorado Department of Public Health and Environment (Page 5, Section V.H). • State Law Changes: Informing members of changes in State laws regarding advance directives no later than 90 days following the changes (Page 1, Section II.B). • Staff Education: Educating staff on policies and procedures related to advance directives (Page4, Section V.E). • Community Education: Components for community education on advance directives, including what constitutes an advance directive, the purpose of advance directives,	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	and applicable State laws (Page 5, Section V.I). Please refer to **269L_AdvanceDirectivesPolicy**, Entire Document for the complete policy. NHP offers quarterly Advance Directives training for members, families, care coordinators, and providers. Our community outreach manager, a certified advance directives facilitator, arranges group or individual training sessions as needed. NHP also has a member engagement staff member to assist with Spanish interpretation is needed. For evidence, see **AdvancedDirectivesTrainingFlyer**, Entire Document, **AdvancedDirectivesTrainingFlyerSpanish**, **EntireDocument,PTLearningCollaborative**, slides **AD-NHCA**, Entire Document. NHP promotes the Advance Directives training through various channels and trains staff on advanced directives. These promotion and training opportunities include: • Social media • Care coordination meetings • "Getting started" webinars • Member advocate meetings • Practice transformation coaches • Provider roundtables	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Provider newsletters For more information, see **AdvanceDirectivesFlyer**, Entire Document, **AdvanceDirectivesTrainingFlyerSpanish**, Entire Document, **AdvanceDirectives-NCHA**, Entire Document, **AdvanceDirectives_SocialMedia**, Entire Document, **CareCoordinationPresentation**, Slide 10, **GettingStarted**, Slide 15, **AdvocateMeetingPresentation**, Slide 26, **PTLearningCollaborative**, Slides 23-34, **JulyProviderRoundtable**, Slides 30-31, and **ProviderNewsletter**, Page 3. Providers are informed about advance directives through provider handbooks, refer to the **BehavioralHealthProviderHandbook**, pages 17-18, and the **PrimaryCareProviderHandbook**, pages 12-13. The Quality Department conducts chart audits to ensure providers discuss advance directives with members aged 18 and older. This information is documented in the chart audit tool, see **ChartAuditTool**, Line A6.	

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

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

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	CR203.17PractitionerCredentialingProcessPolicy details the credentialing process for initial practitioners to ensure turn-around-time of performance guarantees as applicable to state requirements, review of the practitioner application, supporting documentation, and currently attested information within the application. Files that meet established criteria outlined in this policy are submitted to the Medical Director for clean approvals and the credentialing system is updated to reflect the practitioner's status as Credentialed. Should a practitioner not meet the established criteria the file is forwarded for further review and decision to the National Credentialing Committee. **CR 209.15PractitionerRecredentialingProcess** details the process for recredentialing existing network practitioners within thirty-six months of the previous credentialing decision. Practitioners are notified four months prior to their recredentialing date and once a current application and the supporting documentation is received, this information is updated and uploaded into the credentialing system and assigned to credentialing staff for processing. The practitioner files are reviewed by credentialing staff for completeness following the detailed criteria in this policy. While certain criteria initially reviewed during the initial credentialing process are not reviewed during the recredentialing process (i.e. education verification and work history	

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	review), Potential Quality Issues are also reviewed. Recredentialing files deemed clean are forwarded to the Medical Director for approved submission and the credentialing system is updated to reflect the practitioner's status as Recredentialed. Should the credentialing staff determine that the practitioner file has been found to include findings requiring further review, the file is forwarded to the National Credentialing Committee for this review for final decision.	
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners it credentials and recredentials. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. The Contractor shall document and post on its public website policies and procedures for the selection and retention of providers. *Examples of behavioral health practitioners include psychiatrists, physicians, addiction medicine specialists, doctoral or master's level psychologists, master's level clinical social workers, master's level clinical nurse*	**Documents Submitted/Location Within Documents:** 1.CR225.22DisciplineSpecificCredentialingCriteriaPractitionersPolicy, Section VI.B, Page 3 2.NWCO_003_NetworkDevelopmentAccessStandards, Entire Document 3. MasterGridCOCriteria, Entire Document **Description of Process:** **CR225.22DisciplineSpecificCredentialingCriteriaPractitioners** outlines the independently-practicing practitioner types within scope for credentialing who meet the educational and licensure requirements of their practicing state, CMS, state-specific Medicaid, and NCQA standards to be eligible for NHP network approval. Practitioners wishing to join the NHP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

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

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

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

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

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	recredentialing approvals through monitoring of quality of care, disciplinary actions, augmenting coverage areas to ensure access to required practitioner types and administrative disenrollments, resignations, and reporting to authorities, reference **CR202.11OverviewNationalNetworkServicesPolicy**, Section VI.C.4, Pages 3-4.	
2.F. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. *Examples include nondiscrimination of applicant, a process for preventing and monitoring discriminatory practices, and monitoring the credentialing/recredentialing process for discriminatory practices at least annually.* *42 CFR 438.214(c)* NCQA CR1—Element A6	**Documents Submitted/Location Within Documents:** 1. CR226.12PreventionMonitoringNon-DiscriminatoryPolicy, Section VI, Page 2-3 2. CR210.9 RolesResponsibilitiesReimbursementNCCPolicy, Section VI.F, Page 4 3. CR202.11OverviewNationalNetworkServicesPolicy, Section VI.C, Page 3 4. CR202AAnnualMonitoringPotentialDiscriminationReportTemplate, Entire Policy 5. 023CRMonitoringAuditNon-Discrimination2.6, Entire Document **Description of Process:** NHP does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, age, sexual orientation, licensure or certification type, or the type(s) of procedure(s) or patients in which the practitioner specializes, or in the conditions that require costly treatment. Annually, the designated credentialing auditor randomly selects	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	credentialing and recredentialing files from all states' services areas which fall under Carelon Behavioral Health's legal entities and audits these files to ensure no discrimination occurred during the processing of the files including during the method of the credentialing decision. Documentation submitted to the National Credentialing Committee for clean approvals, denied and pended practitioners are reviewed, and findings are notated on the Non-Discrimination Audit Report Template, which is then forwarded to the Director of Credentialing or designee. The Director of Credentialing/designee then forwards these results to the National Credentialing Committee, as detailed in CR 226.12PreventionMonitoringNon-DiscriminatoryCredentialingRe-CredentialingPolicy. The NCC receives this audit report and reviews it for any potential discrimination findings found by the auditor and the specific credentialing file is then again reviewed following advisement of the NCC Chairperson to the committee members of the inappropriate and irrelevant demographics and discriminatory criteria during its review, as detailed in **CR210.9 RolesResponsibilitiesReimbursementNCCPolicy**. The process of this audit review is detailed in **CR202.11OverviewNationalNetworkServicesPolicy**; audit review criteria of the randomly selected credentialing and recredentialing files is recorded on the	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	CR202AAnnualMonitoringPotentialDiscrimination ReportTemplate. Please reference **2023CRMonitoringAuditNon-Discrimination2.6** as evidence of non-discrimination audit.	
2.G. The process for notifying practitioners if information obtained during the Contractor's credentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A7	**Documents Submitted/Location Within Documents:** 1. CR205.12ProviderRightsNotificationPolicy, Section VI.C.1-6, Page 3 **Description of Process:** During the credentialing process and review of a file's completeness and primary source verification of required credentialing elements, should information provided by a practitioner in the attested application be found to conflict with verified information obtained by third party primary verification source, **CR205.12ProviderRightsNotificationPolicy** details the process NHP implements to notify the practitioner to review the conflicting information, make necessary corrections, and the timeframe the practitioner has to respond to this request, as well as the process of determining whether or not a practitioner's response resolves the discrepancy and the process should a practitioner not respond to this notification.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

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

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

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

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	and supporting documentation that will be listed on the Provider Directory as well as updates to practitioner and provider information for existing practitioners/providers.	
3. The Contractor notifies practitioners about their rights: 3.A. To review information submitted to support their credentialing or recredentialing application. *The Contractor is not required to make references, recommendations, or peer-review protected information available.* NCQA CR1—Element B1	**Documents Submitted/Location Within Documents:** 1. CR205.12ProviderRightsNotificationPolicy, Section VI.A, Pages 2-3; Section VI.B, Page 3 2. PractitionerRightsNotificationLetter, Entire Document 3. BehavioralHealthProviderHandbook, Page 13, *Misc **Description of Process:** Prior to the Credentialing process and following the nomination of a practitioner into the NHP network, Contracting sends each practitioner a letter with an addendum informing them of their rights, where to find these rights, and the methods the practitioner may use to outreach to NHP to exercise these rights. See **PractitionerRightsNotificationLetter**. Providers can also find this information in the **BehavioralHealthProviderHandbook**, page 13. NHP practitioners and facility/organizational providers have the right to review the contents of their credentialing application, which NHP will oblige by forwarding only those specific documents being requested by credentialing management within thirty	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3.C. To receive the status of their credentialing or recredentialing application, upon request. NCQA CR1—Element B3	**Documents Submitted/Location Within Documents:** 1. CR205.12ProviderRightsNotificationPolicy, Section VI.D, Page 3 **Description of Process:** NHP practitioners and facility/organizational providers have the right to request the status of their credentialing application, and should any further information be required, the practitioner/provider will be notified of this, as referenced in **CR205.12ProviderRightsNotificationPolicy**, Section VI.D., Page 3.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor designates a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions. NCQA CR2	**Documents Submitted/Location Within Documents:** 1. CR210.9 RolesResponsibilitiesReimbursement NCCPolicy, Section V, Page 2 **Description of Process:** The National Credentialing Committee (NCC), which includes the Medical Director and Co-Chair(s) along with members of the NCC, who are experts in their fields, are representative of the practitioners in scope for credentialing to be reviewed. **CR210.9RolesResponsibilitiesReimbursementNCCPolicy**, Section V, Page2 details the NCC's direct involvement in the review, oversight, monitoring and decision-making for clean files and files requiring	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

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

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– The organization is not required to obtain this information for practitioners who had a hospital insurance policy during a residency or fellowship. *Note: Education/training and work history are NA for recredentialing. Verification of board certification does not apply to nurse practitioners or other health care professionals unless the organization communicates board certification of those types of providers to members.* NCQA CR3—Element A	**CR206.22PrimarySourceVerificationPolicy**, Section VI.B.2, Page 3. NHP verifies the highest level of education/training completed by an initial credentialing practitioner within 180 days of the approval date, as applicable by practitioner type and is not reverified during the recredentialing process. Board certification for applicable practitioners is verified within 180 days of the approval date for both initial and recredentialing practitioners through the type-specific specialty board; if board certification has not been obtained by an applicable practitioner during the initial process, the practitioner's education and training is verified within 180 days of decision date, reference **CR206.22PrimarySourceVerificationPolicy** Section VI.B.3-4. NHP verifies an initial practitioner's work history within one year of the approval date for a lookback period of five years, reviewing the attested information within the credentialing application and/or on the practitioner's curriculum vitae, as available. Gaps in work history greater than six months require a verbal or written explanation from the practitioner. Work history gap(s) greater than one year requires a written explanation from the practitioner, reference **CR206.22PrimarySourceVerificationPolicy**, Section VI.D.1, Page 5.	

