COLORADO

Department of Health Care Policy & Financing

Fiscal Year 2022–2023 Compliance Review Report

for

Health Colorado, Inc.

Region 4

June 2023

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

Introduction

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

This report documents results of the fiscal year (FY) 2022–2023 compliance review activities for **Health Colorado, Inc.** (**HCI**). For each of the four standard areas reviewed this year, this section contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 2 describes the background and methodology used for the FY 2022–2023 compliance monitoring review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2021–2022 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 denials of authorization of services (denials), grievances, and appeals record review tools. Appendix C lists HSAG, RAE, and Department personnel who participated in some way in the compliance review process. Appendix D describes the corrective action plan (CAP) process that the RAE will be required to complete for FY 2022–2023 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*, October 2019.[1-1]

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: May 9, 2023. At the start of FY 2022–2023 compliance review, CMS had not finalized the 2023 CMS EQR Protocol 3; therefore, the 2019 CMS EQR Protocol 3 was used for the period under review.

Summary of Compliance Results

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

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

Table 1-1—Summary of Scores for Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
I. Coverage and Authorization of Services	32	32	30	2	0	0	94%
II. Adequate Capacity and Availability of Services	14	14	12	2	0	0	86%
VI. Grievance and Appeal Systems	35	35	32	3	0	0	91%
XII. Enrollment and Disenrollment	5	5	5	0	0	0	100%
Totals	**86**	**86**	**79**	**7**	**0**	**0**	**92%**

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

Table 1-2 presents the scores for **HCI** for the denials, grievances, and appeals record reviews. Details of the findings for the record reviews are 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)
Denials	100	74	68	6	26	92%
Grievances	60	50	50	0	10	100%
Appeals	60	60	58	2	0	97%
Totals	**220**	**184**	**176**	**8**	**36**	**96%**

*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.

Standard I—Coverage and Authorization of Services

Evidence of Compliance and Strengths

HCI delegated utilization management (UM) functions for all behavioral health services to Beacon Health Options (Beacon), which has rebranded to Carelon Behavioral Health. This report will refer to the name Beacon, which was in use during the review period (CY 2022).

Beacon UM staff members described innovations since the last review period which included adding automation solutions to the Provider Connect system to improve providers' experience in requesting services; reducing barriers for prior authorization requests where appropriate; and working to educate providers about frequently requested services such as methadone, medication assisted treatment, and other substance use disorder (SUD) services which have continued to increase since the implementation of the SUD benefit. Beacon drafted additional policies such as the RAE Authorization of Inpatient and Residential SUD Services to further describe SUD authorization procedures, which accurately included all applicable time frames.

Staff members on the UM team participated in annual interrater reliability assessments and met the 80 percent passing rate during the review period. Due to staff exceeding the 80 percent scores during the July 2022 testing, Beacon stated that leadership decided to raise the passing threshold to 90 percent.

Opportunities for Improvement and Recommendations

Peer-to-peer reviews to obtain additional information were stated in policy as a strict 24-hour turnaround. HSAG encourages **HCI** to consider the full 72-hour, 10 calendar day, or 24 calendar day turnaround (in cases involving extensions) when it is in the member's best interest to wait more than 24 hours for additional information.

HCI has an opportunity to track the time frame of implementing single case agreements, from service request to member appointment, to ensure that when **HCI** is unable to provide a service within the network, the member receives the service in accordance with timeliness standards.

Required Actions

The notices of adverse benefit determination (NABDs) in denial samples one through five included incorrect information regarding the time frame to file a State fair hearing. Due to **HCI** correcting this issue before the end of the review period, no required action is needed.

Of the 10 NABDs reviewed, one was sent to the member a day late. Additionally, the Medical Necessity Determination Timelines policy often referred to timelines for URAC standards, which sometimes conflicted with Colorado regulations. In some instances, the time frames for notification were stated to be based on the date of receipt of additional information from the provider or after the decision was

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

Standard II—Adequate Capacity and Availability of Services

Evidence of Compliance and Strengths

Policies, procedures, network adequacy quarterly reports, and GeoAccess reports all demonstrated that **HCI** made efforts to contract with each specialty type required by the contract and expand its provider network quarter over quarter. Region 4 spans the south and southeast regions of Colorado and comprises 19 counties, only one of which is urban. Staff members described that in recent years, providers showed an increased interest in working with the Medicaid population; however, much of the network growth occurred in the urban counties. Telehealth services declined from one third during the coronavirus disease 2019 pandemic down to one fifth of utilization in the first quarter of FY 2022–2023, with members being more and more likely to request in-person services during the review period.

Both internal documentation and provider- and member-facing educational materials showed how **HCI** would provide access to family planning services and offer second opinions, at no cost to the member. And according to the Network Adequacy Quarterly Report for FY 2022–2023, just over 30 percent of **HCI**'s physical and behavioral health providers offered after-hours appointments. Provider relations staff members described a focus on responding to provider questions, tracking metrics such as inquiry response time which is monitored and reported to the Department monthly.

Beacon monitored one quarter of the provider network each quarter to assess adherence to timely appointment standards. While adherence to the timely appointment standards fell below 50 percent for primary care medical providers (PCMPs), behavioral health adherence during the quarter ranged from 60 percent to almost 90 percent. Beacon implemented corrective action plans (CAPs) for providers not meeting the standards and worked to resolve these deficiencies through scheduling system updates or reassigning members; providers were reassessed within 90 days.

HCI ensured physical and mental health accommodations for members by collecting provider data during the contracting process and posting the specialty accommodations in its online provider directory. Filters included languages offered, gender preference, provider's race and ethnicity, whether the office is wheelchair accessible, and proximity to public transportation.

Opportunities for Improvement and Recommendations

Physical health services during the first quarter of FY 2022–2023 showed a notable gap in the number of physician assistants in the one urban county, Pueblo, and almost met other time and distance standards, at 99.9 percent. Regarding mental health services, urban, rural, and frontier counties showed a gap in the

number of psychiatric hospitals or psychiatric units in acute care facilities, which has been observed throughout Colorado's RAEs. Similarly, SUD services fell just below the required time and distance standards for the urban county, meeting these standards 98.5 percent to 99.9 percent of the time for American Society of Addiction Medicine (ASAM) 3.1, 3.2 withdrawal management (WM), 3.5, and 3.7, with gaps in only 3.3 and 3.7 WM. Only two counties showed access to 3.7 WM, and staff members stated there were no licensed facilities to provide 3.3 level of care. **HCI** has the opportunity to continue working with the Department to identify ways to improve compliance with time and distance standards for SUD treatment practitioners and psychiatric units in acute care hospitals.

Required Actions

The PCP Practitioner Agreement included two incorrect time frames: urgent care was listed as 48 hours instead of 24 hours, and well visits were listed as 45 days instead of one month. **HCI** must correct the timely appointment standards in the PCP Practitioner Agreement.

HCI hosted a Health Equity Roundtable every six months. The content was aligned with and delivered in partnership with the Department. Providers and staff members had the opportunity to learn about cultivating positive healthcare attitudes when serving Hispanic, Latino, African American, refugee, and LGBTQ (lesbian, gay, bisexual, transgender, and queer) members. However, during the interview, staff members were unable to describe current efforts to identify members within Region 4 or assess members whose cultural norms and practices may affect their access to healthcare. Any related initiatives referenced seemed to be new, implemented after the review period (CY 2022), or had not yet started but were in discussion. **HCI** must develop a way to identify its Region 4 membership and gain an understanding of the membership's cultural norms and practices and how they may affect access to healthcare. HSAG suggests a review of current data, utilization trends, cultural subgroups, and community partners as sources of information to explore.

Standard VI—Grievance and Appeal Systems

Evidence of Compliance and Strengths

Beacon employs community outreach managers to receive and process appeals, and delegates to four CMHCs and one FQHC who employ member advocates to receive and process grievance requests from members. All staff involved in grievance and appeal procedures were trained during onboarding, annually, and during routine one-on-one meetings. Additionally, Beacon submitted an Appeal and Complaint Training Microsoft PowerPoint Presentation and Complaint Job Aid that were used in conjunction with routine training.

Appeals can be requested by a member orally or in writing. Community outreach managers are trained to educate the members of their rights to appeal and to request a State fair hearing as well as communicate to the member the limited time frame to receive additional evidence to support the member's appeal request. If clinical expertise is needed, Beacon maintains a panel of peer advisors with

clinical expertise to review appeals and make decisions regarding the information collected during the request. Of the 10 appeal sample records, one was expedited, and Beacon staff members made a reasonable effort to contact the member about the resolution within the 72-hour time frame. Beacon submitted documentation such as the 305L Appeal Policy, Appeal Guide, Appeal Job Aid, and State Fair Hearing Guide that accurately defined "appeal" and "adverse benefit determination." **HCI** submitted a full appeal record sample and overall met 97 percent compliance for 10 appeal sample records.

Member advocates and Beacon staff members are to follow the same policies and procedures when a member files a complaint and enters the grievance into the Feedback database for tracking. All staff members demonstrated full understanding of the definition of "grievance" and accepted grievances verbally or in writing. Staff also demonstrated understanding through submitted documentation which included the 303L Grievance Policy, Complaint Delegation Procedures, Call Center Training, and the Complaint Flow Chart. **HCI** submitted a full grievance record sample and overall met 100 percent compliance for 10 grievance sample records. Member letters were written in an easy-to-understand language and met the sixth-grade reading level requirement.

Opportunities for Improvement and Recommendations

Grievance and appeal member letters were included in both sets of sample records reviewed by HSAG. However, system notes were not included in the grievance or appeal sample records. HSAG recommends that system notes be included in future compliance monitoring audits when records are requested.

Beacon and HSAG discussed one grievance case that should have been investigated as a quality of care concern (QOCC). However, it appeared the case was not fully investigated due to a lack of information from the member regarding the provider's name and date of events, and a release of information (ROI) was not signed by the member to allow Beacon to speak on the member's behalf. The member was then directed by the Quality-of-Care Committee to file a report with the Department of Regulatory Agencies (DORA), and the member resolution letter included a link to the DORA website where the member could submit the report and complaint. HSAG recommends that Beacon communicate and clarify with the Department the responsibilities and procedures related to investigating QOCC issues and revisit Health Insurance Portability and Accountability Act (HIPAA) laws that may or may not apply regarding when Beacon or **HCI** may share information with providers about a member's care and treatment.

Required Actions

HCI accepts appeals orally and in writing. However, some documentation stated that a verbal appeal request should be followed by a written request, or the coordinator should reach out to the member to obtain a signed appeal. The following documents must be updated to remove language stating that the member must follow a verbal appeal request with a written request. Additionally, **HCI** must share updated documentation with other staff members to ensure awareness of the updated requirement.

- Appeal Job Aid, page 2, stated the "appeal must be signed by the member."

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

An extension of up to 14 calendar days can be granted if the extension is in the member's best interest, and Beacon must make reasonable efforts to notify the member verbally of the delay. However, one of 10 grievance sample records involved an extension. This grievance record did not include evidence of an oral outreach to the member documented in the system notes; therefore, Beacon could not provide evidence that outreach was conducted. Beacon must make reasonable efforts to notify the member of an extension and must enhance documentation of such attempted communications between the member and staff member. Additionally, the 305L Appeals Policy on page 12, section J.4, did not state that the coordinator will make a reasonable attempt to contact the member to notify the member of the delay when an extension is used. **HCI** must update this policy to include that the coordinator will make reasonable efforts to notify the member of an extension.

HCI's sample included two out of 10 appeal sample records containing language that required the member to request a State fair hearing "no earlier than 90 days and no later than 120 days" from the notice of appeal resolution. However, the State requirement is 120 days, and the MCE cannot be any more restrictive than the State requirements. Due to **HCI** correcting this issue before the end of the review period, no required action is needed.

Standard XII—Enrollment and Disenrollment

Evidence of Compliance and Strengths

HCI partners with Beacon who receives Electronic Data Interchange (EDI) 834 files from the State five days a week, Tuesday through Saturday, and accepts members into the Beacon data system in the order in which they are enrolled. Evidence submitted for review included the Non-Discrimination Policy, Enrollment and Disenrollment of Medicaid Members policy and procedure, Disenrollment Rights, Enrollment Workflow, and Member Services Presentation. Beacon described the process of completing edits and reconciliations routinely.

Policies, procedures, and training that were submitted supported efforts and awareness around member nondiscrimination and staff members described how members are not to be discriminated against. During the interview, staff members stated that if a member did make a complaint regarding discrimination, the complaint would be documented and sent through the proper channels for investigation and resolved within the grievance resolution time frame.

Regarding disenrollment, Beacon staff members did not report any requests for disenrollment for this review period. However, staff members described a process wherein they would work with the member and provide resources that are necessary to assist the member. If the member moved out of the region, Beacon described the process used to complete a warm hand off to the new region and help the member through the transition. Members could also request disenrollment, and Beacon described how staff would work with the member to assist in a smooth transition. However, Beacon reported that the only instances of disenrollment during the review period were due to the member moving out of the region.

Opportunities for Improvement and Recommendations

HSAG recommends that **HCI** develop a mechanism to compare disenrollment files to member-reported quality-of-care concerns for tracking and trending.

Required Actions

HSAG identified no required actions for this standard.

2. Overview and Background

Overview of FY 2022–2023 Compliance Monitoring Activities

For the FY 2022–2023 compliance review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services, Standard II—Adequate Capacity and Availability of Services, Standard VI—Grievance and Appeal Systems, and Standard XII—Enrollment and Disenrollment. 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 November 2020, with an effective date of December 2020. HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable.* The Department determined that the review period was January 1, 2022, through December 31, 2022. HSAG conducted a desk review of materials submitted prior to the compliance review activities; a review of records, documents, and materials requested during the compliance review; and interviews of key RAE personnel to determine compliance with applicable federal managed care regulations and contract requirements. Documents submitted for the desk review and compliance review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to denials of authorization, grievances, and appeals.

HSAG reviewed a sample of the RAE's administrative records related to denials, grievances, and appeals to evaluate implementation of federal and State healthcare regulations. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records (to the extent that a sufficient number existed) for each of the denials, grievances, and appeals. Using a random sampling technique, HSAG selected the samples from all RAE denial, grievance, and appeal records that occurred between January 1, 2022, and December 31, 2022. For the record review, the RAE received a score of *Met (M)*, *Not Met (NM)*, or *Not Applicable (NA)* for each required element. Results of record reviews were considered in the review of applicable requirements in Standard I—Coverage and Authorization of Services and Standard VI—Grievance and Appeal Systems. HSAG separately calculated a record review score for each record review requirement and an overall record review score.

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*, October 2019. 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 2022–2023 compliance reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights, Protections, and Confidentiality, Standard V—Member Information Requirements, Standard VII—Provider Selection and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontractual Relationships and Delegation, Standard X—Quality Assessment and Performance Improvement, and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT).

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 and timeliness of, and access to, services furnished by the RAE, as assessed by the specific areas reviewed.
- Possible interventions recommended to improve the quality of the RAE's services related to the standard areas reviewed.

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

FY 2021–2022 Corrective Action Methodology

As a follow-up to the FY 2021–2022 compliance review, each RAE that received one or more *Partially Met* or *Not Met* scores was required to submit a CAP to the Department addressing those requirements found not to be fully compliant. If applicable, the RAE was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the RAE and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **HCI** until it completed each of the required actions from the FY 2021–2022 compliance monitoring review.

Summary of FY 2021–2022 Required Actions

For FY 2021–2022, HSAG reviewed Standard III—Coordination and Continuity of Care; Standard IV—Member Rights, Protections, and Confidentiality; Standard V—Member Information Requirements; and Standard XI—EPSDT.

Related to Standard V—Member Information Requirements, **HCI** was required to complete two required actions—revise critical member materials to include all required components of a tagline, and develop and implement a mechanism to monitor that, upon request, members would be provided with printed materials within five business days and at no cost.

Related to Standard XI—EPSDT, **HCI** was required to complete one required action, which was to update the EPSDT Tip Sheet and any associated documents to include the correct Bright Futures Guidelines time frame for annual well visits as well as enhance annual non-utilizer outreach to ensure that this outreach is timely and has a reasonable chance to reach the member.

Summary of Corrective Action/Document Review

HCI submitted a proposed CAP in July 2022. HSAG and the Department reviewed and approved the proposed plan and responded to **HCI**. **HCI** submitted final documents and completed the CAP in November 2022.

