COLORADO

Department of Health Care Policy & Financing

Fiscal Year 2023–2024 Compliance Review Report

for

Colorado Access

Region 5

March 2024

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Summary of Results

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

Colorado Access (COA) showed a moderate understanding of federal regulations. COA demonstrated a comprehensive quality assessment and performance improvement program; however, for two standards reviewed, COA's scoring decreased when compared with the prior review.

Table 1-1 presents the scores for COA RAE 5 for each of the standards. Findings for all requirements are summarized in the Assessment and Findings section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* follow in Appendix A—Compliance Monitoring Tool.

Table 1-1—Summary of Scores for Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
V. Member Information Requirements	18	18	17	1	0	0	94%~
VII. Provider Selection and Program Integrity	16	16	15	1	0	0	94%∨
IX. Subcontractual Relationships and Delegation	4	4	1	3	0	0	25%∨
X. Quality Assessment and Performance Improvement (QAPI)**	16	16	16	0	0	0	100%~
Totals	**54**	**54**	**49**	**5**	**0**	**0**	**91%**

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

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

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

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

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

Standard V—Member Information Requirements

Evidence of Compliance and Strengths

HSAG reviewed a variety of COA's policies pertaining to effective communication, accessibility, and cultural sensitivity that outlined the steps COA takes to ensure effective communication with members. These steps include, but are not limited to, testing readability, keeping the message simple, and understanding the audience. COA had a Member Advisory Council (MAC) in place to provide user experience insights. The MAC is a group of members, family members, and caregivers facilitated by COA that reviews (i.e., member tests) and provides input on all member-facing materials prior to dissemination. COA provided MAC meeting minutes from May 2023 that detailed an ongoing review process for such materials.

COA submitted a Member Materials policy that outlined the procedures and standards for ensuring that the information in the member materials is effectively communicated. HSAG found that the member materials provided for review were easily understood and compliant with Section 508 guidelines. Staff members discussed the accessibility widget tool that enabled COA to internally ensure accessibility and readability of member information on its website. The Culturally Sensitive Services for Diverse Populations policy described health literacy techniques that staff members must follow.

COA submitted an *Effective Communication with Limited English Proficiency (LEP) and Sensory Impaired/Speech Impaired (SI-SI) Persons* policy that stated the availability of language interpretation/translation, including American Sign Language (ASL), and/or auxiliary aids and services provided at no cost to members.

HSAG noted that COA had processes to ensure that specific documents available electronically on the COA website are machine readable and comply with Section 508 guidelines, Section 504 of the Rehabilitation Act, and the World Wide Web Consortium (W3C) Web Content Accessibility Guidelines. During the interview, staff members responsible for these processes stated that COA had contracted with an outside resource to ensure that its website remained compliant as information was added and updated. HSAG reviewed several webpages for compliance with Section 508 guidelines using the WAVE evaluation tool and assessed compliance.

COA's maintained an electronic provider directory that enabled members to search and select providers using different criteria such as the provider's name and group affiliation, street address(es), telephone number(s), specialty, and whether the provider will accept new members. The provider directory also included the cultural and linguistic capabilities offered by the provider or provider's office as well as the Americans with Disabilities Act (ADA) accessibility options at the provider's office.

Opportunities for Improvement and Recommendations

HSAG reviewed COA's provider directory on its website and identified the following statement at the top of the page: *If you need this document in another language, large print or on tape, please call Customer Service at 1-800-511-5010 (toll free). TTY/TDD users call 1-888-803-4494*. During the interview, HSAG asked if the statement referred to a cassette tape and if COA offers translation, interpretation, or records member information on cassette tapes as an auxiliary aid to members. COA stated that it does not offer information on cassette tape. HSAG recommends that COA update this statement on the website and in any other member materials where applicable to indicate available media.

Required Actions

COA's electronic provider directory did not include the provider website URLs as required. COA must update its provider directory to include the provider URLs.

Standard VII—Provider Selection and Program Integrity

Evidence of Compliance and Strengths

Regarding provider retention, COA described a claims report that provided information for the practice facilitators and practice support staff members how to identify providers who had not submitted claims in a year or had submitted a lower volume of claims in the past year. COA staff members described that providers are targeted for outreach, with a focus on specialty providers. Additionally, staff members described heat map reports to identify where providers are located in relation to members. COA also hosted quarterly forums and professional networking opportunities as part of its efforts to maintain its provider network. Staff members described the Language First Effort initiative which pays providers who speak languages other than English an additional 10 percent.

COA submitted detailed documentation regarding credentialing and recredentialing procedures in alignment with the National Committee for Quality Assurance. The Contracting department staff members stated that COA rarely declines a provider's application to join the network and that there are three systems used to track contract execution: DocuSign, Salesforce, and Formstack.

The Sanction and Exclusion Screening policy and Ongoing Monitoring of Providers policy described in detail the processes for monitoring exclusion lists. Staff members shared that any providers with hits in Department of Regulatory Agencies, List of Excluded Individuals/Entities, System for Award Management, or the Streamline Verify exclusion software system are typically retrospective hits for providers who have already been terminated, and if an active provider was identified, the provider would be subject to immediate termination for cause.

COA communicated methods of reporting fraud, waste, or abuse to providers through the provider agreement and provider manual, and to staff members through onboarding and annual trainings. COA monitored the efficacy of communication mechanisms by surveying staff members' comfort levels regarding self-reporting, which was found to have improved 3 percent since the previous year.

COA maintained a clear reporting structure from the Core Policy team and Provider Performance Committee up through the Executive Compliance Committee to the Finance, Audit, and Compliance Committee (FACC), and ultimately to the Board of Directors. To gather meaningful data about trends and risks, COA used the EthicsPoint system to track any incidents as well as track and trend issues and questions that it received from members, staff members, and providers. Staff members also described the employee newsletter, which features a "Compliance Corner" article regarding identified trends and risks as well as regular reminders related to program integrity.

COA staff members described the process for regularly monitoring service verification feedback from members, and detailed common findings. HSAG recognized that the timeliness of available data regarding member service verification and summary of trends is a best practice.