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

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	CR206.22PrimarySourceVerificationPolicy Section VI.B.7, Page 4; Section VI.B.9, 15, Page 4.	
8. Applications for credentialing include the following (attestation verification time limit is 365 days): • Reasons for inability to perform the essential functions of the position, with or without accommodation. • Lack of present illegal drug use. • History of loss of license and felony convictions. • History of loss or limitation of privileges or disciplinary actions. • Current malpractice insurance coverage (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate). • Current and signed attestation confirming the correctness and completeness of the application. NCQA CR3—Element C	**Documents Submitted/Location Within Documents:** 1. CR203.17PractitionerCredentialingProcessPolicy, Section VI.E.1-7, Page 3; Section VI.E.5, Page 3; Section V, Page 2 2. CR209.15PractitionerRecredentialingProcessPolicy, Section VI.D.1-6, Page 4; Section VI.D.5, Page 4; Section V, Page 3 3. CR206.22PrimarySourceVerificationPolicy, Section VI.D.2, Page 5 **Description of Process:** During the credentialing and recredentialing practitioner file review, NHP reviews the application disclosure questions for completeness and responses regarding inability to perform essential functions of the practitioner's position, history of loss of license and/or limitation of privileges, felony convictions, and illegal drug use as referenced in **CR203.17PractitionerCredentialingProcessPolicy**, Section VI.E.1-7, Page 3 and **CR209.15PractitionerRecredentialingProcessPolicy**, Section VI.D.1-6, Page 4. During the credentialing and recredentialing practitioner file review, NHP reviews the application section for attested-to current malpractice insurance	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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	coverage which must be current at the time of attestation, reference **CR203.17PractitionerCredentialingProcessPolicy**, Section VI.E.5, Page 3, **CR209.15PractitionerRecredentialingProcessPolicy**, Section VI.D.5, Page 4, and **CR206.22PrimarySourceVerificationPolicy** Section VI.D.2, Page 5. During the credentialing and recredentialing practitioner file review, NHP reviews the application attestation date which must be within 180 days of the decision date to ensure accuracy of the complete credentialing and recredentialing file review, reference **CR203.17PractitionerCredentialingProcessPolicy**, Section V, Page 2 and **CR209.15PractitionerRecredentialingProcessPolicy**, Section V, Page 3.	

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9. The Contractor formally recredentials its practitioners within the 36-month time frame. NCQA CR4	**Documents Submitted/Location Within Documents:** 1. CR209.15PractitionerRecredentialingProcessPolicy, Section V, Page 3 **Description of Process:** Credentialing staff reviews a practitioner's recredentialing application for completeness and existing practitioners must be recredentialed within 36 months of the previous credentialing date to remain in compliance with NCQA standards as referenced in **CR209.15PractitionerRecredentialingProcessPolicy**, Section V, Page 3.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor implements policies and procedures for ongoing monitoring and takes appropriate action, including: • Collecting and reviewing Medicare and Medicaid sanctions. • Collecting and reviewing sanctions or limitations on licensure. • Collecting and reviewing complaints. • Collecting and reviewing information from identified adverse events. • Implementing appropriate interventions when it identifies instances of poor quality related to the above. *42 CFR 438.214(d)(1)*	**Documents Submitted/Location Within Documents:** 1. CR211.16OngoingMonitoringPractitionerOrganizationalSanctionsPolicy, Section VI.A.1-3, 5, Page 3-4; Section VI.B, Page 4 2. CR216.12PractitionerProviderDisenrollmentPolicy, Entire Document 3. CR211BOIGGSAOFACSanctionMedicareOptOutReportReviewLogTemplate, Entire Document 4. SanctionsReviewLog2023, Entire Document 5. QM_4H_MemberSafetyProgram_SeriousReportableEvent_QOCGIssuesandOutlierPracticePatterns, Entire Document 6. QOC_AcknowledgementLtr_QM, Entire Document 7. QOC_ResolutionLtr_QM, Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
NCQA CR5—Element A	8. QOCC_Minutes_Draft_2024August013, Entire Document 9. QOCC_Minutes_Draft_2024November19, Entire Document 10. QOCC_Minutes_Draft_2024September24, Entire Document 11. QOC_MHProvider_ProcessFlow_QM, Entire Document 12. QOC_PHProvider_ProcessFlow_QM, Entire Document **Description of Process:** To ensure existing NHP providers are monitored for possible sanctions, credentialing staff reviews published reports monthly, within 30 days of their release, which detail sanctions for the Office of Inspector General, the General Service Administration, System Awards Management, the Office of Foreign Assets Control, state agency sanctions, Medicare Opt Out preclusions and exclusions, adverse state license sanctions, as well as potential quality issues and complaints between recredentialing cycles as referenced in **CR211.16OngoingMonitoringPractitionerOrganizationalSanctionsPolicy**, Section VI.A.1-3, 5, Page 3-4. Should a practitioner be found on these reports to have been sanctioned and excluded/debarred, on the Medicare Opt Out listing, or found with potential quality issues and complaints, NHP initiates the disenrollment process for the practitioner to have the	

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	practitioner removed from all Medicare networks as reference in **CR211.16OngoingMonitoringPractitionerOrganizationalSanctionsPolicy**, Section VI.B, Page 4. For the practitioner and provider disenrollment process, reference **CR216.12PractitionerProviderDisenrollment** , Entire Document. Following review of the published sanction reports, credentialing staff documents these reviews on the sanction review logs, see **CR211BOIGGSAOFACSanctionMedicareOptOutReportReviewLogTemplate and SanctionsReviewLog2023**. As indicated in the Quality of Care (QOC) policy, **QM_4H_MemberSafetyProgram_SeriousReportableEvent_QOCGIssuesandOutlierPracticePatterns**, an acknowledgement letter is sent, **QOC_AcknowledgementLtr_QM**, and an investigation completed when a QOC is reported. Upon receipt, each QOC issue is evaluated to determine the urgency of the issue and assess immediate follow-up actions to assure well-being of the Member. Once the QOC is closed, a resolution letter will be sent to the parties involved. See **QOC_ResolutionLtr_QM** Since adverse incidents may also be quality of care issues, all serious reportable events are evaluated upon receipt to	

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	determine whether there are any urgent safety issues to be addressed. The QOCC reviews the results of the investigation, **QOCC_Minutes_Draft_2024August013**, **QOCC_Minutes_Draft_2024November19**, and **QOCC_Minutes_Draft_2024September24** and makes a determination as to whether the investigation has identified a quality of care issue, and provides direction as to the appropriate follow-up, which may include obtaining more information, developing and monitoring a corrective action, etc. The following documents demonstrate the process flow for a Quality of Care incident submission: • QOC_MHProvider_ProcessFlow_QM • QOC_PHProvider_ProcessFlow_QM	
11. The Contractor has policies and procedures for taking action against a practitioner who does not meet quality standards that include: • The range of actions available to the Contractor. • Making the appeal process known to practitioners. *Examples of range of actions: how the organization reviews practitioners whose conduct could adversely affect members' health or welfare; the range of actions that may be taken to improve practitioner performance before termination; reporting actions taken to the appropriate authorities.*	**Documents Submitted/Location Within Documents:** 1. CR213.11PractitionerProviderAppealRightsRangeActionsAppealProcessPolicy, Section VI.C, Page 4-5; Section VI.B, Page 3 2. CR216.12PractitionerProviderDisenrollmentPolicy Entire Document **Description of Process:** Findings of adverse conduct that have potential impact on member safety, NHP implements actions to attempt	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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NCQA CR6—Element A	to improve practitioner performance by means of continued monitoring, improvement actions plan(s), leading up to and including suspension or termination from the network. These actions are implemented by the National Credentialing Committee (NCC), who will recommend, oversee and monitor these actions. Quality investigations may lead to reporting to the health plan, the National Practitioner Data Bank and/or state agency(s) and is reported to the program director(s) and the legal department to coordinate appropriate actions regarding this reporting. Practitioner/providers notified of denial of network participation, NHP makes the appeal process known of the NCC's decision at the time of the denial decision via written notification detailing reason(s) for the action. See **CR213.11PractitionerProviderAppealRightsRangeActionsAppealProcessPolicy**, Section VI.C, Page 4-5; Section VI.B, Page 3 and **CR216.12PractitionerProviderDisenrollmentPolicy** for more information.	
12. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of *organizational* health care delivery providers and specifies that before it contracts with a provider, and for at least every 36 months thereafter:	**Documents Submitted/Location Within Documents:** 1. CR218.15CredentialingCriteriaFacilityOrganizationalProvidersPolicy, Section VI.N.1-2, Page 6; Section VII, Page 13 2. CarelonFacilityMasterGridDetails, Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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12.A. The Contractor confirms that the organizational provider is in good standing with State and federal regulatory bodies. *Policies specify the sources used to confirm good standing—which may only include the applicable State or federal agency, agent of the applicable State or federal agency, or copies of credentials (e.g., State licensure) from the provider. Attestations are not acceptable.* *42 CFR 438.214(d)(1)* NCQA CR7—Element A1	**Description of Process:** Credentialing staff reviews an organizational provider's application and supporting documentation to verify licensure and any potential issues through applicable state agency(s), hard copy(s) of the license(s) issued by the state agency in charge, primary source verification through the licensing state agency and licensing review reports to ensure compliance with state and federal regulations for each license and/or certification held by the organization provider for each service location; this is re-verified at least once during the recredentialing process for organizational providers in the NHP network. See **CR218.15CredentialingCriteriaFacilityOrganizationalProvidersPolicy**, Section VI.N.1-2, Page 6 for further details. Our working Facility Master Grid for all states is attached to the policy and includes contacts for license verification, referenced in **CR218.15CredentialingCriteriaFacilityOrganizationalProvidersPolicy**, Section VII, Page 13. The screen shots to the specific license verification contacts are provided – please reference **CarelonFacilityMasterGridDetails** for sources and site links specific to Colorado facilities.	

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12.B. The Contractor confirms that the organizational provider has been reviewed and approved by an accrediting body. *Policies specify the sources used to confirm accreditation—which may only include the applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, or copies of credentials (e.g., licensure, accreditation report, or letter) from the provider. Attestations are not acceptable.* NCQA CR7—Element A2	**Documents Submitted/Location Within Documents:** 1. CR218.15CredentialingCriteriaFacilityOrganizationalProvidersPolicy, Section VI.G, Page 4; Section VI.N.6, Page 6-7 **Description of Process:** Credentialing staff reviews an organizational provider's application and its supporting certificates to primary source verify accreditation through the accrediting body's official website; this verification must be current at the time of credentialing decision as described in **CR218.15CredentialingCriteriaFacilityOrganizationalProvidersPolicy**, Section VI.G, Page 4. Accrediting bodies recognized by NHP for verification of accreditation include The Joint Commission, The Rehabilitation Accreditation Commission, Council on Accreditation, American Osteopathic Association, Healthcare Facilities Accreditation Program, Accreditation Association for Ambulatory Care, Det Norske Veritas, Community Health Accreditation Program, or the Institute for Medical Quality. For more information reference **CR218.15CredentialingCriteriaFacilityOrganizationalProvidersPolicy**, Section VI.N.6, Pages 6-7.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12.C. The Contractor conducts an on-site quality assessment if the organizational provider is not accredited. *Policies include on-site quality assessment criteria for each type of unaccredited organizational provider, and a process for ensuring that the provider credentials its practitioners.* *The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: The CMS or State review is no more than three years old; the organization obtains a survey report or letter from CMS or the State, from either the provider or from the agency, stating that the facility was reviewed and passed inspection; the report meets the organization's quality assessment criteria or standards. (Exception: Rural areas.)* NCQA CR7—Element A3	**Documents Submitted/Location Within Documents:** 1. CR218.15CredentialingCriteriaFacilityOrganizationalProvidersPolicy, Section VI.H, Pages 4-5 **Description of Process:** For organization provider applicants wishing to join the NHP network (with the exception of organization providers in rural areas), but are found to not be accredited by a recognized accreditation body, NHP may substitute a Center for Medicare & Medicaid Services (CMS) or a state review site visit which meet the requirements for site visit review and the resulting survey report/CMS letter indicates a passing inspection score and upon review, is forwarded to the Medical Director for approval. Structured site visits, as needed, are requested by appropriate staff and once returned, the results are reviewed for favorable passing inspection score, see **CR218.15CredentialingCriteriaFacilityOrganizationalProvidersPolicy**, Section VI.H, Page 4-5.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
13. The Contractor's organizational provider assessment policies and processes includes: • For behavioral health, facilities providing mental health or substance abuse services in the following settings: – Inpatient – Residential	**Documents Submitted/Location Within Documents:** 1. CR218.15CredentialingCriteriaFacilityOrganizationalProvidersPolicy, Section I, Page 1 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Ambulatory NCQA MBHO CR7—Elements B and C	NHP reviews organizational providers providing mental health and substance abuse services during the credentialing and recredentialing processes in inpatient, residential and ambulatory settings, see **CR218.15CredentialingCriteriaFacilityOrganizationalProvidersPolicy**, Section I, Page 1.	
14. The Contractor has documentation that it assesses providers every 36 months. NCQA MBHO CR7—Elements D and E	**Documents Submitted/Location Within Documents:** 1. CR218.15CredentialingCriteriaFacilityOrganizationalProvidersPolicy, Section V, Page 3; Section VI.U-CC, Pages 9-10 **Description of Process:** Participating organizational providers in the NHP network are recredentialed within thirty-six months of the previous credentialing decision upon receipt of a completed and signed application. Details can be found in **CR218.15CredentialingCriteriaFacilityOrganizationalProvidersPolicy**, Section V, Page 3; Section VI.U-CC, Pages 9-10	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The RAE shall submit a monthly Credentialing and Contracting Report to the Department with information about Provider contracting timelines, using a format determined by the Department. Contract Amendment 17: B-13—9.1.6.5.5	**Documents Submitted/Location Within Documents:** 1. CredConRpt_06-24, Entire Document 2. CredConRpt_07-24, Entire Document 3. CredConRpt_08-24, Entire Document 4. Carelon Performance Report_Contracting and Credentialing_12.2024, Entire Document 5. NHP_Network_CAP_Letter – 11.2024 **Description of Process:** The RAE extracts data from the system on providers who are contracted and credentialed within the reporting period. This report is due monthly to HCPF to ensure providers are credentialed and contracted within 90 days of receiving a clean application. The contracting team matches the providers who were credentialed and contracted with our internal online application report to ensure accuracy. Evidence of these reports can be found in **CredConRpt_06-24**, **CredConRpt_07-24** and **CredConRpt_08-24**. NHP also monitors timelines for contracting and credentialing on a monthly basis to assess contract adherence. Evidence of this can be found in Carelon Performance Report_Contracting and **Credentialing_12.2024** and **NHP_Network_CAP_Letter – 11.2024**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The delegate must provide to Carelon at least semi-annual reports to ensure any and all updates to practitioner and provider changes notifications including data for new and existing practitioners, providers and provider closures, see **CR220.15DelegationCredentialingRecredentialingPolicy**, Section V.E.4, Page 3 and Section VI.C.17, Pages 9-10 for more information. The delegated function(s) must be evaluated in its performance and reporting, leading up to and including appropriate actions taken to terminate the delegation should the delegate fail to fulfill its obligations to Carelon. Annual evaluations of the delegate are performed by Carelon to determine if the delegate has performed its specified delegated functions according to NCQA standards and Carelon expectations. See **CR220.15DelegationCredentialingRecredentialingPolicy**, Section V.E.5, Page 3 and Section VI.C, Page 7 for more information. The delegation agreement between Carelon and the delegate specifies that Carelon has the right to approve, suspend and terminate practitioners and organizational providers, and retains this right regardless of Carelon delegates decision-making, see **CR220.15DelegationCredentialingRecredentialingPolicy**, Section V.E.6, Page 3 and Section VI.D, Pages 10-11.	