Summary of Continued Required Actions

HCI successfully completed the FY 2021–2022 CAP, resulting in no continued corrective actions.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor ensures that all services are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished. *42 CFR 438.210(a)(3)(i)* Contract: Exhibit B-8—14.6.2	**Documents Submitted/Location Within Documents:** 1. HCI_Administrative Services Agreement, Pages 14-15 [Medical Management]. *Misc 2. COS_EC_202L--Medical Necessity Determinations-FY22-23, Entire Policy 3. Health-First-Colorado-Member-Handbook, Page 25. **Description of Process**: All utilization management (UM) functions for the capitated behavioral health benefit of Health Colorado's Medicaid contract are delegated to Beacon Health Options as the administrative services organization for HCI (see HCI_Administrative Services Agreement, pages 14-15 [Medical Management]. As UM functions are delegated to Beacon, its policies and procedures demonstrate HCI's adherence to State and Federal requirements for the coverage and authorization of services. Thus, Beacon's policies and procedures are referenced throughout this compliance-monitoring tool. The amount, duration, and scope of services is limited only by the determination of medical necessity (see Section II, A-H of COS_EC_202L--Medical Necessity Determinations-FY22-23). Services that are determined to be medically necessary are not otherwise limited. For example, there are no episode of care, annual, or lifetime benefit limits. Services under this health plan are not less than the amount, duration, and scope of services that are available under fee-for-service Medicaid. A description of the covered behavioral health services can be found in the Health First Colorado Member Handbook as well (see page 25).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42 CFR 438.210(a)(3)(ii)* Contract: Exhibit B-8—14.6.4	**Documents Submitted/Location Within Documents:** 1. COS_EC_202L--Medical Necessity Determinations-FY22-23, Section II.D 2. Health Colorado Inc - RAE Contract - Amendment 11 - 10.31.2022, Exhibit I-6 3. COS_EC_303L--peer advisor adverse determinations--FY22-23, Entire Policy 4. Medical Necessity Criteria -Entire Folder **Description of Process:** This required element is delegated to Beacon Health Options by HCI. Beacon's UM staff refer to the medical necessity policy (see COS_EC_202L--Medical Necessity Determinations-FY22-23, II.D), the list of covered diagnoses (see Health Colorado Inc - RAE Contract - Amendment 11 - 10.31.2022, Exhibit I-6), and the clinical level of care criteria (Medical Necessity Criteria~~.zip~~) to authorize care to help ensure that care is not arbitrarily reduced or denied based on diagnostic categories or conditions. Only the Medical Director or the Clinical Peer Advisor (see COS_EC_303L--peer advisor adverse determinations--FY22-23) can deny care. Variables such as the member's situation and other care available are considered in each individual situation. UM staff work with providers to review the member's care and give input into discharge planning to help members achieve long-term stabilization and sustained improvement. Beacon's UM staff refer cases for possible adverse clinical decisions to the Medical Director/Peer Advisor for review.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor may place appropriate limits on services— • On the basis of criteria applied under the Medicaid State plan (such as medical necessity). • For the purpose of utilization control, provided that the services furnished can reasonably achieve their purpose. – For Utilization Management, provided family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used. *Note: The Contractor shall not deny or reduce the amount, duration, and scope of services provided under EPSDT as long as the service is supporting a member to maintain stability or level of functioning or making treatment progress.* *42 CFR 438.210(a)(4)* Contract: Exhibit B-8—14.6.2.1, 14.6.5, 14.6.5. 2, and 14.6.5.2.3	**Documents Submitted/Location Within Documents:** 1. COS_EC_202L--Medical Necessity Determinations-FY22-23, Sections I. and II.D and E. 2. Health Colorado Inc - RAE Contract - Amendment 11 - 10.31.2022, Exhibit I-6 3. Medical Necessity Criteria, Entire Folder **Description of Process:** This required element is delegated to Beacon Health Options by HCI. The Medical Necessity Determinations policy incorporates the elements of the State's definition for medical necessity and notes that Beacon can make medical necessity determinations for the purpose of utilization control (see Medical Necessity Criteria and COS_EC_202L--Medical Necessity Determinations-FY22-23, Section I and II. D and E). The list of covered diagnoses is stipulated by HCI's Medicaid contract (see Health Colorado Inc - RAE Contract - Amendment 11 - 10.31.2022, Exhibit I-6). The level of Care guidelines, Medical Necessity Criteria, are the basis for any limits placed on services authorized to control utilization and focus it on the members who will benefit from services and achieve their goals. Each level of care guideline contains evidence-informed inclusion and exclusion criteria designed to authorize care for the members who would reasonably be expected to benefit from the service. Criteria are outlined to continue authorization for members who are progressing in treatment or who need to have treatment plans adjusted by providers to address any lack of progress. Care managers actively	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	work with providers during reviews, based on the LOC criteria to shape treatment so that it will achieve the care needs of members.	
4. The Contractor may place appropriate limits on services for utilization control, provided that any financial requirement or treatment limitation applied to mental health or substance use disorder (SUD) benefits in any classification is no more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to members (whether or not the benefits are furnished by the same Contractor). • The Contractor may only apply a Non-Quantitative Treatment Limitation (NQTL) for mental health or substance use disorder benefits, in any classification, in a manner comparable to, and no more stringently than, the processes, strategies, evidentiary standards, or other factors applied to the same NQTL in the same benefit classification of the members' medical/surgical benefits. *42 CFR 438.905* *HB19-1269: Section 3–10-16-104(3)(B)*	**Documents Submitted/Location Within Documents:** 1. HCI_Administrative Services Agreement, Pages 14-15 *Misc. 2. COS_EC_202L--Medical Necessity Determinations-FY22-23, Section II.F **Description of Process:** This required element is delegated to Beacon Health Options by HCI. This responsibility is defined in the HCI_Administrative Services Agreement. The RAE is committed to ensuring access to and coverage of services that are in parity with all medical/surgical benefits in the same classification furnished to members. The amount, duration and scope of covered behavioral health services is limited by only the determination of medical necessity (see Section II.F of COS_EC_202L--Medical Necessity Determinations-FY22-23). Beacon may place limits on services for utilization control, as agreed to by HCI, provided that any financial requirement or treatment limitation applied to mental health or substance use disorder (SUD) benefits in any classification is no more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to members. Services that are determined to be medically necessary are not otherwise limited. For example, there are no financial, episode of care, annual, or lifetime benefit limits. Services under this health plan are not less than the amount,	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract: Exhibit B-8—14.6.5.2.1, 14.6.5.2.2	duration, and scope of services that are available under fee-for-service Medicaid.	
5. The Contractor covers all medically necessary covered treatments for covered behavioral health (BH) diagnoses, regardless of any co-occurring conditions. The Contractor must ensure that the diagnosis of an intellectual or developmental disability, a neurological or neurocognitive disorder, or a traumatic brain injury does not preclude an individual from receiving a covered BH service. *HB19-1269: Section 12—25.5-5-402(3)(h-i)*	**Documents Submitted/Location Within Documents:** 1. COS_EC_202L--Medical Necessity Determinations-FY22-23, Sections II.G and II.H 2. Health Colorado Inc - RAE Contract - Amendment 11 - 10.31.2022, Exhibit I-6 **Description of Process:** This required element is delegated to Beacon Health Options by HCI. All medically necessary covered treatments for covered behavioral health diagnoses are covered; regardless of any co- occurring conditions (see Sections II.G and II.H. of COS_EC_202L--Medical Necessity Determinations-FY22-23). The list of covered services and diagnoses is provided in Exhibit I-6-Covered Behavioral Health Services and Diagnoses Health Colorado Inc – RAE Contract – Amendment 11 – 10.31.2022.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The Contractor definition of "medically necessary": • Is no more restrictive than that used in Colorado's Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in Colorado statutes and regulations, the Health First Colorado plan, and other Colorado policies and procedures; and	**Documents Submitted/Location Within Documents:** 1. COS_EC_202L--Medical Necessity Determinations-FY22-23 Section II.A **Description of Process:** This required element is delegated to Beacon Health Options by HCI. Medically necessary services are needed for the diagnosis or treatment of health	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Addresses the extent to which the RAE is responsible for covering services that address: – The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability. – The ability for a member to achieve age-appropriate growth and development. – The ability for a member to attain, maintain, or regain function capacity. – The opportunity for a member receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and to live and work in the setting of their choice. *Note: For the purposes of EPSDT, medical necessity includes a good or service that will, or is reasonably expected to, assist the client to achieve or maintain maximum functional capacity in performing one or more Activities of Daily Living; and meets the criteria set forth at Section 8.076.1.8.b–g.*	impairments and also to prevent deterioration in functioning as a result of a covered mental health disorder (see Section II.A. of COS_EC_202L--Medical Necessity Determinations-FY22-23).	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
The Contractor shall determine medical necessity under EPSDT based on an individualized clinical review of a member's medical status and in consideration that the requested treatment can correct or ameliorate a diagnosed health condition. *Note: The Contractor shall utilize the American Society of Addiction Medicine (ASAM) criteria to determine medical necessity for residential and inpatient substance use disorder treatment services.* *42 CFR 438.210(a)(5)* Contract: Exhibit B-8—14.6.5.1.1 10 CCR 2505-10 8.280.4.E.2 10 CCR 2505-10 8.205.10.B.4.a		
7. The Contractor and its subcontractors have in place and follow written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42 CFR 438.210(b)(1)* Contract: Exhibit B-8—14.8.2	**Documents Submitted/Location Within Documents:** 1. COS_EC_204L--Data Collection HLOC--FY22-23, Entire Policy 2. COS_EC_202L--Medical Necessity Determinations-FY22-23, Entire Policy 3. COS_EC_206L—Data Collection for Continued Authorization of HLOC—FY22-23, Entire Policy **Description of Process:** This required element is delegated to Beacon Health Options by HCI. Beacon policies clearly define and outline the procedures and information needed for	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	initial and continuing authorization of services (see COS_EC_204L--Data Collection HLOC--FY22-23). The first step in the process is to gather the clinical data and determine if medical necessity is being met (see policies 202L and 204L). If additional services are requested, the process for conducting continuing reviews is reflected in COS_EC_206L—Data Collection for Continued Authorization of HLOC—FY22-23.	
8. The Contractor and its subcontractors have mechanisms in place and to ensure consistent application of review criteria for authorization decisions. *42 CFR 438.210(b)(2)(i)* Contract: Exhibit B-8—14.8.2.6	**Documents Submitted/Location Within Documents:** 1. CCM Audit Tools, Entire Document 2. CSNT 116.9 Interrater Reliability, Entire Document **Description of Process:** This required element is delegated to Beacon Health Options by HCI. Beacon has a policy and procedure in place that outlines the process to ensure consistent application of the review for authorizing decisions. Beacon clinical care managers complete quarterly peer audits utilizing a web-based audit tool that focuses on the content of documentation for UM decision making (see CCM Audit Tools). The audit reviews inpatient and acute treatment unit (ATU) admissions that occurred the previous quarter. Each CCM has 2 admissions per month that are randomly selected, and then their peers review the documentation in Care Connect. Care Connect is Beacon's integrated system for authorization, documentation, and claims management. The cases are selected by the UM Manager and distributed to the CCM team to complete. The web-based tool calculates the scoring for the documentation audit, which includes timeliness of decision-making and content elements. If the results of the audit are below the standard of 85% compliance corrective action plan is	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	implemented to improve staff knowledge. Staff must complete the plan and achieve competency. Results are reported to the team and to the Clinical Peer Advisor. Beacon also requires clinical staff to take an annual inter- rater reliability test (IRR) to evaluate the appropriateness of clinical decision-making and to establish a systematic method to monitor the consistency with which clinicians and Peer Advisors apply medical necessity criteria in decision-making and documentation. Clinical staff must achieve a passing score of 80% on this examination; if they do not achieve a passing score, then they must complete a corrective action plan to achieve competency. See CSNT 116.9 Interrater Reliability. Beacon relies on multiple other methods to ensure consistency in decision-making. These methods include individual and group supervision, weekly rounds, peer audits, and live or recorded call supervision/call monitoring.	
9. The Contractor and its subcontractors have in place mechanisms to consult with the requesting provider for medical services when appropriate. *42 CFR 438.210(b)(2)(ii)* Contract: Exhibit B-8—14.8.2.5	**Documents Submitted/Location Within Documents:** 1. COS_EC_303L--peer advisor adverse determinations--FY22-23, Section IV.A. 2. COS_EC_ 203L--Medical Necessity Determination Timelines--FYF22-23-Entire Policy **Description of Process:** This required element is delegated to Beacon Health Options by HCI. Beacon policies direct staff to contact the provider, when necessary, for a review determination.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Authorizations or denials of services involve immediate telephonic notification of providers (see COS_EC_ 203L--Medical Necessity Determination Timelines--FYF22-23, Section IV. A). In addition, Beacon policies outline a formal process which includes consultation with a requesting provider, upon request, for reconsideration when initial or continued authorization is denied (see Section IV.A of COS_EC_303L--peer advisor adverse determinations--FY22-23). If providers fail to request additional services, Beacon staff will reach out to coordinate with the provider to determine whether the member has discharged from care. If there is not enough information available to make a determination, the provider is notified along with details about the information needed. Attempts are made to contact the requesting provider for reconsideration/peer to peer review before finalizing any adverse clinical decisions (see Section IV.A of COS_EC_ 203L--Medical Necessity Determination Timelines--FYF22-23).	
10. The Contractor ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the member's medical or BH needs. The Contractor's utilization management program includes identification of the type of personnel responsible for each level of utilization management decision-making. *42 CFR 438.210(b)(3)* Contract: Exhibit B-8—14.6.6, 14.8.2.4	**Documents Submitted/Location Within Documents:** 1. COS_EC_303L--peer advisor adverse determinations--FY22-23, Section II.C **Description of Process:** This required element is delegated to Beacon Health Options by HCI. Beacon policy COS_EC_303Lpeer advisor adverse determinations—FY22-23 notes that denial decisions can be made by only qualified Peer Advisors, as defined in Section II.C.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor notifies the requesting provider and gives the member written notice of any decision by the Contractor to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. *Note: Notice to the provider may be oral or in writing.* *42 CFR 438.210(c)* Contract: Exhibit B-8—8.6.1 10 CCR 2505-10 8.209.4.A.1	**Documents Submitted/Location Within Documents:** 1. COS_EC_ 203L--Medical Necessity Determination Timelines--FYF22-23, Entire Policy **Description of Process:** This required element is delegated to Beacon Health Options by HCI. The RAE policy outlines the processes for notifying the requesting provider and involved member of any decision to deny or authorize less care than requested, for all types of requests and levels of care (see entire policy of the COS_EC_203L--Medical Necessity Determination Timelines—FYF22-23). The content of the notifications is defined in Section IV.C of this policy. Additionally, the notifications must comply with the following requirements by contract: a. Is in writing. b. Is available in the state-established prevalent non-English languages in its region. c. Is available in alternative formats for persons with special needs. d. Is in an easily understood language and format. e. Explains how each dimension of the most recent edition of ASAM criteria was considered when determining medical necessity for any adverse determination concerning residential or inpatient substance use disorder services.; and f. The Contractor shall ensure that decision makers take into account all comments, documents, records, and other information submitted by the Member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor adheres to the following time frames for making standard and expedited authorization decisions: • For standard authorization decisions—as expeditiously as the member's condition requires and not to exceed 10 calendar days following the receipt of the request for service. • If the provider indicates, or the Contractor determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service. *42 CFR 438.210(d)(1–2)* *Memo: HCPF FFS UM Policy Requirements for SUD Benefit—August 4, 2020* Contract: Exhibit B-8—8.6.6, 8.6.8 10 CCR 2505-10 8.209.4.A.3(c)	**Documents Submitted/Location Within Documents:** 1. COS_EC_ 203L--Medical Necessity Determination Timelines--FYF22-23, Section IV. **Description of Process:** This required element is delegated to Beacon Health Options by HCI. In Beacon's policy titled COS_EC_203L--Medical Necessity Determination Timelines—FYF22-23, the following timeframes are noted for mailing of Notices of Action: • All authorization decisions are made as expeditiously as the member's health condition requires (see Section IV, A.2 and B.5). • For standard service authorization decisions that deny or limit services, within 10 calendar days of the receipt of request for service (see Section IV.B.5). If the provider indicates that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, Beacon's UM team makes an expedited authorization. For expedited decisions, providers are notified by telephone when a decision is made and letters are mailed no later than 72 hours from the receipt of the request for services (see Section IV.B.7).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor may extend the time frame for making standard or expedited authorization decisions by up to 14 additional calendar days if: • The member or the provider requests an extension, or • The Contractor justifies (to the Department, upon request) a need for additional information and how the extension is in the member's interest. *42 CFR 438.210(d)(1)(i–ii) and (d)(2)(ii)* Contract: Exhibit B-8—8.6.6.1, 8.6.8.1	**Documents Submitted/Location Within Documents:** 1. COS_EC_ 203L--Medical Necessity Determination Timelines--FYF22-23 Section IV.B.5 **Description of Process:** This required element is delegated to Beacon Health Options by HCI. Beacon rarely extends decision timeframes; however, when extensions are made, the policy titled COS_EC_203L--Medical Necessity Determination Timelines—FYF22-23 provides the guidelines that are followed when extended decision timeframes (see Section IV.B.5). Authorization Decisions are made as quickly as the member's health condition requires, but no longer, than ten (10) calendar days following the request for service for standard authorization decisions that deny or limit services. The RAE may extend the service authorization notice timeframe up to fourteen (14) additional days if the member or provider requests extension, or if the RAE shows a need for additional information and how the extension is in the member's best interest. The RAE will give the member written notice of the reason for the extension and the Member's right to file a grievance if they disagree with this extension.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The notice of adverse benefit determination must be written in language easy to understand, available in State-established prevalent non-English languages in the region, and available in alternative formats for persons with special needs. *42 CFR 438.404(a)* Contract: Exhibit B-8—8.6.1–8.6.1.4 10 CCR 2505-10 8.209.4.A.1	**Documents Submitted/Location Within Documents:** 1. COS_EC_307L_MemberInfoReqPolicy--FY22-23 Entire Policy *Misc. 2. NOABD_CHCI_EFFECTIVE 01.01.2022, Entire Document *Misc. **Description of Process:** This required element is delegated to Beacon Health Options by HCI. Beacon follows COS_EC_307L_MemberInfoReqPolicy—FY22-23 when developing member-facing materials. All commonly used member materials that were originally created in English are translated into Spanish, which has been deemed a prevalent language by the state. We also recognize that a large proportion of Medicaid enrollees have low health literacy, thus we follow guidelines developed by CMS in developing the Beacon member materials policy for low literacy readers. For example, when we present a concept that may be unknown to a low literacy reader, we offer a definition in simple language. The NOABD letter [NOABD_CHCI_EFFECTIVE 01.01.2022] is translated into Spanish, and we are prepared to translate it into other languages, when necessary. We test our materials to ensure they are at or below the 6th grade reading level.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to and	**Documents Submitted/Location Within Documents:** 1. NOABD_CHCI_EFFECTIVE 01.01.2022, Entire Document *Misc. 2. COS_EC_ 203L--Medical Necessity Determination Timelines--FYF22-23, Section IV.C	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
copies of all documents and records relevant to the adverse benefit determination (includes medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits). • The member's right (or member's designated representative) to request one level of appeal with the Contractor and the procedures for doing so. • The date the appeal is due. • The member's right to request a State fair hearing after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State fair hearing. • The circumstances under which an appeal process can be expedited and how to make this request. • The member's rights to have benefits/services continue (if applicable) pending the resolution of the appeal, how to request that benefits continue, and the circumstances (consistent with State policy) under which the member may be required to pay the cost of these services.	**Description of Process:** This required element is delegated to Beacon Health Options by HCI. Beacon ensures that members receive Notices of Adverse Benefit Determination (NOABD_CHCI_EFFECTIVE 01.01.2022) that contain all required elements. These elements are also described in Policy 203L, Section IV.C. In an effort to only include elements in the letter which pertain specifically to the member in question, Directions on how to file a Grievance or Appeal is included within the Notice of Adverse Benefit Determination letter. All Notices of Adverse Benefit Determination (NOABD_CHCI_EFFECTIVE 01.01.2022) include the following information: • The adverse benefit determination the Contractor has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to and copies of all documents and records relevant to the adverse benefit determination (includes medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits). • The member's right (or member's designated representative) to request one level of appeal with the Contractor and the procedures for doing so. • The date the appeal is due. • The member's right to request a State fair hearing after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State fair hearing.	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• How each dimension of the most recent edition of ASAM criteria was considered when determining medical necessity for any adverse determination concerning residential or inpatient substance use disorder services. *42 CFR 438.404(b)* *SB21-137: Section 10-25.5-5-424(3)* Contract: Exhibit B-8—8.6.1.5–8.6.1.13 10 CCR 2505-10 8.209.4.A.2	• The circumstances under which an appeal process can be expedited and how to make this request. • The member's rights to have benefits/services continue (if applicable) pending the resolution of the appeal, how to request that benefits continue, and the circumstances (consistent with State policy) under which the member may be required to pay the cost of these services. How each dimension of the most recent edition of ASAM criteria was considered when determining medical necessity for any adverse determination concerning residential or inpatient substance use disorder services.	
Findings: The NABDs in files one through five included incorrect information regarding the time frame to file a State fair hearing. Due to HCI correcting this issue before the end of the review period, no required action is needed.		
16. The Contractor mails the notice of adverse benefit determination within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, as defined in 42 CFR 431.211, 431.213 and 431.214 (see below). • For denial of payment, at the time of any denial affecting the claim. • For standard service authorization decisions that deny or limit services,	**Documents Submitted/Location Within Documents:** 1. COS_EC_ 203L--Medical Necessity Determination Timelines--FYF22-23, Section IV **Description of Process:** This required element is delegated to Beacon Health Options by HCI. In Beacon's policy titled Policy COS_EC_203L--Medical Necessity Determination Timelines—FYF22-23, the following outlines the timeframes noted for mailing of Notices of Action: • For termination, suspension or reduction of previously authorized services, notices must be mailed at least 10 calendar days before the effect of the action (see Section IV.K)	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
within 10 calendar days following the receipt of the request for service. • For expedited service authorization decisions, within 72 hours after receipt of the request for service. • For extended service authorization decisions, no later than the date the extension expires. • For service authorization decisions not reached within the required time frames, on the date the time frames expire. *42 CFR 438.404(c)* *42 CFR 438.210(d)* Contract: Exhibit B-8—8.6.3.1, 8.6.5–8.6.8 10 CCR 2505-10 8.209.4.A.3	• At the time of the action for denial of payment. (see Section IV.B.4 and Section IV.M) • For standard service authorization decisions that deny or limit services, within 10 calendar days of the receipt of request for service (see Section IV.H and Section IV.I) • For expedited authorization decisions, within 72 hours (see Section IV.B.7) • For extended service authorization decisions, no later than the date the extension expires (see Section IV.F to Section IV.I). For service authorization decisions not reached within the required timeframes, on the date timeframes expire (see Section IV. A.5).	
Findings: One NABD was sent to the member a day late. Additionally, the Medical Necessity Determination Timelines policy often referred to timelines for URAC standards, which sometimes conflicted with Colorado regulations. In some instances, the time frames for notification were stated to be based on the date of receipt of additional information from the provider or after the decision was made, rather than the date of the request.		
Required Actions: HCI must enhance its procedures and monitoring to ensure that all member notices are sent within time frame requirements. HCI must update its Medical Necessity Determination Timelines policy and any supporting documentation to clarify that the notification time frame is based on the date of the service request until the deadline.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. For reduction, suspension, or termination of a previously authorized Medicaid-covered service, the Contractor gives notice at least 10 days before the intended effective date of the proposed adverse benefit determination except: • The Contractor gives notice on or before the intended effective date of the proposed adverse benefit determination if: – The Contractor has factual information confirming the death of a member. – The Contractor receives a clear written statement signed by the member that the member no longer wishes services or gives information that requires termination or reduction of services and indicates that the member understands that this must be the result of supplying that information. – The member has been admitted to an institution where the member is ineligible under the plan for further services. – The member's whereabouts are unknown, and the post office returns Contractor mail directed to the	**Documents Submitted/Location Within Documents:** 1. COS_EC_ 203L--Medical Necessity Determination Timelines--FYF22-23, Section IV.K.1 **Description of Process:** This required element is delegated to Beacon Health Options by HCI. See Section IV.B of COS_EC_203L--Medical Necessity Determination Timelines—FYF22-23 and IV.K.1.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
member indicating no forwarding address. – The Contractor establishes that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth. – A change in the level of medical care is prescribed by the member's physician. – The notice involves an adverse benefit determination made with regard to the preadmission screening requirements. • If probable member fraud has been verified, the Contractor gives notice five calendar days before the intended effective date of the proposed adverse benefit determination. *42 CFR 438.404(c)* *42 CFR 431.211* *42 CFR 431.213* *42 CFR 431.214* Contract: Exhibit B-8—8.6.3.1–8.6.3.2, 8.6.4.1–8.6.4.8 10 CCR 2505-10 8.209.4.A.3(a)		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. If the Contractor extends the time frame for standard authorization decisions, it must give the member written notice of the reason for the extension and inform the member of the right to file a grievance if the member disagrees with that decision. *42 CFR 438.404(c)(4)* Contract: Exhibit B-8—8.6.6.2 10 CCR 2505-10 8.209.4.A.3(c)(1*)*	**Documents Submitted/Location Within Documents:** 1. COS_EC_ 203L--Medical Necessity Determination Timelines--FYF22-23, Entire Policy **Description of Process:** This required element is delegated to Beacon Health Options by HCI. Beacon's policy details the requirements to send written notification to the member and to carry out the determination as expeditiously as the member's health condition requires. The written notice also includes information about their right to file a grievance, if he or she disagrees with that decision. Written notification requirements can be found in Beacon's policy titled COS_EC_203L--Medical Necessity Determination Timelines—FYF22-23 in the following locations: • IV.F.3.a • IV.G.3.a • IV.H.2-3 • IV.I.2 • IV.I.3 The policy also outlines the fact that authorization decisions are made as required by the member's health condition and no later than the date the extension expires. See the following sections: • IV.F.1 • IV.G.1 • IV.H.1 • IV.I.1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
19. The Contractor provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42 CFR 438.210(e)* Contract: Exhibit B-8—14.8.7	**Documents Submitted/Location Within Documents:** 1. CSNT 117.9 Objectivity in Clinical Decision Making-Entire Policy **Description of Process:** This required element is delegated to Beacon Health Options by HCI. Beacon has policies in place that define conflict of interest and specifically state that employees are not provided incentives, nor permitted to accept gifts in relation to any UM activities. (See CSNT 117.9 Objectivity in Clinical Decision Making). During new employee orientation and annually thereafter, Beacon staff receives training regarding conflict of interest and employee code of conduct, including signing an annual attestation agreeing with policies that they are not given incentives to deny or limit care for members.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
20. The Contractor defines emergency medical condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or	**Documents Submitted/Location Within Documents:** 1. COS_EC_270L--Emergency and Post-Stabilization Services-FY22-23, Section II.A 2. Health First Colorado Member-Handbook, Page 14 3. BHMedicaidProviderHandbook_HCI, Page 20 *Misc **Description of Process:** This required element is delegated to Beacon Health Options by HCI. Beacon's policy titled COS_EC_270L--Emergency and Post-Stabilization Services—FY22-23, Section II.A defines emergency medical conditions that correspond with the State's definition of this term. Members receive information in the Health-First Colorado-Member-Handbook (p. 14) about	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Serious dysfunction of any bodily organ or part. *42 CFR 438.114(a)* Contract: Exhibit B-8—2.1.36; 7.3.8.1.6.1	what defines an emergency or crisis and how to obtain emergency services. Beacon staff assist members and direct them to the nearest facility/ER when there is any question of an emergency medical condition. The BHMedicaidProviderHandbook_HCI (p. 20) also includes the following definition: Behavioral Health Emergency Services 1. Emergency care is defined as a medical condition manifested by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in: a. placing the patient's health in serious jeopardy b. serious impairment to bodily functions c. serious dysfunction of any bodily organ or part 2. Emergency services do not require prior authorization. Documentation must accompany claims for emergency services in order to support covered diagnosis. This documentation will be reviewed on a retrospective basis, after the member has received care.	
21. The Contractor defines emergency services as covered inpatient or outpatient services furnished by a provider that is qualified to deliver these services and are needed to evaluate or stabilize an emergency medical condition. *42 CFR 438.114(a)* Contract: Exhibit B-8—2.1.37	**Documents Submitted/Location Within Documents:** 1. COS_EC_270L--Emergency and Post-Stabilization Services—FY22-23, Section II.C. 2. BHMedicaidProviderHandbook_HCI Page 9 *Misc.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Description of Process: This required element is delegated to Beacon Health Options by HCI. Beacon's policy titled COS_EC_270L--Emergency and Post-Stabilization Services—FY22-23, Section II.C provides this exact definition of Emergency Services. The following definition is also included in the BHMedicaidProviderHandbook_HCI: Emergency Services: Services used during a behavioral health emergency, which are unscheduled immediate, and medically necessary to evaluate or stabilize an emergency condition (Page 9).	
22. The Contractor defines poststabilization care services as covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or provided to improve or resolve the member's condition. *42 CFR 438.114(a)* Contract: Exhibit B-8—2.1.82	**Documents Submitted/Location Within Documents:** 1. COS_EC_270L--Emergency and Post-Stabilization Services—FY22-23, Section II.D. 2. BHMedicaidProviderHandbook_HCI, Page 10 *Misc. **Description of Process:** This required element is delegated to Beacon Health Options by HCI. Beacon's policy titled COS_EC_270L--Emergency and Post-Stabilization Services—FY22-23, Section II.D provides this exact definition of post-stabilization services. This definition is also provided in the BHMedicaidProviderHandbook_HCI p. 10: Post-stabilization Services: Services that are provided in relation to an emergency medical condition and are provided after a member is stabilized in order to maintain the stabilized condition.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
23. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. *42 CFR 438.114(c)(1)(i)* Contract: Exhibit B-8—14.5.6.2.2	**Documents Submitted/Location Within Documents:** 1. COS_EC_270L--Emergency and Post-Stabilization Services--FY22-23, Entire Policy **Description of Process:** This required element is delegated to Beacon Health Options by HCI. Beacon's policy titled COS_EC_270L-Emergency and Post-Stabilization Services—FY22-23 provides an overview of how emergency services are covered and reimbursed. Members can access these services without prior authorization and claims for emergency services are accepted and paid for to any provider, regardless of network status.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
24. The Contractor may not deny payment for treatment obtained under either of the following circumstances: • A member had an emergency medical condition, including cases in which the absence of immediate medical attention would *not* have had the following outcomes: – Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; – Serious impairment to bodily functions; or	**Documents Submitted/Location Within Documents:** 1. COS_EC_270L--Emergency and Post-Stabilization Services--FY22-23, Section I.C.1 **Description of Process:** This required element is delegated to Beacon Health Options by HCI. Beacon's policy titled COS_EC_270L--Emergency and Post-Stabilization Services—FY22-23, Section I.C.1 clearly outlines that payment may not be denied under either of these circumstances. There is no authorization requirement for emergency services. These services are not denied when billed as emergency services, regardless of the actual outcome	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Serious dysfunction of any bodily organ or part. *(Note: The Contractor bases its coverage decisions for emergency services on the severity of the symptoms at the time of presentation and covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. 42 CFR 438.114—Preamble)* • A representative of the Contractor's organization instructed the member to seek emergency services. *42 CFR 438.114(c)(1)(ii)* Contract: Exhibit B-8—14.5.6.2.6		
25. The Contractor does not: • Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms. • Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent failing to notify the member's primary care provider or the Contractor of the member's screening and treatment within 10 calendar days of presentation for emergency services.	**Documents Submitted/Location Within Documents:** 1. COS_EC_270L--Emergency and Post-Stabilization Services--FY22-23, Section I.D **Description of Process:** This required element is delegated to Beacon Health Options by HCI. Beacon's policy titled COS_EC_270L--Emergency and Post-Stabilization Services—FY22-23 contains the following specific language in Section I.D:	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.114(d)(1) Contract: Exhibit B-8—14.5.6.2.8	Beacon does not: • Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms. Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, Beacon, the Department of the member's screening and treatment within 10 days of presentation for emergency services.	
26. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42 CFR 438.114(d)(2)* Contract: Exhibit B-8—14.5.6.2.9	**Documents Submitted/Location Within Documents:** 1. COS_EC_270L--Emergency and Post-Stabilization Services--FY22-23, Section I.E. **Description of Process:** This required element is delegated to Beacon Health Options by HCI. The Beacon policy titled COS_EC_270L--Emergency and Post-Stabilization Services—FY22-23 releases the member from liability for payment for any subsequent screening and treatment needed to stabilize an emergency medical condition. The policy states the following: Beacon does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member, or for post stabilization services, regardless of whether these services were obtained through COS_EC or not. Members are not charged for these services.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
27. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment. *42 CFR 438.114(d)(3)* Contract: Exhibit B-8—14.5.6.2.10	**Documents Submitted/Location Within Documents:** 1. COS_EC_270L--Emergency and Post-Stabilization Services--FY22-23, Section I.F **Description of Process:** This required element is delegated to Beacon Health Options by HCI. Beacon's policy titled COS_EC_270L--Emergency and Post-Stabilization Services—FY22-23, Section I.F states the attending physician/facility makes decisions independent of any contact with the RAE (or Beacon) regarding stabilization, as there is no preauthorization required for emergency services, and no authorization needs to be on file for the claim to be paid. The provider makes treatment decisions and submits the bill after services have been rendered. The policy states the following: Beacon allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on COS_EC (Beacon) who is responsible for coverage and payment.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
28. The Contractor is financially responsible for poststabilization care services that are prior authorized by an in-network provider or the Contractor's representative, regardless of whether they are provided within or outside the Contractor's network of providers. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(i)*	**Documents Submitted/Location Within Documents:** 1. COS_EC_270L--Emergency and Post-Stabilization Services--FY22-23, Section I.H **Description of Process:** This required element is delegated to Beacon Health Options by HCI. The RAE (or Beacon) is financially responsible for post stabilization care services obtained within or outside the network that have been pre-approved by a plan provider or other organization representative, regardless of whether they are	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract: Exhibit B-8—14.5.6.2.11	provided within or outside of the RAE's network of providers. Section I.H. of Beacon's policy titled COS_EC_270L--Emergency and Post- Stabilization Services—FY22-23 clearly states this financial responsibility. The policy reads as follows: • Beacon is financially responsible for post stabilization care services obtained within or outside the network that are: o Pre-approved by a plan provider or a representative of Beacon. o Not pre-approved by a plan provider or Beacon representative but are administered to maintain the member's stabilized condition within 1 hour of a request to Beacon for pre-approval of further post stabilization care services. o Not pre-approved by a plan provider of Beacon representative but are administered to maintain, improve, or resolve the member's stabilized condition if: • Beacon does not respond to request for pre-approval within 1 hour • Beacon cannot be contacted Beacon representative and the treating physician cannot reach agreement concerning the member's care and the Beacon Medical Director is not available for consultation. In this situation, the Beacon representative will assist the treating physician in arranging consultation with the Beacon Medical Director and the treating physician may continue with care of the member until the Beacon Medical Director is reached or any of the following criteria are met, and at this time the financial responsibility of Beacon ends:	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• An in network physician with privileges at the treating hospital assumes responsibility for the member's care • An in network physician assumes responsibility for the member's care through transfer • A Beacon representative and the treating physician reach an agreement concerning the member's care. • The member is discharged.	
29. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition within one hour of a request to the organization for pre-approval of further poststabilization care services. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(ii)* Contract: Exhibit B-8—14.5.6.2.12	**Documents Submitted/Location Within Documents:** 1. COS_EC_270L--Emergency and Post-Stabilization Services--FY22-23, Section I.H **Description of Process:** This required element is delegated to Beacon Health Options by HCI. Beacon is financially responsible for post stabilization care services obtained within or outside the network that have been pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition within one (1) hour of a request to the organization for pre-approval of further post-stabilization care services. Beacon's policy titled COS_EC_270L--Emergency and Post-Stabilization Services—FY22-23 states the following: • Beacon is financially responsible for post stabilization care services obtained within or outside the network that are: • Pre-approved by a plan provider or a representative of Beacon. • Not pre-approved by a plan provider or Beacon representative but	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	are administered to maintain the member's stabilized condition within 1 hour of a request to Beacon for pre-approval of further post stabilization care services. • Not pre-approved by a plan provider of Beacon representative but are administered to maintain, improve, or resolve the member's stabilized condition if: • Beacon does not respond to request for pre- approval within 1 hour • Beacon cannot be contacted • Beacon representative and the treating physician cannot reach agreement concerning the member's care and the Beacon Medical Director is not available for consultation. In this situation, the Beacon representative will assist the treating physician in arranging consultation with the Beacon Medical Director and the treating physician may continue with care of the member until the Beacon Medical Director is reached or any of the following criteria are met, and at this time the financial responsibility of Beacon ends: • An in network physician with privileges at the treating hospital assumes responsibility for the member's care • An in network physician assumes responsibility for the member's care through transfer • A Beacon representative and the treating physician reach an agreement concerning the member's care The member is discharged	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
30. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the member's stabilized condition if: • The organization does not respond to a request for pre-approval within one hour. • The organization cannot be contacted. • The organization's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the organization must give the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with care of the patient until a plan provider is reached or one of the criteria in 422.113(c)(2)(iii) is met. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(iii)* Contract: Exhibit B-8—14.5.6.2.12	**Documents Submitted/Location Within Documents:** 1. COS_EC_270L--Emergency and Post-Stabilization Services--FY22-23, Section I.H **Description of Process:** This required element is delegated to Beacon Health Options by HCI. Beacon is financially responsible for post stabilization care services obtained within or outside the network that have not been pre-approved by a plan provider or other organization representative but are administered to maintain the member's stabilized condition if the following circumstances are met: • The RAE's UM delegate (i.e., Beacon) does not respond to a request for pre-approval within one hour. • The RAE's UM delegate cannot be contacted. • The RAE's representative (i.e., Beacon) and the treating physician cannot reach an agreement concerning the member's care and the RAE's Medical Director is not available for consultation. In this situation, the RAE must give the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with the care of the patient until a plan physician is available to consult on the treatment or until one of the criteria in 422.113 (c)(3) is met. Beacon's policy titled COS_EC_270L--Emergency and Post- Stabilization Services—FY22-23, Section I.H states this financial responsibility.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
31. The Contractor's financial responsibility for poststabilization care services it has not pre-approved ends when: • A plan physician with privileges at the treating hospital assumes responsibility for the member's care, • A plan physician assumes responsibility for the member's care through transfer, • A plan representative and the treating physician reach an agreement concerning the member's care, or • The member is discharged. *42 CFR 438.114(e)* *42 CFR 422.113(c)(3)* Contract: Exhibit B-8—14.5.6.2.14	**Documents Submitted/Location Within Documents:** 1. COS_EC_270L--Emergency and Post-Stabilization Services--FY22-23, Section I.H **Description of Process:** This required element is delegated to Beacon Health Options by HCI. Beacon's policy titled COS_EC_270L--Emergency and Post-Stabilization Services—FY22-23 (see Section I.H) explains that financial responsibility for post-stabilization care services that have not been pre-approved ends when the following is met: • A plan physician with privileges at the treating hospital assumes responsibility for the member's care; • A plan physician assumes responsibility for the member's care through transfer; • The organization's representative and the treating physician reach an agreement concerning the member's care; • Or the member is discharged.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
32. If the member receives poststabilization care services from a provider outside the Contractor's network, the Contractor does not charge the member more than they would be charged if the member had obtained the services through an in-network provider. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(iv)*	**Documents Submitted/Location Within Documents:** 1. COS_EC_270L--Emergency and Post-Stabilization Services--FY22-23, Section I.E. **Description of Process:** This required element is delegated to Beacon Health Options by HCI. Beacon's policy titled COS_EC_270L--Emergency and Post Stabilization	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract: Exhibit B-8—14.5.6.2.13	Services—FY22-23, Section I.E states that members are not charged for post-stabilization services regardless of whether the services are obtained through a Beacon network provider or not. The policy states the following: Beacon does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member, or for post stabilization services, regardless of whether these services were obtained through Beacon or not. Members are not charged for these services.	

