Colorado Children's Health Insurance Program
Child Health Plan *Plus* (CHP+)

FY 2012–2013 Site Review Report

for

Colorado Access

April 2013

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

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Overview of FY 2012–2013 Compliance Monitoring Activities

Public Law 111-3, The Children's Health Insurance Program Reauthorization Act of 2009, requires that each state's Children's Health Insurance Program (CHIP) applies several provisions of Section 1932 of the Social Security Act in the same manner as the provisions apply under Title XIX of the Act. This requires managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to comply with specified provisions of the Balanced Budget Act of 1997, Public Law 105-33 (BBA). The BBA requires that states conduct a periodic evaluation of their MCOs and PIHPs to determine compliance with regulations and contractual requirements. The Department of Health Care Policy and Financing (the Department) has elected to complete this requirement for Colorado's Child Health Plan *Plus* (CHP+) managed care health plans by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This is the second annual external quality review of compliance with federal managed care regulations performed for the CHP+ program by HSAG. For the fiscal year (FY) 2012–2013 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the four performance areas chosen. The standards chosen were Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement.

The health plan's administrative records were also reviewed to evaluate implementation of National Committee for Quality Assurance (NCQA) Standards and Guidelines related to credentialing and recredentialing. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of 5 records. Using a random sampling technique, HSAG selected the samples from all applicable practitioners who had been credentialed or recredentialed in the previous 36 months. For the record review, the health plan received a score of *Yes* (compliant), *No* (not compliant), or *Not Applicable* for each of the elements evaluated. Compliance with federal managed care regulations was evaluated through review of the four standards. HSAG calculated a percentage of compliance score for each standard and an overall percentage of compliance score for all standards reviewed. HSAG also separately calculated an overall record review score.

This report documents results of the FY 2012–2013 site review activities for the review period—July 1, 2012, through December 31, 2012. Section 2 contains summaries of the findings, strengths, opportunities for improvement, and required actions for each standard area. Appendix A contains details of the findings for the review of the standards. Appendix B contains details of the findings for the credentialing and recredentialing record reviews. Appendix C lists HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process the health plan will be required to complete for FY 2012–2013 and the required template for doing so.

Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the health plan's contract requirements, NCQA Credentialing and Recredentialing Standards and Guidelines, and regulations specified by the BBA, with revisions issued June 14, 2002, and effective August 13, 2002. HSAG conducted a desk review of materials submitted prior to the on-site review activities, a review of documents and materials provided on-site, and on-site interviews of key health plan personnel to determine readiness to comply with federal managed care regulations. Documents submitted for the desk review and during the on-site document review consisted of policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials.

The four standards chosen for the FY 2012–2013 site reviews represent a portion of the Medicaid managed care requirements. Standards that will be reviewed in subsequent years are: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

The site review processes were consistent with the February 11, 2003, Centers for Medicare & Medicaid Services (CMS) final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs).* Appendix D contains a detailed description of HSAG's site review activities as outlined in the CMS final protocol.

Objective of the Site Review

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

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

Summary of Results

Based on the results from the compliance monitoring tool and conclusions drawn from the review activities, HSAG assigned each requirement within the standards in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. HSAG assigned required actions to any individual requirement within the compliance monitoring tool receiving a score of *Partially Met* or *Not Met*. HSAG also identified opportunities for improvement with associated recommendations for enhancement for some elements, regardless of the score. Recommendations for enhancement for requirements scored as *Met* did not represent noncompliance with contract requirements or BBA regulations.

Table 1-1 presents the score for **Colorado Access** for each of the standards. Details of the findings for each standard follow in Appendix A—Compliance Monitoring Tool.

Table 1-1—Summary of Scores for the Standards

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
III Coordination and Continuity of Care	9	9	9	0	0	0	100%
IV Member Rights and Protections	5	5	5	0	0	0	100%
VIII Credentialing and Recredentialing	50	50	49	1	0	0	98%
X Quality Assessment and Performance Improvement	11	11	11	0	0	0	100%
Totals	**75**	**75**	**74**	**1**	**0**	**0**	**99%**

Table 1-2 presents the scores for **Colorado Access** for the record reviews. Details of the findings for the record reviews are in Appendix B—Record Review Tools.

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

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Credentialing Record Review	80	79	79	0	1	100%
Recredentialing Record Review	80	76	76	0	4	100%
Totals	**160**	**155**	**155**	**0**	**5**	**100%**

Overall Summary of Performance

Colorado Access is a health plan with several lines of business, one of which is a health maintenance organization (HMO) that provides a CHP+ health benefits plan to selected Colorado CHP+ members. For the four standards reviewed by HSAG, **Colorado Access** earned an overall compliance score of 99 percent. **Colorado Access**' strongest performances were in Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, and Standard X—Quality Assessment and Performance Improvement, all earning a compliance score of 100 percent. HSAG identified one required action in Standard VIII—Credentialing and Recredentialing, resulting in a score of 98 percent compliance for that standard. **Colorado Access** demonstrated strong performance overall and an understanding of the federal health care regulations, the Colorado Medicaid Managed Care Contract, and NCQA Standards and Guidelines.

Standard III—Coordination and Continuity of Care

Summary of Findings and Opportunities for Improvement

Colorado Access policies and procedures outlined the responsibilities of the primary care provider to coordinate covered services and provide continuity of care for CHP+ members. **Colorado Access** allowed the member to select a primary care physician (PCP) and assigned a PCP, when required. Policies described the processes for **Colorado Access** to support the PCP in the provision of care coordination for members with complex medical, behavioral, and cultural needs. The policies addressed care coordination with multiple providers and agencies, including coordination with mental health providers. **Colorado Access** defined several processes for addressing members' cultural and linguistic needs. **Colorado Access** demonstrated the Altruista case management software, which was used to document all components of the member's care coordination record, including member assessments, the individual care coordination plan, and follow-up progress notes. **Colorado Access** informed providers of medical record requirements, which included components of the member treatment plan. HSAG recommended that **Colorado Access** consider adding a requirement for the assessment of members' social and cultural needs to the provider medical record documentation standards.