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

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

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
NCQA CR8—Element C	During the annual evaluation of the delegate, Carelon will request a sample of credentialing and recredentialing files to be reviewed for compliance with NCQA, CMS, applicable state regulations, and Carelon standards which is outlined in **CR220.15DelegationCredentialingRecredentialingPolicy**, Section VI.C.2, Page 7. Carelon evaluates the delegate's performance against NCQA and Carelon standards, see **CR220.15DelegationCredentialingRecredentialingPolicy**, Section VI.C.2, Page 7. At least semi-annually, delegates must submit reports to Carelon which detail the specified data in the delegation agreement; Carelon analyzes these reports for any data changes including any terminated practitioners and/or organizational providers as referenced in **CR220.15DelegationCredentialingRecredentialingPolicy**, Section VI.C.17-18, Pages 9-10. At minimum annually, Carelon on behalf of NHP will request the delegate's credentialing system controls policy(s) and procedures(s) for review to ensure this documentation has met NCQA standards and aligns with the delegation agreement. The delegate must forward to Carelon its credentialing systems control reports for analysis and determination of compliance. For more details see	

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	CR220.15DelegationCredentialingRecredentialingPolicy, Section VI.C.22.a-b, Page 10. Should the credentialing system controls report submitted by the delegate be found to have deficiencies, quarterly monitoring for three consecutive quarters is implemented until the delegate demonstrated correction and improvement as outlined in **CR220.15DelegationCredentialingRecredentialingPolicy**, Section VI.C.22.c, Page 10.	
19. For delegation agreements that have been in effect for more than 12 months, at least once in each of the past two years, the Contractor identified and followed up on opportunities for improvement, if applicable. NCQA CR8—Element D	**Documents Submitted/Location Within Documents:** 1. CR220.15DelegationCredentialingRecredentialingPolicy, Section VI.C.8a-c &9, Page 8 **Description of Process:** This required element is delegated to Carelon Behavioral Health by NHP. Carelon Behavioral Health (Carelon) has no existing delegation agreements of twelve months or longer. If Carelon did enter into a delegation agreement, it affords delegates the opportunity for improvement following a completed annual evaluation of the delegate's performance which resulted in an Approval with Recommendations (CAP). The delegate must respond to the CAP thirty days upon receipt of the CAP notification and must be completed within ninety days of submission of the response. An extension may be granted at Carelon's discretion and	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	will take into consideration extenuating circumstances requiring additional time to respond. See **CR220.15DelegationCredentialingRecredentialingPolicy**, Section VI.C.8-9, Page 8 for more details.	