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	30	X	1.00	=	30
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	32	**Total Score**		=	30
Total Score ÷ Total Applicable						=	94%

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor maintains and monitors a PCMP and BH network of providers that is supported by written agreements and is sufficient to provide adequate access to all covered services to all members, including those with limited English proficiency or physical or mental disabilities. The provider networks include the following provider types and areas of expertise: primary care (adult and pediatric), OB/GYN providers, mental health providers (adult and pediatric), SUD providers, psychiatrists (adult, child, and prescribers), and family planning providers. *42 CFR 438.206(b)(1)* Contract: Exhibit B-8—9.3.1, 9.5.1.1, 9.5.1.3	**Documents Submitted/Location Within Documents:** 1. R4_NetworkMangPln_FY22-23, Page 4-5, 6 2. NWCO 003 Network Development and Access Standards, Pages 1,2, 5 3. R4_GeoAccess_Q1FY22-23 - Entire Document 4. R4_NetworkRpt_Q1FY22-23, Pages 17, 18, 20 5. BH_Practitioner_Agreement_Executed – Entire Document 6. R4_PCP_Practitioner_Agreement_Executed – Entire Document 7. PRCO 007 Access to Care Analysis and Reporting-Entire Document **Description of Process:** Health Colorado Inc. (HCI) delegates this function to Beacon Health Options. Beacon Health Options has policies in place to select providers (NWCO 003 Network Development and Access Standards) and develops annual Network Adequacy Plan (R4_NetworkMangPln_FY22-23) that outlines the goal and strategies to maintain and monitor our PCMP and BH network of providers. The plan includes processes to ensure sufficient number of practitioners to provide adequate access to all covered services to all members, including those with limited English proficiency or physical or mental disabilities. The plan also ensures the provider networks includes the following provider types and areas of expertise: primary care (adult and pediatric), OB/GYN providers, mental health providers (adult and pediatric), SUD providers, psychiatrists (adult, child, and prescribers), and family planning providers. The plan is based on the monitoring of the network throughout the year through the review of the GeoAccess (R4_GeoAccess_Q1FY22-23) to identify network needs and incorporate into the selection of providers to meet the needs. The selection of	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	providers to meet the needs. Any identified gaps in meeting the standard are communicated in the Network Adequacy Report (R4_NetworkRpt_Q1FY22-23) and inform of strategies taken during the reporting period or in future to address the need. Beacon, as the delegated entity for the RAE, completes and maintains a signed contract or participating agreement with each practitioner in the network. This is evidenced by examples provided of signed agreements for both a primary care provider and behavioral health practitioner. BH_Practitioner_Agreement_Executed – Entire Document R4_PCP_Practitioner_Agreement_Executed – Entire Document	
2. The Contractor ensures that its PCMP provider network complies with time and distance standards as follows: • Adult primary care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Pediatric primary care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes	**Documents Submitted/Location Within Documents:** 1. R4_NetworkMangPln_FY22-23, Page 7 2. NWCO 003 Network Development and Access Standards Page 6 3. R4_GeoAccess_Q1FY22-23- Entire Document 4. R4_NetworkRpt_Q1FY22-23, Pages 17, 18, 20 **Description of Process:** Health Colorado Inc. (HCI) delegates this function to Beacon Health Options. Beacon Health Options has policies in place to select providers (NWCO 003 Network Development and Access Standards) and develops an annual Network Adequacy Plan (R4_NetworkMangPln_FY22-23) that outlines the strategies to ensure that its PCMP provider network complies with time and distance standards for Adult and Pediatric primary care and Obstetrics or gynecology. The plan is based on the monitoring of the network throughout the year through the review of the GeoAccess (R4_GeoAccess_Q1FY22-23).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Frontier counties—60 miles or 60 minutes • Obstetrics or gynecology: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes *42 CFR 438.206(a); 438.68(b)* Contract: Exhibit B-8—9.4.7	Any identified gaps in meeting the standard are communicated in the Network Adequacy Report and inform of strategies taken during the reporting period or in future to address the need (R4_NetworkRpt_Q1FY22-23).	
3. The Contractor ensures that its BH provider network complies with time and distance standards as follows: • Acute care hospitals: – Urban counties—20 miles or 20 minutes – Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes • Psychiatrists and psychiatric prescribers for both adults and children: – Urban counties—30 miles or 30 minutes	**Documents Submitted/Location Within Documents:** 1. R4_NetworkMangPln_FY22-23, Page 7 2. NWCO 003 Network Development and Access Standards, Page 7 3. R4_GeoAccess_Q1FY22-23- Entire Document 4. R4_NetworkRpt_Q1FY22-23, Page 17, 18-19, 20-21 **Description of Process:** Health Colorado Inc. (HCI) delegates this function to Beacon Health Options. Beacon Health Options has policies in place to select providers (NWCO 003 Network Development and Access Standards) and develops an annual Network Adequacy Plan (R4_NetworkMangPln_FY22-23) that outlines the strategies to ensure that its BH provider network complies with time and distance standards for each required provider type: Acute care hospitals,	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes • Mental health providers for both adults and children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes • SUD providers for both adults and children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes *Note: If there are no BH providers that meet the BH provider standards within the defined area for a specific member, then the Contractor shall not be bound by the time and distance requirements. (Exhibit B-8—9.4.10.1)*	Psychiatrists and psychiatric prescribers, mental health providers, and SUD providers for all. The plan is based on the monitoring of the network throughout the year through the review of the GeoAccess report (R4_GeoAccess_Q1FY22-23). Any identified gaps in meeting the standard are communicated in the Network Adequacy Report and inform strategies taken during the reporting period or in future to address the need (See: R4_NetworkRpt_Q1FY22-23).	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.206(a) Contract: Exhibit B-8—9.4.9		
4. The Contractor provides female members with direct access to a women's health care specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health care specialist. *42 CFR 438.206(b)(2)* Contract: Exhibit B-8—9.2.7	**Documents Submitted/Location Within Documents:** 1. R4_NetworkMangPln_FY22-23, Page 3 2. NWCO 003 Network Development and Access Standards, Page 8 3. R4_NetworkRpt_Q1FY22-23, Page 6 **Description of Process:** Health Colorado Inc. (HCI) delegates this function to Beacon Health Options. Beacon Health Options has policies in place to select providers (NWCO 003 Network Development and Access Standards) and develops an annual Network Management Plan (R4_NetworkMangPln_FY22-23) that outlines the strategies to ensure female members with direct access to a women's health care specialist within the network for covered care necessary to provide women's routine and preventive health care services, in addition to the primary care providers. This includes member education of benefits, assisting members with finding family planning services, and monitoring member complaints regarding access to family planning services. Beacon incorporated a quarterly analysis of available claims data for family planning services to monitor the volume of services rendered across all Medicaid providers. In addition to the member's designated source of primary care if that source is not a women's health care specialist, and identify high volume providers. This is reported in the R4_NetworkRpt_Q1FY22-23.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor provides for a second opinion from a network provider or arranges for the member to obtain one outside the network (if there is no qualified provider within the network), at no cost to the member. *42 CFR 438.206(b)(3)* Contract: Exhibit B-8—9.4.17	**Documents Submitted/Location Within Documents:** 1. CREF 100.8; Section IV.E.- Entire Document 2. COS_EC_274L--Request for Out of Network Provider--FY 22-23-Entire Document 3. BHMedicaidProviderHandbook_HCI, Page 14-15 *Misc. 4. PCPMedicaidProviderHandbook_HCI, Page 12-13 *Misc. 5. https://www.healthcoloradorae.com/members/rights-responsibilities/ **Description of Process:** Health Colorado Inc. (HCI) delegates this function to Beacon Health Options. The policy CREF 100.8 on Section IV.E, states that a Medicaid member or their legal representative can request a second opinion at no cost. If a network provider is not available, the second opinion can be provided through a Single Case Agreement. See Policy COS_EC_274L, Request for Out of Network Provider FY 22 - 23. If the requested service does not require prior authorization, a member may self-refer to a network provider for a second opinion at any time. If the requested service normally requires prior authorization, the second opinion provider must request authorization for the service. CREF 100.8; Section IV.E. A Medicaid member or legal representative can request a second opinion. Beacon will provide referrals for a second opinion from a network provider, or arrange for the member to obtain one outside the network, at no cost to the member if an in network provider is not available (42 CFR § 438.206).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	A member or their legal representative can request a second opinion from HCI. Information about this right can be found in HCI's Rights & Responsibilities document located on our website, see https://www.healthcoloradorae.com/members/rights-responsibilities/. This document is provided in both English and Spanish. The right to request a second opinion is found on page one, #14 of this document. Members may call HCIs call center to ask for a provider who can offer a second opinion. HCI's call center team creates an inquiry record in Beacon's Connects system if a second opinion is requested, documents the call, and provides referrals to members of health care professionals who can make available a second opinion. A call center associate will provider referrals for a second opinion with an in-network provider or assist in arranging for an out-of-network provider. Information about how the member services call center can assist members find a provider who can offer a second opinion can be found in the provider handbook on page 14-15 (HCI PCPMedicaid Handbook 2022 8-19-22) or page 12-13 of the PCMP provider handbook (HCI PCPMedicaid Handbook 2022 8-19-22).	
6. If the provider network is unable to provide necessary covered BH services to a particular member in network, the Contractor must cover the services (in accordance with the access to care standards) out of network for as long as the Contractor is unable to provide them. *42 CFR 438.206(b)(4)* Contract: Exhibit B-8—14.6.1	**Documents Submitted/Location Within Documents:** 1. COS_EC_274L--Request for Out of Network Provider--FY22-23 Entire Policy 2. SCA_Letter_RAE_Practitioner_HCI –Entire Document 3. BHMedicaidProviderHandbook_HCI, Page 24 *Misc. **Description of Process:** Health Colorado Inc. (HCI) delegates this function to Beacon Health Options. Beacon has a policy and procedure specific for the RAE to process requests for covered services through an out of network provider in a timely manner.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	(See COS_EC_274L Request for Out of Network Provider—FY22-23 Policy). This policy details the approval process and situations where Single Case Agreements are approved for covered services by an out-of-network provider. Providers are sent an individual contract (SCA_Letter_RAE_Practitoner_HCI). The SCA Letters reference the provider handbook that educate providers that they may not bill members for any services covered by Medicaid. (See BHMedicaidProviderHandbook_HCI, page 24).	
7. The Contractor requires out-of-network providers to coordinate with the Contractor for payment and ensures that the cost to the member is no greater that it would be if the services were furnished within the network. *42 CFR 438.206(b)(5)* Contract: Exhibit B-8—14.6.11.1	**Documents Submitted/Location Within Documents:** 1. BHMedicaidProviderHandbook_HCI Page 24, "No Balance Billing" *Misc. 2. SCA_Letter_RAE_Practitioner_HCI-Entire Document 3. COS_EC_274L--Request for Out of Network Provider-FY22-23. Entire Policy **Description of Process:** Health Colorado Inc. (HCI) delegates this function to Beacon Health Options. Beacon Health Options requires that all out-of-network providers coordinate with Beacon in regards to payment. Included in the BHMedicaidProviderHandbook_HCI, providers are educated that they are not able to balance bill members for Medicaid covered services (p. 24, “No Balance Billing”). Providers are limited to only charge Medicaid members for established co-pays for services received and cannot bill members directly for any services rendered. Beacon has a policy and procedure to contract and negotiate fee schedules (payment) for out- of -network providers approved for a Single Case	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Agreement (see COS_EC_274L--Request for Out of Network Provider--FY22-23). Beacon's team managing the Single Case Agreement coordinates rate negotiation with the Director of Provider Relations, to ensure it is within Colorado Medicaid rates. For Medicaid members, this process ensures the cost to the member is no greater than the services furnished within the network. Included in the individual single case contract (See SCA_Letter_RAE_Practitioner_HCI) providers are informed of and required to agree to the terms of the agreement, which details that the provider cannot hold the member financially liable for any portion of received services that are covered by Medicaid.	
8. The Contractor must meet, and require its providers to meet, the State standards for timely access to care and services, taking into account the urgency of the need for services. The Contractor ensures that services are available as follows: • Emergency BH care: – By phone within 15 minutes of the initial contact. – In-person within 1 hour of contact in urban and suburban areas. – In-person within 2 hours of contact in rural and frontier areas. • Urgent care within 24 hours from the initial identification of need.	**Documents Submitted/Location Within Documents:** 1. PCPMedicaidProviderHandbook_HCI, Pages 19-20 *Misc 2. BHMedicaidProviderHandbook_HCI, Pages 18-20 *Misc 3. R4_NetworkRpt_Q1FY22-23 Pages 4-1 to 4-3 4. PRCO 007 Access to Care Analysis and Reporting-Entire Document **Description of Process:** This required element is delegated to Beacon Health Options by HCI. Each quarter, the network is monitored for adequacy through the (R4_NetworkRpt_Q1FY22-23) page 4-1 to 4-3 report. Health Colorado uses a variety of mechanisms to measure member's access to care with participating practitioners. The following methods may be used to monitor participating provider primary care service availability and member access to care: • Analysis of member complaints and grievances related to availability and access to care	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Non-urgent symptomatic care visit within 7 days after member request. • Well-care visit within 1 month after member request. • Outpatient follow-up appointments within 7 days after discharge from hospitalization. • Members may not be placed on waiting lists for initial routine BH services. *42 CFR 438.206(c)(1)(i)* Contract: Exhibit B-8—9.4.13, 9.4.13.1-4, 9.4.13.5.1-2	• Member satisfaction surveys specific to their experience in accessing care and routine appointment availability • Referral line calls are monitored for timeliness of referral appointments given to members • Analysis and trending of information on appointment availability obtained during site visits • Analysis of call statistics (e.g., average speed of answer, abandonment rate over five seconds) • Annual Geo-Access and network density analysis (see Network policies and procedures) • Open shopper staff surveys for appointment availability. Should a participating provider receive an open shopper call and not meet the access to care standards, the participating provider will receive a notice of their results and information about the standards. The participating provider will receive a follow up call within 90-days to monitor compliance. If the participating provider fails the second audit, then a corrective action plan (CAP) may be requested. The CAP should include how the participating provider intends to correct any access to care discrepancies and how these will be avoided in the future. The CAP will be monitored to ensure the activities outlined are completed and will receive an additional call to demonstrate the participating provider meets the standard. Participating providers that continue to not meet the standards will be presented to the Quality Oversight Care Committee (QOCC) for further actions. In addition to these monitoring activities, participating providers are required by contract to report to network management when they are at capacity. This assists customer service in selecting appropriate, available participating practitioners for member referral. The Contractor shall not place members on waiting lists for initial routine service requests	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI outlines timely access to care and service standards for participating providers located in the PCPMedicaidProviderHandbook_HCI (pg. 19-20) under section Appointment and Availability Standards. PCMP practices shall provide extended hours on evenings and weekends as effective alternatives for emergency room visits for after-hours urgent care. At a minimum, the PCMPs will provide twenty-four (24) hour a day availability of information and referral for treatment of emergency medical conditions. PCMP Appointment Availability standards are: • Within twenty-four (24) hours of a member's request for urgent care. • Within seven (7) calendar days of a member's request for non-urgent, symptomatic care. • Within seven (7) days after discharge from a hospitalization and outpatient Follow-up Appointments. • Within one (1) month of a member's request for non-symptomatic care, unless an appointment is required sooner to ensure the provision of screenings in accordance with Early and Periodic Screening, Diagnostic and Treatment (EPSDT). Colorado's Medicaid program has adopted and follows the Bright Futures scheduling guidelines as the standard of care in the state. HCI describes timely access to care and service standards for participating providers located in the BHMedicaidProviderHandbook_HCI (pg. 18-20) located in section Appointment and Availability Standards. All participating providers must have appointments available for Health First Colorado members as specified below, according to State/Federal regulation and the provider contract.	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Emergency: By phone within fifteen (15) minutes after the initial contact, including TTY accessibility; in person within one (1) hour of contact in Urban and suburban areas, in person within two (2) hours after contact in Rural and Frontier areas. • Urgent: Within twenty-four (24) hours after the initial identification of need. Adults Substance Use Disorder Provider; serving children • Outpatient Follow Up Appointments: Within seven (7) days after discharge from a hospitalization • Non-urgent, Symptomatic Behavioral Health Services: Within seven (7) days after the member's request The PRCO 007 Access to Care Analysis and Reporting policy outlines the policy for monitoring the Primary Care Providers and Behavioral Health Providers for access standards. Health Colorado Inc. is in compliance with State standards for timely access to care and services and ensures requirements are met by auditing and reporting to the State each quarter.	
Findings: The PCP Practitioner Agreement included two incorrect time frames: urgent care was listed as 48 hours instead of 24 hours, and well visits were listed as 45 days instead of one month.		
Required Actions: HCI must correct the timely appointment standards in the PCP Practitioner Agreement.		