Opportunities for Improvement and Recommendations

HSAG recommends that COA expand its Selection and Retention of Providers policy to include the additional details regarding provider retention monitoring efforts that were described during the interview, as well as any provider training and professional networking opportunities.

HSAG encourages COA to further detail expectations regarding prompt reporting timelines in its employee training and related policies. Additionally, HSAG recommends that COA document compliance training expectations for its management level staff members and its compliance officer.

While COA's provider agreement clearly stated that members are not held liable for the provider's debts, services, or payments, as outlined in 42 CFR 438.106, COA has an opportunity to further clarify in the Compliance Operations Manual that the member is not held liable for:

- COA's debts in the event of the contractor's insolvency.
- Covered services provided to the member for which the State does not pay COA.
- Covered services provided to the member for which the State or COA does not pay the health care provider that furnishes the services under a contractual, referral, or other arrangement.
- Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if COA provided the services directly.

Required Actions

COA's policies and procedures stated that COA would not knowingly employ any staff members who are excluded from participation in federal health care programs. However, the policies and procedures

did not state that COA would not knowingly employ any staff members who are *debarred* or *suspended*. COA must update its policies and procedures to align in full detail with the federal and State requirements.

Standard IX—Subcontractual Relationships and Delegation

Evidence of Compliance and Strengths

COA has written delegation agreements for the following services: credentialing, printing, and pharmacy benefit management. HSAG reviewed a sample of the delegation agreements to determine their compliance with federal requirements. The written agreements included language that required the subcontractor to comply with all applicable laws, regulations, and applicable subregulatory guidance and contract provisions.

COA's Delegation policy included a process that required the compliance officer or applicable business representative to conduct an evaluation of a potential subcontractor's ability to perform the functions of the agreement and comply with regulatory requirements. During the interview, a COA staff member discussed the process as it related to a credentialing agreement and submitted evidence of a completed pre-delegation audit.

Opportunities for Improvement and Recommendations

HSAG identified no opportunities for improvement for this standard.

Required Actions

HSAG reviewed a sample of the delegation agreements submitted by COA and found that the RAE did not maintain ultimate responsibility for subcontractor agreements. Staff members were unaware of contract status and were unable to communicate a current process that addresses corrective action plans (CAPs) in relation to subcontractor performance. COA must maintain ultimate responsibility of subcontractor agreements by ensuring centralized oversight (i.e., by the legal department) of all agreements and ensure that a process is outlined (e.g., a desktop procedure or policy) that addresses CAPs in relation to subcontractor performance.

COA's contract with OneTouchPoint Mountain States, LLC, did not include the delegated activities or obligations and related reporting responsibilities. During the interview, a COA staff member confirmed that the language was missing. COA must ensure that all contracts, including the one with OneTouchPoint Mountain States, LLC, specify the delegated activities or obligations and related reporting responsibilities.

HSAG reviewed a sample of contracts across the delegated activities and found the written agreements did not include all of the required language. COA must ensure, via revisions or amendments, that subcontractor agreements include the following language:

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

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

Evidence of Compliance and Strengths

HSAG reviewed COA's annual Quality Assessment and Performance Improvement (QAPI) documents, including its QAPI Program Description, the Annual Quality Report, and the Annual Quality Improvement Plan. Within its QAPI Program Description and Annual Quality Report, COA described a comprehensive program that included processes to address appropriateness of care, quality of care, and member experience. Quality and appropriateness of care for members with special healthcare needs was addressed through various care management initiatives and included the identification of treatment barriers and the supports needed to improve member health.

During the compliance interview, the quality director further described a thorough and comprehensive QAPI program that has evolved and grown over time to meet the changing needs of COA members and the health quality landscape of COA's service region in Colorado. The director described mechanisms used to address member over- and underutilization of services, which were delineated within COA's policies. Within its policies, COA described processes to monitor, assess, and intervene to reduce over- and underutilization of medically necessary services and ensure appropriate levels of care. Among the methods, COA monitored utilization through implementation of the Colorado Client Overutilization Program (COUP) to address members with high utilization of emergency department visits or prescription drug benefits. Other strategies included ongoing review of utilization criteria, identifying impatient utilization trends, assuring timely utilization management decisions, and a process that assessed the interrater reliability of decision-makers.

Grievance data, member survey results, secret shopper calls, and population-based data analyses were used by COA to evaluate access to care and identify areas of need.

COA adopted and disseminated clinical practice guidelines which were reviewed annually and included a process for soliciting feedback from contracted providers. The guidelines were posted to the COA website and were accessible to providers as well as members. COA established processes to communicate changes to the guidelines with internal teams to ensure consistency among various operational departments.

COA submitted a COA System Architecture diagram and a summary of the systems utilized by COA to manage health information data that included the following:

- HealthEdge HealthRules Payer: Payer transaction system to manage member enrollment and eligibility data as well as claims reimbursement and payments.
- HealthEdge GuidingCare: System that includes utilization and care management, claims appeals, and grievances.
- HealthProof ePlus: System for customer service call documentation.

COA staff members reported that health information data were collected and managed through multiple systems and configured through COA's enterprise data warehouse, which allowed COA to integrate and submit the necessary data to the Department in the required standardized 837 file format. COA described how claims, encounter, utilization, grievance, appeal, and other data were available for extraction from the data warehouse to complete analyses and reporting, calculate performance, and identify cost and care trends for use across the organization.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Required Actions

HSAG identified no required actions for this standard.

3. Background and Overview

Background

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

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

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

Overview of FY 2023–2024 Compliance Monitoring Activities

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

Compliance Monitoring Review Methodology

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

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

Objective of the Compliance Review

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

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

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

FY 2022–2023 Corrective Action Methodology

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

Summary of FY 2022–2023 Required Actions

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

Related to Standard I—Coverage and Authorization of Services, COA was required to complete the following required actions:

- Update its procedures to further delineate provider claims issues which are separate from member-related issues in which a service is denied or partially denied. Policies, procedures, and monitoring must be enhanced to ensure that the member is notified in writing of the denial or partial denial of a service.
- Enhance its monitoring procedures to ensure that all authorization decisions are made within required time frames.
- Improve its Notice of Adverse Benefit Determination (NABD) template and monitoring procedures to ensure clinical language, including abbreviations, are clearly defined and explained in plain language (e.g., partial hospitalization program [PHP], a part-time treatment for addiction where members do not live on-site but may visit several times a week).