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

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE onboards and informs members and their families regarding the services provided by EPSDT. This includes: • Informing the member about the EPSDT program generally within 60 days of the member's initial Medicaid eligibility determination, or after a member regains eligibility following a greater than 12-month period of ineligibility, or within 60 days of identification of the member being pregnant. • At least one time annually, the RAE outreaches members who have not utilized EPSDT services in the previous 12 months in accordance with the American Association of Pediatrics (AAP) "Bright Futures Guidelines" and "Recommendations for Preventive Pediatric Health Care." • Information about benefits of preventive health care, including the AAP "Bright Futures Guidelines," services available under EPSDT, where services are available, how to obtain services, that services are without cost to the member, and how to request transportation and scheduling assistance. Contract Amendment 17: Exhibit B—7.3.12.1, 7.6.2	**Documents Submitted/Location Within Documents:** 1. AdministrativeServicesAgreement, Pages 18-20, *Misc 2. HCPFWelcomeLetter, Entire Document, *Misc 3. OnboardingIVRScript, Entire Document 4. PregnantWelcomeLetter_EN Pages 3-4 5. PregnantWelcomeLetter_SP, Pages 3-5 6. ChildWelcomeLetter _EN, Pages 3-4 7. ChildWelcomeLetter_SP, Pages 3-4 8. WellVisitIVRScript, Entire Document 9. WellVisitLetter_EN, Page 3 10. WellVisitLetter_SP, Page 3 11. WelcomeandBenefitTextMessages, Entire Document *Misc 12. AdolescentTextCampaign, Entire Document 13. BirthdayCard, Entire Document 14. Text4Baby, Entire Document 15. Text4Baby_TempCampaign, Entire Document 16. Text4Kids, Entire Document 17. Text4Kids_TempCampaign, Entire Document 18. EPSDTTipSheet_EN, Entire Document 19. EPSDTTipSheet_SP, Entire Document 20. R2_EPSDTPln_FY24-25, Entire Document 21. R2_EPSDTRpt_Q3FY23-24, Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	22. R2_EPSDTRpt_Q3FY23-24_Accepted, Entire Document 23. R2_EPSDTRpt_Q4FY23-24, Entire Document 24. R2_ESPDTRpt_Q1FY24-25_HCPF Response_Accepted, Entire Document **Description of Process:** NHP delegates EPSDT functions to our ASO, Carelon Behavioral Health, see **AdministrativeServicesAgreement, Pages 18-20.** For consistency throughout this tool, NHP will refer to efforts being conducted on behalf of NHP by Carelon, as NHP. NHP informs members and their families about the services provided by the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, as outlined in the entire **R2_EPSDTPln_FY24-25** document. This approach includes notifying members and their families about EPSDT services within 60 days of members' initial eligibility determination with Health First Colorado, within 60 days of a member being identified as pregnant, or if a member regains eligibility following a greater than 12-month period of ineligibility.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	NHP collaborated with the Colorado Department of Health Care Policy and Financing (HCPF) in 2020 to utilize HCPF's welcome letter as one method of outreach to EPSDT-eligible members and their families. NHP uses HCPF's letter to streamline communications and reduce the volume of correspondences members receive. HCPF's welcome letter includes NHP's contact information, such as our website and toll-free number, as well as, instructions on how to obtain a Health First Colorado member handbook to locate benefit information. See the entire **HCPFWelcomeLetter** for content. Additionally, members can access onboarding materials like the NHP welcome letter and the NHP "Getting Started" guide, as well as EPSDT service details, under the New Member & EPSDT Resources section of the NHP website. To determine which members are eligible for EPSDT outreach, NHP uses the weekly EPSDT member files provided by HCPF. The Data Analytic Reporting Team (DART), managed by Carelon, filters member data to create two outreach lists. The first outreach list is created for households with a valid phone number and is scrubbed to remove duplicate numbers or phone numbers on the "do not call list". NHP has identified most of our members are English or Spanish speaking and therefore also sorts the outreach list by English or	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Spanish to match speaking preferences. Members on this list receive an automated call. The second outreach list is created for households without a valid phone number and is sorted by language preference and member type (pregnant members or members under 21). Members on this list receive a specific welcome letter based on member type and language preference. Members who have opted out of our IVR calling system are also mailed a unique welcome letter. See **PregnantWelcomeLetter_EN, PregnantWelcomeLetter_SP, ChildWelcome Letter_EN,** and **ChildWelcomeLetter_SP** for details. The outreach lists are sent to the member engagement team, managed by Carelon, who oversee the Interactive Voice Response (IVR) automated calling process. NHP uses this method to outreach households within the first sixty (60) days of Health First Colorado enrollment. The IVR system is a bi-directional outreach approach that allows members to speak to a call center staff member in real time, or the option to receive NHP's call back number so the member to contact NHP at their convenience. Carelon runs monthly IVR optout reports for onboarding telephonic campaigns to remove any members who no longer wish to receive automated calls. See the	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	OnboardingIVRScript document for additional details of the onboarding messaging. NHP issues a texting campaign message for newly enrolled members to onboard and inform members of their Health First Colorado benefits. NHP uses the personalized health platform, Personify Health (formerly known as Virgin Pulse and Welltok) to administer our texting campaigns. Personify Health receives NHP eligibility data to enrolls members in the welcome and benefit campaign. See the **WelcomeandBenefitTextMessages** document for details of the campaign. Additionally, NHP annually outreaches members who have not utilized EPSDT services within 12 months in accordance with the American Association of Pediatrics (AAP) "Bright Futures Guidelines" and "Recommendations for Preventive Pediatric Health Care". Monthly reports are created to identify non-utilizing EPSDT eligible members, those who have not had a well visit or dental visit within the past year and creates three different outreach lists. The first outreach list is created for members/households with valid phone numbers. This list is scrubbed to remove duplicate numbers or phone numbers on the "do not call" list and sorted by English and Spanish language preferences. Members	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	on this list are sent an automated call in either Spanish or English. See **WellVisitIVRScript** for details of this call. The second outreach list is for members/households without a valid phone number and is sorted by language preference to receive a well visit/dental visit reminder letter. See **WellVisitLetter_EN** and **WellVisitLetter_SP** for additional details. The third outreach list is created for members who have not had a well visit or dental visit in the previous 12 months to receive a birthday card mailer during their birthday month. See the entire **BirthdayCard** document for messaging details. NHP's phone number is included in all outreach methods and members can contact our toll-free number if they need assistance with scheduling appointments or making transportation arrangements. NHP has a central location, the New Member & EPSDT Resources section on our website to house information about the benefits of preventative health care (including the American Association of Pediatrics' Bright Futures Guidelines), services available under EPSDT, where services are available, how to obtain services, information that service are at no cost to the member, and how to request	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	transportation arrangements for our members. Families can find information about where services are available for children and youth, how to obtain services, that services are at no cost to the member and how to request transportation are also included in our EPSDT: Children & Youth Health Care Services health information sheet, see the entire **EPSDTTipSheet_EN** and **EPSDTTipSheet_SP** for details. Additionally, NHP provides the following links for members to better understand their benefits on our website: • HCPF's EPSDT webpage • HCPF's transportation webpage • Bright Futures Guidelines webpage • Getting Started Webinar Information • Getting Started Webinar Information, Spanish • EPSDT: Children and Youth Health Care Services health information sheet • EPSDT: Atencion sanitaria infantile y juvenil (Spanish health information sheet) NHP submits an EPSDT quarterly report to HCPF to reflect the work we have conducted with outreaching newly eligible and non-utilizing EPSDT members. Newly eligible members are those under 21 years of age or pregnant members. Non-utilizing members are those who have not had a well visit or dental visit in	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	the previous twelve (12) months and are under 20 years of age. The report contains a breakdown of outreach attempts and the success of each outreach attempt. See **R2_EPSDTRpt_Q3FY23-24, R2_EPSDTRpt_Q3FY23-24_HCPF Response_Accepted, R2_EPSDTRpt_Q4FY23-24, R2_EPSDTRpt_Q4FY23-24_HCPF Response_Accepted, R2_EPSDTRpt_Q1FY24-25,** and **R2_EPDTRpt_Q1FY24-25_HCPF Response_Accepted** for additional information.	
2. The EPSDT informational materials use a combination of oral and written approaches to outreach EPSDT-eligible members to ensure members receive regularly scheduled examinations, including physical and mental health services: • Mailed letters, brochures, or pamphlets • Face-to-face interactions • Telephone or automated calls • Video conferencing • Email, text/SMS messages Contract Amendment 17: Exhibit B—7.6.6	**Documents Submitted/Location Within Documents:** 1. R2_EPSDTPln_FY24-25, Entire Document 2. R2_EPSDTPln_FY24-25_HCPF Response_ Accepted, Entire Document 3. WellVisitLetter_EN, Page 3 4. WellVisitLetter_SP, Page 3 5. Text4Baby, Entire Document 6. Text4Baby_TempCampaign, Entire Document 7. Text4Kids, Entire Document 8. Text4Kids_TempCampaign, Entire Document 9. AdolescentTextCampaign, Entire Document 10. GettingStartedEmail, Entire Document 11. BirthdayCard, Entire Document 12. EPSDTTipSheet_EN, Entire Document 13. EPSDTTipSheet_SP, Entire Document 14. WellVisitIVRScript, Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	15. GettingStartedInvite_EN, Entire Document, *Misc 16. GettingStartedInvite_SP, Entire Document, *Misc 17. Jan2024WellVisitGettingStarted, Entire Document 18. WellVisitTipSheet_EN, Entire Document 19. WellVisitTipSheet_SP, Entire Document 20. WellVisitvsSportsPhysicalTipSheet_EN, Entire Document 21. WellVisitvsSportsPhysicalTipSheet_SP, Entire Document 22. Feb2024StressReductionGettingStarted, Entire Document 23. StressReductionTipSheet_EN, Entire Document 24. StressReductionTipSheet_SP, Entire Document 25. Mar2024HealthyEatingGettingStarted, Entire Document 26. SNAP_WICTipSheet_EN, Entire Document 27. SNAP_WICTipSheet_SP, Entire Document 28. ExerciseTipSheet_EN, Entire Document 29. ExerciseTipSheet_SP, Entire Document 30. EatingHealthierTipSheet_EN, Entire Document 31. EatingHealthierTipSheet_SP, Entire Document 32. Apr2024BehavioralHealthGettingStarted, Entire Document	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	33. AlcoholandSubstanceUseTipSheet_EN, Entire Document 34. AlcoholandSubstanceUseTipSheet_SP, Entire Document 35. MentalHealthTipSheet_EN, Entire Document 36. MentalHealthTipSheet_SP, Entire Document 37. May2024FamilyPlanningGettingStarted, Entire Document 38. FamilyPlanningTipSheet_EN, Entire Document 39. FamilyPlanningTipSheet_SP, Entire Document 40. June2024MensHealthGettingStarted, Entire Document 41. MensHealthTipSheet_EN, Entire Document 42. MensHealthTipSheet_SP, Entire Document 43. July2024EPSDTGettingStarted, Entire Document 44. ImmunizationsTipSheet_EN, Entire Document 45. ImmunizationsTipSheet_SP, Entire Document 46. DentalTipSheet_EN, Entire Document 47. DentalTipSheet_SP, Entire Document 48. Aug2024PrentalGettingStarted, Entire Document 49. Sept2024STIGettingStarted, Entire Document 50. WomensSexualHealthTipSheet_EN, Entire Document 51. WomensSexualHealthTipSheet_SP, Entire Document	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	52. MensSexualHealthTipSheet_EN, Entire Document 53. MensSexualHealthTipSheet_SP, Entire Document 54. Oct2024WomensCancerScreeningGettingStarted, Entire Document 55. WomensCancerScreeningTipSheet_EN, Entire Document 56. WomensCancerScreeningTipSheet_SP, Entire Document 57. Nov2024_SmokingCessationGettingStarted, Entire Document 58. ColoradoQuitLineTipSheet_EN, Entire Document 59. ColoradoQuitLineTipSheet_SP, Entire Document 60. TeenVapingTipSheet_EN, Entire Document 61. TeenVapingTipSheet_SP, Entire Document 62. CrisisServicesTipSheet_EN, Entire Document 63. CrisisServicesTipSheet_SP, Entire Document 64. NHP_MemberCoverLetter, Entire Document 65. EPSDTScreening_Example, Entire Document **Description of Process:** NHP outlined our strategy for EPSDT outreach efforts in our annual plan submitted and accepted HCPF, see **R2_EPSDTPln_FY24-25** and **R2_EPSDTPln_FY24-25, HCPF**	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Response_Accepted. The plan outlines the variety of approaches NHP employs to outreach members who are eligible for the EPSDT program. NHP's goal is to assist our members in receiving regularly scheduled visits and to help them understand the benefits available to them for free, such as physical health, behavioral health, vision, and dental services. NHP care coordinators send reminders (via calls, texts, emails, or letters) to EPSDT-eligible members and their families about upcoming physical or mental health examinations, based on the state's periodicity schedule. This includes well-child visits, immunizations, dental checkups, and developmental screenings. Care coordinators work directly with PCMPs, behavioral health providers, and dental providers to identify members who are overdue for EPSDT services. Coordinators help families schedule appointments and, if needed, assist with rescheduling missed appointments. Coordinators connect families with Medicaid-covered non-emergency medical transportation (NEMT) to ensure they can attend scheduled exams and follow-up visits. Coordinators use generated reports identifying gaps in preventive care services (e.g., missed screenings or vaccinations) and use this data to prioritize outreach efforts. Care coordinators educate parents and guardians about the importance of preventive care services, including the benefits of regular physical and mental health	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	screenings, immunizations, and dental care. Care coordinators ensure that members are referred for behavioral health screenings alongside physical health checkups. If concerns arise, they facilitate referrals to mental health specialists or developmental services NHP also uses the following combination of methods to outreach EPSDT eligible members: Mailed Letters: NHP sends well visit/dental visit reminder letters to EPSDT eligible members who have not had a well visit or dental visit in the previous 12 months. These letters are mailed to members who do not have a valid phone number or members who have opted out of either our texting campaign or IVR campaigns. The letters are mailed in English or Spanish, based on a member's language preference, and include a cover sheet with a tagline offering the letter in 16 languages for members who may speak another language. See **NHP_MemberCoverLetter, WellVisitLetter_EN and WellVisitLetter_SP** for details. Additionally, members who have not had a well-visit in the prior 12 months are sent a birthday card mailer during their birthday month to encourage members to schedule a well visit or dental appointment. See **BirthdayCard** for complete details.	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Face-to-Face Interactions: NHP leverages the relationships our healthcare professionals and community partners have with our members. NHP has created materials, such as an EPSDT tip sheet, to provide information about the benefits of preventive healthcare, the services available under EPSDT, and guidance on where and how members can access these services, for our providers and community partners to share with members during in person interactions. The tip sheet details the physical and behavioral services that are covered for members at no cost to them. See **EPSDTTipSheet_EN** and **EPSDTTipSheet_**SP for more information. In addition to the EPSDT tipsheet, NHP has developed numerous health information tip sheets for healthcare professionals that highlight the services and benefits available to Health First Colorado members. These health information tip sheets are distributed to care coordinators, practice transformation coaches, community organizations, and healthcare professionals. NHP's practice transformation coaches regularly meet with PCMP practices to distribute the EPSDT tip sheets directly to PCMPs, who can then share this information with members at in person appointments. NHP also educates healthcare professionals, including care coordinators and	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	behavioral and physical healthcare providers, on EPSDT benefits to maximize their knowledge and ability to impact our members health outcomes. All health information tip sheets are located on our website under Prevention & Wellness Resources. NHP care coordinators may use in person interactions to assist EPSDT-eligible members in receiving regularly scheduled examinations, including physical and mental health services, during care planning and intake assessments. NHP and care coordinators have access to member level information to determine if a member has received the appropriate EPSDT screenings. If screenings have not been conducted, care coordinators can assist with scheduling and coordinating services. See **EPSDTScreening_Example,** for details. Telephonic and Automated Calls: NHP uses an automated IVR calling system to outreach members to inform them of Health First Colorado benefits, including preventative and dental services, (newly enrolled members) and to remind members (non-utilizers) to schedule well visits and/ or dental visits. When a member receives an automated call through our IVR system, they have the option to speak with an NHP call center associate who can help answer any questions related to their health or EPSDT benefits. See **WellVisitIVRScript** for messaging.	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Emails and Texting: NHP has several texting campaigns to inform members about the services and benefits available to them. Members have the option to opt in and to opt out of multiple campaigns, including our Welcome and Benefits campaign, Text4Baby campaign, Text4Kids campaign, Text4Health campaign, Well-Visit campaign, and Adolescent Wellness campaign. See **Text4Baby, Text4BabyTempCampaign, Text4Kids, Text4KidsTempCampaign**, and **AdolescentTextCampaig**n documents for additional details of each campaign. For members who have consented and provided their email address, NHP distributes a monthly email invitation to join our "Getting Started" webinar to learn more about Health First Colorado benefits, including EPSDT services. See **GettingStartedEmail**, for details Video Conferencing: NHP's prevention and wellness strategy is structured to focus on a specific topic or benefit each month. This targeted topic is prominently featured in various meetings we conduct with members, healthcare professionals, quality teams, and care coordination entities. NHP disseminates information about these meetings and accompanying	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	topics via our social media channels and ongoing meetings. For example, NHP hosts a monthly webinar, "Getting Started", aimed at educating members, their families, healthcare professionals, and community members about the benefits of preventive healthcare. Scheduled for the first Thursday of every month, the webinar highlights the importance of preventive health, Health First Colorado benefits and services, and how members can effectively utilize these benefits. During these sessions, subject matter experts deliver presentations and engage with attendees, answering questions and providing valuable insights to the benefits of preventative and routine healthcare services. To extend the reach of the information shared, NHP uploads recordings of these webinars and the accompanying slide decks to our website under the Calendar and Events section. Members, healthcare professionals, and other interested parties can view or download these resources at their convenience, making it a helpful tool for anyone interested in preventive healthcare. For 2024, the specific "Getting Started" topics that offered education on the benefits of preventive health care included:	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• January 2024 focused on well visits. NHP concentrated on the significance of annual well visits as a cornerstone of preventive care. To support this initiative, NHP provided healthcare professionals with tip sheets on Well Visits and Well Visits vs. Sports Physicals. These professionals played a crucial role in disseminating this information to our members. The Well Visit tip sheet included essential details on what to expect during a well visit, while the Well Visit vs. Sports Physical tip sheet was designed to educate members and their families on the differences between a comprehensive well visit and physical sports. See **Jan2024WellVisitGettingStarted, WellVisitTipSheet_EN, WellVisitTipSheet_SP, WellVisitvsSportsPhysicalTipSheet_EN** and **WellVisitvsSportsPhysicalTipSheet_SP** for more information. • February 2024 focused on the importance of stress reduction. NHP promoted health information sheets that highlighted breathing techniques as an effective method for reducing stress. Noting the significant increase in anxiety and stress among children and adolescents in recent years, NHP targeted practical strategies to mitigate stress. See **Feb2024StressReductionGettingStarted,**	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	StressReductionTipSheet_EN and **StressReductionTipSheet_SP** for more information. • March 2024 focused on healthy eating. NHP emphasized the significance of healthy eating and exercise in maintaining optimal health and promoting diabetes prevention. To support this initiative, NHP provided resources, including SNAP/WIC resource sheets and health information tip sheets on healthy eating and exercise, for distribution to members. The SNAP/WIC resource sheet details eligibility criteria and application processes for programs such as WIC and SNAP. The healthy eating and exercise tip sheets offer practical advice on maintaining health through wellness practices. See **Mar2024HealthyEatingGettingStarted, SNAP_WICTipSheet_EN, SNAP_WICTipSheet_SP, EatingHealthierTipSheet_EN, EatingHealthierTipSheet_SP, ExerciseTipSheet_EN,** and **ExerciseTipSheet_SP** for additional details. • April 2024 focused on behavioral health services. NHP promoted the available behavioral health benefits, which include mental health counseling and substance use disorder (SUD) services and benefits. To disseminate this information, NHP distributed	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	health information sheets detailing SUD and mental health benefits to members, their families, and healthcare professionals. See **Apr2024BehavioralHealthGettingStarted, AlcoholandSubstanceUseTipSheet_EN, AlcoholandSubstanceUseTipSheet_SP, MentalHealthTipSheet_EN,** and **MentalHealthTipSheet_SP** for complete content. • May 2024 focused on family planning. NHP detailed the family planning benefit, which included resources on sexual health for our EPSDT eligible adolescent members and pregnant members. NHP distributed family planning health information sheets to both members and healthcare professionals for further dissemination. See **May2024FamilyPlanningGettingStarted, FamilyPlanningTipSheet_EN,** and **FamilyPlanningTipSheet_SP** for more information. • June 2024 focused on men's health. NHP concentrated on men's health, emphasizing preventive measures such as well visits for our male population, particularly those aged 18-20. To support this initiative, NHP distributed a men's health tip sheet to healthcare professionals and members. See **June2024MensHealthGettingStarted, MensHealthTipSheet_EN**, and	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	MensHealthTipSheet_SP for additional details. • July 2024 focused on EPSDT/Bright Futures Screenings. NHP reviewed the screenings covered by EPSDT at no cost, in accordance with the Bright Futures guidelines. The review reminded participants that multiple well-visits are recommended for infants aged 0-30 months and annual visits are recommended for individuals aged 3-20 years. NHP reviewed specific screenings such as hearing, vision, lead testing, developmental assessments, STI screenings, alcohol and drug evaluations, and behavioral health assessments. To support this initiative, NHP distributed tip sheets on EPSDT, well visits, immunizations, and dental visits to both members and healthcare professionals. See **July2024EPSDTGettingStarted, EPSDTTipSheet_EN, EPSDTTipSheet_SP, WellVisitTipSheet_EN, WellVisitTipSheet_SP, DentalTipSheet_EN, DentalTipSheet_SP, ImmunizationsTipSheet_EN,** and **ImmunizationsTipSheet_SP** for details. • August 2024 focused on prenatal and postpartum care. NHP concentrated on the benefits of prenatal and postpartum care to support newly pregnant members. NHP distributed our Pregnancy Guide to members	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	and healthcare professionals to help guide members through their maternity benefits. Additional resources, including NHP's "Taking Care of Baby and Me" flyer and the National Maternal Mental Health Hotline, are available under the Pregnant? tab on the NHP website. See the **Aug2024PrenatalGettingStarted** presentation for additional content. • September 2024 focused on Sexually Transmitted Infections (STIs). NHP provided information on resources to obtain testing and treatment. Our women's sexual health and men's sexual health information sheets were distributed to members and health care professionals. This is relevant to our adolescent male and female members. See **Sept2024STIGettingStarted, WomensSexualHealthTipSheet_EN, WomensSexualHealthTipSheet_SP, MensSexualHealthTipSheet_EN**, and **MensSexualHealthTipSheet_SP** for additional details. • October 2024 focused on women's cancer screenings. NHP concentrated on women's cancer screenings in alignment with Breast Cancer Awareness Month. The initiative targeted both cervical and breast cancer screenings, which are particularly relevant for our pregnant members. NHP distributed our	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	health information sheet on women's health during the month of October. See **Oct2024WomensCancerScreeningGettingStarted, WomensCancerScreeningTipSheet_EN,** and **WomensCancerScreeningTipSheet_SP** for more information. • November 2024 focused on smoking cessation. NHP shared preventative efforts on smoking cessation, resources, and programs available through the Colorado QuitLine. Some of the available smoke cessation resources applicable to EPSDT members is MyLifeMyQuit for adolescents, the Colorado QuitLine for members 18 and above, and the pregnancy resources for pregnant females. NHP also distributed health information sheets on the Colorado Quit Line to distribute to members as well as teen vaping. See **Nov2024SmokingCessationGettingStarted, TeenVapingTipSheet_EN, TeenVapingTipSheet_SP, ColoradoQuitLineTipSheet_EN, and ColoradoQuitLineTipSheet_SP** for more information. • December 2024 focused on available crisis services. NHP concentrated our educational efforts on crisis services available for all members in our region. NHP distributed health information sheets on crisis services to	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	members and health care providers to educate all about these services. This health information sheet was created by members of our Member Material Work Group. See **CrisisServicesTipSheet_EN** and **CrisisServicesTipSheet_SP** for details. The information above and additional information is also offered on our website under Calendar and Events, New Member and EPSDT Resources, and Prevention and Wellness Resources sections.	
3. The RAE makes network providers aware of the Colorado Medicaid EPSDT program information by: • Using Department materials to inform network providers about the benefits of well-child care and EPSDT. • Ensuring that trainings and updates on EPSDT are made available to network providers every six months. Contract Amendment 17: Exhibit B—12.9.2.1, 12.9.3	**Documents Submitted/Location Within Documents:** 1. HCPF_EPSDT_PolicyGuidelines, Entire Document 2. 248L_EPSDTPolicy, Page 6 3. Feb2024ProviderRoundtable, Slides 17-31, *Misc 4. Aug2024ProviderRoundtable, Slides 10-38 5. ProviderDocumentationTraining, Slides 16, 32-33 6. July2024EPSDTGettingStarted, Entire Document 7. BehavioralHealthProviderHandbook, Pages 41-46 *Misc 8. PrimaryCareProviderHandbook, Pages 28-34 *Misc **Description of Process:** NHP is committed to educating network providers about the EPSDT program. To achieve this,	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	our EPSDT training initiatives are structured to maintain a high level of awareness and compliance and are offered at least twice throughout the year. We leverage materials provided by the Colorado Department of Health Care Policy & Financing (HCPF), such as the HCPF EPSDT Policy Guidelines, in our training sessions to increase awareness of well-child care and the comprehensive benefits under the EPSDT program. NHP adheres to Carelon's **248L_EPSDT Policy**, which outlines our procedures for oversight of the EPSDT program, including education for our providers. An integral component of the policy includes facilitating education for healthcare providers. This includes offering information designed to increase providers' understanding of the EPSDT program, the health benefits it offers children, how to adhere to guidelines, and ways to effectively communicate these benefits to children's parents or caregivers. See **248l_EPSDTPolicy, Page 6** for additional information. NHP hosts a monthly provider webinar, known as provider roundtables, and issues biannual EPSDT trainings in these forums. In 2024, the February and August provider roundtables included a thorough review of the EPSDT benefit, emphasized the program's importance, and reminded participants of the need for consistent implementation of EPSDT guidelines to improve healthcare outcome. These	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	training sessions are part of our strategy to support providers in delivering high-quality care that meets the preventive, diagnostic, and treatment needs of children and adolescents under the EPSDT program. By regularly equipping our network providers with the latest information and guidelines, we aim to see that all eligible members receive timely and appropriate care. To facilitate accessibility, NHP posts recordings of these training sessions online to our website. This enables providers who were unable to attend the live sessions to review the material and gain the knowledge at their convenience. See documents **HCPF_EPSDT_PolicyGuidelines, Feb2024ProviderRoundtable**, and **Aug2024ProviderRoundtable** for additional details. Additionally throughout 2024, four training sessions were offered on March 22, 2024, June 27, 2024, September 26, 2024, and December 31, 2024 to educate providers about the federal and state clinical documentation requirements. During these sessions, network providers were informed of the required administrative chart and care coordination requirements, including those of the EPSDT program. For further information, see **ProviderDocumentationTraining, slides 16 and 32-33**.	