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor and its providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service. The Contractors network provides: • Minimum hours of provider operation from 8:00 a.m. to 5:00 p.m. Mountain Time, Monday through Friday. • Extended hours on evenings and weekends, including access to clinical staff, not just an answering service or referral service. • Alternatives for emergency department visits for after-hours urgent care. *42 CFR 438.206(c)(1)(ii)* Contract: Exhibit B-8—9.4.3–9.4.4	**Documents Submitted/Location Within Documents:** 1. PCPMedicaidProviderHandbook_HCI, Page 19 *Misc. 2. BHMedicaidProviderHandbook_HCI, Page 19 *Misc. **Description of Process:** Health Colorado Inc. (HCI) delegates this function to Beacon Health Options. Beacon, as the delegated entity for the RAE, requires contracted providers to offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service. As described in the PCPMedicaidProviderHandbook_HCI (pg. 18) under section Access and Availability Standards, PCMP practices shall provide extended hours on evenings and weekends as effective alternatives for emergency room visits for after-hours urgent care. At a minimum, the PCMPs will provide twenty-four (24) hour a day availability of information and referral for treatment of emergency medical conditions. Extended Hours of Operation: Extended Hours of Operation and covered service coverage must be provided at least two (2) days per week at clinic treatment sites, which should include a combination of additional morning, evening or weekend hours, to accommodate members who are unable to attend appointments during standard business hours. Evening and/or Weekend Support Services: Members and families should have access to clinical	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	staff over evenings and weekends, not just an answering service or referral service staff. And as noted in the BHMedicaidProviderHandbook_HCI (pg. 19) in the Provider Availability section, Hours of Operation: Providers who serve Health First Colorado members shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees. Minimum hours of provider operation shall include covered service coverage from 8 a.m. to 5 p.m. Monday through Friday and emergency coverage twenty-four (24) hours a day, seven (7) days a week. Emergency Access: Emergency services shall be available by phone, including by TTY accessibility, within fifteen (15) minutes of the initial contact, in person within one (1) hour of contact in urban and suburban areas, in person within two (2) hours of contact in rural and frontier areas.	
10. The Contractor shall ensure that its network provides for 24 hours a day availability of information, referral, and treatment of emergency medical conditions. *42 CFR 438.206(c)(1)(iii)* *42 CFR 438.3(q)(1)* Contract: Exhibit B-8—9.4.6	**Documents Submitted/Location Within Documents:** 1. PCPMedicaidProviderHandbook_HCI, Page 19 *Misc. 2. BHMedicaidProviderHandbook_HCI, Page 19 *Misc. 3. PRCO 007 Access to Care Analysis and Reporting-Entire Document **Description of Process:** Health Colorado Inc. (HCI) delegates this function to Beacon Health Options. Beacon, as the delegated entity for the RAE, requires contracted practitioners to provide for 24 hours a day availability of information, referral, and treatment of emergency medical conditions. As indicated in the PCPMedicaidProviderHandbook_HCI (pg. 19), PCMP practices shall provide extended hours on evenings and weekends as effective	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	alternatives for emergency room visits for after-hours urgent care. At a minimum, the PCMPs will provide twenty-four (24) hour a day availability of information and referral for treatment of emergency medical conditions. As noted in the BHMedicaidProviderHandbook_HCI (pg. 19), Hours of Operation: Providers who serve Health First Colorado members shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees. Minimum hours of provider operation shall include covered service coverage from 8 a.m. to 5 p.m. Monday through Friday and emergency coverage twenty-four (24) hours a day, seven (7) days a week. Evening and/or Weekend Support Services: Members and families should have access to clinical staff over evenings and weekends, not just an answering service or referral service staff. The PRCO 007 Access to Care Analysis and Reporting policy outlines the policy for monitoring the Primary Care Providers and Behavioral Health Providers for access standards	
11. The Contractor ensures timely access by: • Establishing mechanisms to ensure compliance with access (e.g., appointment) standards by network providers. • Monitoring network providers regularly to determine compliance. • Taking corrective action if there is failure to comply. *42 CFR 438.206(c)(1)(iv)–(vi)*	**Documents Submitted/Location Within Documents:** 1. R4_NetworkMangPln_FY22-23, Page 7 2. NWCO 003 Network Development and Access Standards-Entire Document 3. R4_NetworkRpt_Q1FY22-23, Pages 4-1 to 4-3 4. PCPMedicaidProviderHandbook_HCI, Page 20 *Misc. 5. BHMedicaidProviderHandbook_HCI, Pages 54-55 *Misc. 6. PRCO 007 Access to Care Analysis and Reporting-Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract: Exhibit B-8—9.4.14	**Description of Process:** Health Colorado Inc. (HCI) delegates this function to Beacon Health Options. Beacon Health Options has policies in place to select providers (NWCO 003 Network Development and Access Standards) and develops annual Network Adequacy Plan (R4_NetworkMangPln_FY22-23) that outlines the strategies to ensure that its PCMP and BH provider network complies with appointment availability standards. The findings are reported on a quarterly basis on the Network Adequacy Report (R4_NetworkRpt_Q1FY22-23). As described in the PCPMedicaidProviderHandbook_HCI (pg. 20), under Service Availability and Access to Care Monitoring, Health Colorado uses a variety of mechanisms to measure member's access to care with participating practitioners. The following methods may be used to monitor participating provider primary care service availability and member access to care: • Analysis of member complaints and grievances related to availability and access to care • Member satisfaction surveys specific to their experience in accessing care and routine appointment Availability • Referral line calls are monitored for timeliness of referral appointments given to members • Analysis and trending of information on appointment availability obtained during site visits • Analysis of call statistics (e.g., average speed of answer, abandonment rate over five seconds) • Annual Geo-Access and network density analysis (see Network policies and procedures)	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Open shopper staff surveys for appointment availability The open shopper method is an approach to measuring timeliness of appointment access in which a surveyor contacts participating provider's offices to inquire about appointment availability and identifies from the outset of the call that he or she is calling on behalf of Health Colorado. Should a participating provider receive an open shopper call and not meet the access to care standards, the participating provider will receive a notice of their results and information about the standards. The participating provider will receive a follow up call within 90-days to monitor compliance. If the participating provider fails the second audit, then a corrective action plan (CAP) may be requested. The CAP should include how the participating provider intends to correct any access to care discrepancies and how these will be avoided in the future. The CAP will be monitored to ensure the activities outlined are completed and will receive an additional call to demonstrate the participating provider meets the standard. Participating providers that continue to not meet the standards will be presented to the Quality Oversight Care Committee (QOCC) for further actions which may include panel closures, suspension of referrals, continued of correction plan, or other activities deemed appropriate up to termination from the network. In addition to these monitoring activities, participating providers are required by contract to report to network management when they are at capacity. This assists customer service in selecting appropriate, available participating practitioners for member referral. As indicated in the BHMedicaidProviderHandbook_HCI (pg. 54-55) under section Service Availability and Access to Care, Beacon uses a variety of mechanisms to measure member's access to care with participating practitioners. Unless other appointment availability standards are required by a	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	specific client or government-sponsored health benefit program. The following methods may be used to monitor participating provider behavioral health service availability and member access to care: • Analysis of member complaints and grievances related to availability and access to care • Member satisfaction surveys specific to their experience in accessing care and routine appointment availability • Open shopper staff surveys for appointment availability—an approach to measuring the timeliness of appointment access in which a surveyor contacts participating provider's offices to inquire about appointment availability and identifies from the outset of the call that he or she is calling on behalf of Beacon. Should a provider receive a test call and not meet the access to care standards, a corrective action plan (CAP) may be requested. The CAP should include how the provider intends to correct any access to care discrepancies and how these will be avoided in the future. • Referral line calls are monitored for timeliness of referral appointments given to members • Analysis and trending of information on appointment availability obtained during site visits • Analysis of call statistics (e.g., average speed of answer, abandonment rate over five (5) seconds) • Annual Geo-Access and network density analysis (see Network policies and procedures) The open shopper method is an approach to measuring the timeliness of appointment access in which a surveyor contacts participating provider's offices to inquire about appointment availability and identifies from the outset	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	of the call that he or she is calling on behalf of the RAE. Should a provider receive an open shopper call and not meet the access to care standards, the provider will receive a notice of their results and information about the standards. The participating provider will receive a follow-up call within ninety (90) days to monitor compliance. If the participating provider fails the second audit, then a corrective action plan (CAP) may be requested. The CAP should include how the participating provider intends to correct any access to care discrepancies and how these will be avoided in the future. The CAP will be monitored to ensure the activities outlined are completed and will receive an additional call to demonstrate the participating provider meets the standard. Participating providers that continue to not meet the standards will be presented to the Quality Oversight Care Committee (QOCC) for further actions which may include panel closures, suspension of referrals, continued correction plan, or other activities deemed appropriate up to termination from the network. In addition to these monitoring activities, participating providers are required by contract to report to network management when they are at capacity. This assists customer service in selecting appropriate, available participating practitioners for member referral. The Contractor shall not place members on waiting lists for initial routine service requests. Providers and Behavioral Health Providers is outlined in the Policy PRCO007 Access to Care Analysis and Reporting. HCI has completed the timely access requirement by establishing mechanisms to ensure compliance, monitoring network providers, and taking corrective action when necessary.	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. This includes: • Making written materials that are critical to obtaining services available in prevalent non-English languages. • Providing cultural and disability competency training programs, as needed, to network providers and health plan staff regarding: – Health care attitudes, values, customs and beliefs that affect access to and benefit from health care services. – Medical risks associated with the member population's racial, ethnic, and socioeconomic conditions. • Identifying members whose cultural norms and practices may affect their access to health care. These efforts shall include, but are not limited to, inquiries conducted by the Contractor of the	**Documents Submitted/Location Within Documents:** 1. R4_NetworkMangPln_FY22-23, Page 8-9 2. NWCO 003 Network Development and Access Standards, Page 6 3. Data USA 2020_HCI, Entire Document 4. HCPF's Health Equity Plan_HCI, Entire Document 5. Health Equity Roundtable_April_HCI, Entire Document 6. VOIANCE Use_HCI, Entire Document 7. Cover Sheet_HCI, Entire Document 8. Culture Provider Training_HCI, Entire Document 9. Health Equity Roundtable_Nov_HCI-Entire Document 10. ProviderDirectory_HCI, Page 1 11. MemberHandbook_SP_HCI Entire Document **Description of Process:** Health Colorado Inc. (HCI) delegates this function to Beacon Health Options. Beacon Health Options has policies in place to select providers (NWCO 003 Network Development and Access Standards) and develops annual Network Adequacy Plan (R4_NetworkMangPln_FY22-23) that outlines the strategies to promote the delivery of services in a culturally competent manner to all members. HCI participates in the state's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. The way this was reflected in 2022 was through HCI's participation in HCPF's Health	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
language proficiency of individual members. • Providing language assistance services for all Contractor interactions with members. *42 CFR 438.206(c)(2)* Contract: Exhibit B-8—7.2.1–7.2.6	Equity Workgroup and hosting Aaron Green, Sr., MSM, MSW, Health Disparities and Equity, Diversity, and Inclusion Officer from HCPF to our April 11, 2022 Cultural Competency Roundtable. Aaron presented on the state's health equity plan (see HCPF's Health Equity Plan _HCI and Health Equity Roundtable_April_HCI). The roundtable is for all health care professionals, partners, and stakeholders to collaborate on best practices relating to cultural competency and health equity for our members. HCI also hosted a Cultural Competency/Health Equity Roundtable on November 10, 2022. See Health Equity Roundtable_Nov_HCI. HCI makes written information available for members, which are critical to obtain services available in prevalent non-English languages in our nineteen counties. HCI identified Spanish as the most prevalent non-English language in Region 2 according to the 2020 Data USA report. The report identified that the most common non-English language spoken in households to be Spanish. 11.2% of the households in Colorado reported speaking Spanish at home, as the primary shared language. See Data USA 2020_HCI. The materials, which are identified as critical to obtain services include the provider directory, member handbooks, and notices for appeals, grievances, denials and terminations. The provider directory and member handbook are both located in a prominent position on the main page of our website. See: https://www.healthcoloradorae.com/. Members will see a tagline in both English and Spanish when they connect to our website. The tagline states: "If you need any document from our website in large print, Braille, other formats or languages, or read aloud, please contact us. We will send this to you free of charge within five (5) business days. We can also connect you to language services or help you find a provider with ADA accommodations. Our number is 888-502-4185. If you have speech or hearing disabilities, there are auxiliary	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	aids you may use (TTY/TDY/American Sign Language at 800-432-9553 or State Relay 711). These services are free." Members can find the member handbook in both English and Spanish on the middle of the main page and the provider directory embedded in the "find a provider" tab located on the top purple bar or through the member icon. HCI's provider directory has taglines on how members can request additional support in both English and Spanish. Please see https://s18637.pcdn.co/wp-content/uploads/sites/26/Provider-Directory-Health-Colorado.pdf. See ProviderDirectory_HCI and MemberHandbook_SP_HCI. HCI developed a cover sheet to protect members' privacy and has taglines in both English and Spanish on how members can request information in alternative formats, oral interpretation, or written translation free. The cover sheet is written in large font, has the toll free and TTY/TDD number listed, and is used when a member requests a copy of a member handbook and/or a provider directory. HCI uses this cover sheet when sending out our provider directory, the member handbook, and notices for appeals, complaints, terminations, or denials. See Cover Sheet_HCI. HCI facilitated a provider training in February 2022 titled Cultivating Meaningful Connections with Members. The training reviewed health care attitudes, values, customs, and beliefs that affect access to and benefit from health care services. The training reviewed the mental health disparities and medical risks associated with members' racial, ethnic, and socioeconomic conditions. The training also outlined how we provide assistance for interpreter services and tips for using an interpreter. See Culture Provider Training_HCI.	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI offers PCMPs to participate in a process that assesses cultural competency and language fluency. For PCMPs who choose to engage in our Practice Transformation (PT) program, PT Coaches complete a Practice Transformation Readiness Assessment to understand the strengths and areas for improvement across the network, as well as build a foundation for the year. The assessment is broken down into categories based off The Quadruple Aim, NCQA Patient Centered Medical Home (PCMH) Standards, and the Bodenheimer Building Blocks of High-Performing Primary Care. Each category is scored as either a one (not started), two (just beginning), three (actively addressing), or four (completed). Cultural Competency is assessed in the "Inclusivity and Equity" section of the assessment. Outcomes from the assessment are used to track the progress of key competencies as well as with the identification of focus areas for practice support plans. Assessments are generally completed from March to June each year. In 2022, HCI enhanced the practice assessment questions for the Inclusivity and Equity section include: • Practice leadership incorporates health equity into quality improvement initiatives. • Practice develops and implements a process to routinely gather and update patient demographics information, including race, ethnicity, language and communication needs, sexual orientation and gender identity. • Practice includes consideration of patient demographics and health equity in quality improvement efforts. • Practice develops clear, holistic hiring process that increase the diversity of team members. • Practice implements a team-based communication strategy to improve engagement of all team members.	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Practice develops and provides individualized professional development for all staff. • Practice recruits and retains members of the PFAC that represent the diversity of the population served. • Practice assess the inclusivity of the practice through items on their patient experience survey. • The practice identifies and addresses equity issues impacting patient access to care including telehealth services. HCI's call center associates utilize the VOIANCE language line when members, who contact our call center, are identified as having difficulty in accessing health care by communicating in the English language. To demonstrate that we provide language assistance services for all of our interactions with members, we have pulled a copy of the VOIANCE language line report. During the period of November 91, 2021 and November 7, 2022, 274 callers were connected with the language line to help access care. See VOIANCE Use_HCI.	
Findings: HCI's documentation regarding this requirement consisted of multiple trainings, reports regarding language line access from 2021 (compiled in 2022), and a view of Colorado's demographic and race statistics. However, during the interview, staff members were unable to describe current efforts to identify members whose cultural norms and practices may affect their access to healthcare. Any related initiatives referenced seemed to be new, implemented after the review period (CY 2022), or had not yet started but were in discussion.		
Required Actions: HCI must develop a way to identify its Region 4 membership and gain an understanding of the membership's cultural norms and practices and how they may affect access to healthcare. HSAG suggests a review of current data, utilization trends, cultural subgroups, and community partners as sources of information to explore. HCI has an opportunity to come into compliance through upcoming work that will be part of the Health Equity Plan.		

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities. *42 CFR 438.206(c)(3)* Contract: Exhibit B-8—9.1.4.5, 9.1.7.1, 9.5.1.2	**Documents Submitted/Location Within Documents:** 1. R4_NetworkMangPln_FY22-23, Page 8 **Description of Process:** Health Colorado Inc. (HCI) delegates this function to Beacon Health Options. Beacon Health Options develops annual Network Management Plan (R4_NetworkMangPln_FY22-23) that outlines the strategies to ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor submits to the State (in a format specified by the State) documentation to demonstrate that the Contractor offers an appropriate range of preventive, primary care, and specialty services that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. • A Network Adequacy Plan is submitted to the State annually. • A Network Report is submitted to the State quarterly. *42 CFR 438.207(b)* Contract: Exhibit B-8—9.5.1–9.5.4	**Documents Submitted/Location Within Documents:** 1. R4_NetworkMangPln_FY22-23 – Entire Document 2. R4_NetworkMangPln_FY22-23_HCPFApproval – Entire Document 3. R4_NetworkRpt_Q1FY22-23 – Entire Document 4. R4_NetworkRpt_Q1FY22-23_HCPFApproval– Entire Document **Description of Process:** Beacon Health Options, as the administrative service organization for the RAE, has a process in place to submit to the State (in a format specified by the State) documentation to demonstrate that the Contractor offers an appropriate range of preventive, primary care, and specialty services that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. The annual Network Management Plan (R4_NetworkMangPln_FY22-23) was submitted on time using HCPF	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	directed template and approved (R4_NetworkMangPln_FY22-23_HCPFApproval). The Network Adequacy Plan was changed to Network Management Plan at the request of HCPF for FY 2023 annual submission. The quarterly Network Adequacy Report (R4_NetworkRpt_Q1FY22-23) was submitted on time using HCPF directed template and approved (R4_NetworkRpt_Q1FY22-23_HCPFApproval).	

Results for Standard II—Adequate Capacity and Availability of Services							
Total	Met	=	12	X	1.00	=	12
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	14	**Total Score**		=	12
Total Score ÷ Total Applicable						=	86%

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an established internal grievance and appeal system in place for members, or providers acting on their behalf, or designated member representatives. A grievance and appeals system means the processes the Contractor implements to handle grievances and appeals of an adverse benefit determination, as well as processes to collect and track information about grievances and appeals. *42 CFR 438.400(b)* *42 CFR 438.402(a)* Contract: Exhibit B-8—8.1 10 CCR 2505-10 8.209.1	**Documents Submitted/Location Within Documents:** 1. ComplaintDelegationandProcedures_HCI-Entire Document 2. 305LAppealPolicy_HCI-Entire Policy 3. 303LGrievancePolicy_HCI-Entire Policy 4. ComplaintJobAid_HCI-Entire Document 5. AppealJobAid_HCI-Entire Document 6. ComplaintGuide_HCI-Entire Document 7. AppealGuide_HCI-Entire Document 8. StateFairHearingGuide_HCI-Entire Document 9. NOABD_CHCI_EFFECTIVE 01.01.2022_HCI-Pages 3-7 *Misc 10. ComplaintReceiptLetter_HCI-Entire Document 11. BHMedicaidProviderHandbook_HCI -Pages 21-22, and 51-57 *Misc 12. PCPMedicaidProviderHandbook_HCI -Page 15 and 39 *Misc 13. AppealandComplaintTraining_HCI-Entire Document 14. AppealReceiptLetter_HCI-Entire Document 15. AppealDecisionLetter_HCI-Entire Document 16. R4GrieveAppealRptQ4-FY21-22_HCI-Entire Document, 17. R4GrieveAppealRptQ4FY21-22Summary-Entire Document 18. ComplaintLettersandHealthLiteracy_HCI-Entire Document 19. EvidenceofAcceptedGrievanceandAppealReport_HCI-Entire Document **Description of Process:** Health Colorado, Inc. (HCI) has an established grievance and appeals system in place for members in the HCI region. HCI developed a Complaint Delegation and Procedures document that outlines the responsibilities of HCI and the responsibilities of Advocates at the community mental health centers in handling grievances. See ComplaintDelegationandProcedures_HCI, entire document.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI staff lead a quarterly Member Services Subcommittee with the community mental health center advocates to discuss complaint operations and to ensure fidelity to the complaint process HCI has a Community Outreach Manager who is available to train the community mental health center staff on the complaint requirements. See ComplaintLettersandHealthLiteracy_HCI-Entire Document. HCI follows their 305LAppealPolicy_HCI to process any appeal that a Member, Legal Guardian, or Designated Client Representative (DCR) initiates following the receipt of a Notice of Adverse Benefit determination for any denied behavioral health service. HCI defines a DCR as a family member, provider, or anyone else the member chooses to act on their behalf. See 305LAppealPolicy_HCI-Entire document. HCI follows 303LGrievancePolicy_HCI that outlines the grievance process for Members, Legal Guardians or DCRs. The policy outlines that a grievance can be made for any behavioral or physical health service other than an adverse benefit determination notification. See 303LGrievancePolicy_HCI-Entire document. HCI developed a Complaint Job Aid and an Appeal Job Aid to operationalize the systems of handling complaints and appeals. See ComplaintJobAid_HCI-Entire document and AppealJobAid_HCI-Entire document. HCI developed and implemented a Complaint Guide, an Appeal Guide, and a State Fair Hearing guide to assist members and providers with the procedures to make a complaint, request an appeal, or request a State Fair Hearing. See ComplaintGuide_HCI-Entire document, AppealGuide_HCI-Entire document, and StateFairHearingGuide_HCI-Entire document. These guides can be found on our website,	

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The appeal process is outlined in the Notice of Adverse Benefit Determination letter which is sent to a member when there is any denial in behavioral health services. See NOABD_CHCI_EFFECTIVE 01.01.2022_HCI-Pages 3-7. If a member, legal guardian, or DCR requests an appeal, HCI sends a receipt notification letter within two (2) business days and includes the Appeal Guide. See AppealReceiptLetter_HCI-Entire document. If an appeal is upheld, HCI will send the State Fair Hearing Guide with the appeal determination letter so that Members know their right to request a State Fair Hearing. See AppealDecisionLetter_HCI-Entire document. HCI sends a complaint receipt letter within two (2) business days when a member files a complaint. HCI attaches the complaint guide with the receipt letter so members have information about what to expect when filing a complaint. See ComplaintReceiptLetter_HCI-Entire document. HCI educates providers on the grievance and appeal process through the BHMedicaidProviderHandbook_HCI and PCPMedicaidProviderHandbook_HCI and by providing training at the Provider Roundtables. HCI oversees the appeal process for behavioral health appeals. Health First Colorado oversees the appeal process for the denial of physical health services. BHMedicaidProviderHandbook_HCI, Pages 22-23, and 51-57, PCPMedicaidProviderHandbook_HCI, Pages 15 and 39, and AppealandComplaintTraining_HCI-Entire document. HCI uses a feedback database to collect and track complaints and compliments. Advocates at the community mental health centers have access to the feedback database and are responsible for entering in processed complaints on a monthly basis. See ComplaintJobAid_HCI-Entire document for a detailed explanation of the processes we use to collect complaint information. HCI collects and tracks appeals in our secure file storage system which includes all of the information that members would want considered in their appeal.	

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI submits all appeals and grievances in a quarterly report to Healthcare, Policy and Financing (HCPF) forty-five days after the end of the quarter. In this report, we track the totals of all complaints and appeals. See R4GrieveAppealRptQ4-FY21-22_HCI-Entire document, and R4_ GrieveAppealRptQ4-FY21-22Summary_HCI-Entire document. HCPF sends a response if the grievance and appeal report was accepted, accepted with changes, or rejected. For evidence that all of the grievance and appeal reports have been accepted, please see EvidenceofAcceptedGrievanceandAppealReport_HCI-Entire document.	
2. The Contractor defines adverse benefit determination as: • The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. • The reduction, suspension, or termination of a previously authorized service. • The denial, in whole, or in part, of payment for a service. • The failure to provide services in a timely manner, as defined by the State. • The failure to act within the time frames defined by the State for standard resolution of grievances and appeals. • The denial of a member's request to dispute a member financial liability	**Documents Submitted/Location Within Documents:** 1. 305LAppealPolicy_HCI- Pages 3-5 2. 303LGrievancePolicy_HCI- Pages 2-3 3. 274LRequestforOutofNetworkProviderPolicy_HCI, Entire Document 4. BHMedicaidProviderHandbook_HCI - Page 51-53 *Misc 5. AppealGuide_HCI- Page 2 **Description of Process:** Health Colorado, Inc. (HCI) has the definition of an adverse benefit determination located in internal and external documents which include the required definitions as well as the definition in 42 CFR 438.400 which states that members who live in rural locations can exercise their right to obtain services outside of the network. Internally, HCI follows the grievance policy and the appeals policy which has the full definition of an Adverse Benefit Determination for all staff to follow. See 305LAppealPolicy_HCI- Pages 3-5 and 303LGrievancePolicy_HCI pages 2-3.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
(cost-sharing, copayments, premiums, deductibles, coinsurance, or other member financial liabilities). *42 CFR 438.400(b)* Contract: Exhibit B-8—2.1.3 10 CCR 2505-10 8.209.2.A	HCI follows the 274LRequestforOutofNetworkProviderPolicy_HCI which outlines the single case agreement process. The policy describes the procedures HCI will follow when Members request seeing an out-of-network provider, including members living in rural communities who want to exercise their right to obtain services outside of the network. See 274LRequestforOutofNetworkProviderPolicy, entire document. Externally, HCI has an appeal guide available for members which has a simplified definition of adverse benefit determination. This is located on our website and is sent to members with the Appeal Receipt Letter. See AppealGuide_HCI- Page 2. HCI has a BHMedicaidProviderHandbook_HCI_HCI posted on the website available to providers that has the definition of an adverse benefit determination. See BHMedicaidProviderHandbook_HCI– Pages 52-53.	
3. The Contractor defines an appeal as a review by the Contractor of an adverse benefit determination. *42 CFR 438.400(b)* Contract: Exhibit B-8—2.1.6 10 CCR 2505-10 8.209.2.B	**Documents Submitted/Location Within Documents:** 1. 305LAppealPolicy_HCI- Page 3 2. 303LGrievancePolicy, Page 3 3. AppealGuide_HCI- Pages 2 4. BHMedicaidProviderHandbook_ - Page 51 *Misc 5. PCPMedicaidProviderHandbook_HCI– Page 39 *Misc 6. AppealandComplaintTraining_HCI, Slide 3 **Description of Process:** HCI defines “Appeal” as a review by the RAE of an adverse benefit determination made by the RAE. This definition is outlined in HCI’s policies and procedures as this is a delegated function. See 305LAppealPolicy_HCI- Page 3 and 303LGrievancePolicy on page 3. This definition of an appeal is communicated to members through the Appeal Guide. See AppealGuide_HCI- Page 2 and to providers through the	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	BHMedicaidProviderHandbook_HCI Page 52-53. Appeals regarding the denial of physical health services are handled by Health First Colorado. See PCPMedicaidProviderHandbook_HCI_ Page 39. HCI developed a training on appeals and grievances for use with internal staff and external providers that is completed on an annual basis. The definition of an appeal can be found in this training. See AppealandComplaintTraining, HCI. Slide 3.	
4. The Contractor defines a grievance as an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. A grievance includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision. *42 CFR 438.400(b)* Contract: Exhibit B-8—2.1.46, 8.6.6.2 10 CCR 2505-10 8.209.2.D, 8.209.4.A.3.c.(i)	**Documents Submitted/Location Within Documents:** 1. 303LGrievancePolicy_HCI Page 3-4 2. 305LAppealPolicy_HCI- Page 6 3. ComplaintGuide_HCI- Page 1 4. AppealExtensionLetter_HCI- Page 2 5. QuickAppealDeniedRequest_HCI- Page 2 6. AppealandComplaintTraining_HCI, slide 12 7. BHMedicaidProviderHandbook_HCI- Page 21 *Misc 8. PCPMedicaidProviderHandbook_HCI- Page 15 *Misc **Description of Process:** HCI defines grievance as an expression of dissatisfaction about any matter other than an adverse benefit determination. This definition is outlined in HCI's policies, as this is a delegated function. See 303LGrievancePolicy_HCI pages 3-4 and 305LAppealPolicy_HCI- Page 6. Members can find the definition of a grievance in the complaint guide. HCI has simplified the definition to incorporate plain language guidelines in the Complaint Guide. The Complaint Guide can be found on our website. See ComplaintGuide_HCI- Page 1.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI notifies members that they can file a grievance if they disagree with HCIs' decision to extend the time frame to make an appeal authorization decision. See AppealExtensionLetter_HCI- Page 2. HCI notifies members verbally and in written format that they can file a grievance if a member's request for an expedited appeal is denied. See QuickAppealDenied Request_HCI- Page 2. HCI has developed an annual training for internal staff and external providers on the definition of a grievance. See AppealandComplaintTraining_HCI, slide 12. The definition of a grievance can be found in both the BHMedicaidProviderHandbook_HCI and PCPMedicaidProviderHandbook_HCI. See BHMedicaidProviderHandbook_HCI– Page 21 and PCPMedicaidProviderHandbook_HCI, page 15.	
5. The Contractor has provisions for who may file: • A member may file a grievance or a Contractor-level appeal and may request a State fair hearing. • With the member's written consent, a provider or authorized representative may file a grievance or a Contractor-level appeal and may request a State fair hearing on behalf of a member. *Note: Throughout this standard, when the term "member" is used it includes providers and authorized representatives acting on behalf of the member (with the exception that providers cannot exercise the member's right*	**Documents Submitted/Location Within Documents:** 1. DesignatedClientRepresentativeForm_HCI- Entire document 2. 305LAppealPolicy_HCI- Page 1 IA, C, Page 5 E 3. 303LGrievancePolicy_HCI- Page 1, Id, page 2 IIC 4. NOABD_CHCI_EFFECTIVE 01.01.2022_HCI- Pages 3 and 6 *Misc. 5. BHMedicaidProviderHandbook_HCI-Pages 21-22 and 53 *Misc 6. PCPMedicaidProviderHandbook_HCI– Page 15 *Misc 7. ComplaintGuide_HCI- Page 1 8. AppealGuide_HCI- Page 2 9. StateFairHearingGuide_HCI- Pages 1- 2 **Description of Process:** HCI has provisions for who can file a grievance, appeal, or a State Fair Hearing. HCI allows anyone to act on a member's behalf as long as the member has authorized the	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
to request continuation of benefits under 42 CFR 438.420). *42 CFR 438.402(c)* Contract: Exhibit B-8—8.5.1, 8.7.1, 8.7.15.1, 8.7.5	individual to act as their Designated Client Representative (DCR) in writing. See DesignatedClientRepresentativeForm_HCI- Entire document. As this is a delegated function, HCI follows HCI's 303L_Grievance Policy which states that anyone, including a health care professional, may act as a representative as long as the member names them in writing. See 303LGrievancePolicy_HCI pages 1 and 2. HCI also follows HCI's 305L Appeals Policy which outlines that members, guardians, or a member's DCR have the right to initiate an appeal or State Fair Hearing as long as members have signed a DCR form or it is in writing. See 305LAppealPolicy_HCI- Pages 1 IA, C, Page 5 E. The Designated Client Representative (DCR) Form is located on HCIs' website which members can use to designate a representative to act on their behalf. See DesignatedClientRepresentativeForm_HCI. Members can sign this form designating an individual to act on their behalf in the grievance, appeal, or State Fair Hearing process. Members are made aware of this right in the Complaint Guide, Appeal Guide, and State Fair Hearing Guide. See ComplaintGuide_HCI- Page 1, AppealGuide_HCI- Page 2, and StateFairHearingGuide_HCI- Pages 1- 2. Members are sent a Notice of Adverse Benefit Determination (NOABD) Letter when services have been denied for behavioral health treatment. The letter outlines that a member, guardian, or someone they designate can request an appeal on their behalf. See NOABD_CHCI_EFFECTIVE 01.01.2022_HCI- Page 3 and 6. HCI educates providers on who can file an appeal or grievance in the in both the BHMedicaidProviderHandbook_HCI and PCPMedicaidProviderHandbook_HCI. See BHMedicaidProviderHandbook_HCI– Pages 21-22 and 53 and PCPMedicaidProviderHandbook_HCI, page 15.	