Related to Standard II—Adequate Capacity and Availability of Services, HSAG identified no required actions.

Related to Standard VI—Grievance and Appeal Systems, COA was required to complete one required action:

- Remove the inaccurate statement in its Member Appeal Process policy that states that a member must follow an oral request for an appeal in writing.

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

Summary of Corrective Action/Document Review

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

Summary of Continued Required Actions

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

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE provides all required member information to members in a manner and format that may be easily understood and is readily accessible by members. • The RAE ensures that all member materials (for large-scale member communications) have been member tested. *Note: Readily accessible means electronic information which complies with Section 508 guidelines, Section 504 of the Rehabilitation Act, and World Wide Web Consortium Web Content Accessibility Guidelines 2.0 Level AA and successor versions.* *42 CFR 438.10(c)(1)* RAE Contract: Exhibit B-8—7.2.5 and 7.2.7.9	• ADM206 Culturally Sensitive Services for Diverse Populations o Procedure 2.A-B • ADM207 Effective Communication with LEP and SI-SI Persons o Definitions-Plain Language • ADM208 Member Materials o Procedure 3 • MKT DP03 Accessibility Standards - 508/ADA Compliance • MAC Minutes 5-16-23 o Pg 4 Member Materials	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The RAE has in place a mechanism to help members understand the requirements and benefits of the plan. *42 CFR 438.10(c)(7)* RAE Contract: Exhibit B-8—7.3.8.1	• See COA website content and link to o HCPF Member Handbook: https://www.coaccess.com/members/care/ • RAE New Member Booklet	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. For consistency in the information provided to members, the RAE uses the following as developed by the State, when applicable and when available: • Definitions for managed care terminology, including: appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health	• PD Ops DP03 Monitoring Terminology in Contracts	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, participating provider, physician services, plan, preauthorization, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. • Model member handbooks and member notices. *42 CFR 438.10(c)(4)* RAE Contract: Exhibit B-8—3.6		
4. The RAE makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • Written materials that are critical to obtaining services include, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices. • All written materials for members must: – Use easily understood language and format. – Use a font size no smaller than 12-point. – Be available in alternative formats and through provision of auxiliary aids and service that take into consideration the special needs of members with disabilities or limited English proficiency. – Include taglines in large print (conspicuously-visible font size) and prevalent non-English languages	• ADM206 Culturally Sensitive Services for Diverse Populations o Procedure 2 A-B • ADM207 Effective Communication with LEP and SI-SI o Policy Section • ADM208 Member Materials o Definitions-Tagline o Policy 1-3 o Procedure 3 • MKT201 Printed Marketing/Informational and Corporate Branding Material o Procedure 2 A-D	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDD customer service numbers and availability of materials in alternative formats. – Be member tested. *42 CFR 438.10(d)(2-3) and (d)(6)* RAE Contract: Exhibit B-8—7.2.7.3-9 and 7.3.13.3		
5. *If the RAE makes information available electronically:* Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of "readily accessible" above). • The information is placed in a website location that is prominent and readily accessible. • The information can be electronically retained and printed. • The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge upon request and is provided within five business days. • Provide a link to the Department's website on the RAE's website for standardized information such as member rights and handbooks. *42 CFR 438.10(c)(6)* RAE Contract: Exhibit B-8—7.3.9.2 and 7.3.14.1	• MKT203 Website Design Maintenance and Oversight • MKT DP03 Accessibility Standards 508/ADA Compliance • COA Website: https://www.coaccess.com/ o Accessibility Widget in lower left corner of screen o See "For our Members" on the homepage	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The RAE makes available to members in electronic or paper form information about its formulary: • Which medications are covered (both generic and name brand). • What tier each medication is on. • Formulary drug list must be available on the RAE's website in a machine-readable file and format. *42 CFR 438.10(h)(4)(i)* RAE Contract: Exhibit B-8—None	○ See COA website for link (https://www.coaccess.com/members/care/) section on Physical Health: ▪ Prescription Drug Benefit Information	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The RAE makes interpretation services (for all non-English languages) and use of auxiliary aids such as TTY/TDD and American Sign Language available free of charge, notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and informs about how to access those services. *42 CFR 438.10 (d)(4) and (d)(5)* RAE Contract: Exhibit B-8—7.2.6.2-4	• ADM207 Effective Communication with LEP and SI-SI Persons ○ Policy Section • ADM208 Member Materials • CS DP28 Nextalk for TTY_TTD • CS DP29 Interpreting Services • COA Website: https://www.coaccess.com/members/services/	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The RAE ensures that: • Language assistance is provided at all points of contact, in a timely manner and during all hours of operation. • Customer service telephone functions easily access interpreter or bilingual services. RAE Contract: Exhibit B-8—7.2.6.1 and 7.2.6.4	• ADM207 Effective Communication with LEP and SI-SI Persons • CS DP29 Interpreting Services • Provider Manual o Section 2, pg. 2-1 Effective Communication and Language Assistance • See COA website and language options at top of page: www.coaccess.com	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The RAE provides each member with a member handbook within a reasonable time after receiving notification of the member's enrollment. *42 CFR 438.10(g)(1)* RAE Contract: Exhibit B-8—7.3.8.1	• RAE New Member Booklet • New Member Mailing BRD	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The RAE gives members written notice of any significant change (as defined by