Colorado Access described mechanisms for communicating member assessment with other health care providers and organizations, as pertinent to meeting the member's needs. Policies outlined the process for performing a health risk assessment and developing an individualized care coordination plan with member and family involvement in treatment plan decisions, but **Colorado Access** did not clearly document member agreement to the care management plan in the care management record. HSAG recommended that **Colorado Access** consider mechanisms to clearly document the member's agreement with the care coordination plan in the Altruista case management file and inform providers of the requirement to obtain member and family agreement with the treatment plan. Policies defined multiple circumstances in which members are allowed direct access to a specialist, and communication materials informed members and providers of these provisions. Policies and procedures delineated processes to ensure the confidentiality and security of member protected health information in the coordination of care and other **Colorado Access** operations.

During on-site review, **Colorado Access** presented a care coordination case for a 15-year-old male with post-traumatic stress disorder (PTSD), schizophrenia, acute medical issues, self-aggressive behavior, and a history of multiple hospitalizations and family instability. The member lived with the grandmother (guardian) who was the child's caregiver. The case presentation demonstrated the need for coordination of services with multiple mental health and physical health providers, community services, and wraparound service providers. The documentation included multiple assessments of member needs over the length of care coordinator involvement, implementation of a care coordination plan with interventions based on assessed needs, and frequent follow-up with the family regarding progress. The case presentation also demonstrated that the member had both physical health and behavioral health primary care providers and a designated care coordinator and demonstrated family involvement in the care coordination plan.

Summary of Strengths

Colorado Access had a well-defined care coordination program and processes that were applicable to all lines of business, including the HMO that served the CHP+ population. **Colorado Access** had a qualified care coordination staff of health care professionals. There was evidence that care coordination staff members provided frequent monitoring of members' needs and progress, and were actively involved in coordinating essential services with providers and agencies on behalf of the member and family. **Colorado Access** developed several focused assessment tools to support care coordination in specific member circumstances such as transition of care or disease management of specific conditions. **Colorado Access** used the Altruista case management software to support documentation of the detailed comprehensive care coordination record.

Summary of Required Actions

There were no required actions for Standard III.

Standard IV—Member Rights and Protections

Summary of Findings and Opportunities for Improvement

Colorado Access had numerous policies and procedures that included each of the member rights. **Colorado Access** had mechanisms to notify members of their rights (e.g., the member handbook and newsletters). Providers were notified of member rights and the requirement that providers take those rights into consideration through the provider manual. **Colorado Access** had processes for initial and ongoing training for its staff and providers, including cultural competency.

HSAG recommended that **Colorado Access** consider placing member rights information under the provider tab on the Web site, including brief member rights trainings as part of the provider overview training, or including topic-specific rights information in the provider bulletin periodically.

Summary of Strengths

Colorado Access had processes for ensuring that members and providers understand member rights. **Colorado Access** also provided periodic communication that reminded staff, members, and providers about member rights and the need to ensure these rights are taken into consideration at all times. Processes for ensuring member rights are taken into account were consistent across all lines of business. **Colorado Access** provided frequent training for staff and employees. **Colorado Access** had several mechanisms to engage providers in a partnership (e.g., a user-friendly Web site; frequent provider newsletters available electronically; and an impressive number of trainings delivered in person and/or via Webinar, publicized through its Web site).

Summary of Required Actions

There were no required actions for this standard.

Standard VIII—Credentialing and Recredentialing

Summary of Findings and Opportunities for Improvement

Colorado Access performed the credentialing and recredentialing processes for providers serving its CHP+ line of business. **Colorado Access** had a well-defined credentialing program that included NCQA-compliant policies, procedures, and practices. The policies and procedures delineated each type of practitioner subject to **Colorado Access**' credentialing processes, acceptable methods for primary source verification, and specific criteria required for acceptance into and continued participation in the Colorado Access provider network. HSAG found ample evidence that **Colorado Access** monitored and provided oversight of its delegates. On-site review of credentialing and recredentialing records demonstrated that primary source verification for credentialing and recredentialing was completed within the required time frames and that recredentialing was completed within the required 36-month time frame.

Although there was one organizational provider in the file review that was reassessed at 37 months, **Colorado Access** provided evidence that it followed NCQA processes (multiple scheduled contacts with the provider and initiation of termination procedures for noncooperation with **Colorado Access**' policies for organizational provider reassessment/recredentialing).

Summary of Strengths

Credentials Committee meeting minutes were detailed and demonstrated the role of the medical director consistent with the **Colorado Access** policy. The minutes also evidenced that the committee reviewed files that did not initially meet the required criteria. The Credentials Committee also reviewed ongoing monitoring for sanction activity, quality of care issues, and delegates' reports of credentialing activities.

Practitioner credentialing and recredentialing files were comprehensive, neat, and very well organized as were organizational provider records. Practitioner and provider records demonstrated **Colorado Access**' performance of all required credentialing and recredentialing activities.

Summary of Required Actions

While **Colorado Access** had numerous and appropriate methods to prevent discrimination during credentialing and recredentialing processes, there were no methods in place for monitoring to ensure nondiscriminatory credentialing practices, as required by NCQA. **Colorado Access** must develop processes for monitoring to ensure nondiscriminatory credentialing practices.

Standard X—Quality Assessment and Performance Improvement

Summary of Findings and Opportunities for Improvement

Colorado Access had defined a comprehensive Quality Assessment and Performance Improvement (QAPI) program, applicable to all lines of business, which included monitoring of accessibility, provider availability, clinical practice guidelines (CPGs), care management, Healthcare Effectiveness Data and Information Set (HEDIS®)[2-1] clinical performance measures, member satisfaction, performance improvement projects (PIP), grievances and appeals, utilization, and medical record documentation. The program was accountable to the **Colorado Access** Board of Directors through the Quality Improvement Committee (QIC) and the Medical Behavioral Quality Improvement Committee (MBQIC), whose members reviewed information on the outcomes of quality improvement (QI) monitoring and initiatives conducted by **Colorado Access** staff. HSAG recommended that Colorado Access consider increasing the formality and documentation of operational reviews of pertinent data and QI study findings. **Colorado Access** provided examples of multiple utilization monitoring reports and evidence that it monitors CHP+ member perceptions through surveys, focus groups, grievance trending, and enrollment trends. **Colorado Access** had mechanisms for taking corrective action based on patterns of dissatisfaction or serious complaints, but no corrective actions were required during the review period. **Colorado Access** expressed concern that a recent CHP+ eligibility and enrollment issue at the State will impact future member satisfaction measures, as well as HEDIS measures.