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	NHP also hosted a "Getting Started webinar in July 2024 to educate members, families, caregivers, and healthcare professionals about EPSDT benefits and Bright Futures Screening Guidelines. This webinar is posted on Calendar & Events section of the NHP website and details can be found in the **July2024EPSDTGettingStarted** presentation. Lastly, NHP maintains two handbooks, one for our behavioral health providers and one for our physical health providers, which includes information on EPSDT requirements, state resources and links to provider trainings. See **BehavioralHealthProviderHandbook, Pages 41-46 and PrimaryCareProviderHandbook, Pages 28-34.**	
4. For children under the age of 21, the RAE provides or arranges for the provision of all medically necessary *Capitated Behavioral Health Benefit* covered services in accordance with 42 CFR Sections 441.50 to 441.62 and 10 CCR 2505-10 8.280 (EPSDT program). For the *Capitated Behavioral Health Benefit*, the RAE: • Has written policies and procedures for providing EPSDT services to members ages 20 and under. • Ensures provision of all appropriate mental/behavioral health developmental screenings to EPSDT beneficiaries who request it.	**Documents Submitted/Location Within Documents:** 1. 248L_EPSDTPolicy, Pages 1, 5, 6 2. BehavioralHealthProviderHandbook, Page 43-44 Misc. 3. PrimaryCareProviderHandbook, Pages 29-32 *Misc. 4. Violet_Dashboard 5. ProviderDirectorySearchExample, Entire Document 6. ProviderDocumentationTraining, Slides 16, 18-21, 32-34 7. 203LMedicalNecessityDeterminationsPolicy, Pages 1, 4-5	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Ensures screenings are performed by a provider qualified to furnish mental health services. • Ensures screenings are age appropriate and performed in a culturally and linguistically sensitive manner. • Ensures results of screenings and examinations are recorded in the child's medical record and include, at a minimum, identified problems, negative findings, and further diagnostic studies and/or treatments needed, and the date ordered. • Provides diagnostic services in addition to treatment of mental illnesses or conditions discovered by any screening or diagnostic procedure. *42 CFR 441.55; 441.56(c)* Contract Amendment 17: Exhibit B—14.5.3 10 CCR 2505-10 8.280.8.A, 8.280.4.A (3)(d), 8.280.4.A (4), 8.280.4.A (5), 8.280.4.C (1–3)	8. ClinicalAuditTool, Rows 23, 24 and 65 *Misc 9. AdministrativeServicesAgreement, Entire Document *Misc **Description of Process:** NHP is committed to providing or arranging for the provision of all medically necessary behavioral health benefits for our members under the age of twenty-one (21) as part of our capitated service offerings. In accordance with 42 CFR Sections 441.50-441.62 and 10 CCR 2505-10.8280, our approach sees that young members receive the comprehensive behavioral health care they need, or when requested, without unnecessary barriers to access. According to the policy titled **248L_EPSDTPolicy**, we outline the following requirements: • That eligibility for the EPSDT benefits is for any member enrolled in Health First Colorado who is 20 years old or younger (**Page 1**) • That we will provide or arrange for the provision of all medically necessary behavioral health services (**Page 5**) • Ensure the provision of all appropriate mental or behavioral health developmental screenings to members/families who request this information (**Page 5**)	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Ensure screenings are performed by a provider qualified to furnish mental health services (**Page 5**) • Ensures that screenings are age appropriate and performed in a culturally and linguistically sensitive manner (**Page 5**) • That the RAE educates providers to record the results of all screenings and examinations in the child's medical record. Documentation shall include, at a minimum, identified problem(s) and negative findings and further diagnostic studies and/or treatments needed, and the date(s) ordered (**Page 6)** • The RAE will provide or arrange for the provision of a diagnostic service in addition to the treatment of a mental illness or condition discovered by any screening or diagnostic procedure (**Page 6**) NHP delegates behavioral health utilization management (UM) functions per the **AdministrativeServicesAgreement** (Pages 26-27) to our ASO, Carelon. Carelon oversees all aspects of capitated behavioral health utilization management and follows the **248L_EPSDT policy** to define medical necessity for EPSDT services, goods, and programs. To streamline access to essential mental health services, all Current Procedural Terminology (CPT)	