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, as well as providing interpreter services and toll-free numbers that have adequate TeleTYpe/Telecommunications Device for the Deaf (TTY/TDD) and interpreter capability. *42 CFR 438.406(a)* Contract: Exhibit B-8—8.3 10 CCR 2505-10 8.209.4.C	**Documents Submitted/Location Within Documents:** 1. 305LAppealPolicy_HCI- Page 6, Section IV 3a 2. 303LGrievancePolicy_HCI- Page 1 3. 311LRespondingtoMemberRequestswithLimitedEnglishSpeakingProficiency_HCI-Entire document 4. NOABD_CHCI_EFFECTIVE 01.01.2022_HCI- Pages 1 and 3 *Misc. 5. ComplaintGuide_HCI- Page 2 6. AppealGuide_HCI- Pages 1 and 4 7. ComplaintReceiptLetter_HCI- Page 1 and 2 8. AppealReceiptLetter_HCI- Page 1and 2 **Description of Process:** HCI assists members who request help with completing any forms and/or using any auxiliary aids for both grievances and appeals. As this is a delegated function, HCI follows HCI's policies which outline that we will assist members with filling out forms or providing interpreter services at member's request. Please see 305LAppealPolicy_HCI- Page 6, section IV 3a and 303LGrievancePolicy_HCI- Page 1. HCI also follows HCI's 311L Responding to Member Requests with Limited English Speaking Skills policy to link members with interpreter services. See 311LRespondingtoMemberRequestsWithLimitedEnglishSpeakingProficiency_HCI- Entire document. The NOABD informs the member that HCI will assist the member if they need assistance requesting a regular appeal, quick appeal or State Fair Hearing. HCI will assist with forms and accessing interpreter services. See NOADB_HCI- Pages 1 and 3. HCI developed a complaint guide and an appeal guide to educate members on how HCI will assist them with filling out any forms related to their grievance or appeal as	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	well as helping members utilize interpreter services. See ComplaintGuide_HCI- Page 2 and AppealGuide_HCI- Pages 1 and 4. These guides are kept on the HCI website and are mailed to members with the Complaint Receipt Letter and Appeal Receipt Letter. HCIs' toll free numbers and TTY/TTD numbers are provided in these letters. HCI has a Community Outreach Manager who will link members with any interpreter services that members request. See ComplaintReceiptLetter_HCI- Pages 1 and 2 and AppealReceiptLetter_HCI- Pages 1 and 2. Taglines are in both English and Spanish. All letters and guides have taglines that provide HCIs' toll-free numbers and TTY/TTD numbers. Those letters and guides are: • Complaint Receipt Letter • Complaint Extension Letter • Complaint Resolution Letter • Appeal Receipt Letter • Appeal Extension Letter • Appeal Not Processed Letter • Appeal Decision Letter • Complaint Guide • Appeal Guide • State Fair Hearing Guide	

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who: • Were not involved in any previous level of review or decision-making nor a subordinate of any such individual. • Have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding any of the following: – An appeal of a denial that is based on lack of medical necessity. – A grievance regarding the denial of expedited resolution of an appeal. – A grievance or appeal that involves clinical issues. *42 CFR 438.406(b)(2)* Contract: Exhibit B-8—8.5.4, 8.7.4 10 CCR 2505-10 8.209.5.C, 8.209.4.E	**Documents Submitted/Location Within Documents:** 1. 305LAppealPolicy_HCI- Page 5, 7, 9 2. AppealDecisionLetter_HCI- Page 2 3. 303LGrievancePolicy_HCI- Page 7 4. AppealJobAid_HCI- Pages 3 5. QuickAppealDeniedRequest_HCI- Page 2 6. ComplaintReceiptLetter_HCI- Page 2 7. AppealReceiptLetter_HCI- Page 2 8. ComplaintGuide_HCI- Page 2 9. AppealGuide_HCI- Page 4 10. NOABD_CHCI_EFFECTIVE 01.01.2022_HCI- Page 5 *Misc. **Description of Process:** Health Colorado, Inc. ensures that the individuals who make decisions on grievances and appeals are people who were not involved in any previous level of review or decision-making, nor a subordinate of any such individual. HCI also ensures that these individuals have the appropriate clinical expertise to make a decision. HCI follows 305L Appeal Policy which defines a Peer Advisor as a health professional employed or contracted with the RAE (see page 5). The Peer Advisor has a current and active, unrestricted license to practice medicine or a health profession. The Peer Advisor is board certified and in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment and is not the individual who made the original non-certification nor the subordinate of one who made decision. Peer advisors are the individuals who review denial decisions. On page 7, the policy outlines that a request for an expedited appeal will be reviewed with a Peer Advisor. On page 9, the policy outlines the types of appeals that the Peer	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Advisor will review. See 305LAppealPolicy_HCI- Pages 5, 7, and 9. HCIs' appeal decision letter has a standard paragraph with an attestation that the Peer Advisor was not involved in HCIs' original determination and documents the scope of the Peer Advisor's licensure. See AppealDecisionLetter_HCI- Page 2. HCI follows HCI's 303L Grievance Policy which states that the staff person investigating the grievance shall ensure that the individuals who make decisions on grievances are individuals who were not involved in any previous level of review or decision- making, nor are they a subordinate of that individual and who have the appropriate clinical expertise in treating the client's condition if deciding a grievance that involves clinical issues. See 303LGrievancePolicy_HCI page 7. HCI developed an Appeal Job Aid which demonstrates the process staff follow when we receive a request for an expedited appeal and who can process the appeal. HCIs' Community Outreach Manager will review the request with the medical director to see if the request meets criteria for an expedited request. If the medical director does not believe that it meets requirements, the member will receive a Quick Appeal Denied Request letter. The letter explains qualifications for the person who reviewed the request for the expedited appeal and the member's right to file a grievance about the denied request. See AppealJobAid_HCI- Pages 3. See QuickAppealDeniedRequest_HCI- Page 2. HCI sends a Complaint Receipt Letter and an Appeal Receipt letter within two (2) business days of receipt of the complaint or appeal. The letter outlines that the person who will investigate the complaint or review the appeal will be a person who was not associated with their situation. See ComplaintReceiptLetter_HCI- Page 2 and AppealReceiptLetter_HCI- Page 2. HCI sends a Complaint Guide and an Appeal Guide in these letters which also explains that those who make decisions on grievances and appeals are people who	

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	were not involved in any previous level of review or decision-making for the member nor a subordinate of that individual. These guides can be found on our website. See ComplaintGuide_HCI- Page 2 and AppealGuide_HCI- Page 4. HCI sends a Notice of Adverse Benefit Determination letter (NOABD) when there is any denial of coverage. The letter explains that he person who makes a decision regarding an appeal or complaint was not involved in the original decision. See pages NOABD_CHCI_EFFECTIVE 01.01.2022_HCI- Page 5.	
8. The Contractor ensures that the individuals who make decisions on grievances and appeals: • Take into account all comments, documents, records, and other information submitted by the member or the member's representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. *42 CFR 438.406(b)(2)* Contract: Exhibit B-8—8.6.2 10 CCR 2505-10 8.209.5.C, 8.209.4.E	**Documents Submitted/Location Within Documents:** 1. 305LAppealPolicy_HCI- Pages 2G, Page 7c 2. 303LGrievancePolicy_HCI- Page 7 section 10 3. ComplaintGuide_HCI- Page 2 4. AppealGuide_HCI- Page 5 5. ComplaintReceiptLetter_HCI- Entire Document 6. AppealReceiptLetter_HCI- Page 2 7. NOABD_CHCI_EFFECTIVE 01.01.2022_HCI- Page 4-5 *Misc. 8. AppealDecisionLetter_HCI- Page 2 9. EvidenceofRequestforRecords_HCI- Entire document 10. EvidenceofRecordsSubmittedforReview_HCI- Entire document **Description of Process:** Health Colorado, Inc. ensures that the individuals who make decisions on grievances and appeals take into account all comments, documents, records, and other information submitted by the member or the member's representative without regard if the information was submitted or considered in the initial adverse benefit determination.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	As this is a delegated function, HCI follows HCI's 305LAppealPolicy_HCI and 303L_Grievance Policy_HCI. These policies outline procedures that those who make decisions on grievances or appeals will take into account all information provided by the member. See 305LAppealPolicy_HCI- Pages 2G and 7c and 303LGrievancePolicy_HCI page 7, section 10. Members are made aware that they can provide additional information for their complaint or appeal in the Complaint Guide and Appeal Guide. See ComplaintGuide_HCI- Page 2 and AppealGuide_HCI- Page 5. These guides are sent along with the complaint receipt letter and appeal receipt letter. See ComplaintReceiptLetter_HCI- Entire Document and AppealReceiptLetter_HCI, page 2. The guides can also be found on the HCI website at www.healthcoloradorae.com. Members are also informed that they can provide information for an appeal in the Notice of Adverse Benefit Determination letter. See NOABD_CHCI_EFFECTIVE 01.01.2022_HCI- Page 4-5. To demonstrate that HCI takes into account all comments, documents, records, and other information submitted by the member or their representative without regard if this information was submitted or considered in the initial adverse benefit determination. See EvidenceofRequestforRecords_HCI- Entire document. HCI's Community Outreach Manager compiles all information received from member/DCR into a secure file storage system. This information is sent to the Peer Advisor who reviews all of the information that the member wants considered in the appeal. See EvidenceofRecordsSubmittedforReview_HCI- Entire document. The Peer Advisor makes a determination to uphold or overturn the denial based on the information reviewed. The member is informed of the information used in making the appeal decision in the appeal decision letter. See AppealDecisionLetter_HCI- Page 2.	

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor accepts grievances orally or in writing. *42 CFR 438.402(c)(3)(i)* Contract: Exhibit B-8—8.5.3 10 CCR 2505-10 8.209.5.D	**Documents Submitted/Location Within Documents:** 1. 303LGrievancePolicy_HCI- Page 1 2. ComplaintGuide_HCI- Pages 1 3. BHMedicaidProviderHandbook_HCI- Page 21 *Misc 4. PCPMedicaidProviderHandbook_HCI- Page 15 *Misc 5. GettingStarted_HCI-Slide 8 6. AppealandComplaintTraining_HCI-Slide 13 7. EvidenceofCallCenterTraining_HCI- Page 1 8. EvidenceofProviderRountable_HCI- Page 2 **Description of Process:** Health Colorado, Inc. will accept a grievance orally or in writing. HCI follows 303L_Grievance Policy which states that grievances can be filed orally or in writing. See 303LGrievancePolicy_HCI page 1. Members can file a grievance at their community mental health center or be directed to contact HCIs' Community Outreach Manager to assist in the grievance. Members are informed that they can file a grievance orally or in writing in HCIs' Complaint Guide. See ComplaintGuide_HCI- Page 1. This Complaint Guide can be found on HCI's website. See www.healthcoloradorae.com. Members are also made aware of their right to file a grievance orally or in writing at the monthly onboarding "Getting Started" Webinar which HCI hosts to make members aware of their rights and responsibilities. See GettingStarted_HCI, Slide 8. HCIs' Community Outreach Manager also provides an annual training for staff who work in HCI's Call Center. The staff are educated on members' rights to make a grievance in writing or verbally. See AppealandComplaintTraining_HCI, slide 13. See EvidenceofCallCenterTraining_HCI- Page 1.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Providers are made aware that Members can file a grievance orally or in writing in both the BHMedicaidProviderHandbook_HCI and PCPMedicaidProviderHandbook_HCI. See BHMedicaidProviderHandbook_HCI, Page 21 and PCPMedicaidProviderHandbook_HCI, page 15. HCI also educates providers on the members right to file a complaint orally in writing during Provider Round Tables. See EvidenceofProviderRountable_HCI- Page 2.	
10. Members may file a grievance at any time. *42 CFR 438.402(c)(2)(i)* Contract: Exhibit B-8—8.5.3 10 CCR 2505-10 8.209.5.A	**Documents Submitted/Location Within Documents:** 1. 303LGrievancePolicy_HCI Page 1 Ic 2. Complaint Guide_HCI- Page 1 3. AppealandComplaintTraining_HCI, Slide 13 4. EvidenceofCallCenterTraining_HCI- Page 1 5. EvidenceofProviderRoundTable_HCI- Page 2 6. BHMedicaidProviderHandbook_HCI- Page 21 *Misc 7. PCPMedicaidProviderHandbook_HCI- Page 15 *Misc 8. EvidenceofComplaintReceived_HCI- Entire Document **Description of Process:** Health Colorado, Inc. allows members to file a grievance at any time. As a delegated function, HCI follows HCI's 303L_Grievance Policy which states that members can file a grievance at any time. See 303LGrievancePolicy_HCI page 1, section Ic. Members are made aware of this right to make a complaint at any time in HCIs' Complaint Guide. See ComplaintGuide_HCI- Page 1. This guide is on HCIs' website, HCIs' Community Outreach Manager also provides an annual training for staff who work in HCI's Call Center, Providers, and Care Coordinators. The staff are educated on members' rights to make a grievance at any time. See AppealandComplaintTraining_HCI, slide 13. See	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	EvidenceofCallCenterTraining_HCI-Page 1, EvidenceofProviderRoundTable_HCI-Page 2 Providers are made aware that members can make a grievance at any time in both the BHMedicaidProviderHandbook_HCI and PCPMedicaidProviderHandbook_HCI. See BHMedicaidProviderHandbook_HCI- Page 21 and PCPMedicaidProviderHandbook_HCI, page 15. For an example of a grievance that can be file at any time, please see EvidenceofComplaintReceived_HCI- Entire Document.	
11. The Contractor sends the member written acknowledgement of each grievance within two working days of receipt. *42 CFR 438.406(b)(1)* Contract: Exhibit B-8—8.1 10 CCR 2505-10 8.209.5.B	**Documents Submitted/Location Within Documents:** 1. 303LGrievancePolicy_HCI Page 6 section 5 2. ComplaintJobAid_HCI- Page 3 3. ComplaintReceiptLetter_HCI, Entire Document 4. ComplaintContactRecord_HCI, Entire Document 5. FeedbackDatabase_HCI, Entire Document 6. R4GrieveAppealRptQ4FY21-22Summary_HCI- Page 14 7. ComplaintGuide_HCI- Page 2 **Description of Process:** Health Colorado, Inc. sends members a written acknowledgement letter within two (2) working days of the receipt of the grievance. As a delegated function, HCI follows HCI's 303L_Grievance Policy which states that HCI will send out an acknowledgement letter within two working days. See 303LGrievancePolicy_HCI page 6. HCI's Community Outreach Manager and community mental health center Advocates follow HCIs' Complaint Job Aid which outlines the requirement to send an acknowledgement letter within two (2) working days to members. The date that the acknowledgment letter is sent is recorded in the feedback database. The Community Outreach Manager audits the feedback database to ensure that acknowledgement letters are being sent within two business days. See ComplaintJobAid_HCI- Page 3. For an example of the letter that is sent, please see ComplaintReceiptLetter_HCI.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The date the grievance is received sets the clock for the two-day turnaround time to send an acknowledgment letter. This could be the date the phone call is received, the date the fax is received, the letter is opened, or in a few cases, the date the e-mail is opened. This date is logged in the member's Complaint Contact Record which is kept in a secure file storage system. The complaint receipt date is also logged into HCI's feedback database. See ComplaintContactRecord_HCI, entire document. The feedback database includes required fields for the date that the complaint was received and the date that the acknowledgement letter was sent. See FeedbackDatabase_HCI, entire document. HCI sends quarterly reports to Colorado's Department of Health Care, Policy, and Financing (HCPF). For evidence that we are at 100% compliance in this area, please see R4GrieveAppealRptQ4FY21-22Summary_HCI- Page 14 HCI developed a Complaint Guide for members which outlines what members can expect when they make a complaint which includes a written receipt letter from HCI. See ComplaintGuide_HCI- Page 2.	

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor must resolve each grievance and provide notice as expeditiously as the member's health condition requires, and within 15 working days of when the member files the grievance. • Notice to the member must be in a format and language that may be easily understood by the member. *42 CFR 438.408(a); (b)(1); and (d)(1)* Contract: Exhibit B-8—8.5.5, 7.2.7.3, 7.2.7.5 10 CCR 2505-10 8.209.5.D	**Documents Submitted/Location Within Documents:** 1. ComplaintResolutionLetter_HCI- Entire document 2. 303LGrievancePolicy- Page 7 Sections 11 and 12 3. ComplaintJobAid_HCI- Pages 3 and 4-7 4. ComplaintFlowChart _HCI- Entire Document 5. ComplaintGuide_HCI- Page 2 6. COS_EC_307L_MemberInfoReqPolicy—FY22-23- Page 1 *Misc. 7. ComplaintReceiptLetter_HCI- Page 2 8. FeedbackDatabaseSummary_HCI- Entire Document 9. R4GrieveAppealRptQ4F-Y21-22Summary_HCI- Page 14 10. ComplaintLettersandHealthLiteracy_HCI- Entire Document **Description of Process:** Health Colorado, Inc. aims to resolve each grievance and provide notice to the Member of the resolution of their grievance as expeditiously as possible. This resolution time frame is within 15 working days from the receipt of the grievance. There are times for which HCI may need to extend this time frame at the member's request or because HCI needs more time to resolve a grievance. The date the grievance is received establishes the clock for investigating and resolving the grievance. This could be the date the phone call is received, the date the fax is received, the letter is opened, or in a few cases, the date the e-mail is opened. The 15 working days is used to investigate the complaint such as gathering facts, consulting with others, and reviewing policies. When a resolution is found, the person handling the grievance notifies the member by letter. See ComplaintResolutionLetter_HCI, entire document. HCI follows the 303L_GrievancePolicy which outlines that those resolving grievances will attempt to resolve the grievance as expeditiously as possible and	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	within the state and federal regulations of fifteen (15) working days. See 303LGrievancePolicy_HCI page 7. The Community Outreach Manager and/or Advocates who help to resolve the complaint follow the ComplaintJobAid_HCI which outlines the fifteen (15) day business day timeframe. See ComplaintFlowChart_HCI- Entire document and ComplaintJobAid_HCI- Pages 3 and 4. HCI developed a Complaint Guide to educate members on the timeframes to resolve their complaint. See ComplaintGuide_HCI- Page 2. HCI also sends out a Complaint Receipt Letter which informs the member that we have fifteen (15) business days to find a resolution to the complaint. See ComplaintReceiptLetter_HCI- Page 2. HCI follows HCI's COS_EC_307L_MemberInfoReqPolicy—FY22-23- to guide the content in the Complaint Resolution Letter. The Complaint Resolution Letter is written at an appropriate reading level and in a format to be easily understood by members. See COS_EC_307L_MemberInfoReqPolicy—FY22-23- - Page 1. HCI's Complaint Job Aid outlines the process to write a resolution letter that is easily understood by the member. See ComplaintJobAid_HCI- Pages 4-7. HCI tracks the number of days it takes to resolve a grievance in the feedback database. See FeedbackDatabaseSummary_HCI- Entire document. HCI sends HCPF a quarterly report which documents the number of business days to resolve a grievance. See R4GrieveAppealRptQ4-FY21-21Summary_HCI- Page 14. All letters written by advocates are reviewed by the Community Outreach Manager to ensure the letter is written in language easy for a Medicaid member understand. HCI provides yearly Plain Language training to advocates that are responsible for writing complaint resolution letters. See ComplaintLettersandHealthLiteracy_HCI- Entire document. HCI has also added reminders to the Complaint Resolution Letter	

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Templates that direct the writer to use 6th grade language and to use the Flesch-Kincaid Readability Test. See ComplaintResolutionLetter_HCI- Entire Document.	
13. The written notice of grievance resolution includes: • Results of the disposition/resolution process and the date it was completed. *42 CFR 438.408(a)* Contract: Exhibit B-8—8.5.8 10 CCR 2505-10 8.209.5.G	**Documents Submitted/Location Within Documents:** 1. 303LGrievancePolicy_HCI- Page 7 Section 13.b and d 2. ComplaintResolutionLetter_HCI- Entire document 3. ComplaintJobAid_HCI- Page 4 **Description of Process:** Health Colorado, Inc. sends a resolution letter which includes the disposition/resolution of the member's grievance as well as the date the grievance was resolved. See ComplaintResolutionLetter_HCI, entire document. As a delegated function, HCI follows HCI's 303L_Grievance Policy which states that we will include the disposition/resolution as well as date of resolution in the letter which is sent to the member. See 303LGrievancePolicy_HCI- Page 7 section 13.b and d. The Community Outreach Manager and/or Advocates who process complaints follow the Complaint Job Aid which states that the results of the grievance and the date it was completed should be sent in a complaint resolution letter. See ComplaintJobAid_HCI- Page 4.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor may have only one level of appeal for members. *42 CFR 438.402(b)* Contract: Exhibit B-8—8.1.1	**Documents Submitted/Location Within Documents:** 1. 305LAppealPolicy_HCI- Page 1 2. AppealGuide_HCI- Page 1 3. AppealDecisionLetter_HCI- Pages 3-4 4. BHMedicaidProviderHandbook_HCI- Page 51 *Misc 5. PCPMedicaidProviderHandbook_HCI- Page 39*Misc 6. AppealJobAid_HCI- Page 2 **Description of Process:** Health Colorado, Inc. has only one level of an appeal for the member. HCI follows the 305 L Appeals Policy which states there is only one level of appeal for a member. See 305LAppealPolicy_HCI- Page 1. HCI follows an Appeal Job Aid which outlines the procedures for resolving member appeals and states that there is only one level of appeal for members. See AppealJobAid_HCI- Page 2. HCI has developed an appeal guide to educate members that there is only one level of an appeal. See AppealGuide_HCI- Page 1. HCI sends an appeal decision letter to a member after an appeal decision is made. The letter outlines the next steps members can take if they are in disagreement with the appeal decision letter. The letter explains that members can request a State Fair Hearing with the Administrative Law Judge. See AppealDecisionLetter_HCI- Pages 3-4. HCI developed and maintains a BHMedicaidProviderHandbook_HCI which states that members will have only one (1) level of appeal at the regional organization. See	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	BHMedicaidProviderHandbook_HCI- Page 52. Providers are informed that Health First Colorado manages all physical health appeals. See PCPMedicaidProviderHandbook_HCI, page 39.	
15. A member may file an appeal with the Contractor within 60 calendar days from the date on the adverse benefit determination notice. *42 CFR 438.402 (c)(2)(ii)* Contract: Exhibit B-8—8.7.5.1 10 CCR 2505-10 8.209.4.B	**Documents Submitted/Location Within Documents:** 1. NOABD_CHCI_EFFECTIVE 01.01.2022 - Page 4 *Misc. 2. 305LAppealPolicy_HCI- Pages 1 I A, 6 IV 2, 8Cb 3. AppealGuide_HCI- Pages 2, 3, and 6 4. AppealNotProcessed_HCI- Entire document 5. BHMedicaidProviderHandbook_HCI- Pages 53, 54, and 55 *Misc 6. PCPMedicaidProviderHandbook_HCI- Page 39 *Misc **Description of Process:** Health Colorado, Inc. allows members, legal guardians, or DCR to file an appeal with HCI within 60 calendar days from the date on the Notice of Adverse Benefit Determination Letter (NOABD). HCI provides the date the member can request an appeal in the Notice of Adverse Benefit Determination letter. This date is 60 calendar days from the date on the NOABD. This letter is a primary way that members know that they can request and appeal and the time frame to request an appeal. See NOABD_CHCI_EFFECTIVE 01.01.2022 - Page 4. HCI follows the 305LAppealPolicy_HCI which states that members can file an appeal within sixty (60) calendar days. See 305LAppealPolicy, Pages 1 I A, 6 IV 2, 8Cb. When HCI receives an appeal request, the Community Outreach Manager will ascertain if the appeal was received within the 60-day time frame. If a member, legal guardian or DCR requests an appeal outside of the 60-day time frame, the Community Outreach Manager will send a letter stating that the appeal was not processed and the reason it was not processed. See Appeal Not Processed HCI- Entire document. HCI developed an Appeal Guide which outlines that members have sixty (60) days to file a complaint. This guide can be found on HCI's website, www.healthcoloradorae.com. See AppealGuide_HCI- Page 2, 3, and 6.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI developed and maintains the BHMedicaidProviderHandbook_HCI which explains that members have sixty (60) days to file an appeal. See BHMedicaidProviderHandbook_HCI- Pages 53, 54, and 55. Providers are informed that Health First Colorado manages all physical health appeals. See PCPMedicaidProviderHandbook_HCI, page 39.	
16. The member may file an appeal either orally or in writing, and the Contractor must treat oral appeals in the same manner as appeals received in writing. The Contractor may not require that oral requests for an appeal be followed with a written request. *42 CFR 438.402(c)(3)(ii)* *42 CFR 438.406 (b)(3)* Contract: Exhibit B-8—8.7.6 10 CCR 2505-10 8.209.4.F	**Documents Submitted/Location Within Documents:** 1. 305LAppealPolicy_HCI- Pages 1, IA, Page 6 IV 2 2. NOABD_CHCI_EFFECTIVE 01.01.2022 Page 4 *Misc 3. AppealGuide_HCI- Page 3 4. AppealJobAid_HCI- Page 2 **Description of Process:** Health Colorado, Inc. allows members to file an appeal either orally or in writing. The Community Outreach Manager treats oral appeals in the same manner as appeals received in writing. HCI does not require the member to follow up with a written appeal request. HCI follows the 305LAppealPolicy_HCI which states that a member can request an appeal orally, in writing, by email, telephonically, or by fax. See 305LAppealPolicy- Pages 1, IA, Page 6 IV 2. HCI educates members that they can request an appeal orally or in writing through several avenues. HCI sends a Notice of Adverse Benefit Determination letter which states that members can request an appeal orally or in writing. See NOABD_CHCI_EFFECTIVE 01.01.2022 - Page 4. HCI developed an Appeal Guide which states that a member can file an appeal orally or in writing. See AppealGuide_HCI- Page 3. This guide is located on HCIs' website, www.healthcoloradorae.com.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCIs' Community Outreach Manager manages all behavioral health appeals received from members. The Community Outreach Manager follows the Appeal Job Aid when an appeal is requested. The Appeal Job Aid outlines that members can request an appeal verbally or in writing. See AppealJobAid_HCI- Page 2.	