Colorado Access reported that the first CHP+ annual report of QI program effectiveness is scheduled for production in September 2013, and indicated that the report will be similar in format and content to the well-designed report for Colorado Access' behavioral health line of business while incorporating all of the components outlined in the CHP+ annual report requirement. **Colorado Access** adopted CHP+ CPGs for the required topic areas and met the requirements for development, dissemination, and application to other **Colorado Access** processes. Member and provider communications, however, did not clearly address CPGs. HSAG recommended that **Colorado Access** consider updating the CHP+ member handbook and the CHP+ provider manual to inform members and providers of the availability of CPGs and how to access or request them. **Colorado Access** had an integrated health information system (HIS) that collected and processed member, provider, and service data from multiple databases to support the QI program.

Summary of Strengths

Colorado Access had experienced management staff to support the CHP+ line of business and QI programs. **Colorado Access** had previous organizational experience with the Colorado Medicaid program that could be accessed as the CHP+ contract requirements evolve toward Medicaid requirements. **Colorado Access** defined one QI program that was applicable to all lines of business and that enabled the CHP+ HMO to be well resourced with QI policies, staff, systems, and committees.

[2-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Colorado Access was invested in the development of high-functioning HISs that integrate data and produce reports to support QI monitoring and activities.

Summary of Required Actions

There were no required actions for this standard.

The completed compliance monitoring tool follows this cover page.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has written policies and procedures to ensure timely coordination with any of a member's other providers of the provision of Covered Services to its members and to ensure: ◆ Service accessibility. ◆ Attention to individual needs. ◆ Continuity of care to promote maintenance of health and maximize independent living. Contract: Exhibit A—2.7.4.1	**Documents Submitted:** • CCS305-Care Coordination; page 2, Section II.A.1-6, Sect III A-C. • CCS310-Access to Primary and Specialty Care; Section II, Section III • CHP+ Provider Manual; pp. 17-Culturally Sensitive Services, p. 45-Out of Area Services, pp. 50-51-Authorization and Coordination of Benefits, Authorization Processing Timeframe, pp. 52-63-Authorization Categories and General Authorization Rules, pp. 63-64 – Continuity of Care and Transition of Care, p. 52 Consideration of Individual Needs **Description of Process:** CCS305 Care Coordination Policy - Colorado Access Care Coordination policy (CCS305) outlines our care coordination program. The CCS305 policy statement (page 2) reads: Through Care Coordination efforts, Colorado Access will develop and maintain means to identify, screen, assess and assist in the management of members with complex physical, mental, and cultural healthcare needs. Colorado Access' efforts will effectively coordinate care with multiple providers, human service agencies, and payers, on behalf of the member. The activities focus on coordinating provision of services, promoting and assuring service accessibility, with attention to the individual needs, continuity of care, comprehensive and coordinated service delivery, cultural competence and fiscal and professional accountability.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This policy also details member identification for care coordination through methods such as: 1. Internal data sources such as condition specific profiles, emergency room visits reports, inpatient census reports, readmission reports and historical costs; 2. Telephonic outreach and screening; 3. Referrals from members, DCRs, Authorized Representative, or family members; 4. Referrals from primary care, specialty care including mental health providers, schools, home health care or ancillary service providers, human service agencies, the State, and other community agencies; 5. Institutional providers (e.g., hospitals, skilled nursing, rehabilitation, residential, and sub-acute facilities); and 6. Referrals from other Colorado Access departments (Section II.A.1-6., page 4). In addition, the Facilitation of Care Coordination (Section III, A-C., pages 4-5) support this requirement.	
Findings: The Colorado Access Care Coordination policy (applicable to all lines of business) stated that care coordination focuses on promoting and assuring service accessibility, continuity of care, and attention to individual needs for members with complex cultural, physical health, and mental health needs. Methods included supporting members in reaching their optimal state of wellness and independent living within the community. The policy described the processes of member identification; assessment of member needs; sharing assessments of member needs with members, families, providers, and staff members; developing an individual plan of care; providing care coordination interventions; and monitoring and revising the plan of care as needed. The Access to Primary and Specialty Care policy stated that the primary care physician (PCP) is responsible for providing all routine care for assigned members and for making referrals for necessary specialty and ancillary services. The CHP+ Provider Manual described the responsibilities and processes for referrals and coordination with other providers, and for maintaining continuity of care for members transitioning into Colorado Access or changing providers within the network.		
Required Actions: None.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor's procedures are designed to address those members who may require services from multiple providers, facilities, and agencies; and require complex coordination of benefits and services and those members who require ancillary, social, or other community services. The Contractor coordinates with the member's mental health providers to facilitate the delivery of mental health services, as appropriate. *42CFR438.208(b)(2)* Contract: Exhibit A—2.7.4.2, 2.7.4..3..2, 2.7.4.3.3	**Documents Submitted:** • CCS305-Care Coordination; Section I, Section III.B & C • CCS310-Access to Primary and Specialty Care; Sections II • QM302-Review of Provider Medical Records; Section I.D • CHP+ Provider Manual; Section V – pp. 31-32, 52 **Description of Process:** Colorado Access Care Coordination policy (CCS305) addresses the coordination of services with primary care as one of the specific care management interventions (Section III.C., pg 4-5). This section also outlines the process for care coordination with behavioral health care providers, physical health care providers, long term care providers, waiver service providers, pharmacists, county and state agencies, and other organizations that may be providing wrap around services. This is also addressed in the definition of care coordination (page 2). Coordination between CHP providers and a member's PCPs is a direct responsibility of our providers. This is explicitly stated in the Provider Manual (pages 31-32) In addition, Appendix A of the Provider Manual requires documentation of coordination with medical providers and other ancillary service providers Assuring appropriate authorization has been obtained from Colorado Access before treating a member and following authorization rules when necessary, as well as coordinating the member's care with the PCP. (CHP HMO Provider Manual Page 32). Documentation of active treatment must include documentation of continuity and coordination of care with the member's PCP and other ancillary service providers Colorado Access considers a clinical referral to be communication between the PCP and specialty provider for the purposes of care continuity and treatment planning. (CHP HMO Provider Manual Page 52) Clinical documentation standards in	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Appendix A of the Provider Manual are reviewed during routine random provider chart audits. Colorado Access policy QM302 outlines the process for provider medical chart reviews to ensure providers are following these requirements.	