the State) in the information required at 438.10(g) at least 30 days before the intended effective date of the change. *42 CFR 438.10(g)(4)* RAE Contract: Exhibit B-8—7.3.8.2.2	• ADM328 Significant Changes in Members Rights, Benefits or Processes	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. For any RAE member handbook or supplement to the member handbook provided to members, the RAE ensures that information is consistent with federal requirements in 42 CFR 438.10(g). • The RAE ensures that its member handbook or supplement includes a link to the online Health First Colorado member handbook. *42 CFR 438.10* RAE Contract: Exhibit B-8—7.3.9.2	• ADM208 Member Materials • RAE New Member Booklet ○ Page 1 (as identified in the booklet)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The RAE makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice or 30 days prior to the effective date of the termination, whichever is later, to each member who received their primary care from, or was seen on a regular basis by, the terminated provider. *42 CFR 438.10(f)(1)* RAE Contract: Exhibit B-8—7.3.10.1	• ADM300 Provider Terminations	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
13. The RAE shall develop and maintain a customized and comprehensive website that includes: • The RAE's contact information. • Member rights and handbooks. • Grievance and appeal procedures and rights. • General functions of the RAE. • Trainings. • Provider directory. • Access to care standards.	• Colorado Access website ○ https://www.coaccess.com/members/care/ ○ https://www.coaccess.com/contact/ ○ https://www.coaccess.com/members/services/rights/ ○ https://www.coaccess.com/members/services/grievances/ ○ https://www.coaccess.com/ ▪ Find a Provider	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Health First Colorado Nurse Advice Line. • Colorado Crisis Services information. • A link to the Department's website for standardized information such as member rights and handbooks. RAE Contract: Exhibit B-8—7.3.9	○ https://www.coaccess.com/members/services/quality/ ○ https://www.coaccess.com/members/mentalhealth/ ○ https://www.coaccess.com/members/services/resources/	
14. The RAE makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, pharmacies (and for RAE 1, behavioral health providers): • The provider's name and group affiliation, street address(es), telephone number(s), website URL, specialty (as appropriate), and whether the provider will accept new members. • The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office. • Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment. *Note: Information included in a paper provider directory must be updated at least monthly if the RAE does not have a mobile-enabled, electronic directory; or quarterly if the RAE has a mobile-enabled, electronic provider directory; and electronic provider directories must be updated no later than 30 calendar days after the contractor receives updated provider information.* *42 CFR 438.10(h)(1-3)* RAE Contract: Exhibit B-8—7.3.9.1.6-8	Provider Directory Link: https://secure.healthx.com/s/COA_Provider_DIrectory (members may also access the directory by going to the Colorado Access website, and use the Find a Provider link)	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: COA's electronic provider directory did not include the provider website URLs as required.		
Required Actions: COA must update its provider directory to include the provider URLs.		
15. Provider directories are made available on the RAE's website in a machine-readable file and format. *42 CFR 438.10(h)(4)* RAE Contract: Exhibit B-8—7.3.9.1.9	Provider Directory Link: https://secure.healthx.com/s/COA_Provider_DIrectory (members may also access the directory by going to the Colorado Access website, and use the Find a Provider link)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. The RAE shall develop electronic and written materials for distribution to newly enrolled and existing members that include all of the following: • The RAE's single toll-free customer service phone number. • The RAE's email address. • The RAE's website address. • State relay information. • The basic features of the RAE's managed care functions as a primary care case management (PCCM) entity and prepaid inpatient health plan (PIHP). • The service area covered by the RAE. • Medicaid benefits, including State Plan benefits and those in the Capitated Behavioral Health Benefit. • Any restrictions on the member's freedom of choice among network providers. • A directory of network providers.	• New Member Booklet ○ Page 2 (as identified in the booklet) ○ Page 4 (as identified in the booklet) ○ Page 5 (as identified in the booklet) ○ Page 12 (as identified in the booklet) • COA Website ○ https://www.coaccess.com/members/ ○ https://www.coaccess.com/members/services/apply/	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The requirement for the RAE to provide adequate access to behavioral health services included in the Capitated Behavioral Health Benefit, including the network adequacy standards. • The RAE's responsibilities for coordination of member care. • Information about where and how to obtain counseling and referral services that the RAE does not cover because of moral or religious objections. • To the extent possible, quality and performance indicators for the RAE, including member satisfaction. RAE Contract: Exhibit B-8—7.3.6.1		
17. The RAE provides member information by either: • Mailing a printed copy of the information to the member's mailing address. • Providing the information by email after obtaining the member's agreement to receive the information by email. • Posting the information on the website of the RAE and advising the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost. • Providing the information by any other method that can reasonably be expected to result in the member receiving that information. *42 CFR 438.10(g)(3)* RAE Contract: Exhibit B-8—None	• RAE New Member Booklet • ADM207 Effective Communication with LEP and SI-SI Persons • ADM230 Member Disability Rights Request • See language on web, "For Our Members": ○ www.coaccess.com	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. The RAE must make available to members, upon request, any physician incentive plans in place. *42 CFR 438.10(f)(3)* RAE Contract: Exhibit B-8—None	• PNS218 Physician Incentive Plans	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard V—Member Information Requirements						
Total	Met	=	17	X	1.00	= 17
	Partially Met	=	1	X	.00	= 0
	Not Met	=	0	X	.00	= 0
	Not Applicable	=	0	X	NA	= NA
Total Applicable		=	18	**Total Score**		= 17
				Total Score ÷ Total Applicable		= 94%