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	codes for outpatient behavioral health services and psychological testing do not require prior authorization. This enables quicker and more efficient access to necessary care, promoting early intervention and ongoing support. By removing the authorization requirement for these services, we reduce administrative burdens for providers and help ensure timely treatment for our young members. For more intensive behavioral health services such as inpatient care, residential treatment, and intensive outpatient treatment (IOP), NHP, through Carelon, employs a thorough utilization management (UM) process as outlined in Carelon's **203LMedicalNecessityDeterminationsPolicy**. The UM team is responsible for reviewing and approving authorization requests for these higher levels of care. This process is designed to see that members receive appropriate, medically necessary services while also maintaining quality and cost-effectiveness. The utilization management team follows evidence-based guidelines, EPSDT medical necessity criteria, and best practices in the review process. See the **203LMedicalNecessityDeterminationsPolicy, Pages 1 and 4-5** for details. In situations where a family, provider, or Department of Human Services (DHS) staff member identifies that a member may require residential services, an independent assessment can be requested. Carelon's	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	UM team is responsible for coordinating these independent assessments, ensuring they are conducted by qualified individuals. The individual performing the independent assessment must have completed the Behavioral Health Administration's (BHA) training and be certified in the Child and Adolescent Needs and Strengths (CANS) assessment. This certification safeguards that the assessment is conducted thoroughly and accurately, focusing on the comprehensive needs and strengths of the child or adolescent. Our partnership with Carelon's UM team has assisted with 34 completed independent assessments from January 1, 2024 - October 10, 2024. The following services related to independent assessments are coordinated appropriately: • Assessment and Planning: Should the independent assessment identify a need for residential services or other treatment interventions, the UM team will take the necessary steps to arrange or provide the recommended services. Additionally, the UM team will engage care coordination teams to assist the member and their family throughout the treatment process. This multi-faceted approach creates a seamless transition to appropriate care settings and supports continuity of care. • Service Provision: If residential services or other treatments are approved under the	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	capitated benefit, the member's treatment team will actively assist in locating suitable treatment facilities. This collaborative effort involves working closely with various providers to see that the member can access the necessary services in a timely manner. If a different level of care is recommended by the independent assessment, the treatment team will assist in arranging the recommended treatment to make sure member needs are adequately met. • Interim Support Services: In instances where residential services are approved but there is a wait list for available placements, the treatment team will identify and coordinate community-based services. These services are designed to provide necessary community supports to maintain the member's stability while awaiting placement in a residential facility. This approach aims to mitigate risks and coordinate appropriate interim care, thereby promoting overall well-being during the waiting period. NHP's strategy in managing behavioral health benefits reflects our commitment to high-quality, accessible care for young members. By differentiating the authorization requirements based on the type and intensity of the service, we can see that necessary care is provided efficiently while maintaining oversight for	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	more complex cases requiring intensive interventions. Our processes are designed to support providers in delivering effective treatment, minimize delays in service delivery, and see that all behavioral health services are aligned with best practices and regulatory standards. As NHP's ASO, Carelon also manages and supervises network providers on behalf of NHP. See **AdministrativeServicesAgreement**, Pages 23-24. Carelon is responsible for monitoring providers' cultural and linguistic abilities, as well as cultural competency training. Each provider is tasked with logging their cultural skills and attesting to any cultural competency trainings via the Council for Affordable Quality Healthcare (CAQH), a healthcare industry alliance that collaborates with payers, providers, and stakeholders to streamline operations, reduce costs, and enhance member experience. By allowing providers to input their information once and share it across all plans, CAQH helps to minimize administrative hassles and errors. Carelon surveys NHP's providers annually to fulfill the National Committee for Quality Assurance (NCQA) requirement. The survey requires providers to acknowledge whether they have taken cultural humility or competency training courses. This information is then stored and monitored by Carelon in the "Provider Details" section on the ProviderConnect portal and can be viewed via the	

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	Behavioral Health Provider Search function. See **ProviderDirectorySearchExample** to view a sample search. NHP and Carelon offer a variety of cultural competency trainings and resources for network providers available on the Webinar and Training section of the NHP website to assist providers develop the skills to serve our members in a culturally appropriate manner. Additionally, in October 2024, NHP launched a new partnership with Violet, a health equity training and analytics platform designed to support providers in delivering culturally competent care. Through this platform, NHP can monitor provider demographics and cultural competencies, as assessed by Violet. The application offers a variety of training courses available to our provider network, allowing them to increase their ability to deliver culturally competent care and helping NHP optimize healthcare delivery in our region. See **Violet_Dashboard** for an example of data NHP can monitor with this tool and/or visit the NHP Violet Webpage for additional information about this partnership. Lastly, our provider handbooks, with which all providers are contractually obligated to comply, contain essential language service resources that	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	providers may utilize when an interpreter is needed to further aid in delivering culturally competent care. By offering clear, comprehensive guidelines, NHP permits providers to be well-informed about their roles and responsibilities in delivering EPSDT services. Both the behavioral and physical health provider handbooks clearly outline the responsibilities related to EPSDT services. A significant focus within these handbooks is placed on the critical importance of documenting the results of all screenings and examinations in members' medical records and service coordination. Providers are explicitly instructed on the necessity of thorough documentation to see that all aspects of the members' health and well-being are accurately captured and monitored. Furthermore, the handbooks provide detailed guidance on the obligation of providers to either provide or facilitate access to any necessary services identified during these screenings. This includes establishing effective referral processes and linking members with appropriate services to address any identified health concerns promptly. See **BehavioralHealthProviderHandbook, Pages 34-44** and **PrimaryCareProviderHandbook, Pages 29-32**. To reiterate the importance of adequate clinical documentation, Carelon conducts quarterly training sessions to certify providers are well-versed in all	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	documentation requirements. This training course covers the following key areas: • Administrative Chart Elements: Providers receive detailed instruction on necessary administrative chart elements, including EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) or Well Child questions and referrals, as detailed on **slide 16.** • Cultural Considerations: We emphasize the importance of considering cultural factors and their impact on treatment, as outlined on **slide 20.** • Data Collection: Providers are trained to collect comprehensive data on current and past information, including screening results, medical and dental issues, allergies, current medications, and developmental history for clients under 18, as shown on **slides 19 and 21.** • Clinical Application: Guidance is provided on using gathered information effectively in clinical formulations and the treatment of a member's diagnosis, as highlighted on **slide 24** and during the treatment review on **slide 34**.	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• EPSDT Documentation: Providers are instructed to record whether members have had an EPSDT exam in the past year, including the date and provider, as detailed on **slide 32**, with additional highlights on **slide 33**. These training sessions were conducted on March 22, 2024, June 27, 2024, September 26, 2024, and December 31, 2024. For further details, please refer to the **ProviderDocumentationTraining** presentation**.** Through chart audits, NHP's Quality Department monitors the documentation of screenings, examinations, and follow-up referrals against claims. The quality team reviews member charts to ascertain if providers have documented developmental history for members under 18 y/o, if linguistic or cultural/spiritual factors that may impact treatment protocols were assessed, and if providers assessed health/services needs other than mental health services and made appropriate referrals. Providers must score 80% or more on each of the audited sections to pass. Failing to pass any section can result in added training on proper documentation and/or being placed on a Corrective Action Plan (CAP) and reaudited in six months. See **ClinicalAuditTool,** Rows 23, 24 and 65.	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. *For the Capitated Behavioral Health Benefit,* the RAE: • Provides referral assistance for treatment not covered by the plan but found to be needed as a result of conditions disclosed during screening and diagnosis. • Provides assistance with transportation and scheduling appointments for services if requested by the member/family. • Makes use of appropriate State health agencies and programs including vocational rehabilitation; maternal and child health; public health, mental health, and education programs; Head Start; social services programs; and Women, Infants and Children (WIC) supplemental food program. *42 CFR 441.61–62* Contract Amendment 17: Exhibit B—14.5.3 10 CCR 2505-10 8.280.4.C	**Documents Submitted/Location Within Documents:** 1. 248L_EPSDTPolicy, Pages 2, 5, 6 2. HealthCloudReferralProcess, Entire Document 3. HealthCloud_TransportationReferrals, Entire Document 4. HealthCloud_Referrals_2024, Entire Document 5. HealthCloud_ReferralsandScreening_Config, Entire Document 6. TitleV_Referrals, Entire Document 7. CallCenterReferralTraining, Slides 7-10 8. CareCoordinationFactSheet_EN, Entire Document *Misc. 9. CareCoordinationFactSheet_SP, Entire Document *Misc. 10. CareCoordinationReferralForm, Entire Document 11. CCM_EPSDTWorkflow, Entire Document 12. CareCoordinationAuditTool, Lines 16, 29, 30 *Misc. 13. BehavioralHealthProviderHandbook, Pages 43-46 *Misc. 14. PrimaryCareProviderHandbook, Pages 28-34 *Misc	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Description of Process: NHP uses the policy titled, **248L_EPSDTPolicy,** to adhere to the requirements in this section. Specifically, the policy outlines: • The provision of referral assistance for treatment, which is not covered by the plan but is found to be needed as of a result of conditions disclosed during screening and diagnosis (**Page 6**) • Assistance with transportation and scheduling appointments for services if requested by the member/family (**Pages 2, 5**) • Providing referrals to appropriate state health agencies and programs including vocational rehabilitation, maternal and child health, public health, mental health and education programs; Head Start; social service programs, and Women, Infants and Children (WIC) supplemental food program (**Page 2**) The Utilization Management Director created an internal document for the utilization management team to coordinate ESPDT services that are not covered under the capitated benefit. This document outlines the process for care coordination referrals, as well as submitting EPSDT review requests to HCPF or through the Colorado Prior Authorization Review	