Findings:

HCI accepts appeals orally or in writing. However, some documentation stated that a verbal appeal request should be followed by a written request, or the coordinator should reach out to the member to obtain a signed appeal.

The following documentation was inaccurate:

- Appeal Job Aid
- Appeal Guide
- 305L Appeal Policy
- Appeal Form

Required Actions:

HCI must update the following documents to remove language that the member must follow a verbal appeal request with a written request. Additionally, HCI must share updated documentation with other staff members to ensure awareness of the updated requirement.

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

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The Contractor sends written acknowledgement of each appeal within two working days of receipt, unless the member or designated client representative requests an expedited resolution. *42 CFR 438.406(b)(1)* Contract: Exhibit B-8—8.1, 8.7.2 10 CCR 2505-10 8.209.4.D	**Documents Submitted/Location Within Documents:** 1. 305LAppealPolicy_HCI- Pages 3 II A, 7 A4, 12 J3 2. NOABD_CHCI_EFFECTIVE 01.01.2022_HCI- Page 4*Misc 3. AppealReceiptLetter_HCI- Entire Document 4. AppealJobAid_HCI- Pages 2 and 15 5. QuickAppealDeniedRequest_HCI- Entire Document 6. AppealGuide_HCI- Pages 3 and 4 7. R4GrieveAppealRpt-Q4-FY21-22 Summary_HCI- Page 10 and 11 **Description of Process:** The Community Outreach Manager sends the member a written acknowledgement of an appeal request within two (2) working days of the request, unless the member or designated client representative requests an expedited resolution. For an example of the template letter sent, please see AppealReceiptLetter_HCI, entire document. HCI follows state and federal regulations for acknowledging appeals and keeping within deadlines for appeals. As a delegated function, HCI follows the 305LAppealPolicy_HCI which states that we will send an acknowledgement letter within two (2) working days from the date that we receive the standard appeal request. See 305LAppealPolicy_HCI- Pages 3 II A, 7 A4, 12 J3. The date the appeal is received sets the clock for the appeal. This could be the date the phone call is received, the date the fax is received, the letter is opened, or in a few cases, the date the e-mail is opened. The Community Outreach Manager documents the appeal receipt date in HCI's Connects System. The Community Outreach Manager sends an Appeal Receipt Letter to the member. See AppealReceiptLetter_HCI, entire document. A printed copy of the AppealGuide_HCI is sent with the AppealReceiptLetter_HCI. The AppealGuide_HCI informs the member that a receipt letter for the appeal will be sent within two (2) business days of the appeal request. See AppealGuide_HCI- Pages 3 and 4.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The NOABD_CHCI_EFFECTIVE 01.01.2022_HCI informs the member that a receipt letter will be sent within two (2) business days from the day they requested the appeal. See NOABD_CHCI_EFFECTIVE 01.01.2022_HCI- Page 4. If a member is requesting an expedited appeal, the Community Outreach Manager will follow the Appeal Job Aid and review with the Medical Director. If the Medical Director denies the expedited appeal request, the Community Outreach Manager will send a Denied Expedited Appeal Request letter which explains that their appeal will be treated like a standard. See AppealJobAid_HCI- Page 3 and 15. See QuickAppealDeniedRequest_HCI, entire document.	
18. The Contractor's appeal process must provide that included, as parties to the appeal, are: • The member and the member's representative, or • The legal representative of a deceased member's estate. *42 CFR 438.406(b)(3) and (6)* Contract: Exhibit B-8—8.7.6, 8.7.7, 8.7.11 10 CCR 2505-10 8.209.4.I	**Documents Submitted/Location Within Documents:** 1. 305LAppealPolicy_HCI- Page 7 A3f 2. AppealGuide_HCI- Page 5 3. BHMedicaidProviderHandbook_HCI- Page 55 *Misc 4. PCPMedicaidProviderHandbook_HCI- Page 39 *Misc **Description of Process:** HCI's appeal process outlines that parties to the appeal are the member and/or their representative, as well as the legal representative of a deceased member's estate. HCI follows 305LAppealPolicy_HCI that states that the appeal process will include the member and/or their representative, as well as the legal representative of a deceased member's estate as parties to an appeal or State Fair Hearing. See 305LAppealPolicy_HCI- Page 7 A3f. HCI sends an Appeal Guide with each Appeal Receipt Letter. The Appeal Guide informs the member that the parties that can be included in their appeal are the member and their representative. In the case of a Member who has died, the party to the appeal	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	is the legal representative of a deceased Member's estate. See AppealGuide_HCI- Page 5. HCI developed a Behavioral Health Handbook that explains that the parties to an appeal or State Fair Hearing are the member and/or their representative, and in the case of a member who has died, the party to the appeal is the legal representative of a deceased Member's estate. HCI's Behavioral Health Provider Handbook can be found online at https://www.healthcoloradorae.com/providers/provider-handbook. See BHMedicaidProviderHandbook_HCI- Page 55. Providers are informed that Health First Colorado manages all physical health appeals. See PCPMedicaidProviderHandbook_HCI, page 39.	
19. The Contractor's appeal process must provide: • The member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. (The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution time frame in the case of expedited resolution.) • The case file to the member and their representative, including medical records, other documents and records, and any new or additional documents considered, relied upon, or generated by the Contractor in connection with the appeal. This information must be provided free of charge and sufficiently	**Documents Submitted/Location Within Documents:** 1. 305LAppealPolicy- Pages 2G, 2H, 7 Section 3.c 2. AppealGuide_HCI- Pages 4 and 5 3. NOABD_CHCI_EFFECTIVE 01.01.2022_HCI- Pages 3 and 4 *Misc. 4. AppealJobAid_HCI- Pages 3, 15 5. AppealReceiptLetter_HCI- Page 2 6. EvidenceofRequestforRecords_HCI- Entire Document 7. EvidenceofRecordsSubmittedforReview_HCI- Entire Document 8. AppealDecisionLetter_HCI- Page 2 **Description of Process:** Health Colorado, Inc.'s appeal process ensures that the member has a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments when they request an appeal. HCI informs the member of the limited time available to receive this information, especially in the case of an expedited appeal request. HCIs' appeal process also ensures that the member and his or her representative know what is in the member's case file, including medical records, other documents and	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
in advance of the appeal resolution time frame. *42 CFR 438.406(b)(4-5)* Contract: Exhibit B-8—8.7.8–8.7.10 10 CCR 2505-10 8.209. 4.G, 8.209.4.H	records, and any new or additional documents considered, relied upon, or generated in connection with the appeal. If a member requests these records, this information is provided free of charge and sufficiently in advance of the appeal resolution period. HCI follows 305LAppealPolicy_HCI, which outlines the information we will obtain from the member to take into consideration for the appeal as well as the information we will provide to the member upon request within a reasonable time frame of the appeal resolution. See 305LAppealPolicy_HCI pages 2 and 7. Members are made aware that they can provide additional information for their appeal as well as the limited time that they may have to provide this information in the Appeal Guide. See AppealGuide_HCI- Pages 4 and 5 and AppealReceiptLetter_HCI, Page 2. The Appeal Guide is sent with the appeal receipt letter. The guide can also be found on the website at www.healthcoloradorae.com. Members are also informed that they can provide information for an appeal in the Notice of Adverse Benefit Determination letter and that they can request the records used in making the appeal. See NOABD_CHCI_EFFECTIVE 01.01.2022_HCI- Pages 3 and 4. The Community Outreach Manager follows the Appeal Job Aid which has a check list to ensure that we communicate the limited time frame that members or their representatives have to provide any information which they would like considered for their appeal. See AppealJobAid_HCI- Page 3 and 15. To demonstrate that HCI takes into account all comments, documents, records, and other information submitted by the member or their representative without regard if this information was submitted or considered in the initial adverse benefit determination, see EvidenceofRequestforRecords_HCI- Entire document. The Community Outreach Manager compiles all information received from the member/DCR into a secure file storage system. See EvidenceofRecordsSubmittedforReview_HCI- Entire document. This information is sent to the Peer Advisor. Also, in HCIs' Appeal Decision Letter, there is standard	

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	wording to show what information was used in making the appeal decision. See AppealDecisionLetter_HCI- Page 2.	
20. The Contractor maintains an expedited review process for appeals when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. The Contractor's expedited review process includes that: • The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. *42 CFR 438.410(a–b)* Contract: Exhibit B-8—8.7.14.2.1, 8.7.12 10 CCR 2505-10 8.209.4.Q-R	**Documents Submitted/Location Within Documents:** 1. 305LAppealPolicy_HCI- Pages 5 F, 7 B, 10 section 6 2. AppealGuide_HCI- Page 4 3. NOABD_CHCI_EFFECTIVE 01.01.2022_HCI- Page 5 *Misc. 4. BHMedicaidProviderHandbook_HCI- Pages 54, 57 *Misc 5. PCPMedicaidProviderHandbook_HCI- Page 39 *Misc **Description of Process:** Health Colorado, Inc. maintains an expedited review process for appeals for when we determine, or the provider indicates, that taking the time for a standard resolution could seriously jeopardize the member's life. HCI ensures that punitive action is not taken against a provider who requests an expedited appeal or supports an appeal on a member's behalf. HCI follows 305LAppealPolicy_HCI which highlights that the RAE maintains an expedited review process for appeals when the provider or RAE believe that a standard decision could jeopardize the member's life. The policy outlines that we do not take punitive action against a provider acting on the member's behalf. See 305LAppealPolicy_HCI Pages 5 F, 7 B, 10 section 6. HCI notifies members of their right or their designated representative's right to request an expedited appeal in the Notice of Adverse Benefit Determination Letter. This portion of the letter explains that members can request a quick appeal if they or their health care provider believes that waiting ten (10) business days for HCI to decide their appeal would put their health at risk. See NOABD_CHCI_EFFECTIVE 01.01.2022_HCI- Page 5.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI developed an Appeal Guide which informs members who can request an appeal on their behalf and that they or their DCR can request an expedited appeal if they believe that waiting for a decision will be harmful to their health. The Appeal Guide also assures the member or their DCR that there provider will not be punished for requesting an expedited appeal on their behalf. See AppealGuide_HCI- Page 4. The BHMedicaidProviderHandbook_HCI informs the provider that an expedited appeal can be requested by the member or their DCR if the member or provider feels waiting ten business days would be harmful to the member's health. See BHMedicaidProviderHandbook_HCI- Pages 54 and 57. Providers are informed that Health First Colorado manages all physical health appeals. See PCPMedicaidProviderHandbook_HCI, page 39.	
21. If the Contractor denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the time frame for standard resolution. • Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and within two calendar days provide the member written notice of the reason for the decision and inform the member of the right to file a grievance if the member disagrees with that decision. *42 CFR 438.410(c)*	**Documents Submitted/Location Within Documents:** 1. 305LAppealPolicy_HCI- Page 7 2. AppealGuide_HCI- Page 4 3. QuickAppealDeniedRequest- Entire Document 4. AppealJobAid_HCI- Pages 3 and 15 5. NOABD_CHCI_EFFECTIVE 01.01.2022_HCI- Page 5 *Misc. 6. BHMedicaidProviderHandbook_HCI- Pages 54 and 57 *Misc **Description of Process:** Health Colorado, Inc. has a protocol in place to transfer a denied expedited appeal request into standard time frames. HCIs' Community Outreach Manager contacts the member when there is a denied expedited appeal request and explains the transfer to a standard time frame to make an appeal decision. Members are denied. See	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract: Exhibit B-8—8.7.14.2.2 10 CCR 2505-10 8.209.4.S	QuickAppealDeniedRequest_HCI- Entire Document, entire document. In this letter, we explain that we will transfer the appeal to the timeframe for standard resolutions and that they can file a grievance if they are in disagreement with the denial to expedite their appeal. HCI follows 305LAppealPolicy_HCI. The policy outlines that any denied expedited appeal request will be transferred to standard appeal timeframes. The policy also outlines the procedures to communicate the denied expedited request to the member and the member's right. HCI follows 305LAppealPolicy_HCI. The policy outlines that any denied expedited appeal request will be transferred to standard appeal timeframes. The policy also outlines the procedures to communicate the denied expedited request to the member and the member's right to file a grievance about the denied expedited appeal request. See 305LAppealPolicy_HCI- Page 7. HCI developed an Appeal Job Aid which outlines that the appeal will be transferred to the timeframe of a standard resolution if an expedited request is denied. See AppealJobAid_HCI- Pages 3 and 15. HCI developed an Appeal Guide, which outlines what happens when a request for an expedited appeal is denied. The guide informs the member that if denied, the appeal will be processed as a Standard Appeal. The member will be informed by phone and a letter will be sent to explain the reason the request was not approved. The guide also informs the member that they have the right to file a complaint if their request for an expedited appeal is denied. See AppealGuide_HCI- Page 4. The appeal guide can be found on our website, www.healthcoloradorae.com. HCI sends members a Notice of Adverse Benefit Determination letter whenever there is a denial of behavioral health services. The letter outlines that when there is a	

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	request for an expedited appeal and the expedited time frame request is denied, that the appeal decision will be transferred to the standard appeal time frame. The Community Outreach Manager attempts to communicate verbally and will send a letter of this denied expedited appeal request. The letter also states that a member can make a complaint if they are unhappy with the decision to deny an expedited request. See NOABD_CHCI_EFFECTIVE 01.01.2022_HCI- Page 5. HCI notifies providers that if the quick appeal is denied, the appeal will still be processed but according to the Standard Appeal timeframes. See BHMedicaidProviderHandbook_HCI- Pages 54 and 57.	
22. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)* *42 CFR 438.408(d)(2)(i)* *42 CFR 438.10* Contract: Exhibit B-8—8.7.14.1. 7.2.7.3, 7.2.7.5 10 CCR 2505-10 8.209.4.J.1	**Documents Submitted/Location Within Documents:** 1. 305LAppealPolicy_HCI- Pages 1 E, 4 section 5.b, 10 F 1.a and G.1 2. AppealJobAid_HCI- Pages 3, 14, 16-18 3. AppealGuide_HCI- Page 3 4. COS_EC_307L_MemberInfoReqPolicy—FY22-23- - Pages 1, 3 *Misc 5. AppealReceiptLetter_HCI- Page 2 6. AppealDecisionLetter_HCI, Entire Document 7. BHMedicaidProviderHandbook_HCI- Pages 54 and 57 *Misc 8. PCPMedicaidProviderHandbook_HCI- Page 39 *Misc. 9. R4GrieveAppealRptQ4FY21-22Summary_HCI-Entire Document **Description of Process:** Health Colorado, Inc. aims to make a decision on each appeal and provide notice to the member of the resolution of their appeal as expeditiously as the member's health condition requires. This resolution time frame is within ten (10) working days from the receipt of the appeal. There are times that HCI may need to extend this time frame at the member's request or because HCI needs more time to resolve an appeal.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The date the appeal is received establishes the clock for resolving the appeal. This could be the date the phone call is received, the date the fax is received, the letter is opened, or in a few cases, the date the e-mail is opened. The ten (10) working days is used to collect information to be used in the appeal decisions. HCI follows 305_Appeals Policy, which outlines that those making appeal decisions will attempt to resolve the appeal as expeditiously as the member's health condition requires or within the ten (10) working days of receipt of the appeal. The policy states that the written notification to the member must be in a format easily understood by the member. See 305LAppealPolicy_HCI- Pages 1 E, 4 section 5.b, 10 F 1.a and G.1. The Community Outreach Manager follows the Appeal Job Aid which outlines the ten (10) day business day time frame and standards to review the letter to ensure that it is easily understood. See AppealJobAid_HCI- Page 3, 14, 16-18 HCI developed an Appeal Guide to educate members on the timeframes to make an appeal decision. See AppealGuide_HCI- Page 3. HCI also sends out an Appeal Receipt Letter which states the date that we hope to have an appeal decision. See AppealReceiptLetter_HCI- Page 2. HCI follows COS_EC_307L_MemberInfoReqPolicy—FY22-23- to guide the content in the Appeal Decision Letter. The Appeal Decision Letter is written at an appropriate reading level and in a format to be easily understood by members. The Appeal Job Aid outlines the process for the readability testing to ensure that the letter can be easily understood by the member. The decision letter needs to be sent to the supervisor for approval prior to sending out the letter to the member. See 307L_Member Information Requirements_HCI- Pages 1, 3. See AppealJobAid_HCI- Pages 16-18. HCI sends members an Appeal Decision Letter within ten (10) working days of the member filing the appeal. See AppealDecisionLetter_HCI, entire document.	

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI developed a Behavioral Health Provider Handbook that informs providers that HCI will provide a decision on the appeal within ten (10) business days of filing the appeal. Written notice will be sent to the member and the DCR. See BHMedicaidProviderHandbook_HCI- Pages 54 and 57. Providers are informed that Health First Colorado manages all physical health appeals. See PCPMedicaidProviderHandbook_HCI, page 39. HCI sends HCPF a quarterly report which documents HCIs' compliance of sending out the appeal decision letter within ten (10) business days. See R4GrieveAppealRptQ4FY21-22Summary_HCI- Entire document.	
23. For expedited appeal, the Contractor must resolve the appeal and provide written notice of disposition to affected parties within 72 hours after the Contractor receives the appeal. • For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. *42 CFR 438.408(b)(3) and (d)(2)(ii)* Contract: Exhibit B-8—8.7.14.2.3, 8.7.14.2.6 10 CCR 2505-10 8.209.4.J.2, 8.209.4.L	**Documents Submitted/Location Within Documents:** 1. AppealDecisionLetter_HCI- Entire Document 2. 305LAppealPolicy_HCI- Pages 4 5c, 7B, 10 E7, 10 F1c 3. AppealGuide_HCI- Page 3 4. AppealJobAid_HCI- Pages 2, 3 and 14 **Description of Process:** Health Colorado, Inc. resolves each expedited appeal and provides written notification within seventy-two (72) hours of receipt of the expedited appeal. See AppealDecisionLetter_HCI, entire document. HCIs' Member's Engagement Specialist also makes reasonable efforts to verbally notify the member of the appeal resolutions. An Appeal Decision Letter is sent to the member and/or DCR the same day as the decision. For an example of the letter, see AppealDecisionLetter_HCI, entire document. HCI follows 305 L_Appeals Policy which outlines that expedited appeal requests will be resolved within seventy-two (72) hours after the RAE receives the appeal. The policy also states that the RAE will make reasonable efforts to provide oral notification	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	of the expedited appeal resolution. See 305LAppealPolicy_HCI- Pages 4 5c, 7B, 10 E7, 10 F1c. HCI developed an Appeal Guide which list what members can expect when they make an expedited appeal request. The guide explains that HCI will make a decision within seventy-two (72) hours for an expedited appeal request. See AppealGuide_HCI- Page 3. The Community Outreach Manager follows the Appeal Job Aid which outlines the processes for both approved and denied expedited appeal requests. See AppealJobAid_HCI- Pages 2, 3. For expedited appeals, the Community Outreach Manager will make all possible attempts to notify the member verbally and will send an Appeal Decision Letter the day of the decision. See AppealJobAid_HCI- Page 14.	
24. The Contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: • The member requests the extension; or • The Contractor shows (to the satisfaction of the Department, upon request) that there is need for additional information and how the delay is in the member's interest. *42 CFR 438.408(c)(1)* Contract: Exhibit B-8—8.7.14.2, 8.7.14.2.4, 8.5.6 10 CCR 2505-10 8.209.4.K, 8.209.5.E	**Documents Submitted/Location Within Documents:** 1. 303LGrievancePolicy_HCI- Page 7 Section 14.a-b 2. ComplaintExtensionLetter_HCI- Entire Document 3. 305LAppealPolicy_HCI- Pages 2 E, 2 F1, 7 Section 3.d, 9 Section 5 4. AppealExtensionLetter_HCI- Entire Document 5. ComplaintGuide_HCI- Page 2 6. AppealGuide_HCI- Pages 3 and 5 7. NOABD_CHCI_EFFECTIVE 01.01.2022_HCI- Page 5 *Misc. 8. AppealandComplaintTraining_HCI-Slide 14 9. ComplaintJobAid_HCI- Page 3 **Description of Process:** Health Colorado, Inc. can extend the time frames for resolution of grievances or appeals (both expedited and standard appeals) by up to 14 calendar days when a member requests the extension or when HCI believes that there is a need for	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	additional information and communicates how the delay in making a decision would be in the member's best interest. HCI follows all state and federal guidelines for extending time frames for resolution of grievances and appeals (both expedited and standard appeals) by fourteen (14) calendar days. HCI follows 303L_Grievance Policy which outlines that we can extend the time frame for the resolution of a grievance by up to 14 calendar days if the member requests the extension or if there is a need for additional information and that the delay is in the member's best interest. See 303LGrievancePolicy_HCI page 7, section 14 a-b. HCI notifies the member within 2 business days when there has been a request for an extension and attempts to contact the member on the phone. HCI sends out a letter to the member to notify them of the need for additional time and explains why it is in their best interest. See ComplaintExtensionLetter_HCI- Entire document. HCI follows HCI's 305LAppealPolicy_HCI which outlines the protocols followed when either a member requests an extension, or when the RAE believes it would be in the member's best interest to have additional time to make a decision. We send the member written notification when the time frame is extended. The policy states that we will include the reason for the extension, the date by which a final determination will be made, and the notification of member's rights to file a grievance if the member disagrees with the extension. See 305LAppealPolicy_HCI- Pages 2 E, 2 F1, 7 section 3.d, 9 section 5. The Community Outreach Manager will send notification to the member within two (2) business days once it is ascertained that additional days are needed. See AppealExtensionLetter_HCI, entire document. In the body of the letter, we document why it is in the member's best interest to delay the appeal.	

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Members are made aware of the ability to delay either a grievance or appeal by up to fourteen (14) calendar days in the Appeal Guide and Complaint Guide located on our website, www.healthcoloradorae.com. See ComplaintGuide_HCI- Page 2. See AppealGuide_HCI- Pages 3 and 5. Members are also alerted about this ability to delay a grievance or appeal decision in the NOABD_CHCI_EFFECTIVE 01.01.2022_HCI- Page 5. HCI also provides training to the shareholder advocates that research complaints. They are informed of the process to follow when either a member requests an extension, or when the RAE believes it would be in the member's best interest to have additional time to make a decision. See AppealandComplaintTraining_HCI, Slide 14 and ComplaintJobAid_HCI- Page 3.	
25. If the Contractor extends the time frames for a grievance or appeal, it must—for any extension not requested by the member: • Make reasonable efforts to give the member prompt oral notice of the delay. • Within two calendar days, give the member written notice of the reason for the delay and inform the member of the right to file a grievance if the member disagrees with that decision. • Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires (14 days following the expiration of the original grievance or appeal resolution time frame).	**Documents Submitted/Location Within Documents:** 1. 303LGrievancePolicy_HCI- Page 7, section 14b-c 2. 305LAppealPolicy_HCI- Pages 2 F 1b and 2, 10 5bi 3. ComplaintExtensionLetter_HCI- Entire Document 4. AppealExtensionLetter_HCI- Entire Document 5. ComplaintGuide_HCI- Page 2 6. AppealGuide_HCI- Pages 3 and 5 7. ComplaintJobAid_HCI- Page 3 **Description of Process:** Health Colorado, Inc. makes reasonable efforts to verbally notify the member promptly if there an extension in making a decision about an appeal or a grievance when it is not requested by the member. HCI sends a letter within two (2) calendar days of when the decision was to be made and alerts the member in this letter that they can file a grievance about the delay. HCI will attempt to expeditiously resolve the appeal as the	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.408(c)(2) Contract: Exhibit B-8—8.5.7, 8.7.14.1, 8.7.14.2.1, 8.7.14.2.5-6 10 CCR 2505-10 8.209.4.L, 8.209.4.K, 8.209.4.A. 3.C(ii), 8.209.5.E	member's health condition requires and no longer than the expiration of the extension date. HCI's 303L_Grievance Policy which outlines the procedures for when a resolution timeframe needs to be extended. This includes verbally notifying the member and sending a letter with information on how to file a grievance if the member does not agree with the extension. See 303LGrievance Policy, page 7, section 14b-c. HCI follows HCI's 305LAppealPolicy_HCI which outlines the procedures for when a resolution timeframe needs to be extended for an appeal. This includes verbally notifying the member, sending a letter with information on the reason for the delay and how to file a grievance if the member does not agree with the extension, and our intent to make a decision as expeditiously as the member's health requires. See 305LAppealPolicy_HCI- Pages 2 F 1b and 2, 10 5bi. HCI notifies the member within 2 business days when there has been a request for an extension for an appeal or grievance and attempts to contact the member on the phone to communicate this information. HCI sends out letters to the member to notify them of the delay. See ComplaintExtensionLetter_HCI- Entire Document and AppealExtensionLetter_HCI- Entire Document. HCI developed a Complaint Guide and an Appeal Guide to educate members on the reason there may be a delay in resolving their complaint or appeal. The guides state that HCI may extend the decision date by up to fourteen (14) calendar days. These guides can be found on HCI's website, www.healthcoloradorae.com. See ComplaintGuide_HCI- Page 2 and AppealGuide_HCI- Pages 3 and 5.	