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements written policies and procedures for selection and retention of providers. *42 CFR 438.214(a)* RAE Contract: Exhibit B-8—9.1.6	• PNS202 Selection and Retention of Providers	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor follows a documented process for credentialing and recredentialing of providers that complies with the standards of the National Committee for Quality Assurance (NCQA). • The Contractor ensures that all laboratory testing sites providing services under this contract have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration. *42 CFR 438.214(b)* RAE Contract: Exhibit B-8—9.3.5.2.1 and 9.3.6	• CR301 Provider Credentialing and Recredentialing • CR305 Assessment of Organizational Providers	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor's provider selection policies and procedures include provisions that the Contractor does not: • Discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. • Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42 CFR 438.12(a)(1) and (2)* *42 CFR 438.214(c)* RAE Contract: Exhibit B-8—9.1.6.1-2	• PNS202 Selection and Retention of Providers • CR301 Provider Credentialing and Recredentialing ○ Procedure #2 • CR305 Assessment of Organizational Providers	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This is not construed to: • Require the Contractor to contract with providers beyond the number necessary to meet the needs of its members. • Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. • Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members. *42 CFR 438.12(a-b)* RAE Contract: Exhibit B-8—9.1.6.4, 9.1.9, and 14.4.11	• PNS202 Selection and Retention of Providers o Procedure #1.F • CR301 Provider Credentialing and Recredentialing • CR305 Assessment of Organizational Providers	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Contractor has a signed contract or participation agreement with each provider. *42 CFR 438.206(b)(1)* RAE Contract: Exhibit B-8—9.1.13	• PNS202 Selection and Retention of Providers o Procedure #1.G-H • PNS217 Single Case Agreements Policy • Provider Participation Agreement	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The Contractor does not employ or contract with providers or other individuals or entities excluded for participation in federal health care programs under either Section 1128 or 1128 A of the Social Security Act. • The Contractor performs monthly monitoring against HHS OIG's List of Excluded Individuals. *(This requirement also requires a policy.)*	• CMP206 Sanction and Exclusion Screening • CR DP04 Ongoing Monitoring of Providers	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.214(d) *42 CFR 438.610* RAE Contract: Exhibit B-8—9.1.15 and 17.10.5		
7. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549. *42 CFR 438.610* RAE Contract: Exhibit B-8—17.9.4.2.3	• CMP206 Sanction and Exclusion Screening • CMP DP08 Compliance Program Operations Manual ○ Conducting Exclusion Screens • CR DP04 Ongoing Monitoring of Providers	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: COA's policies and procedures stated that COA would not knowingly employ any staff members who are excluded from participation in federal health care programs. However, the policies and procedures did not state that COA would not knowingly employ any staff members who are *debarred* or *suspended*.		
Required Actions: COA must update its policies and procedures to align in full detail with the federal and State requirements.		
8. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: • The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered. • Any information the member needs in order to decide among all relevant treatment options. • The risks, benefits, and consequences of treatment or non-treatment.	• CS212 Member Rights & Responsibilities • Provider Participation Agreement • Provider Manual Section 2 ○ Alternative Treatment Options	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. *42 CFR 438.102(a)(1)* RAE Contract: Exhibit B-8—14.7.3		
9. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: • To the State upon contracting or when adopting the policy during the term of the contract. • To members before and during enrollment. • To members 30 days prior to adopting the policy with respect to any particular service. *42 CFR 438.102(a)(2)-(b)* RAE Contract: Exhibit B-8—7.3.6.1.13-14 and 14.4.8	• Colorado Access does not object to providing any services under the contract • Provider Manual Section 2 ○ Moral or Religious Objections	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor has administrative and management arrangements or procedures, including a compliance program to detect and prevent fraud, waste, and abuse and includes: • Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal, State, and contract requirements. • The designation of a compliance officer who is responsible for developing and implementing policies, procedures and practices to ensure compliance with requirements of the	• SFY 23-24 Compliance Plan and Program Overview • CMP204 Compliance Education and Training • CMP211 Fraud Waste and Abuse • CMP212 False Claims Acts • CMP213 Internal Compliance Reviews • CM DP08 Compliance Operations Manual • Board of Directors FACC Charter	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
contract and reports directly to the Chief Executive Officer and Board of Directors. • The establishment of a Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program. • Training and education of the compliance officer, management, and organization's staff members for the federal and State standards and requirements under the contract. • Effective lines of communication between the compliance officer and the Contractor's employees. • Enforcement of standards through well-publicized disciplinary guidelines. • Implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks. • Procedures for prompt response to compliance issues as they are raised, investigation of potential compliance problems identified in the course of self-evaluation and audits, correction of such problems quickly and thoroughly to reduce the potential for reoccurrence, and ongoing compliance with the requirements under the contract. *42 CFR 438.608(a)(1)* RAE Contract: Exhibit B-8—17.1.3 and 17.1.5.1-7	• Code of Conduct • 2023 New Hire Training Compliance FWA	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor's administrative and management procedures to detect and prevent fraud, waste, and abuse include: • Written policies for all employees, subcontractors or agents that provide detailed information about the False Claims Act, including the right of employees to be protected as whistleblowers. • Provisions for prompt referral of any potential fraud, waste, or abuse to the Department and any potential fraud to the State Medicaid Fraud Control Unit. • Provisions for suspension of payments to a network provider for which the State determines there is credible allegation of fraud (in accordance with 455.23). *42 CFR 438.608(a)(6-8)* RAE Contract: Exhibit B-8—17.1.5.9, 17.1.6, 17.5.1, and 17.7.1 10 CCR 2505-10, Section 8.076	• SFY 23-24 Compliance Plan and Program Overview • CM DP08 Compliance Operations Manual ○ Overpayments ○ Reporting Suspected Provider or Member Fraud-Suspending Payments • CMP211 Fraud Waste and Abuse • CMP212 False Claims Acts	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor's Compliance Program includes: • Provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potential fraud. • Provision for prompt notification to the State about member circumstances that may affect the member's eligibility, including change in residence and member death. • Provision for notification to the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care	• ADM300 Provider Termination • ADM DP02 Notification to the State-Change in Network Providers Circumstances • CM DP08 Compliance Operations Manual ○ Overpayments ○ Member Services Verification • CS DP25 Change in Member Status	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
program, including termination of the provider agreement with the Contractor. • Provision for a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. *42 CFR 438.608 (a)(2-5)* RAE Contract: Exhibit B-8—17.1.5.7.1, 17.1.5.7.2-6, 17.3.1.1.2.3-4, and 17.3.1.3.1.1		
13. The Contractor ensures that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure screening, and enrollment requirements of the State. • The Contractor may execute network provider agreements pending the outcome of the State's screening and enrollment process of up to one-hundred and twenty days (120) days, but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one one-hundred and twenty days (120)-day period without enrollment of the provider, and notify affected members. *42 CFR 438.608(b)* RAE Contract: Exhibit B-8—9.2.1.1, 9.3.2, and 17.9.2	• CR301 Provider Credentialing and Recredentialing ○ Procedure #7 • CR305 Assessment of Organizational Providers ○ Procedure #2 • PNS 202 Selection and Retention of Providers ○ Procedure #1.B • Provider Participation Agreement	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor has procedures to provide to the State: • Written disclosure of any prohibited affiliation (as defined in 438.610). • Written disclosure of ownership and control (as defined in 455.104) • Identification within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract. *42 CFR 438.608(c)* RAE Contract: Exhibit B-8—17.3.1.5.1.1, 17.9.4.3, and 17.10.2.1	• CMP 206 Sanction Screening • LGL DP02 Disclosure of Change in Ownership and Control • The State automatically adjusts capitation payments	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. The Contractor has a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days of identifying the overpayment, and to notify the Contractor in writing of the reason for the overpayment. • The Contractor reports semi-annually to the State on recoveries of overpayments. *42 CFR 438.608 (d)(2) and (3)* RAE Contract: Exhibit B-8—17.1.5.8 and 17.3.1.2.4.4	• CM DP08 Compliance Operations Manual o Overpayments • CLM DP10 Provider Identified Claim Overpayments • Provider Manual Sections 2 & 6 o Overpayments	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The Contractor provides that members are not held liable for: • The Contractor's debts in the event of the Contractor's insolvency. • Covered services provided to the member for which the State does not pay the Contractor. • Covered services provided to the member for which the State or the Contractor does not pay the health care provider that furnishes the services under a contractual, referral, or other arrangement. • Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. *42 CFR 438.106* RAE Contract: Exhibit B-8—14.14.1-2 and 17.13.2-4	• Provider Participation Agreement ○ Section C.7 • CM DP08 Compliance Operations Manual ○ Investigating and Reporting Member Balance Billing Issues	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard VII—Provider Selection and Program Integrity							
Total	Met	=	15	X	1.00	=	15
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	16	**Total Score**		=	15
Total Score ÷ Total Applicable						=	94%