Findings:
The Care Coordination policy stated that one of the goals of care coordination was to identify and coordinate medical and/or mental health care, community resources, and social supports for members with complex health care needs. The policy defined care coordination as a collaborative process among Colorado Access, specified providers, and community agencies including mental health and substance abuse agencies as well as multiple services for persons with special health care needs. The policy stated that members appropriate for care coordination services may be identified through data sources, member/family referral, or referrals from providers.

During the on-site interview, staff described the procedures for coordinating member information with mental health providers. Staff stated that Colorado Access has established processes that enable the exchange of confidential member information without a specific release of information from the member. In addition, staff stated that Colorado Access conducts a weekly conference with Mental Health Center of Denver (MHCD), a major mental health provider, concerning complex behavioral care cases.

During the on-site interview, Colorado Access presented a care coordination case for a 15-year-old male with post-traumatic stress disorder (PTSD) and schizophrenia, acute medical issues, self-aggressive behavior, a history of family instability, and multiple hospitalizations. The member lived with the grandmother (guardian) who was the child's caregiver. The Colorado Access care coordinator was actively engaged with the grandmother regarding the care coordination plan over a one-year period. The case presentation demonstrated coordination with multiple mental health providers, home-based services, community-based services (day treatment), physical health providers, and respite care wraparound service providers. At the time of review, Colorado Access was seeking a residential treatment facility for the member.