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	(PAR) site. See the **CCM_EPSDTWorkflow, Entire Document** for details. NHP's delegated care coordination agencies, as well as Carelon's designated Behavioral Care Manager II, can provide additional assistance for members who need referral assistance for treatment that is deemed necessary but is not covered under the capitated behavioral health benefit. When a service is deemed medically necessary but isn't included in the capitated behavioral health benefit, NHP and Carelon's Behavioral Care Manager will coordinate the member's entire care team to facilitate meetings, ensuring appropriate referrals are made and resources are provided to address any gaps in the member's care. NHP and our care coordinators can assist with transportation needs, such as assistance scheduling appointments for services if/when requested by the member or their family. Members can call NHP's toll free number to speak with a call center associate, email or mail NHP, or request help through our contact form located on our website. NHP's call center associates can connect members or their families with one of NHP's delegated care coordination agencies to further assist with transportation and scheduling needs. NHP members receiving care coordination services may also work	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	directly with their care coordinator to identify and request transportation needs as well. NHP's care coordination agencies are embedded in our communities and have extensive experience with scheduling regional transportation. This includes booking transportation services through state and regional transportation vendors, scheduling Lift/Uber rides when appropriate, and assisting members with the completion of transportation paperwork, such as request forms and reimbursement forms. If care coordinators need additional resources to address a transportation request, they can search for transportation needs through the FindHelp function within the care coordination tool, Health Cloud. See the **HealthCloudReferralProcess** for additional information. Referrals made by our care coordinators are tracked in Health Cloud and can be filtered by referral type. This could include the care coordinator initiating the referral, searching for an appropriate provider to make a referral, or following up on transportation referral received from NHP, a provider, hospital, call center, and/or member. In 2024, NHP care coordinators using Health Cloud documented approximately 528 actions related to assisting members with transportation needs. See the entire **HealthCloud_TransportationReferrals** file for additional information.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	NHP recently facilitated an out-of-state residential placement for a youth after exhausting all in-state treatment options. This member was associated with DHS, had a Guardian ad Litem (GAL), and was engaged with juvenile justice/detention services. Given the complexity of the case and the necessity for a chaperone, it was crucial to precisely navigate the Non-Emergent Medical Transportation (NEMT) process. NHP worked closely with HCPF, notably Gina Robinson and Mattew Paswaters, to ensure all required forms were accurately completed and the process was properly followed. Initially, NHP completed the NEMT Prior Authorization Request (PAR) and obtained the corresponding PAR authorization number before submitting the Out-of-State NEMT form. The completed NEMT request form, along with the PAR authorization, was then submitted directly to the designated HCPF email. Subsequently, Transdev, HCPF's NEMT mobility vendor, contacted NHP to arrange the flight dates and times. Considering the member was in juvenile custody, NHP coordinated with the DHS caseworker accompanying the youth out of state to ensure adequate time for facility checkout and timely arrival at the airport. Additionally, NHP liaised with the Utah-based residential facility to guarantee a smooth handoff upon arrival. Finally, NHP collaborated with both Transdev and the DHS caseworker to organize	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	the return flight, ensuring there was sufficient time for the member's safe transition to the residential facility prior to the caseworker's return to Colorado. NHP's makes use of appropriate State health agencies and programs including vocational rehabilitation, maternal and child health, public health, mental health, education programs, Head Start, social services programs, and Women, Infants and Children (WIC) supplemental food program. NHP's call center associates can support or link members or their families with one of NHP's delegated care coordination agencies to further assist with appropriate state health agencies as a general function of care coordination. NHP care coordinators may conduct a variety of screenings upon intake and when creating a member's care plan. This includes social determinants of health screenings (such as the Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE) screening,) behavioral health related screenings, prenatal screenings, etc. Our delegated care coordination agencies use the electronic health record tool, Health Cloud, document referrals, referral tasks, and care plan activities. Care coordinators may also use Health Cloud, via the FindHelp function, to locate and send member referrals as well. NHP can monitor the referrals made by care coordinators by filtering Health Cloud data. For example, in 2024, care coordinators using Health Cloud logged	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	approximately 428 referrals related to WIC and food services. See **HealthCloud_Referrals_2024** for examples of the referral types that are tracked and monitored through Health Cloud. Additionally, see the **HealthCloudReferralProcess** document and the **HealthCloud_ReferralsandScreening_Config** document for more details of this process. Furthermore, NHP and care coordination entities have partnered with social service agencies like Head Start, WIC, SNAP, and Case Management Agencies (community-centered boards and single-entry points) to establish seamless referrals for our members. NHP tracks our call center associates' referrals for Title V programs such as WIC, SNAP, and Head Start. See **TitleV_Referrals, Entire Document** for details of referrals made between January 2024 and September 2024. NHP call center associates receive annual EPSDT training to share resources and inform staff on how to properly issue referrals. In July 2024, the training discussed the EPSDT information available on our website for our members and call center staff were reminded that each member call answered is an opportunity to link members with services they may need including care coordination, transportation, and other social service programs. See **CallCenterReferralTraining,** slides 7-10.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	NHP developed a care coordination fact sheet, which informs members about NHP's care coordination services and shares the fact sheet on our website for members to access in the New Member & EPSDT Resources section. NHP also shares this fact sheet with our providers and community partners to disseminate to members during in person appointments. The care coordination fact sheet has information about how to contact NHP's toll free number to request care coordination for various needs. When members contact NHP's call center, the call center team can make a referral to a care coordinator who assists members with referrals to programs not included in the plan, schedule appointments and transportation, or link a member with a state health agency. See **CareCoordinationFactSheet_EN** and **CareCoordinationFactSheet_SP** for more information. NHP's call center staff are equipped to explain the care coordination benefit and will refer a member identified as needing these services to their assigned care coordination agency using the **CareCoordinationReferralForm** when appropriate**.** The care coordination referral form includes various reasons for which a member may be referred including EPSDT, Title V programs, transportation, etc. Once the form is completed, it is sent via a secure	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	email system to the care coordination agency. The care coordination agency acknowledges receipt of the form and will contact the member. If the call center associate does not receive a response from the care coordination agency, they will follow up to ensure the referral was received. Additionally, NHP offers a care coordination referral form that can be electronically filled out on-line via our website by providers, members, and community partners. See **CareCoordinationReferralForm,** Entire Document for additional information. NHP performs chart audits with our delegated care coordination agencies to ensure that care coordination activities are being conducted effectively. Audit items within **Section A11** (line 16), **Section B1 and B2** (lines 29, 30) may be evaluated as met or not met, based on whether transportation or scheduling assistance needs/goals were identified and met/not met or referrals to state agencies were identified and met/not met. After completing an audit, NHP communicates the results via email to the care coordination agencies, providing specific feedback and highlighting any missing information from a member's chart. Notably, no care coordination entities scored below the targeted 80% in these areas. Additionally, NHP provides support to help these agencies meet documentation standards, should the	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	agency not meet the 80% target. Please refer to the **CareCoordinationAuditTool** for audit criteria. NHP's physical and behavioral health providers are also expected to work with our care coordination entities to assist members and families with referrals, scheduling and transportation issues. See **BehavioralHealthProviderHandbook, Pages 43-46** and **PrimaryCareProviderHandbook, Pages 28-34** for full details.	
6. *For the Capitated Behavioral Health Benefit,* the RAE defines medical necessity for EPSDT services as a program, good, or service that: • Will or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all. • Assists the member to achieve or maintain maximum functional capacity. • Is provided in accordance with generally accepted professional standards for health care in the United States. • Is clinically appropriate in terms of type, frequency, extent, site, and duration.	**Documents Submitted/Location Within Documents:** 1. 248L_EPSDTPolicy, Page 4 2. CCM_Training_EPSDT, Slides 5-9 3. EPSDTDocumentationGuidelines, Entire Document 4. BehavioraHealthProviderHandbook, Pages 41-42, 44-45, *Misc 5. PrimaryCareProviderHandbook, Pages 28, 32-33 *Misc **Description of Process:** NHP uses the definition of medical necessity for EPSDT services as outlined in the **248L_EPSDTPolicy** for the capitated behavioral health benefit. The medical necessity definition is for a program, good, or service that: • Will or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental,	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Is not primarily for the economic benefit of the provider nor primarily for the convenience of the client, caretaker, or provider. • Is delivered in the most appropriate setting(s) required by the client's condition. • Provides a safe environment or situation for the child. • Is not experimental or investigational. • Is not more costly than other equally effective treatment options. Contract Amendment 17: Exhibit B—14.5.3 10 CCR 2505-10 8.076.8; 8.076.8.1; 8.280.4.E	cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all (**Page 4**). • Assists the member to achieve or maintain maximum functional capacity (**Page 4**). • Is provided in accordance with generally accepted professional standards for health care in the United States (**Page 4**). • Is clinically appropriate in terms of type, frequency, extent, site, and duration (**Page 4**). • Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider (**Page 4**). • Is delivered in the most appropriate setting(s) required by the client's condition (**Page 4**). • Provides a safe environment or situation for the child (**Page 4**) • Is not experimental or investigational (**Page 4**). • Is not more costly than other equally effective treatment options (**Page 4**). NHP uses **248L_EPSDTPolicy** to guide our actions related to EPSDT services, including the UM team at Carelon who oversees all aspects of capitated behavioral health utilization management. To facilitate consistency and accuracy in the application	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	of medical necessity criteria, Carelon's UM Manager conducts an annual review of the EPSDT medical necessity criteria with the entire UM team. During calendar year 2024, this training was hosted in October 2024 and ensured that all team members were up-to-date with the latest guidelines and standards for determining medical necessity in EPSDT services. This training session underscores our commitment to continuous education and adherence to established policies, ultimately ensuring high-quality and appropriate care for our members. See **248L_EPSDTPolicy**, **Page 4** and the entire **CCM_Training_EPSDT** document for additional information. Additionally, the UM Director developed a comprehensive document that outlines the guidelines for documenting medical necessity criteria in members' electronic health records. This document provides detailed instructions for composing written communications related to the denial of behavioral health services for EPSDT members. See the **EPSDTDocumentationGuidelines** document for complete content. Finally, NHP shares the EPSDT medically necessary criteria with providers via our behavioral health and physical health provider handbooks. See	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	BehavioralHealthProviderHandbook, Pages 44-45 and **PrimaryCareProviderHandbook, Pages 32-33**.	
7. *For the Capitated Behavioral Health Benefit*, the RAE provides or arranges for the following for children/youth from ages 0 to 21: intensive case management, prevention/early intervention activities, clubhouse and drop-in centers, residential care, assertive community treatment (ACT), recovery services. *Note: All EPSDT services are included in the State Plan or in Non-State Plan 1915(b)(3) Waiver Services (except for respite and vocational rehabilitation).* Contract Amendment 17: Exhibit B—14.5.7.1	**Documents Submitted/Location Within Documents:** 1. 248L_EPSDTPolicy, Page 5 2. October2024_StateBehavioralHealthServicesBillingManual, Pages 173, 194, 195 3. 2024Claims_Encounters, Entire Document **Description of Process:** NHP provides or arranges services for the capitated behavioral health benefit for children and youth ages 20 and under. These services may be in the state plan or in the non-state plan 1915 (b)3 waiver services. NHP adheres to Carelon's **248L_EPSDTPolicy**, which guides our procedures for providing or arranging for the provision of all medically necessary services such as intensive case management, prevention/early intervention activities, clubhouse/drop-in centers, residential care, assertive community treatment, and recovery services. See **248L_EPSDTPolicy,** Page 5 for more information. Many of these services may be delivered through our Federally Qualified Health Centers (FQHCs), community mental health centers (CMHCs), or other licensed providers. Below is a description of the services and the CPT codes which may be associated	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	with the service. NHP ran a de-identified report, **2024Claims_Encounters**, to detect claims and encounters for our EPSDT population between January 1, 2024 – October 14, 2024 to demonstrate services that are being provided. NHP has used the definitions provided by the state behavioral health billing manual for the services below. Intensive Case Management (ICM). According to the **October 2024 State Behavioral Health Services Billing Manual**, ICM services describes community-based services which average more than one hour per week to adults with serious behavioral health diagnoses who are at risk of hospitalization, incarceration and/or homelessness due to multiple needs and impaired level of functioning. Services are designed to provide adequate support to ensure community living. Services may include assessments, service plan development, multi-system referrals, assistance with obtaining wrap-around services and supportive living services, monitoring and follow-up (**Page 194**). There were no specific CPT codes associated with Intensive Case Management for EPSDT eligible members. These services are typically provided by our delegated care coordination agencies, CMHCs, or FQHCs. Prevention/Early Intervention. According to the **October 2024 State Behavioral Health Services Billing Manual**, these services are proactive efforts to	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	educate and empower individuals to choose and maintain healthy life behaviors and lifestyles that promote positive psychological health. Efforts could include behavioral health screenings and community-based services such as Love and Logic classes, and educational programs (**Page 194**). These services are usually provided through our providers or the CMHCs. CPT codes could include: H0022, H0023, H0024, H0025, H0027, H0028, H0029, H0038, H1003, s9453, s9454, s9485. NHP identified 667 instances of prevention/early intervention services for members ages 20 and under. Additionally, for all children in foster care, especially those with complex needs, NHP has dedicated care management staff with specialized training in trauma-based care and the foster care system. NHP participated and facilitated many Creative Solutions team discussions with assigned county case workers, RAE care coordinators, school(s), parents, family members, youth, caregivers, and other service providers (behavioral health, juvenile justice, CMAs) involved with members throughout 2024 to provide and coordinate prevention and early intervention services. Through these meetings, the team develops specific and individualized interventions with the member/family and remains involved until the process is complete. NHP strives to minimize the fragmentation that may occur in foster care with a seamless coordination of medical, behavioral health and social services. Through this work, NHP developed a program with	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Weld County Department of Human Services through which NHP receives a list from Weld County, with information on members placed in foster care, usually within two to three days of placement. NHP sends the information to the RAE care coordinator, who then contacts the foster parents and arranges a well-child check that includes a dental screening and behavioral health screening, along with a traditional physical exam. This enables foster parents to meet state requirements for care required upon transitioning to a new home all in one appointment, rather than needing to coordinate multiple appointments with multiple providers. Understanding resources and limitations, particularly in the rural and frontier areas, is key to a family's success Clubhouse and Drop-In Centers: According to the **October 2024 State Behavioral Health Services Billing Manual**, clubhouse and drop-in centers services are peer support services for people who have behavioral disorders, provided in clubhouses and drop-in centers. Clubhouse services are available for members ages 12 and older and are structured community-based services designed to strengthen and regain the member's interpersonal skills, provide psychosocial support etc. CPT codes include H2030 and H2031. Drop-in centers are for members ages 12 and older and are a form of safe outreach to and engagement with adolescents and adults with mental health conditions (**Page 195**). The CPT code for drop-	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	in centers is H0046. Both Clubhouse and drop-in center services are available through our community mental health centers within our ten (10) counties. NHP identified 66 instances of clubhouse/drop-in services for our members between the ages of 12-20. Residential Care. According to the **October 2024 State Behavioral Health Services Billing Manual**, residential services are defined as 24-hour care, excluding room and board (**Page 195**). There are several CPT codes that are associated with residential care for both mental health and substance use disorders. These services are typically for all ages. CPT codes could include: H0010, H0017, H0018, H0019, H2036 and 0911. These services are provided by contracted behavioral health providers and require prior authorization. NHP identified 320 instances of residential care services for our members ages 20 and under. Assertive Community Treatment (ACT). According to the **October 2024 State Behavioral Health Services Billing Manual**, ACT services is a team-based approach to the provision of treatment rehabilitation and support services for members 18 and older (**Page 195**). The CPT codes usually billed are H0039 and H0040 and are usually provided through our providers or the CMHCs. NHP did not identify any instances of these services being provided to members aged 18-20.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Recovery Services. According to the **October 2024 State Behavioral Health Services Billing Manual**, recovery services are designed to provide choices and opportunities for adults with serious behavioral health disorders. Recovery-oriented services promote self-management of psychiatric symptoms, focusing on relapse prevention, treatment choices, mutual support, enrichment, and rights protections. Services are peer counseling and support services, peer-run drop-in centers, peer-run employment services, peer mentoring, wellness recovery action planning, advocacy, etc. (**Page 173**). These services are offered through our providers or CMHCs. CPT codes include: H0043, H0044, H2015, H2016. NHP identified 53 instances of these services provided to our members aged 20 and under. See the entire **2024Claims_Encounters** file for additional details. NHP utilizes our care coordination entities to connect members with the appropriate Case Management Agency (CMA) or Community Center Board (CCB) for the assessment of services under the 1915(b)(3) waiver program, as needed. Lastly, NHP participates in creative solutions meetings that bring together a diverse range of care teams. These meetings aim to develop comprehensive,	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	community-centered approaches to support youth by collaborating with community agencies, service providers, mental health crisis support teams, and families to identify gaps in services and create innovative solutions. These solutions may include streamlined referral processes, integrating crisis intervention teams, or funding for therapeutic programs. Our goal is to leverage EPSDT services to promote lasting, systemic changes and improve health outcomes for the members in our community	