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. Notwithstanding any relationship(s) with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. *42 CFR 438.230(b)(1)* RAE Contract: Exhibit B-8—4.2.13	• ADM223 Delegation	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: During the interview, HSAG found that COA did not maintain ultimate responsibility for subcontractor agreements. First, COA submitted a delegation agreement for peer review services; however, the COA staff members were unaware of the status of the contract. After consulting with other staff members, COA determined that the contract had been inactive for several years. Second, COA staff members were unable to communicate a current process that addresses CAPs in relation to subcontractor performance.		
Required Actions: COA must maintain ultimate responsibility for subcontractor agreements by ensuring centralized oversight (i.e., by the legal department) of all agreements. COA must also ensure that a process is outlined (e.g., a desktop procedure or policy) that addresses CAPs in relation to subcontractor performance.		
2. All contracts or written arrangements between the Contractor and any subcontractor specify: • The delegated activities or obligations and related reporting responsibilities. • That the subcontractor agrees to perform the delegated activities and reporting responsibilities. • Provision for revocation of the delegation of activities or obligations or specify other remedies in instances where the Contractor determines that the subcontractor has not performed satisfactorily. *Note: Subcontractor requirements do not apply to network provider agreements. In addition, wholly owned subsidiaries of the RAE are not considered subcontractors.*	• ADM223 Delegation	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.230(b)(2) and (c)(1) RAE Contract: Exhibit B-8—4.2.13.6		
Findings: COA's contract with OneTouchPoint Mountain States, LLC, did not include the delegated activities or obligations and related reporting responsibilities. During the interview a COA staff member confirmed that the language was missing.		
Required Actions: COA must ensure that all contracts, including OneTouchPoint Mountain States, LLC, specify the delegated activities or obligations and related reporting responsibilities.		
3. The Contractor's written agreement with any subcontractor includes: • The subcontractor's agreement to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions. *42 CFR 438.230(c)(2)* RAE Contract: Exhibit B-8—4.2.13.6	• ADM223 Delegation	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The written agreement with the subcontractor includes: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State.	• ADM223 Delegation	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