Required Actions:
None.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor has a mechanism to ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating covered services furnished to the member. If a member does not select a primary care physician (PCP), the Contractor assigns the member to a PCP or a primary care facility and notifies the member, by telephone or in writing, of his/her facility's or PCP's name, location, and office telephone number. *42CFR438.208(b)(1)* Contract: Exhibit A—2.5.8.2	**Documents Submitted:** • CCS305-Care Coordination; (all) • CCS310-Access to Primary and Specialty Care; p. 4 – Section I • CHP+ Provider Directory; pp. 31-37 • Member Benefits Booklet; pp. 9-10 **Description of Process:** CCS 310 – Access to Primary and Specialty Care outlines the following standards (page 4, Sect I): A. Colorado Access will allow, to the extent possible and appropriate, each member's selection of a PCP for AA, CHP+ and SMCN. B. If a member does not select a PCP, Colorado Access shall assign the member to a PCP and notify the member, by telephone or in writing, of his/her PCP's name, location, and office telephone number. C. The PCP will be responsible for providing all but inpatient, specialty and emergency services for his/her assigned members. Member Benefits booklet (pg 10) identifies the following process to our members: • If you do not choose an in-network PCP, we will choose a PCP for you in your area. If you do not want to see the PCP we choose for you, please call Customer Service. The PCP designation is listed on the members ID card, which is delivered to the members residence following enrollment into the health plan.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The Access to Primary and Specialty Care policy stated that the member is allowed to select a PCP; and, if the member does not select a PCP, Colorado Access assigns the member to a PCP and notifies the member of the assigned PCP's name, location, and telephone number. The policy stated that the assigned PCP is the member's medical home, responsible for coordinating specialty referrals and maintaining continuity of care. The CHP+ Provider Manual included "coordinating healthcare services for members" in the list of PCP responsibilities and informed providers of the process for assigning a member to a PCP. The CHP+ Member Benefits Booklet informed members of the need to select a PCP from the provider directory, available on request from Member Services or on the Colorado Access Web site, and that Colorado Access would assign a PCP and inform the member if no choice is made. The member benefits booklet also described the role of the PCP in coordinating and making referrals for covered services for the member. The on-site care coordination presentation demonstrated documentation of the member's primary psychiatrist, PCP, primary therapist, and care coordinator.		
Required Actions: None.		
4. The Contractor implements procedures to provide an individual needs assessment after enrollment and at any other necessary time, including the screening for special health care needs (e.g., mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems). The assessment mechanisms must use appropriate health care professionals. *42CFR438.208(c)(2)* Contract: Exhibit A—2.7.4.3.1.1	**Documents Submitted/Location Within Documents:** • CCS305-Care Coordination; page 4 Sections III.B • CCS306-Delivering Continuity and Transition of Care for Members; Section III. B • QM302-Review of Provider Medical Records • QM302b - Clinical Record Requirements Guideline • QM308 - Preventive Health Services, Sect VI. • CHP Provider Manual, pg 11 • Health Risk Assessment (HRA) • Process Guideline • HRA questionnaire **Description of Process:** The practice of sending Health Risk Assessments to all newly enrolled CHP+ HMO members became a contractual requirement effective January 1, 2013. We have created a process outlined in the HRA Process Guideline document which explains in detail how Colorado Access will meet the standard beginning January 1, 2013.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The HRA process is identified in the CHP Provider Manual (pg 11) • **Special Services** Colorado Access has special healthcare programs for diseases such as diabetes, depression, asthma and smoking cessation. In an effort to identify members with special health care needs, Colorado Access provides a Health Risk Assessment to each new member. This assessment is a proactive approach to communicate directly with our members in order to identify, capture and connect each child with any appropriate Care Manager or healthcare program. We also send members important reminders regarding preventive care. CCS 305 – Care Coordination policy identifies the following as needed screening process (Section III.B) • Colorado Access has processes specific to each line of business to identify and screen members for specific services and/or health care needs. • Members with complex or serious physical, cognitive, social and mental healthcare needs may be referred for Care Coordination as indicated for individualized assessment, care planning, developing interventions and providing follow-up based on the needs identified in the assessment and thereafter.	
Findings: The Health Risk Assessment (HRA) questionnaire, distributed to members on enrollment, collected information to identify a child's special health care needs such as disabilities, mental health needs, pregnancy, asthma, or substance abuse problems. The HRA Process document outlined the specific procedures for documenting the HRA in the Altruista case management system and referring data to care management for follow-up. During the on-site interview, staff stated that Colorado Access performs two outreach calls to members who do not respond to the HRA mailing, and that Colorado Access uses interactive voice response (IVR) technology to assist in outreach efforts. Pregnant members and members with asthma are especially targeted with HRA follow-up efforts.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
The Care Coordination policy stated that any members identified to receive care management services will receive an in-depth assessment of physical, behavioral, psychosocial, and environmental information to prioritize the member's needs. The Delivering Continuity and Transition of Care for Members policy described that staff would conduct an assessment of needs for new members needing assistance with transition or continuity of care. During the on-site interview, staff stated that Colorado Access used several different pre-formatted guides for care coordinator assessment of members' individual needs, and provided a sample assessment used for members transitioning from hospital to home. The CHP+ Provider Manual informed providers that Colorado Access would administer a health risk assessment and connect each child with appropriate care management or special health care programs (e.g., asthma management). The provider manual also informed providers of the medical record requirements and guidelines, which included documentation of medical history, physical needs and diagnoses, mental health needs, and substance abuse issues. HSAG recommended that Colorado Access include assessment of the member/family cultural, linguistic, and social needs into the medical record guidelines. The on-site care coordination case presentation demonstrated that the Colorado Access care coordinator performed a comprehensive individual needs assessment that included all of the required elements. Staff stated that several different assessments were performed for this member over the course of the year the member had been enrolled in case management.		
Required Actions: None.		
5. The Contractor shares with other health care organizations serving the member with special health care needs, the results of its identification and assessment of that member's needs, to prevent duplication of those activities. *42CFR438.208(b)(3)* Contract: Exhibit A—2.7.5.2	**Documents Submitted/Location Within Documents:** • CCS305 – Care Coordination; page 2, Sect I.G, Sect I.H, Section III.C.2 • CCS306-Delivering Continuity and Transition of Care for Members; Section III.A.C • CHP+ Provider manual; pg.29 Special Population **Description of Process:** Colorado Access Care Managers, Service Coordinators, and Peer Specialists routinely communicate their activities to providers and others involved in the member's care. This activity is implicit in the definition of Care Coordination (CCS305, page 2). One of the stated goals of our care coordination program is to "to facilitate communication and coordination among providers, caregivers, and stakeholders" (CCS305, I.G, pg 3). "To create efficiencies by decreasing the duplication of services" is another stated goal of the program (CCS305, I.H, pg 3). In addition, it is expected that care	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	coordination interventions are "non-duplicative (CCS305, Section I.H., page 3 and III.C.2, pgs 4-5) and collaborative. Sect III.C.2 of CCS 305 policy also states that Colorado Access takes the following steps: • Conducting coordination with the member, family, DCR, Authorized Representative, provider, and involved Colorado Access physical and/or mental health staff members on an ongoing basis in order to share assessment findings and to develop an agreed upon care plan. The care plan will address the member's needs so that care is collaborative, non-duplicative, and outcomes focused and allows the member to remain in the community. Where applicable, members will be offered support and education in self-care strategies and other measures that the member may take to promote healthy living.	
Findings: The Care Coordination policy stated that care coordinators will communicate with family, providers, and staff members to share assessment findings and develop a care plan in a non-duplicative, collaborated manner. The goals of the care coordination program included facilitating communication among multiple entities to decrease duplication of services. During the on-site interview, staff stated that Colorado Access communicates the assessment of specific member needs with providers and organizations during the referral process and identification of services that are appropriate to meeting the special health care needs of a member. During transition of the member into or out of the health plan, Colorado Access coordinates with other managed care organizations and initiates single case agreements as required to ensure continuity of care for members with special health care needs. Staff stated that, upon request, Colorado Access may send a printed copy of the care coordination plan to other providers participating in the member's health care but generally limits communication of the member's needs to the information pertinent to a particular service provider.		