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

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

Review Period:	January 1, 2024 – December 31, 2024
Completed By:	Elizabeth Yonge
Date of Review:	January 27, 2025
Reviewer:	Crystal Brown
Participating MCE Staff Member During Review:	Christopher Klaric

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10
Provider ID #	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****
Provider Type (e.g., MD, PA, NP, LCSW, PsyD, DDS, DMD)	LADC	LCSW	APRN	LPC	LPC	LCSW	LPC	APRN	APRN	LCSW
Provider Specialty (e.g., PCP, surgeon, therapist, periodontist)	Licensed Addiction Counselor	Licensed Clinical Social Worker	Advanced Practice Nurse Practitioner	Licensed Professional Counselor	Licensed Professional Counselor	Licensed Clinical Social Worker	Licensed Professional Counselor	Advanced Practice Nurse Practitioner	Advanced Practice Nurse Practitioner	Licensed Clinical Social Worker
Date of Completed Application [MM/DD/YYYY]	1/11/2024	2/17/2024	3/12/2024	4/2/2024	5/2/2024	6/14/2024	7/8/2024	7/30/2024	9/9/2024	11/7/2024
Date of Initial Credentialing [MM/DD/YYYY]	2/2/2024	3/5/2024	3/26/2024	4/26/2024	5/21/2024	7/2/2024	8/16/2024	9/13/2024	11/1/2024	12/13/2024
Completed Application for Appointment Met? [VIII.8]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Verification of Current and Valid License Yes, No, Not Applicable (NA)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Verification of Current and Valid License Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Board Certification Yes, No, NA	NA	NA	Yes	NA	NA	NA	NA	Yes	Yes	NA
Evidence of Board Certification Met? [VIII.6]	NA	NA	Met	NA	NA	NA	NA	Met	Met	NA
Evidence of Valid DEA or CDS Certificate (for prescribing providers only) Yes, No, NA	NA	NA	Yes	NA	NA	NA	NA	Yes	Yes	NA
Evidence of Valid DEA or CDS Certificate Met? [VIII.6]	NA	NA	Met	NA	NA	NA	NA	Met	Met	NA
Evidence of Education/Training Verification Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Education/Training Verification Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Work History (most recent five years or, if less, from the time of initial licensure) Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Work History Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Malpractice History Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice History Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence Malpractice Insurance/Required Amount (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate) Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice Insurance/Required Amount Met? [VIII.8]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Verification That Provider Is Not Excluded From Federal Participation Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Verification That Provider Is Not Excluded From Federal Participation Met? [VIII.7]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met

Comments:
N/A

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

Scoring	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10
Applicable Elements	7	7	9	7	7	7	7	9	9	7
Compliant (Met) Elements	7	7	9	7	7	7	7	9	9	7
Percent Compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Total Applicable Elements	76									
Total Compliant Elements	76									
Total Percent Compliant	100%									

Notes:

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

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

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

365 Calendar Days
- Signed application/attestation
- Work history

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

Review Period:	January 1, 2024 – December 31, 2024
Completed By:	Elizabeth Yonge
Date of Review:	January 27, 2025
Reviewer:	Crystal Brown
Participating MCE Staff Member During Review:	Christopher Klaric

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10
Provider ID #	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****
Provider Type (e.g., MD, PA, NP, LCSW, PsyD, DDS, DMD)	LPC	LPC	PysD	PsyD	LMFT	LPC	LPC	LCSW	LPC	APRN
Provider Specialty (e.g., PCP, surgeon, therapist, periodontist)	Licensed Professional Counselor	Licensed Professional Counselor	Licensed Doctor of Psychology	Licensed Doctor of Psychology	Licensed Marriage and Family Therapist	Licensed Professional Counselor	Licensed Professional Counselor	Licensed Clinical Social Worker	Licensed Professional Counselor	Advanced Practice Nurse Practitioner
Date of Last Credentialing [MM/DD/YYYY]	2/4/2021	3/9/2021	4/28/2021	5/28/2021	6/22/2021	8/17/2021	8/20/2021	10/12/2021	11/12/2021	12/10/2021
Date of Recredentialing [MM/DD/YYYY]	1/26/2024	3/15/2024	4/5/2024	5/17/2024	6/28/2024	8/9/2024	8/27/2024	10/29/2024	11/13/2024	12/24/2024
Months From Initial Credentialing to Recredentialing	35	36	35	35	36	35	36	36	36	36
Time Frame for Recredentialing Met? [VIII.9] Is completed at least every three years (36 months)	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Verification of Current and Valid License Yes, No, Not Applicable (NA)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Verification of Current and Valid License Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Board Certification Yes, No, NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	Yes
Evidence of Board Certification Met? [VIII.6]	NA	NA	NA	NA	NA	NA	NA	NA	NA	Met
Evidence of Valid DEA or CDS Certificate (for prescribing providers only) Yes, No, NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	Yes
Evidence of Valid DEA or CDS Certificate Met? [VIII.6]	NA	NA	NA	Met	Met	Met	Met	Met	Met	Met
Evidence of Malpractice History Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice History Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Malpractice Insurance/Required Amount (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate) Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice Insurance/Required Amount Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Ongoing Verification That Provider Is Not Excluded From Federal Participation Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Ongoing Verification That Provider Is Not Excluded From Federal Participation Met? [VIII.10]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Comments:										

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

Scoring	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10
Total Applicable Elements	5	5	5	6	6	6	6	6	6	7
Total Compliant (Met) Elements	5	5	5	6	6	6	6	6	6	7
Total Percent Compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Total Applicable Elements	**58**									
Total Compliant Elements	**58**									
Total Percent Compliant	**100%**									

Notes:

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

   Prior to Credentialing Decision
   - DEA or CDS certificate

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

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

Appendix C. Compliance Review Participants

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

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

HSAG Reviewers	Title
Gina Stepuncik	Associate Director
Sara Dixon	Project Manager III
Crystal Brown	Project Manager I
NHP Participants	**Title**
Michaela Smyth	Behavioral Health Clinical Quality Audit Analyst Senior, Carelon
Jeremy White	Director, Quality Management Improvement, Carelon
Courtney Hernandez	Behavioral Health Clinical Quality Audit Analyst Senior, Carelon
Elizabeth Yonge	Credentialing Specialist, Carelon
Christopher Klaric	Credentialing Manager, Carelon
Lana Martin	Manager II, Credentialing, Carelon
Lynne Fabian	Manager, Health Promotions Outreach Services, Carelon
Dawn Surface	Community Outreach Manager, Carelon
Marissa Gonzalez Martinez	Clinical Service Assistant, Carelon
Matthew Wilkins	Manager II, Behavioral Health Services, Carelon
Christine Anderson	Health Promotion Manager, Carelon
Madeline Dunn	Director, Network Management, Carelon
Tiffany Jenkins	Manager, Behavioral Health Services, Carelon
Jamie Coahran	Account Service Manager Senior, Carelon
Alicia Williams	Business Relation Management Executive Advisor, Carelon
Anna Pittar-Moreno	Behavioral Health Clinical Quality Audit Analyst Senior, Carelon
Wayne Watkins	Chief Information Officer
Kari Snelson	Chief Executive Officer, Compliance Officer
Natasha Lawless	Contract Manager
Jen Hale-Coulson	Chief of Clinical Operations
Chantel Hawkins	Quality Manager
Raina Ali	Community Engagement Specialist
Brian Robertson	Chief Operating Officer, Director of Quality Improvement
Joanna Martinson	Regional Healthcare Transformation Coordinator

NHP Participants	Title
Jennefer Hubbard-Rolf	Project Manager
Jessica Bayer-Homolka	Care Coordination Manager, Colorado Community Managed Care Network
Department Observers	**Title**
Russell Kennedy	Quality and Compliance Specialist
Angela Ukoha	Accountable Care Collaborative Program Specialist
Sandi Wetenkamp	Health Network Accountability Specialist

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

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

Table D-1—CAP Process

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

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

Appendix E. Compliance Monitoring Review Protocol Activities

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

Table E-1—Compliance Monitoring Review Activities Performed

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

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct the Review**
	• During the review, HSAG met with groups of the MCE's key staff members to obtain a complete picture of the MCE's compliance with federal healthcare regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the MCE's performance. • HSAG requested, collected, and reviewed additional documents as needed. • At the close of the review, HSAG provided MCE staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the Department-approved FY 2024–2025 Compliance Review Report template to compile the findings and incorporate information from the pre-review and review activities. • HSAG analyzed the findings and calculated final scores based on Department-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the Department**
	• HSAG populated the Department-approved report template. • HSAG submitted the draft Compliance Review Report to the MCE and the Department for review and comment. • HSAG incorporated the MCE and Department comments, as applicable, and finalized the report. • HSAG included a pre-populated CAP template in the final report for all elements determined to be out of compliance with managed care regulations. • HSAG distributed the final report to the MCE and the Department.