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

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.		

Results for Standard IX—Subcontractual Relationships and Delegation							
Total	Met	=	1	X	1.00	=	1
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	4	**Total Score**		=	1
Total Score ÷ Total Applicable						=	25%

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. *42 CFR 438.330(a)(1)* RAE Contract: Exhibit B-8—16.1.1	• Quality Assessment and Performance Improvement Program ○ Quality Assessment and Performance Improvement Summary and Program Description pages 4-7 (as identified in the document) • Annual Quality Report R5 ○ Quality Assessment and Performance Improvement page 1 (as identified in the document) • Annual Quality Improvement Plan R5 ○ Quality Assessment and Performance Improvement pages 1-2 (as defined in the document)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor's QAPI Program includes conducting and submitting (to the State) annually performance improvement projects (PIPs) that focus on both clinical and nonclinical areas. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. Each PIP includes the following: • Measurement of performance using objective quality indicators. • Implementation of interventions to achieve improvement in the access to and quality of care. • Evaluation of the effectiveness of the interventions based on the objective quality indicators.	• Quality Assessment and Performance Improvement Program ○ Performance Improvement Projects page 17 (as identified in the document) • Annual Quality Report R5 ○ Performance Improvement Projects pages 4-7 (as identified in the document) • Annual Quality Improvement Plan R5 ○ Performance Improvement Projects page 10 (as defined in the document)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Planning and initiation of activities for increasing or sustaining improvement. *For RAEs two PIPs are required, one administrative and one clinical.* *42 CFR 438.330(b)(1) and (d)(2) and (3)* RAE Contract: Exhibit B-8—16.2.1.1, 16.3.5, and 16.3.8		
3. The Contractor's QAPI Program includes collecting and submitting (to the State): • Annual performance measure data using standard measures identified by the State. • Data, specified by the State, which enables the State to calculate the Contractor's performance using the standard measures identified by the State. • A combination of the above activities. *42 CFR 438.330(b)(2) and (c)* RAE Contract: Exhibit B-8—16.4.1 and 16.4.4	• Quality Assessment and Performance Improvement Program ○ Performance Measurement pages 15-16 (as identified in the document) • Annual Quality Report R5 ○ Collection and Submission of Performance Measurement Data pages 9-13 (as identified in the document) • Annual Quality Improvement Plan R5 ○ Collection and Submission of Performance Measurement Data pages 11-12 (as identified in the document)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42 CFR 438.330(b)(3)* RAE Contract: Exhibit B-8—16.6.1	• UM101 Criteria for Utilization Review • UM102 Utilization Review Determinations • Quality Assessment and Performance Improvement Program ○ Under-utilization and Over-utilization of Services pages 11-12 (as identified in the document) • Annual Quality Report R5 ○ Under and Over-Utilization of Services pages 23-41 (as identified in the document) • Annual Quality Improvement Plan R5 Under and Over-Utilization of Services pages 14-18 (as identified in the document)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. *Note: Persons with special health care needs shall mean persons having ongoing health conditions that have a biological, psychological, or cognitive basis; have lasted or are estimated to last for at least one year; and produce one or more of the following: 1) a significant limitation in areas of physical, cognitive, or emotional function; 2) dependency on medical or assistive devices to minimize limitation of function or activities; 3) for children: significant limitation in social growth or developmental function; need for psychological, educational, medical, or related services over and above the usual for the child's age; or special ongoing treatments such as medications, special diets, interventions, or accommodations at home or at school.*	• Quality Assessment and Performance Improvement Plan ○ Quality, Safety, and Appropriateness of Clinical Care and Members with Special Health Care Needs page 15 (as identified in the document) • QM302 Quality Review of Provider Medical Records • Annual Quality Report R5 ○ Quality and Appropriateness of Care Furnished to Members pages 42-48 (as identified in the document) • Annual Quality Improvement Plan R5	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.330(b)(4) RAE Contract: Exhibit B-8—16.2.1.4 and 16.5.5 10 CCR 2505-10, Section 8.205.8	Quality and Appropriateness of Care Furnished to Members pages 18-20 (as identified in the document)	
6. The Contractor monitors member perceptions of accessibility and adequacy of services provided. Tools shall include, at a minimum: • Member surveys • Anecdotal information • Grievance and appeals data • Call center data • Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[A-1] survey RAE Contract: Exhibit B-8—16.5.1-3 and 16.5.6	• Quality Assessment and Performance Improvement Plan ○ Access and Availability of Services page 11 (as identified in the document) • Annual Quality Report R5 ○ Member Experience of Care pages 16-22 (as identified in the document) • Annual Quality Improvement Plan R5 Member Experience of Care pages 12-14 (as identified in the document)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis. *42 CFR 438.330(e)(2)* RAE Contract: Exhibit B-8—16.2.5	• Quality Assessment and Performance Improvement Program ○ QAPI Program Impact and Effectiveness Analysis pages 19-20 (as identified in the document) ○ Appendix A: QAPI Self-Assessment Tool pages 22-27 (as identified in the document)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor adopts practice guidelines that meet the following requirements: • Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. • Consider the needs of the Contractor's members. • Are adopted in consultation with contracted health care professionals. • Are reviewed and updated periodically as appropriate. *42 CFR 438.236(b)* RAE Contract: Exhibit B-8—14.8.9.1-3	• QM311 Clinical Practice Guidelines • Clinical Practice Guideline Annual Review • Colorado Access Provider Manual Section 3 ○ Clinical Practice Guidelines page 8 (as identified in the document) • Colorado Access Website ○ https://www.coaccess.com/providers/resources/quality/	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor disseminates the guidelines to all affected providers, and upon request, to members and potential members. *42 CFR 438.236(c)* RAE Contract: Exhibit B-8—14.8.9	• QM311 Clinical Practice Guidelines • Colorado Access Provider Manual Section 3 ○ Clinical Practice Guidelines page 8 (as identified in the document) • Colorado Access Website ○ https://www.coaccess.com/providers/resources/quality/ • Provider Update from Colorado Access	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42 CFR 438.236(d)* RAE Contract: Exhibit B-8—14.8.10	• QM311 Clinical Practice Guidelines • Clinical Practice Guideline Annual Review	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42 CFR 438.242(a)* RAE Contract: Exhibit B-8—15.1.1	• Systems to Manage Health Information Data • COA System Architecture	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor's health information system provides information on areas including, but not limited to, utilization, encounters, claims, grievances and appeals, and disenrollment (for reasons other than loss of Medicaid eligibility). *42 CFR 438.242(a)* RAE Contract: Exhibit B-8—8.1, 15.1.1, and 15.1.1.3.2.1	• Systems to Manage Health Information Data • COA System Architecture	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor's claims processing and retrieval systems collect data elements necessary to enable the mechanized claims processing and information retrieval systems operated by the State. • Contractor electronically submits encounter claims data in the interchange ANSI X12N 837 format directly to the Department's fiscal agent using the Department's data transfer protocol. The 837-format encounter claims (reflecting claims paid, adjusted, and/or denied by the Contractor) shall be submitted via a regular batch process. *42 CFR 438.242(b)(1)* RAE Contract: Exhibit B-8—15.2.2.3.1-2	• 2.0 Claims and Encounters • COA System Architecture	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor collects data on member and provider characteristics and on services furnished to members through an encounter data system (or other methods specified by the State). *42 CFR 438.242(b)(2)* RAE Contract: Exhibit B-8—15.2.2	• Systems to Manage Health Information Data • 2.0 Claims and Encounters • COA System Architecture	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. The Contractor ensures that data received from providers are accurate and complete by: • Verifying the accuracy and timeliness of reported data, including data from network providers compensated through capitation payments.	• Systems to Manage Health Information Data • Mechanisms to Ensure Accurate and Complete Data	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Screening the data for completeness, logic, and consistency. • Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for Medicaid quality improvement and care coordination efforts. • Making all collected data available to the State and upon request to CMS. *42 CFR 438.242(b)(3) and (4)* RAE Contract: Exhibit B-8—15.2.2.3.1 and 15.2.2.3.6.1		
16. The Contractor: • Collects and maintains sufficient member encounter data to identify the provider who delivers any items or services to members. • Submits member encounter data to the State in standardized ASC X12N 837 formats as appropriate. • Submits member encounter data to the State at the level of detail and frequency specified by the State (within 120 days of an adjudicated provider claim). *42 CFR 438.242(c)* RAE Contract: Exhibit B-8—15.2.2.1-2, 15.2.2.3.2, and 15.2.2.3.4	• Systems to Manage Health Information Data • 2.0 Claims and Encounters • COA System Architecture	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