Required Actions: None.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor implements procedures to develop an individual treatment plan as necessary. *42CFR438.208(c)(3)* Contract: Exhibit A—2.7.4.3.1.2	**Documents Submitted/Location Within Documents:** • Care Manager Desktop Procedure • CCS305 Care Coordination, page 3, I. C **Description of Process:** In policy CCS305, page 3, I. C. states one of the goals of care coordination is to identify opportunities and establish individualized care plans based on needs assessment that will improve access to medical and/or mental health care, community resources and social supports for members with complex physical, mental and cultural needs. The care manager works with the member and/or family and providers as needed in the development of the care plan.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Care Coordination policy outlined the process for care plan development based on the member's assessed needs. Colorado Access assigned members to various risk levels to guide the intensity of care coordination services. The policy defined multiple types of appropriate care plan service interventions. The CHP+ Provider Manual stated that the provider is responsible for maintaining a treatment plan consistent with the member's diagnoses. The on-site care coordination case presentation demonstrated that a care coordination plan was developed to meet the complex mental health, physical health, and social support needs of the member and the family. The case presentation demonstrated frequent follow-up and communications with the family, providers, and support services. The care coordination plan and progress notes were documented in the Altruista case management system.		
Required Actions: None.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor's procedures for individual needs assessment and treatment planning are designed to: ◆ Accommodate the specific cultural and linguistic needs of the members. ◆ Allow members with special health care needs direct access to a specialist as appropriate to the member's conditions and needs. *42CFR438.208(c)(3)(iii)* Contract: Exhibit A—2.7.4.3.1.4	**Documents Submitted:** • ADM206 Culturally Sensitive Services for Diverse Populations • ADM207 Effective Communication with LEP and SI-SI Persons • CCS306-Delivering Continuity and Transition of Care for Members; Section II.F • CCS310-Access to Primary and Specialty Care; p. 5-Section III.A • PNS309 - Primary Care Provider (PCP) Designation and Responsibilities; Section I.H • QM308 Preventive Health Services, Section VI. • Care Management Desktop Procedure; p. 2, 3, 6 **Description of Process:** The Care Management Desktop procedure explains in detail how Colorado Access accommodates to individual needs based on cultural, linguistic as well as other special health care needs. Per the Delivering Continuity and Transition of Care for Members policy (CCS306), Colorado Access will accommodate the specific cultural and linguistic needs of the member and will include authorized family members and/or guardians in the care planning process. Per the CCS 310 Access to Primary and Specialty Care policy, Colorado Access staff will work with the PCP to obtain standing referrals in instances where a member with Special Health Care Needs has a demonstrated history of using a specialist for a particular condition so that the member will have direct access to that specialty provider. This is not the same as the co-managing provider that can function in the capacity of the PCP.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Per the description of policy QM308: • Colorado Access will also reach out to members with specific cultural and ethnic backgrounds for prevention, health education, and treatment for diseases prevalent in those groups.	
Findings: The Care Coordination desktop procedure stated that care managers consider the member's language and linguistic preferences, cultural needs, literacy level, developmental disabilities, and hearing or visual impairments when developing a member's care plan. Colorado Access submitted additional policies that described the use of language interpretation/translation and/or auxiliary aids in the provision of member information, as necessary, and outlined the process for training Colorado Access staff and providers regarding cultural sensitivity. The Preventive Health Services policy stated that Colorado Access will distribute disease prevention and health education information related to a member's specific cultural and ethnic backgrounds. The Access to Primary and Specialty Care policy defined numerous circumstances when members may have direct access to specialists, including standing referrals for members with special health care needs, as well as family planning and women's health services, second opinions, and vision services. The policy also stated that Colorado Access will assist members to obtain out-of-network access to specialists when needed services are not available in network. The Delivering Continuity and Transition of Care for Members policy stated that Colorado Access will allow members with special health care needs direct access to appropriate specialty care when transitioning into the plan. The CHP+ Member Benefits Booklet stated that members do not need a referral or authorization to see an in-network specialist, and it addressed numerous specific situations that do not require referral by the PCP.		
Required Actions: None.		
8. The Contractor ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that they are applicable. In all other operations as well the Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45CFR parts 160 and 164, subparts A and E (HIPAA), to the	**Documents Submitted:** • HIP201-Protection of Health Information • HIP204-Security of Electronic Protected Health Information • CCS305-Care Coordination , Section III.C.6 • CHP+ Provider Manual p. 19-20 **Description of Process:** The sharing of member information for the purposes of continuity and coordination of care is handled in accordance with State and Federal laws and regulations outlined in Colorado Access	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
extent that these requirements are applicable. *42CFR438.208(b)(4)* *42CFR438.224* Contract: Exhibit A—2.7.4.1, 3.1.4.3 (RMHP—3.1.3.3)	Protection of Health Information policy (HIP201). In addition, Colorado Access Security of Electronic Protected Health Information policy (HIP204) outlines the policies for sharing electronic health information. Colorado Access Care Coordination policy (CCS305) states care coordination will work to ensure that member confidentiality is maintained, in accordance with 45 CFR Parts 160 and 164 and other applicable law and regulation, at all times when collaborating with both internal and external parties, as well as assuring that all confidential member information is maintained in an orderly fashion within the member's file (Section III.C.6., page 5). The CHP+ Provider Manual (pages 19-20) outlines member privacy requirements. These policies and procedures pertain to all activities undertaken by Colorado Access staff.	
Findings: The Protection of Health Information policy stated that all employees, providers, Board of Directors, and other entities affiliated with Colorado Access may not use or disclose member PHI except for treatment, payment, and operations. All other instances require the member's written consent. The policy outlined Colorado Access' procedures for ensuring that member privacy is maintained, including confidentiality agreements, provider and vendor contract requirements, staff and provider training, limited access to PHI based on the need to know for specific job functions, and verification of identity and authority of persons receiving PHI. The policy detailed the circumstances in which written member authorization is or is not required to use or disclose PHI and described the procedures for addressing breaches of PHI security. The Security of Electronic Protected Health Information policy described the roles and responsibilities of various staff for maintaining electronic and physical security of PHI. The policy stated that Colorado Access evaluates security policies and procedures for compliance with HIPAA and other legal requirements annually. The Care Coordination policy stated that care coordinators will ensure that confidentiality of member information is maintained when collaborating with both internal and external parties, as well as within the member file. The CHP+ Provider Manual informed providers that Colorado Access maintains confidentiality of member information in compliance with HIPAA standards, and that providers must be aware of expectations regarding privacy and confidentiality of member information.		
Required Actions: None.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor's procedures include a strategy to ensure that all members and/or authorized family members are involved in treatment planning and consent to medical treatment. Contract: Exhibit A—2.7.4.3.4	**Documents Submitted:** • CCS 305 Care Coordination, p. 4 section III, A, 1 and 2 • CHP Provider Manual, Pg 65-66 • CHP Member Handbook **Description of Process:** The member, family members and /or legal representative(s) as appropriate, will, to the degree possible, be involved in developing a mutually agreed-upon healthcare treatment plan in conjunction with the health plan and their providers. The Provider Manual outlines the following: CHP+ offered by Colorado Access covers medically necessary inpatient stays to treat mental health conditions. Covered inpatient stays require prior authorization. Covered services include: • Family counseling with family members to help with diagnosis and treatment.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The CHP+ Member Handbook and CHP+ Provider Manual informed members and providers, respectively, of the member's right to receive information about treatment options and participate in treatment decisions, including refusal of treatment recommendations. The Care Coordination policy stated that members/families must be involved in developing and implementing a mutually agreed-upon health care treatment plan. The on-site coordination of care case presentation demonstrated that the member's guardian was the primary point of contact regarding the member's needs, plans for services, and progress in the treatment plan. HSAG recommended that Colorado Access consider mechanisms to clearly document the member's agreement to the care coordination plan in the Altruista case management file and to inform providers of the requirement to involve the member/ family in the development of, and in the agreement with, the treatment plan.		
Required Actions: None.		