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI also provides training to the shareholder advocates that research complaints. They are informed of the process to follow when either they need an extension to research a complaint. See ComplaintJobAid_HCI- Page 3.	
Findings: Extensions can be granted for up to 14 calendar days if they are in the member's best interest, and Beacon must make reasonable efforts to notify the member verbally of the delay. However, one out of 10 grievance sample records involved an extension. This grievance record did not include evidence of an oral outreach to the member documented in the system notes; therefore, Beacon could not provide evidence that outreach was conducted. Additionally, the 305L Appeals Policy on page 12, section J.4, did not state that the coordinator will make reasonable attempt to contact the member to notify the member of the delay when an extension is used.		
Required Actions: HCI must make reasonable efforts to notify the member of an extension and must enhance documentation of such attempted communications between the member and staff member. HCI must update the Appeals Policy to include that the coordinator will make reasonable efforts to notify the member of an extension.		
26. The written notice of appeal resolution must include: • The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. – The right to request that benefits/services continue* while the hearing is pending, and how to make the request. – That the member may be held liable for the cost of these benefits if the hearing decision upholds the	**Documents Submitted/Location Within Documents:** 1. AppealDecisionLetter_HCI- Entire Document 2. 305LAppealPolicy_HCI- Page 10 G1 and 11 G 3a-d 3. AppealGuide_HCI- Page 6 4. StateFairHearingGuide_HCI- Entire Document **Description of Process:** Health Colorado, Inc. documents in the appeal decision letter the results of the resolution process and the date it was completed. The appeal decision letter includes members' right and procedures to request a State Fair Hearing if an appeal decision is not resolved wholly in favor of the member. The appeal decision letter outlines that members can request that previously authorized benefits continue while the hearing is pending, how to make this request and that the member may be held liable for the cost of these services if the hearing decision upholds HCIs' adverse benefit determination. See AppealDecisionLetter_HCI- Entire Document.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contractor's adverse benefit determination. **Continuation of benefits applies only to previously authorized services for which the Contractor provides 10-day advance notice to terminate, suspend, or reduce.* *42 CFR 438.408(e)* Contract: Exhibit B-8—8.7.14.3, 8.7.14.4 10 CCR 2505-10 8.209.4.M	HCI follows 305LAppealPolicy_HCI. The policy outlines that the written notice will include the date the appeal decision was made, how members can request a State Fair Hearing, how members can request for services to continue throughout the hearing, and the member's responsibility for payment if the State Fair Hearing is not in the member's favor. See 305LAppealPolicy_HCI- Page 10 G1 and 11 G 3a-d. HCI developed an Appeal Guide to educate members on their rights when an appeal decision is not wholly in the member's favor. The guide states that members can file a State Fair Hearing. The Appeal Decision Letter includes a State Fair Hearing Guide so that members know what to expect during a State Fair Hearing. See AppealGuide_HCI- Page 6. HCI also developed the State Fair Hearing guide which states that a member can request a State Fair Hearing when their appeal was not in the member's favor on page 1. The guide outlines that members can request for the previously authorized services to continue during the hearing, what a member can expect from HCI and the members' financial responsibility for the services they received during the course of the hearing if the hearing results are not in their favor. See StateFair HearingGuide_HCI, entire document.	

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
27. The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of appeal resolution. • If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. *42 CFR 438.408(f)(1–2)* Contract: Exhibit B-8—8.7.15.1–8.7.15.2 10 CCR 2505-10 8.209.4.N and O	**Documents Submitted/Location Within Documents:** 1. 305LAppealPolicy_HCI- Pages 1 IC, 11 Section G.3.b and 4.b 2. AppealGuide_HCI- Page 6 3. StateFairHearingGuide_HCI- Page 1 4. AppealDecisionLetter_HCI- Page 3 5. NOABD_CHCI_EFFECTIVE 01.01.2022 - Pages 5-6 *Misc. 6. BHMedicaidProviderHandbook_HCI- Pages 56 *Misc 7. PCPMedicaidProviderHandbook_HCI- Page 39 *Misc **Description of Process:** Health Colorado, Inc. upholds the member's right to request a State Fair Hearing within 120 calendar days upon receipt of an adverse appeal determination or if HCI fails to meet the notice and timing requirements. If HCI does not meet the requirements, the appeal rights will be determined to be exhausted. HCI follows 305LAppealPolicy_HCI which states that members have 120 calendar days from the date on the Adverse Appeal Decision letter to request a State Fair Hearing. The policy outlines that the appeal process will have been considered exhausted if the regional organization does not follow the notice and timing requirements. If the appeal process has been exhausted, members call file a State Fair Hearing. See 305LAppealPolicy_HCI- Pages 1 IC, 11 section G.3.b and 4.b. HCI's Community Outreach Manager sends the member an appeal decision letter which outlines the timeframe that a member can request a State Fair Hearing in the event of an adverse determination. The Appeal Decision letter records the exact date that the member must request a State Fair Hearing by – which is 120 calendar days from the date of the Appeal Decision Letter. See AppealDecisionLetter_HCI- Page 3.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI developed an appeal guide which outlines that a member can request a State Fair Hearing if the appeal decision is not in the member's favor. See AppealGuide_HCI- Page 6. HCI developed a State Fair Hearing Guide which indicates the timeframe that members have to request a state fair hearing. The guide also explains that if HCI did not follow the appeal time frames, that the member can request a state fair hearing before filing an appeal. See StateFairHearingGuide_HCI- Page 1. HCI sends members a notice of adverse benefit determination letter when there is a denial in behavioral health services. The letter explains that members have 120 days to request a state fair hearing if the decision about their appeal is not in the member's favor. The letter also explains that if HCI does not meet the appeal deadlines, that members may request a state fair hearing without waiting for us to decide their appeal. See NOABD_HCI- Pages 5-6. HCI developed and maintains the BHMedicaidProviderHandbook_HCI which educates providers on the 120-day timeframe for members to file a State Fair Hearing in the event of an adverse appeal decision. See BHMedicaidProviderHandbook_HCI- Page 56. Providers are informed that Health First Colorado manages all physical health appeals. See PCPMedicaidProviderHandbook_HCI, page 39.	
Findings: HCI's sample included two out of 10 appeal sample records containing language that required the member to request a State fair hearing "no earlier than 90 days and no later than 120 days" from the notice of appeal resolution. However, the State requirement is 120 days, and the MCE cannot be any more restrictive than the State requirements. Due to HCI correcting this issue before the end of the review period, no required action is needed.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
28. The parties to the State fair hearing include the Contractor as well as the member and their representative or the representative of a deceased member's estate. *42 CFR 438.408(f)(3)* Contract: Exhibit B-8—8.7.15.3	**Documents Submitted/Location Within Documents:** 1. 305LAppealPolicy_HCI- Page 7, Section 3.f 2. StateFairHearingGuide_HCI- Page 2 3. AppealDecisionLetter_HCI- Page 4 **Description of Process:** Health Colorado, Inc. has procedures in place to include HCI, the member, the member's representative, or the representative of a deceased member's estate at a State Fair Hearing. As a delegated function, HCI follows HCI's 305L Appeal Policy which outlines the parties that need to be included in a State Fair Hearing which include the member and their representative or the representative of a deceased member's estate. See 305LAppealPolicy_HCI- Page 7, section 3f. HCI developed a State Fair Hearing Guide which outlines the parties that can participate in the State Fair Hearing which includes a representative from HCI, the member or their designated representative or representative from the member's deceased estate. The Community Outreach Manager sends this guide with the Appeal Decision Letter. See StateFairHearingGuide_HCI- Page 2. See AppealDecisionLetter_HCI- Page 4.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
29. The Contractor provides for continuation of benefits/services (when requested by the member) while the Contractor-level appeal and the State fair hearing are pending if: • The member files in a timely manner* for continuation of benefits—defined as on or before the later of the following:	**Documents Submitted/Location Within Documents:** 1. 305LAppealPolicy_HCI- Page 8 C a-f 2. NOABD_CHCI_EFFECTIVE 01.01.2022 - Page 7 *Misc 3. BHMedicaidProviderHandbook_HCI- Page 56 *Misc 4. PCPMedicaidProviderHandbook_HCI- Page 39 *Misc 5. AppealGuide_HCI- Page 6 6. StateFairHearingGuide_HCI- Page 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Within 10 days of the Contractor mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal in accordance with required time frames. ** This definition of timely filing only applies for this scenario—i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced. (Note: The provider may not request continuation of benefits on behalf of the member.)* *42 CFR 438.420(a) and (b)* Contract: Exhibit B-8—8.7.13.1 10 CCR 2505-10 8.209.4.T	**Description of Process:** Health Colorado, Inc. provides for continuation of benefits/services during an appeal or state fair hearing which may be pending if a member requests for services to be continued within ten (10) days of receiving the Adverse Benefit Determination or the intended effective date of the Adverse Benefit Determination. The services need to be ordered by an authorized provider. For services that were previously authorized, the authorization end date has not expired. And, the member needs to request an appeal within the required timeframes. HCI's 305L Appeal Policy which outlines the requirements for members to request a continuation in their services. The policy states the requirements HCI follows which allow continuation of benefits only under certain circumstances. The member has to: 1) request continuation of service in a timely fashion -- within 10 days of HCI mailing the adverse benefit determination, 2) the appeal is regarding a termination, suspension, or reduction of a previously authorized course of treatment; 3) the services were ordered by an authorized provider; 4) the original period covered by the original authorization has not expired; 5) and the member requests an appeal timely. The policy also states that a provider cannot request continuation of benefits on behalf of a member. See 305LAppealPolicy_HCI- Page 8 C a-f. HCI sends members a Notice of Adverse Benefit Determination Letter when there is a denied behavioral health service. The letter outlines the procedures members need to follow if they would like to request for continuation of services during the appeal. See NOABD_CHCI_EFFECTIVE 01.01.2022 - Page 7. HCI developed an Appeal Guide and a State Fair Hearing Guide which outlines all of these requirements for continuation of benefits to continue. These guides are mailed with the Appeal Receipt Letter or the Appeal Decision Letter and are also located on HCIs' website. See AppealGuide_HCI- Page 6 and StateFairHearingGuide_HCI- Page 3.	

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI has developed and maintains the BHMedicaidProviderHandbook_HCI which documents the requirements for members requesting a continuation of services during an appeal or State Fair Hearing. The handbook notes that a provider cannot request a continuation of services on a member's behalf. See BHMedicaidProviderHandbook_HCI-Page 56. Providers are informed that Health First Colorado manages all physical health appeals. See PCPMedicaidProviderHandbook_HCI, page 39	
30. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of the following occurs: • The member withdraws the appeal or request for a State fair hearing. • The member fails to request a State fair hearing and continuation of benefits within 10 calendar days after the Contractor sends the notice of an adverse resolution to the member's appeal. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR 438.420(c)* Contract: Exhibit B-8—8.7.13.2 10 CCR 2505-10 8.209.4.U	**Documents Submitted/Location Within Documents:** 1. 305LAppealPolicy_HCI- Page 8 D 2. StateFairHearingGuide_HCI- Page 3 3. BHMedicaidProviderHandbook_HCI- Page 56 *Misc 4. PCPMedicaidProviderHandbook_HCI- Page 39 *Misc **Description of Process:** Health Colorado, Inc. will continue or reinstate benefits during the appeal or state fair hearing unless certain conditions occur. The conditions are that the member withdraws the appeal or State Fair Hearing request, the member fails to request a State Fair Hearing and continuation of benefits within ten (10) calendar days of receipt of the Notice of Adverse Resolution, or a State Fair Hearing Officer issues a hearing decision which is adverse to the member. HCI follows 305L_Appeals Policy which states the requested service will continue unless the member withdraws the appeal, the member fails to request a state fair hearing and continuation of benefits within to (10) calendar days after the RAE sends the notice of an adverse resolution to the member's appeal; or the State Fair Hearing Office issues a hearing decision adverse to the member. See 305LAppealPolicy_HCI-Page 8 D.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI developed a State Fair Hearing Guide which outlines that HCI will continue or reinstate benefits unless certain conditions exist. See StateFairHearingGuide_HCI- Page 3. HCI has developed and maintains a BHMedicaidProviderHandbook_HCI which outlines that the regional organization will continue or reinstate member benefits unless certain conditions occur. See BHMedicaidProviderHandbook_HCI- Page 56. Providers are informed that Health First Colorado manages all physical health appeals. See PCPMedicaidProviderHandbook_HCI, page 39.	
31. Member responsibility for continued services: • If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's adverse benefit determination, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. *42 CFR 438.420(d)* Contract: Exhibit B-8—8.7.13.3 10 CCR 2505-10 8.209.4.V	**Documents Submitted/Location Within Documents:** 1. 305LAppealPolicy_HCI- Page 8 D 1 2. AppealGuide_HCI- Page 6 3. StateFairHearingGuide_HCI- Page 3 4. BHMedicaidProviderHandbook_HCI- Page 56 *Misc 5. PCPMedicaidProviderHandbook_HCI- Page 39 *Misc **Description of Process:** Health Colorado, Inc. may recover the cost of services provided to the member while an appeal or State Fair Hearing was pending if the decision upholds the adverse benefit determination and the reason that the services were provided were based on the requirements in this section. HCI follows 305LAppealPolicy_HCI which outlines that costs of services can be recovered by the RAE when services were provided to the member during an appeal or State Fair Hearing and the appeal determination upholds the original decision to deny services to the extent that the services were furnished solely based on the requirements of this section. See 305LAppealPolicy_HCI- Page 8, section D1.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI developed an Appeal Guide and a State Fair Hearing Guide which outlines that members may be financially responsible to repay for any services that were provided during the appeal if the appeal decision was upheld by an external entity. See AppealGuide_HCI- Page 6 and StateFairHearingGuide_HCI- Page 3. HCI developed and maintains the BHMedicaidProviderHandbook_HCI which states that if the RAE's decision on a member's appeal is adverse to the member, the RAE may recover the cost of the services furnished to the member while the appeal is pending, if the reason why the services were furnished was solely because of the requirements of this section. See BHMedicaidProviderHandbook_HCI- Page 56. Providers are informed that Health First Colorado manages all physical health appeals. See PCPMedicaidProviderHandbook_HCI, page 39.	
32. If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services as promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. *42 CFR 438.424(a)* Contract: Exhibit B-8—8.7.13.4 10 CCR 2505-10 8.209.4.W	**Documents Submitted/Location Within Documents:** 1. 305LAppealPolicy_HCI- Page 8, section 2 2. BHMedicaidProviderHandbook_HCI- Page 56 *Misc 3. EvidenceofOverturnedAppealDecisionLetter_HCI- Entire Document 4. EvidenceofPayment_HCI- Entire document **Description of Process:** Health Colorado, Inc. will authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date HCI receives the notice reversing the adverse determination. HCI's 305LAppealPolicy_HCI which outlines that the RAE will authorize or provide the disputed services promptly or as expeditiously as possible but no later than 72 hours from the date that we receive the notice reversing the adverse determination. See 305LAppealPolicy_HCI- Page 8 section 2.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI has submitted Evidence of authorizing services which had been previously denied. A provider requested additional days of inpatient services for the member which were denied. The peer reviewer overturned this decision. See EvidenceofOverturnedAppealDecisionLetter_HCI, entire document. HCI's care manager updated the authorization within 72 hours to reflect that these services would be covered. See EvidenceofPayment_HCI, entire document. HCI's BHMedicaidProviderHandbook informs providers that if an appeal decision is in the member's favor, HCI must authorize or provide the disputed services as promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. See BHMedicaidProviderHandbook_HCI, Page 56.	
33. If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the Contractor must pay for those services. *42 CFR 438.424(b)* Contract: Exhibit B-8—8.7.13.5 10 CCR 2505-10 8.209.4.X	**Documents Submitted/Location Within Documents:** 1. 305LAppealPolicy_HCI- Page 8 section 2.b 2. BHMedicaidProviderHandbook_HCI- Page 56 *Misc 3. AppealJobAid_HCI- Page 20 **Description of Process:** Health Colorado, Inc. will pay for any disputed services a member receives while the appeal was pending if HCI or the State Fair Hearing reverses the decision to deny authorization of services. HCI's 305L Appeal Policy which states that the regional organization will authorize and pay for disputed services while the appeal was pending if the regional organization or the State Fair Hearing officer reverses a decision to deny authorization of services. See 305LAppealPolicy_HCI- Page 8, section 2.b.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The Community Outreach Manager follows the Appeal Job Aid which outlines procedures to be followed when an appeal decision is reversed. The Job Aid states that when we receive notification of a reversal of a decision, the Community Outreach Manager will notify the clinical team to update the authorization and send to claims so that HCI can pay the authorization. See AppealJobAid_HCI- Page 20. HCI has developed and maintains the BHMedicaidProviderHandbook_HCI which states that the regional organization will pay for any disputed service that was provided while the appeal was pending and the decision was reversed by either the regional organization or the State Fair Hearing officer. See BHMedicaidProviderHandbook_HCI- Page 56.	
34. The Contractor maintains records of all grievances and appeals. The records must be accurately maintained in a manner accessible to the State and available on request to CMS. • The record of each grievance and appeal must contain, at a minimum, all of the following information: – A general description of the reason for the grievance or appeal. – The date received. – The date of each review or, if applicable, review meeting. – Resolution at each level of the appeal or grievance.	**Documents Submitted/Location Within Documents:** 1. 305LAppealPolicy_HCI- Pages 12-13 section K 2. 303LGrievancePolicy_HCI- Page 9 section C.A.1.a-j, C.5 3. FeedbackDatabase_HCI- Entire Document 4. R4GrievAppealRpt-Q4-FY21-22_HCI- Entire Document **Description of Process:** HCI maintains records of all grievances and appeals in an accurate manner which is accessible to the State and available upon request to CMS. HCI submits a quarterly report to HCPF with a general description of the reason for each grievance or appeal, the date the appeal/grievance was received and resolved, the name of the person for whom the grievance/appeal was filed, the date of each review if applicable, and the resolution.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Date of resolution at each level, if applicable. – Name of the person for whom the appeal or grievance was filed. • The Contractor quarterly submits to the Department a Grievance and Appeals report including this information. *42 CFR 438.416* Contract: Exhibit B-8—8.9.1–8.9.1.6 10 CCR 2505-10 8.209.3.C	HCI follows 305LAppealPolicy_HCI which has a section entitled Monitoring and Reporting by the Appeals Coordinator. Each appeal is logged upon receipt and assigned expeditiously to an appropriate reviewer with notification to the reviewer of the timeline for a resolution. All required information is recorded and documented in HCI's secure file storage system. See 305LAppealPolicy_HCI- Pages 12-13, section K. HCI follows 303L_Grievance Policy which outlines the necessary information that the Community Outreach Manager or Advocate need to enter into the feedback database which includes the date the grievance is received, member's name, description of grievance, date of and resolution at each level of review for the grievance (if applicable) and the date of grievance resolution. The policy states that the RAE will submit a quarterly report to the state with all of this information. See 303LGrievancePolicy_HCI- Page 9 section C.A.1.a-j, C.5. HCI's Community Outreach Manager is responsible to review the feedback database on a monthly basis to ensure fidelity to the collection of data. See Feedback Database_HCI, entire document. HCI submits the Grievance and Appeal Report on a quarterly basis to HCPF. The report includes an excel spreadsheet that separates out appeals and grievances. HCPF requires that we document the date the grievance or appeal is received, member's name, the description of grievance or appeal, date of and resolution at each level of review for the grievance/appeal (if applicable) and the date of grievance/appeal resolution. See R4GrievAppealRpt-Q4-FY21-22_HCI- Entire document.	

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
35. The Contractor provides the information about the grievance, appeal, and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. – The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member. *42 CFR 438.414*	**Documents Submitted/Location Within Documents:** 1. ProviderContract_HCI- Pages 15 Section 5.5, 20 Section 6.9, and 55 Section F (h) 2. BHMedicaidProviderHandbook_HCI- Pages 21-22, and 51-57 *Misc 3. PCPMedicaidProviderHandbook_HCI Pages 15 and 39 *Misc **Description of Process:** HCI has delegated the provider network responsibilities to Beacon Health Options. Providers must sign a contract when they enter the network which serves Medicaid members. When providers sign the contract, they attest that they will follow the BHMedicaidProviderHandbook_HCI or PCPMedicaidProviderHandbook_HCI which has all of the information about the grievance, appeal, and State Fair Hearing processes and systems. See ProviderContract_HCI, Pages 15 section 5.5, 20 section 6.9, and 55 section F (h). The information in the handbook includes the member's right to file a grievance or appeal, the requirements and timeframes to file grievances and appeals, the member's right to a State Fair Hearing when HCI makes a decision on an appeal which is adverse to the member, availability to help members with the filing process, the member's right to request continuation of services when certain requirements are met and that members may be required to pay for the cost of the service if the State Fair Hearing is adverse to the member. See BHMedicaidProviderHandbook_HCI- Pages 21-22, and 52-57 and PCPMedicaidProviderHandbook_HCI- Pages 15 and 39.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract: Exhibit B-8—8.4 10 CCR 2505-10 8.209.3.B		

Results for Standard VI—Grievance and Appeal Systems							
Total	Met	=	32	X	1.00	=	32
	Partially Met	=	3	X	.00	=	3
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	35	**Total Score**		=	32
Total Score ÷ Total Applicable						=	91%

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor agrees to accept individuals eligible for enrollment into its RAE in the order in which they apply without restriction (unless authorized by CMS) up to the limits set under that contract. *42 CFR 438.3(d)(1)* Contract: Exhibit B-8—6.6	**Documents Submitted/Location Within Documents:** 1. CAC 370_Enrollment and Disenrollment of Medicaid Members_HCI, Pages 2-3 2. Enrollment Workflow_HCI, Entire Document 3. EnrollmentDataTransmission_HCI, Entire Document **Description of Process:** HCI does not determine eligibility for members who are eligible to enroll in Health First Colorado (Colorado's Medicaid Program). HCI accepts all members who are eligible with Health First Colorado and are assigned to HCI per the contract guidelines. The contract states in section 6.6 that HCI shall accept all eligible members that HCPF assigns in the order in which they are assigned without restriction. HCPF assigns members to HCI based on HCPF's attribution and assignment policies and procedures. The contract states in 6.3 that HCPF will enroll Members into the Accountable Care Collaborative on the same day that a Member's Medicaid eligibility notification is received in the Colorado interChange from the Colorado Benefit Management System (CBMS). In alignment with their member enrollment policy, HCPF will allow retroactive enrollment for up to 90 days from when a member received institutes for mental diseases (IMD) services within that time period. HCPF will assign members to the RAE based on the location of the PCMP Practice Site to which the member is attributed. The PCMP attribution effective date will be the same as the RAE assignment date. HCI follows Beacon's policy CAC 370_Enrollment and & Disenrollment of Medicaid Members_HCI, which outlines that we will accept all members eligible	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	for enrollment. The policy lists the standard operating procedures HCI follows in order to maintain an interface that enables us to the use the Colorado interchange Provider Portal to retrieve eligibility, enrollment and attribution information for members. See CAC 370_Enrollment and Disenrollment of Medicaid Members_HCI. Beacon created a workflow to outline how the 834 Eligibility Files are loaded into our database. Beacon accepts and transfers all members eligible for enrollment through the process outlined in this workflow. See Enrollment Workflow_HCI. Evidence of enrollment data transmission and the schedule of run times can be found in the document EnrollmentDataTransmission_HCI.	
2. The Contractor does not discriminate against individuals eligible to enroll or use any policy or practice that has the effect of discriminating against individuals, based upon health status or need for health care services, race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs, or disability. *42 CFR 438.3(d)(3-4)* Contract: Exhibit B-8—6.5	**Documents Submitted/Location Within Documents:** 1. C4H_Enrollment Questions_HCI, Entire Document 2. 310LNonDiscriminationPolicy_HCI, Entire Policy 3. CAC 370_Enrollment and Disenrollment of Medicaid Members_HCI, Pages 2-3 4. Call Center Minutes_December 2022_HCI, Page 1 **Description of Process:** HCI does not determine eligibility for members who are eligible to enroll in Health First Colorado. HCI accepts all members who are eligible with Health First Colorado through the process described in Requirement One (1) of this standard. HCI collaborated with Connect For Health Colorado, Colorado's office health insurance marketplace who confirms they have processes to ensure that no member	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	is discriminated against when enrolling for Health First Colorado. See C4H Enrollment Questions_HCI. HCI has a Non-Discrimination Notice on our website, https://www.healthcoloradorae.com/non-discrimination-notice/. Members who wish to review information about HCI's non-discrimination notice will also have the option to link to HCPF's non- discrimination policy and non-discrimination notice. HCI's non-discrimination notes informs members of the following: Health Colorado complies with applicable Federal and State civil rights laws and does not discriminate against persons or individuals eligible to enroll in the Accountable Care Collaborative on the basis of race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs or disability, handicap (including Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions and shall not use any policy or practice that has the effect of discriminating on the basis of race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs, disability, handicap (including Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions . Health Colorado shall not discriminate against Members in enrollment and re-enrollment on the basis of health status or need for health care services. Health Colorado shall not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive. Health Colorado will ensure that its employees and contracted providers observe and protect these rights. HCI adheres to a non-discrimination policy (See 310L-Non-Discrimination-Policy_HCI) which states that we will not discriminate against individuals eligible to enroll or use any policy or practice that has the effect of discriminating against individuals, based upon health status or need for health care services, race, color,	