Appendix B. Compliance Review Participants

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

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

HSAG Review Team	Title
Gina Stepuncik	Associate Director
Sarah Lambie	Associate Director
Cynthia Moreno	Project Manager III
Crystal Brown	Project Manager I
COA Participants	**Title**
Amanda Fitzsimons	Manager of Compliance and Privacy
Marcy Mullan	Director of Compliance
Richard Akoto	Policy and Privacy Specialist
Lisa Hug	Director of Program Operations
John Priddy	Vice President of Health Plan Operations
Ward Peterson	Director of Enrollment and Child Health Plan Plus
Taylor Mitchell	Child Health Plan Plus Program Manager
Reyna Garcia	Senior Director of Customer Service
Michelle Tomsche	Director of Claims, Operations, and Research
Jeni Sargent	Director of Member and Provider Data Integrity
Beth Coleman	Director of Provider Contracting
Anne Taylor	Provider Recruitment Program Manager
Travis Roth	Manager of Credentialing and Provider Data
Mika Gans	Director of Quality Improvement
Sarah Thomas	Quality Improvement Program Manager
Lauren Ratliff	Quality Improvement Program Manager
Jason Beard	Senior Web Manager
Kellen Roth	Director of Member Affairs
Thomas Mayo	Director of Utilization Management
Kris Cooper	Supervisor of Behavioral Health
Josette Hizon	Supervisor of Behavioral Health
Kathy Nyberg	Manager of Legal Services
Dana Pepper	Vice President of Provider Performance and Network Services

Department Observers	Title
Russell Kennedy	Quality Program Manager
Blue Parish	Program Specialist
Matthew Pfeifer	Unit Supervisor
Sandra Wetenkamp	Network Accountability Specialist
Hilary Erickson	Child Health Plan Plus Integrity Specialist
Jerry Ware	Quality Contract Manager
Helen Desta-Fraser	Quality Section Manager

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

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

Table C-1—Corrective Action Plan Process

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

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

The CAP template follows on the next page.

Table C-2—FY 2023–2024 Corrective Action Plan for COA RAE 5

Standard V—Member Information Requirements
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
14. The RAE makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, pharmacies (and for RAE 1, behavioral health providers): • The provider's name and group affiliation, street address(es), telephone number(s), website URL, specialty (as appropriate), and whether the provider will accept new members. • The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office. • Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment. *Note: Information included in a paper provider directory must be updated at least monthly if the RAE does not have a mobile-enabled, electronic directory; or quarterly if the RAE has a mobile-enabled, electronic provider directory; and electronic provider directories must be updated no later than 30 calendar days after the contractor receives updated provider information.* *42 CFR 438.10(h)(1-3)* RAE Contract: Exhibit B-8—7.3.9.1.6-8
Findings
COA's electronic provider directory did not include the provider website URLs as required.
Required Actions
COA must update its provider directory to include the provider URLs.
Planned Interventions

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

Standard VII—Provider Selection and Program Integrity
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
7. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549. *42 CFR 438.610* RAE Contract: Exhibit B-8—17.9.4.2.3
Findings
COA's policies and procedures stated that COA would not knowingly employ any staff members who are excluded from participation in federal health care programs. However, the policies and procedures did not state that COA would not knowingly employ any staff members who are *debarred* or *suspended*.
Required Actions
COA must update its policies and procedures to align in full detail with the federal and State requirements.
Planned Interventions
Person(s)/Committee(s) Responsible

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

Standard IX—Subcontractual Relationships and Delegation
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
1. Notwithstanding any relationship(s) with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. *42 CFR 438.230(b)(1)* RAE Contract: Exhibit B-8—4.2.13
Findings
During the interview, HSAG found that COA did not maintain ultimate responsibility for subcontractor agreements. First, COA submitted a delegation agreement for peer review services; however, the COA staff members were unaware of the status of the contract. After consulting with other staff members, COA determined that the contract had been inactive for several years. Second, COA staff members were unable to communicate a current process that addresses CAPs in relation to subcontractor performance.
Required Actions
COA must maintain ultimate responsibility for subcontractor agreements by ensuring centralized oversight (i.e., by the legal department) of all agreements. COA must also ensure that a process is outlined (e.g., a desktop procedure or policy) that addresses CAPs in relation to subcontractor performance.
Planned Interventions
Person(s)/Committee(s) Responsible

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

Standard IX—Subcontractual Relationships and Delegation
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
2. All contracts or written arrangements between the Contractor and any subcontractor specify: • The delegated activities or obligations and related reporting responsibilities. • That the subcontractor agrees to perform the delegated activities and reporting responsibilities. • Provision for revocation of the delegation of activities or obligations or specify other remedies in instances where the Contractor determines that the subcontractor has not performed satisfactorily. *Note: Subcontractor requirements do not apply to network provider agreements. In addition, wholly owned subsidiaries of the RAE are not considered subcontractors.* *42 CFR 438.230(b)(2) and (c)(1)* RAE Contract: Exhibit B-8—4.2.13.6
Findings
COA's contract with OneTouchPoint Mountain States, LLC, did not include the delegated activities or obligations and related reporting responsibilities. During the interview a COA staff member confirmed that the language was missing.
Required Actions
COA must ensure that all contracts, including OneTouchPoint Mountain States, LLC, specify the delegated activities or obligations and related reporting responsibilities.
Planned Interventions

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

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

Standard IX—Subcontractual Relationships and Delegation
– The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. – If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.
Planned Interventions
Person(s)/Committee(s) Responsible
Training Required
Monitoring and Follow-Up Activities Planned
Documents to Be Submitted as Evidence of Completion
HSAG Initial Review:

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

Appendix D. Compliance Monitoring Review Protocol Activities

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

Table D-1—Compliance Monitoring Review Activities Performed

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

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