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	9	X	1.00	=	9
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	9	**Total Score**		=	9

Total Score ÷ Total Applicable	=	100%

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has written policies and procedures regarding member rights. *42CFR438.100(a)(1)* Contract: Exhibit A—3.1.1.1	**Documents Submitted/Location Within Documents:** • CS212-Member Rights and Responsibilities, Section I (pg 2) **Description of Process:** Policy CS212 states that Colorado Access will establish and maintain written policies and procedures for treating members in a manner that is consistent with federal and state law, rules and regulations, and contract requirements (Section I, pg 2).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Colorado Access had several polices in place that addressed member rights and protections in accordance with federal health care requirements. The Colorado Access Member Rights and Responsibilities policy described how member rights and responsibilities are communicated to providers, members, and Colorado Access employees. The Nondiscrimination policy defined the health plan's responsibility to protect member rights and to take necessary action to address any allegations of discrimination. In addition, the Protection of Member Individually Identifiable Health Information policy described Colorado Access' role in protecting member confidentiality, including safeguarding members' PHI.		
Required Actions: None.		
2. The Contractor ensures that its staff and affiliated network providers take member rights into account when furnishing services to members. *42CFR 438.100(a)(2)* Contract: Exhibit A—3.1.1.1.1	**Documents Submitted/Location Within Documents:** • CS212- Member Rights and Responsibilities policy, Sections III - IV (pg 2) • Provider Manual, page 14-15 • Grievance, Appeals, Denials Reporting Desktop Procedure-draft version • Grievance Reports FY13 Q1 Report – in folder, Quality dept • Appeals Reports FY13 Q1 Report – in folder, Quality dept **Description of Process:** CS212 Policy - states that "Colorado Access will communicate member rights and responsibilities to members, Colorado Access employees and providers according to applicable federal and state laws, rules and regulations and contract requirements. Distribution channels include, but are not limited to, member handbooks, provider manuals, new provider orientation, provider and member	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	bulletins, company website, newsletters, member complaint and appeal procedures, the Notice of Privacy Practices, and Evidence of Coverage documents". (Section III) CS212 also states that "Colorado Access provider contracts require provider compliance with all applicable federal and state laws, their implementing regulations, and Colorado Access policies and procedures, including member rights as identified herein and the requirement to take those rights into account when providing services to members". (Section IV) Provider Manual - Providers are informed within the Provider Manual that Members have certain rights that they must be aware of (pgs 14-15). Quarterly grievance and appeals report track concerns related to member rights and are addressed. No such member rights concerns were noted in the FY13 for the Q1 report. Q2 report will be completed per the reporting time cycle and available upon request during the on-site audit.	
Findings: The CHP+ HMO Provider Manual included a complete list of CHP+ member rights. Colorado Access provided grievances and appeals reports for July–September that illustrated the health plan had the ability to track and trend grievances related to member rights and protections, and that Colorado Access followed up with members to strive for satisfactory resolution. Compliance training addressed member rights related to HIPAA regulations. During the on-site interview, Colorado Access staff reported that internal staff members were required to attend orientation at the time of hire that included information about member rights. Staff members were also required to participate in annual compliance training that includes member rights information. Customer service staff members attend additional annual training regarding member rights and complete a related quiz each year. The schedule for provider training was available on the Web site. Staff members reported that Cultural Competency training for providers was scheduled as needed or requested. Colorado Access may want to consider placing member rights information under the provider tab on the Web site, including brief member rights trainings as part of the provider overview training, or including-topic specific rights information in the provider bulletin periodically.		
Required Actions: None.		

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's policies and procedures ensure that each member is treated by staff and affiliated network providers in a manner consistent with the following specified rights: ◆ Receive information in accordance with information requirements (42CFR438.10). ◆ Be treated with respect and with due consideration for his or her dignity and privacy. ◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. ◆ Participate in decisions regarding his or her health care, including the right to refuse treatment. ◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. ◆ Request and receive a copy of his or her medical records and request that they be amended or corrected. ◆ Be furnished health care services in accordance with requirements for access and quality of services (42CFR438.206 and 42CFR438.210). *42CFR438.100(b)(2) and (3)* Contract: Exhibit A—3.1.1.1	**Documents Submitted/Location Within Documents:** • CS212 – Member Rights and Responsibilities Policy • Member Handbook - Member Rights and Responsibilities Sections (pgs 17-18) • Provider Manual – Member Rights and Responsibilities Section (pgs 14-15) • Grievance Report – FY13 Q1 • Appeals Report -FY13 Q1 • Grievance, Appeals, Denials Reporting Desktop Procedure – draft version • Annual mailing **Description of Process:** Each new Member receives a new member packet mailing, which includes the CHP Member Handbook. This handbook outlines the members rights and responsibilities on pg 17-18. Member rights are outlined on page 14-15 of the CHP Provider Manual. Quarterly grievance and appeals report track concerns related to member rights are addressed. No such member rights concerns were noted in the FY13 for the Q1 report. Q2 report will be completed per the reporting time cycle and available upon request during the on-site audit. All CHP members receive an Annual Mailing which serves as a reminder to contact Colorado Access for copies of the Member Handbook and the information such as member rights, which it houses.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The CHP+ HMO Member Benefits Booklet, distributed to each member at the time of enrollment and available on the Colorado Access Web site, included the list of member rights, inclusive of those required in 42CFR438.100(b)(2)&(3). The provider manual also included the list of member rights. The CHP+ HMO annual letter informed members that they may request and receive a copy of the benefits booklet at any time and summarized the contents of the booklet, pointing out that the booklet contains information about the member's rights and protections and contains information about filing grievances and appeals. During the on-site interview, Colorado Access staff members reported that the health plan is developing a focus group program for the CHP+ population. The first focus group topic was emergency room (ER) utilization, and participants invited were high ER utilizers. Colorado Access staff discussed plans to develop future focus groups with additional topics that could include member rights topics.		
Required Actions: None.		
4. The Contractor ensures that each member is free to exercise his or her rights and that exercising those rights does not adversely affect the way the Contractor or its providers treat the member. *42CFR438.100(c)* Contract: Exhibit A—3.1.1.1.7	**Documents Submitted/Location Within Documents:** • Member Handbook - page 17, 113 • Grievance, Appeals, Denials Reporting Desktop Procedure-draft version • Provider Manual – page 14 • Grievance Report – FY13 Q1 • Appeals Report -FY13 Q1 **Description of Process:** CHP Members have the right to file a grievance about their care without retaliation. Member rights listed within the Member Handbook and in the Provider Manual states that this is a Member right. The CHP Member Handbook (pg 17) informs members that **As a member, you have the right to exercise these rights without fear of retaliation,** below are several of the outlined rights: • Not be restrained or left by yourself to make you do something you may not want to do. • Tell us about any concerns and complaints you have about the care and services you got. CHP+ HMO will look into it and	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	will take the right action. • File a complaint or appeal a decision with CHP+ HMO without fear of it being used against you (retaliation) CHP ensures that Members are free to exercise their rights without retaliation by monitoring issues that may arise through the grievance process as outlined in the Grievance, Appeals and Denials desktop document.	
Findings: The list of member rights included in the CHP+ HMO Benefits Booklet and the CHP+ HMO provider manual included the member's right to express any complaints and concerns about services received. The benefits booklet and the provider manual also informed members of the right to file a complaint or appeal a decision without fear of retaliation. In addition, Colorado Access' Nondiscrimination policy stated that Colorado Access will not tolerate retaliation of any kind. The Colorado Access annual member letter included a reminder that the member benefits booklet included a statement of member rights. The member benefits booklet included a grievance form for members to use.		
Required Actions: None.		
5. Contractor complies with any other federal and State laws that pertain to member rights including Title VI of the Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act, and titles II and III of the Americans with Disabilities Act. *42CFR438.100(d)* Contract: 21.A	**Documents Submitted/Location Within Documents:** • ADM205-Nondiscrimnination **Description of Process:** Colorado Access policy ADM205 outlines our nondiscrimination policy and adherence to applicable Stated and Federal laws.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Nondiscrimination policy mandated compliance with all State and federal laws and prohibited discrimination based on race, color, national origin, sex, religion, creed, sexual orientation, age, or mental or physical disability. The Protection of Member Individually Identifiable Health Information policy addressed the protection of member privacy and confidentiality, including safeguarding member PHI. In addition, the requirement to comply with federal and State laws was included in both the provider manual and in provider contracts.		
Required Actions: None.		