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs, or disability. See 310L-Non-Discrimination-Policy_HCI. HCI follows an Enrollment & Disenrollment Policy, which states that we will not discriminate against any member eligible for enrollment. See CAC 370_ Enrollment and Disenrollment of Medicaid Members_HCI. Members or potential members who contact HCI's call center will speak with an associate who has been educated on our non-discrimination practices. HCI reviewed the non-discrimination policy, non-discrimination notice, and enrollment and disenrollment policy with our call center associates during a meeting held on December 16, 2022. See Call Center Minutes_December 2022_HCI, 310LNon Discrimination Policy_HCI, CAC 370 Enrollment and Disenrollment of Medicaid Members_HCI and https://www.healthcoloradorae.com/non-discrimination-notice/.	
3. The Contractor may not request disenrollment of a member because of an adverse change in the member's health status or because the member's: • Utilization of medical services • Diminished mental capacity • Uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the Contractor's ability to furnish	**Documents Submitted/Location Within Documents:** 1. CAC 370_Enrollment and Disenrollment of Medicaid Members_HCI, Page 3 2. Call Center Minutes_December 2022_HCI, Page 2 **Description of Process:** HCI follows an Enrollment and Disenrollment policy to outline that we will not request disenrollment of a member because of an adverse change in the member's health status, utilization of medical services, diminished mental capacity, or uncooperative/ disruptive behaviors. The policy outlines when the RAE is able to	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
services to the member or to other members) *42 CFR 438.56(b)(2)* Contract: Exhibit B-8—None	request the disenrollment of a member – in those situations that the member's continued enrollment seriously impairs HCIs ability to furnish services to the member or other members. See CAC 370_Enrollment and Disenrollment of Medicaid Members_HCI HCI reviewed our Enrollment and Disenrollment policy with our call center staff, who oftentimes are in the position to try to help members who are uncooperative or disruptive. See Call Center Minutes_December 2022_HCI. HCI has never requested the disenrollment of any member from our membership since our inception in 2018. If members were identified as uncooperative, they would be referred to care coordination for additional assistance.	
4. To initiate disenrollment of a member's participation with the RAE, the Contractor must provide the Department with documentation justifying the proposed disenrollment. *42 CFR 438.56(b)(3)* Contract: Exhibit B-8—None	**Documents Submitted/Location Within Documents:** 1. CAC 370_Enrollment and Disenrollment of Medicaid Members_HCI, Page 4 2. Call Center Minutes_December 2022_HCI, Entire Document 3. Member Dismissal Request_HCI, Entire Document **Description of Process:** HCI follows our Enrollment and Disenrollment of Medicaid Members policy, which outlines our process to request disenrollment of a member from HCI. This process includes using HCIs Member Dismissal Request form to request any disenrollment. The form will document the justification for the proposed disenrollment, such as when the members continued enrollment seriously impairs	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	our ability to provide services to the member or other members and our attempts made to work with the member prior to requesting disenrollment. Any attempts to work with a member would be documented in Beacon's Connects system under the member's record. The form will be reviewed by HCIs Chief Executive Officer (CEO) prior to submitting to HCPF. This policy was reviewed with HCIs call center associates to outline the procedures we must follow to request disenrollment of a member. See CAC 370_Enrollment and Disenrollment of Medicaid Members_HCI, Member Dismissal Request_HCI, and Call Center Minutes_December 2022_HCI. HCI has never requested the disenrollment of any member from our membership since our inception in 2018.	
5. The member may request disenrollment as follows: • For cause at any time, including: – The member has moved out of the Contractor's service area – The Contractor does not (due to moral or religious objections) cover the service the member seeks – The member needs related services to be performed at the same time, not all related services are available from the Contractor's plan, and the member's primary care provider	**Documents Submitted/Location Within Documents:** 1. CAC 370_Enrollment and Disenrollment of Medicaid Members_HCI, Pages 3-4 2. Disenrollment Rights_HCI, Entire Document 3. Call Center Minutes_December 2022_HCI, Page 2 4. Care Coordination Presentation_HCI, Slide 9 5. Quality Committee Presentation_HCI, Slide 15 6. Member Services Presentation_HCI, Slide 6 7. BH_MedicaidProviderHandbook_HCI, Pages 15-16 *Misc 8. PCPMedicaidProviderHandbook_HCI, Page 13 *Misc	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
(or another provider) determines that receiving the services separately would subject the member to unnecessary risk – Poor quality of care – Lack of access, or lack of access to providers experienced with dealing with the members specific needs • Without cause at the following times: – During the 90 days following the date of the member's initial enrollment – At least once every 12 months thereafter – Upon automatic re-enrollment if temporary loss of eligibility has caused the member to miss the annual disenrollment opportunity – When the Department has imposed sanctions on the RAE (consistent with 42 CFR 438.702(a)(4) *42 CFR 438.56(c)-(d)(2)* Contract: Exhibit B-8—6.10	**Description of Process:** HCI follows CAC 370_Enrollment and Disenrollment of Medicaid Members_HCI policy which outlines the reasons that a member may request disenrollment for cause at any time or without cause at specified times. The policy outlines when a member may request disenrollment with cause at any time: • The member has moved out of the Contractor's service area (page 3) • The Contractor does not (due to moral or religious objections) cover the service the member seeks (page 3) • The member needs related services to be performed at the same time, not all related services are available from the Contractor's plan, and the member's primary care provider (or another provider) determines that receiving the services separately would subject the member to unnecessary risk (page 3) • Poor quality of care (page 3) • Lack of access, or lack of access to providers experienced with dealing with the members specific needs (page 3) The policy covers the times members can request disenrollment without cause: • During the 90 days following the date of the member's initial enrollment (page 4) • At least once every 12 months thereafter (page 4) • Upon automatic re-enrollment if temporary loss of eligibility has caused the member to miss the annual disenrollment opportunity (page 4) • When the Department has imposed sanctions on the RAE (consistent with 42 CFR 438.702(a)(4)) (page 4)	

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Please see CAC 370_Enrollment and Disenrollment of Medicaid Members_HCI. HCI developed a resource sheet for members to know of their right to disenroll from HCI with cause at any time and without cause at any time. This resource sheet is located on our website under Member Rights and Responsibilities. See https://www.healthcoloradorae.com/members/rights-responsibilities/. HCI provided this resource sheet to care coordinators, call center associates, quality committee, and member advocates during regularly scheduled meetings. Disenrollment Rights_HCI, Care Coordination Presentation_HCI, Call Center Minutes_December 2022_HCI, Quality Committee Presentation_HCI, and Member Services Presentation_HCI. HCI has information about member's right to disenroll in HCI's provider handbooks. See BH_MedicaidProviderHandbook_HCI and PCP_MedicaidProviderHandbook_HCI.	

Results for Standard XII—Enrollment and Disenrollment							
Total	Met	=	5	X	1.00	=	5
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	5	**Total Score**		=	5
				Total Score ÷ Total Applicable		=	100%

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2022–2023 External Quality Review
Denials Record Review
for
Health Colorado, Inc. RAE 4

Review Period:	January 1, 2022–December 31, 2022
Date of Review:	April 20, 2023
Reviewer:	Sarah Lambie, MA, CPHQ
Participating MCE Staff Member(s):	Tiffany Jenkins

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Member ID #	*****	****	****	****	****	****	****	****	****	****					
Date of Initial Request [XX/XX/XXXX]	3/15/2022	4/5/2022	6/7/2022	7/5/2022	7/29/2022	8/17/2022	9/28/2022	10/10/2022	11/6/2022	12/12/2022					
Type of Denial: Termination (T), New Request (NR), Claim (CL)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR					
Type of Request: Standard (S), Expedited (E), Retrospective (R), SUD Inpatient/Residential (SUD), or SUD Inpatient/Residential Special Connections (SUD SC)	E	SUD	S	SUD	SUD	S	SUD	S	SUD	SUD					
Date of Decision for Adverse Benefit Determination [XX/XX/XXXX]	3/15/2022	4/8/2022	6/10/2022	7/6/2022	8/1/2022	8/17/2022	9/28/2022	10/18/2022	11/6/2022	12/12/2022					
Date Notice of Adverse Benefit Determination (NABD) Sent [XX/XX/XXXX]	3/17/2022	4/8/2022	6/13/2022	7/7/2022	8/2/2022	8/18/2022	9/30/2022	10/20/2022	11/10/2022	12/15/2022					
Notice Sent to Provider and Member? [I.11]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Number of Hours or Days for Decision (H/D)	0 D	3 D	3 D	1 D	3 D	0 D	0 D	8 D	0 D	0 D					
Number of Hours or Days for Notice (H/D)	2 D	3 D	6 D	2 D	4 D	1 D	2 D	10 D	4 D	3 D					
Adverse Benefit Determination Decision Made Within Required Time Frame? [I.12] Standard: 10 calendar days Expedited: 72 hours SUD: 72 hours (calendar) or 24 hours (calendar) for special connections	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Notice Sent Within Required Time Frame? [I.17] Standard: 10 calendar days Expedited: 72 hours SUD: 72 hours (calendar) or 24 hours (calendar) for special connections Termination: 10 calendar days before the date of action	Met	Met	Met	Met	Met	Met	Met	Met	Not Met	Met					
Was Authorization Decision Timeline Extended? Yes or No	No	No	No	No	No	No	No	No	No	No					
If Extended, Extension Notification Sent to Member? [I.19]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA					
If Extended, Extension Notification Includes Required Content? [I.19]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA					
NABD Includes Required Content [I.15-16]	Not Met	Not Met	Not Met	Not Met	Not Met	Met	Met	Met	Met	Met					
Authorization Decision Made by Qualified Clinician? [I.10]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
If Denied for Lack of Information, Was the Requesting Provider Contacted for Additional Information or Consulted (if applicable)? [I.8]	Met	Met	Met	Met	NA	NA	NA	NA	NA	NA					
Was the Decision Based on Established Authorization Criteria (i.e., not arbitrary)? [I.2]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Was Correspondence With the Member Easy to Understand? [I.14]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					

Scoring	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Applicable Elements	8	8	8	8	7	7	7	7	7	7					
Compliant (Met) Elements	7	7	7	7	6	7	7	7	6	7					
Percent Compliant	88%	88%	88%	88%	86%	100%	100%	100%	86%	100%					
Overall Total Applicable Elements	**74**														
Overall Total Compliant Elements	**68**														
Overall Total Percent Compliant	**92%**														

Comments:
Files 1–5 included incorrect time frames for State fair hearings.
File 9 included an untimely member notification.

Yes and No = not scored—for informational purposes only
**** = Redacted Member ID

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2022–2023 External Quality Review
Grievances Record Review
for
Health Colorado, Inc. RAE 4

Review Period:	January 1, 2022–December 31, 2022
Date of Review:	April 26–27, 2023
Reviewer:	Crystal Brown, CCMA
Participating MCE Staff Member(s):	Dawn Surface and Lynne Fabian

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Member ID #	****	****	****	****	****	****	****	****	****	****					
Date Grievance Received [XX/XX/XXXX]	4/25/2022	4/28/2022	7/22/2022	8/15/2022	8/23/2022	9/7/2022	9/15/2022	9/22/2022	10/6/2022	12/2/2022					
Date of Acknowledgement Letter [XX/XX/XXXX]	4/25/2022	4/29/2022	7/22/2022	8/15/2022	8/24/2022	9/7/2022	9/15/2022	9/23/2022	10/6/2022	12/5/2022					
Days From Grievance Received to Acknowledgement	0	1	0	0	1	0	0	1	0	1					
Acknowledgement Letter Sent in 2 Working Days [VI.11]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Date of Written Notice [XX/XX/XXXX]	4/27/2022	4/29/2022	8/4/2022	8/15/2022	9/1/2022	9/27/2022	10/11/2022	10/11/2022	10/26/2022	12/5/2022					
# of Days to Notice	2	1	9	0	7	14	20	12	14	1					
Resolved and Notice Sent in Time Frame* [VI.12,24] Standard: 15 working days Extension: 15 working days + 14 calendar days	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Decision-Maker Not Involved in Grievance [VI.7]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Appropriate Level of Expertise (If Clinical) [VI.7]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA					
Resolution Letter Includes Required Content [VI.13]**	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Resolution Letter Easy to Understand [VI.12]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Scoring	**File 1**	**File 2**	**File 3**	**File 4**	**File 5**	**File 6**	**File 7**	**File 8**	**File 9**	**File 10**	**File OS1**	**File OS2**	**File OS3**	**File OS4**	**File OS5**
Applicable Elements	5	5	5	5	5	5	5	5	5	5					
Compliant (Met) Elements	5	5	5	5	5	5	5	5	5	5					
Percent Compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%					
Overall Total Applicable Elements	**50**														
Overall Total Compliant Elements	**50**														
Overall Total Percent Compliant	**100%**														

Comments:

* Grievance timeline for resolution and notice sent is 15 working days (unless extended, then up to 14 calendar days).

**Grievance resolution letter required content includes (1) results of the disposition/resolution process and (2) the date the disposition/resolution process was completed.

**** = Redacted Member ID

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2022–2023 External Quality Review
Appeals Record Review
for
Health Colorado, Inc. RAE 4

Review Period:	January 1, 2022–December 31, 2022
Date of Review:	April 26–27, 2023
Reviewer:	Crystal Brown, CCMA
Participating MCE Staff Member(s):	Dawn Surface and Lynne Fabian

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Member ID #	****	****	****	****	****	****	****	****	****	****					
Date Appeal Received [XX/XX/XXXX]	4/14/2022	5/19/2022	6/3/2022	8/8/2022	9/8/2022	9/19/2022	9/30/2022	10/10/2022	12/5/2022	12/21/2022					
Date of Acknowledgement [XX/XX/XXXX]	4/14/2022	5/19/2022					9/30/2022	10/10/2022	12/5/2022	12/21/2022					
Days From Appeal Received to Acknowledgement	0	0					0	0	0	0					
Acknowledgement Sent Within 2 Working Days? [VI.17]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Decision-Maker Not Previous Level [VI.7]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Decision-Maker—Clinical Expertise [VI.7]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Expedited Appeal: Yes or No	No	No	No	No	No	Yes	No	No	No	No					
Time Frame Extended: Yes or No	No	No	No	No	No	No	No	No	No	No					
Date Resolution Notice Sent [XX/XX/XXXX]	4/20/2022	5/23/2022	6/6/2022	8/9/2022	9/9/2022	9/22/2022	10/6/2022	10/17/2022	12/6/2022	12/29/2022					
Hours or Days From Appeal Filed to Resolution Notice Sent	4 D	2 D	1 D	1 D	1 D	3 D	3 D	5 D	1 D	5 D					
Notice Sent Within Time Frame*? [VI.22-25] Standard Resolution: 10 working days Expedited Resolution: 72 hours Time Frame Extended: +14 calendar days	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Resolution Letter Includes Required Content [VI.26]**	Not Met	Not Met	Met	Met	Met	Met	Met	Met	Met	Met					
Resolution Letter Easy to Understand [VI.22]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					

Scoring	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Applicable Elements	6	6	6	6	6	6	6	6	6	6					
Compliant (Met) Elements	5	5	6	6	6	6	6	6	6	6					
Percent Compliant	83%	83%	100%	100%	100%	100%	100%	100%	100%	100%					
Overall Total Applicable Elements	**60**														
Overall Total Compliant Elements	**58**														
Overall Total Percent Compliant	**97%**														

Comments:
Files 1 and 2: Appeal letter stated the member had a minimum time frame for submitting the request for a State fair hearing (no earlier than 90 days and no later than 120 days).

***Appeal resolution letter time frame** does not exceed 10 working days from the day the MCE receives the appeal (unless expedited—72 hours; or unless extended—+14 calendar days).

****Appeal resolution letter required content** includes (1) the result of the resolution process; (2) the date the resolution was completed; (3) if the appeal is not resolved wholly in favor of the member, the right to request a State fair hearing and how to do so; (4) if the appeal is not resolved wholly in favor of the member, the right to request that benefits/services continue while the hearing is pending, and how to make that request (does not apply to CHP+).

**** = Redacted Member ID

Appendix C. Compliance Review Participants

Table C-1 lists the participants in the FY 2022–2023 compliance review of **HCI**.

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

HSAG Review Team	Title
Sarah Lambie	Senior Project Manager
Crystal Brown	Project Manager I
HCI Participants	**Title**
Lora Roberts	Chief Executive Officer and Program Officer—Health Colorado Inc. (HCI)
Sarah Nelson	Director of Operations—HCI
Lynne Fabian	Manager, Health Care Promotion Outreach Specialist
Dawn Surface	Community Outreach Manager
Jeremy White	Clinical Quality Program Manager
Dr. Steve Coen	Director I, Behavioral Health Services
Tiffany Jenkins	Manager, Behavioral Health Services
Karen Talone	Manager I, Network Relations
Alma Mejorado	Director, Network Support
Ron Botten	Director, Information Technology Business Relationship Management
Alicia Williams	Chief Operating Officer/Director, Operations
John Mahalik	Director, Quality Management
Saren Miell	Quality Improvement Analyst, Health Solutions
Kristi Roe	Advocacy Director, Southeast Health Group
Laqueda Bell	Director, Behavioral Health Services
Beth Hodges	Regional Quality Director
Tasha Hughes	Medical Management Specialist II
Courtney Hernandez	Senior Behavioral Health Clinical Quality Audit Analyst
Department Observers	**Title**
Russ Kennedy	Quality Program Manager
Helen Desta	Quality Section Manager
Brooke Powers	Accountable Care Program Specialist
Emily Kelley	Quality Performance Specialist
Sheila Gamueda	Quality Care Specialist

Appendix D. Corrective Action Plan Template for FY 2022–2023

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—Corrective Action Plan Process

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

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

The CAP template follows on the next page.

Table D-2—FY 2022–2023 Corrective Action Plan for HCI

Standard I—Coverage and Authorization of Services
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
16. The Contractor mails the notice of adverse benefit determination within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, as defined in 42 CFR 431.211, 431.213 and 431.214 (see below). • For denial of payment, at the time of any denial affecting the claim. • For standard service authorization decisions that deny or limit services, within 10 calendar days following the receipt of the request for service. • For expedited service authorization decisions, within 72 hours after receipt of the request for service. • For extended service authorization decisions, no later than the date the extension expires. • For service authorization decisions not reached within the required time frames, on the date the time frames expire. *42 CFR 438.404(c)* *42 CFR 438.210(d)* Contract: Exhibit B-8—8.6.3.1, 8.6.5–8.6.8 10 CCR 2505-10 8.209.4.A.3
Findings
One NABD was sent to the member a day late. Additionally, the Medical Necessity Determination Timelines policy often referred to timelines for URAC standards, which sometimes conflicted with Colorado regulations. In some instances, the time frames for notification were stated to be based on the date of receipt of additional information from the provider or after the decision was made, rather than the date of the request.
Required Actions
HCI must enhance its procedures and monitoring to ensure that all member notices are sent within time frame requirements. HCI must update its Medical Necessity Determination Timelines policy and any supporting documentation to clarify that the notification time frame is based on the date of the service request until the deadline.
Planned Interventions:

Standard I—Coverage and Authorization of Services
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard II—Adequate Capacity and Availability of Services
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
8. The Contractor must meet, and require its providers to meet, the State standards for timely access to care and services, taking into account the urgency of the need for services. The Contractor ensures that services are available as follows: • Emergency BH care: – By phone within 15 minutes of the initial contact. – In-person within 1 hour of contact in urban and suburban areas. – In-person within 2 hours of contact in rural and frontier areas. • Urgent care within 24 hours from the initial identification of need. • Non-urgent symptomatic care visit within 7 days after member request. • Well-care visit within 1 month after member request. • Outpatient follow-up appointments within 7 days after discharge from hospitalization. • Members may not be placed on waiting lists for initial routine BH services. *42 CFR 438.206(c)(1)(i)* Contract: Exhibit B-8—9.4.13, 9.4.13.1-4, 9.4.13.5.1-2
Findings
The PCP Practitioner Agreement included two incorrect time frames: urgent care was listed as 48 hours instead of 24 hours, and well visits were listed as 45 days instead of one month.
Required Actions
HCI must correct the timely appointment standards in the PCP Practitioner Agreement.
Planned Interventions:

Standard II—Adequate Capacity and Availability of Services
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard II—Adequate Capacity and Availability of Services
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
12. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. This includes: • Making written materials that are critical to obtaining services available in prevalent non-English languages. • Providing cultural and disability competency training programs, as needed, to network providers and health plan staff regarding: – Health care attitudes, values, customs and beliefs that affect access to and benefit from health care services. – Medical risks associated with the member population's racial, ethnic, and socioeconomic conditions. • Identifying members whose cultural norms and practices may affect their access to health care. These efforts shall include, but are not limited to, inquiries conducted by the Contractor of the language proficiency of individual members. • Providing language assistance services for all Contractor interactions with members. *42 CFR 438.206(c)(2)* Contract: Exhibit B-8—7.2.1–7.2.6
Findings
HCI's documentation regarding this requirement consisted of multiple trainings, reports regarding language line access from 2021 (compiled in 2022), and a view of Colorado's demographic and race statistics. However, during the interview, staff members were unable to describe current efforts to identify members whose cultural norms and practices may affect their access to healthcare. Any related initiatives referenced seemed to be new, implemented after the review period (CY 2022), or had not yet started but were in discussion.
Required Actions
HCI must develop a way to identify its Region 4 membership and gain an understanding of the membership's cultural norms and practices and how they may affect access to healthcare. HSAG suggests a review of current data, utilization trends, cultural subgroups, and community partners as sources of information to explore. HCI has an opportunity to come into compliance through upcoming work that will be part of the Health Equity Plan.

Standard II—Adequate Capacity and Availability of Services
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
16. The member may file an appeal either orally or in writing, and the Contractor must treat oral appeals in the same manner as appeals received in writing. The Contractor may not require that oral requests for an appeal be followed with a written request. *42 CFR 438.402(c)(3)(ii)* *42 CFR 438.406 (b)(3)* Contract: Exhibit B-8—8.7.6 10 CCR 2505-10 8.209.4.F
Findings
HCI accepts appeals orally or in writing. However, some documentation stated that a verbal appeal request should be followed by a written request, or the coordinator should reach out to the member to obtain a signed appeal. The following documentation was inaccurate: • Appeal Job Aid • Appeal Guide • 305L Appeal Policy • Appeal Form
Required Actions
HCI must update the following documents to remove language that the member must follow a verbal appeal request with a written request. Additionally, HCI must share updated documentation with other staff members to ensure awareness of the updated requirement. • Appeal Job Aid, page 2, stated the "appeal must be signed by the member." • Appeal Guide, page 4, in the section "What is the Difference between a Quick Appeal and Standard Appeal?" point 2 stated that "You do need to follow up a verbal standard appeal request in writing," which is incorrect. • 305L Appeal Policy, page 12, section J.2, inaccurately stated that the coordinator or specialist must attempt to get a signed appeal request from the member.

Standard VI—Grievance and Appeal Systems
• Appeal Form, which can be found online, inaccurately stated at the bottom of the page, "Please know that we cannot process this appeal until you sign and return this letter. We have provided a self-addressed stamped envelope."
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
25. If the Contractor extends the time frames for a grievance or appeal, it must—for any extension not requested by the member: • Make reasonable efforts to give the member prompt oral notice of the delay. • Within two calendar days, give the member written notice of the reason for the delay and inform the member of the right to file a grievance if the member disagrees with that decision. • Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires (14 days following the expiration of the original grievance or appeal resolution time frame). *42 CFR 438.408(c)(2)* Contract: Exhibit B-8—8.5.7, 8.7.14.1, 8.7.14.2.1, 8.7.14.2.5-6 10 CCR 2505-10 8.209.4.L, 8.209.4.K, 8.209.4.A. 3.C(ii), 8.209.5.E
Findings
Extensions can be granted for up to 14 calendar days if they are in the member's best interest, and Beacon must make reasonable efforts to notify the member verbally of the delay. However, one out of 10 grievance sample records involved an extension. This grievance record did not include evidence of an oral outreach to the member documented in the system notes; therefore, Beacon could not provide evidence that outreach was conducted. Additionally, the 305L Appeals Policy on page 12, section J.4, did not state that the coordinator will make reasonable attempt to contact the member to notify the member of the delay when an extension is used.
Required Actions
HCI must make reasonable efforts to notify the member of an extension and must enhance documentation of such attempted communications between the member and staff member. HCI must update the Appeals Policy to include that the coordinator will make reasonable efforts to notify the member of an extension.
Planned Interventions:
Person(s)/Committee(s) Responsible:

Standard VI—Grievance and Appeal Systems
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

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*, October 2019.

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, record review tools, report templates, agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all reviewers to ensure consistency in scoring across MCEs.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided MCEs with proposed review dates, group technical assistance, and training, as needed. • HSAG confirmed a primary MCE contact person for the review and assigned HSAG reviewers to participate in the review. • Sixty days prior to the scheduled date of the review, HSAG notified the MCE in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and review agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and the review activities. Thirty days prior to the review, the MCE provided documentation for the desk review, as requested. • Documents submitted for the review consisted of the completed desk review form, the compliance monitoring tool with the MCE's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. • The MCEs also submitted lists denials, grievances, and appeals that occurred between January 1, 2022, and December 31, 2022 (to the extent available at the time of the review). MCEs submitted the lists to HSAG 10 days following receipt of the desk review request. HSAG used a random sampling technique to select records for the review. HSAG notified the MCE five days following receipt of the lists of records regarding the sample records selected.

For this step,	HSAG completed the following activities:
	• 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.
Activity 3:	**Conduct the Review**
	• During the review, HSAG met with groups of the MCE's key staff members to obtain a complete picture of the MCE's compliance with federal healthcare regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the MCE's performance. • HSAG requested, collected, and reviewed additional documents as needed. • At the close of the review, HSAG provided MCE staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2022–2023 Department-approved Compliance Review Report template to compile the findings and incorporate information from the pre-review and review activities. • HSAG analyzed the findings and calculated final scores based on Department-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the Department**
	• HSAG populated the Department-approved report template. • HSAG submitted the draft Compliance Review Report to the MCE and the Department for review and comment. • HSAG incorporated the MCE and Department comments, as applicable, and finalized the report. • HSAG included a pre-populated CAP template in the final report for all elements determined to be out of compliance with managed care regulations. • HSAG distributed the final report to the MCE and the Department.