Results for Standard IV—Member Rights and Protections							
Total	Met	=	5	X	1.00	=	5
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	5	**Total Score**		=	5

Total Score ÷ Total Applicable	=	100%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. NCQA CR1	**Documentation Submitted:** • CR301-Provider Credentialing and Recredentialing, All • CR302-Office Site Visit for Provider Credentialing, All • CMP206-Sanction, Exclusion, Prohibited Affiliation, and Opt-Out Screening, All • CR307- Credentialing and Recredentialing Provider Review Classification, All • CR312-Provider Rights, All • CR213-Adverse Actions and Hearing and Appeals Process for Providers, All • CR318-Ongoing Monitoring of Provider Sanctions, Grievances, and Occurrences of Adverse Actions, All • PNS202-Selection and Retention of Providers, All • ADM223 Delegation, All **Process Description:** Credentialing functions are the responsibility of the Director of Provider Contracting. Credentialing staff consist of the Manager of Contract Systems and a Credentialing Program Coordinator. Colorado Access maintains a credentialing committee consisting of physicians from within our network and chaired by a Colorado Access Medical Director. Minutes will be made available upon request during the site review. All Colorado Access credentialing and recredentialing policies and procedures adhere to NCQA Standards and Guidelines for Credentialing and Recredentialing.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Colorado Access, a health plan with several product lines, performed the credentialing and recredentialing processes for its CHP+ HMO line of business. The Practitioner Credentialing and Recredentialing policy provided an overview of Colorado Access' credentialing and recredentialing processes, referring		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
to other pertinent policies for specific details. Processes reviewed on-site were consistent with the policies and provided evidence of Colorado Access' well-defined credentialing and recredentialing processes.		
Required Actions: None.		
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners to credential and recredential. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. (Examples include doctors of medicine [MDs], doctors of osteopathy [DOs], podiatrists, and each type of behavioral health provider). *42CFR438.214(a)* NCQA CR1—Element A1	**Documentation Submitted:** • CR301-Provider Credentialing and Recredentialing, Section I (pg3) • Credentialing Committee Minutes (available onsite for review) **Process Description:** Colorado Access policy CR301 outlines the company's credentialing practices. Practitioners are credentialed following current NCQA standards. The policies listed in Requirement #1 support the credentialing and recredentialing process. Colorado Access uses the CDPHE Colorado Health Care Professional Credential Application. This common State approved application specifies the types of practitioners to be credentialed. CR301, Section I, specifies the types of practitioners credentialed by Colorado Access (p 3-4).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Credentialing and Recredentialing policy described each type of practitioner subject to Colorado Access' credentialing processes. Practitioners credentialed and recredentialed by Colorado Access included medical doctors, doctors of osteopathy, podiatrists, chiropractors, doctors of dental science, psychologists, psychiatrists, social workers, nurses, and counseling professionals (including family therapists and licensed professional counselors). The Colorado Access provider directory provided evidence that Colorado Access maintained a robust selection of practitioners, which included both primary care and specialty practitioners.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.B. The verification sources used. NCQA CR1—Element A2	**Documentation:** • CR301-Provider Credentialing and Recredentialing, Section XV (pgs 11-15) **Process Description:** The CR301 section noted above specifies the verification sources used for credentialing and recredentialing. If requested, credentialing staff can produce examples of practitioner credentialing file applications as evidence of the verification sources used.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Credentialing and Recredentialing policy described the acceptable primary sources used for verifying licensure, education and training, Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certification, board certification, and malpractice coverage.		
Required Actions: None.		
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	**Documentation:** • CR301-Provider Credentialing and Recredentialing, Section VIII, pgs. 6-7 • CR307-Credentialing and Recredentialing Provider Review Classification, All • Provider Manual (pg 28) **Process Description:** CR301, Section VIII (p6-7) and CR307 outline the criteria used for Credentialing (p59-60). If requested, credentialing staff can produce examples of practitioner credentialing file applications as evidence of the criteria used.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Credentialing and Recredentialing policy described the criteria for network participation, which applied to all practitioners under the scope of Colorado Access' credentialing program. The Credentialing/Recredentialing Practitioner Review Classification and Credentials Committee Determination Process policy (Practitioner Review Classification policy) described the specific criteria for files meeting the standard for clean files and those that are submitted to the Colorado Access Credentials Committee for review. The Colorado Access Provider Manual informed providers of the criteria for participation and continued participation in Colorado Access' provider network.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: None.		
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	**Documentation:** • CR307-Credentialing and Recredentialing Provider Review Classification, All • CR301-Provider Credentialing and Recredentialing, Section IX (pgs 7-8), and Section XVI (pg 15-16) **Process Description:** Colorado Access policy CR307 outlines the process for making credentialing and recredentialing decisions. CR301 also speaks generally to the credentialing decision making process. If requested, credentialing staff can produce Credentialing Committee minutes as evidence of the decision making process.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Credentialing and Recredentialing policy described the Colorado Access Credentials Committee and its processes for reviewing practitioner applications and making credentialing and recredentialing decisions. The Practitioner Review Classification policy described the process and criteria for files that may go directly to the medical director for review.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.E. The process for managing credentialing/ recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	**Documentation Submitted:** • CR301-Provider Credentialing and Recredentialing, Section VIII (pg 6) **Process Description:** CR301 specifies how records are maintained by credentialing staff (p6). Credentialing files are maintained using the Apogee Managed Care Credentialing System (Morrisey Associates, Inc.). Prior to November 2009, we used the MSO product from Morrisey. Apogee software is a web-based comprehensive membership management system. During the site review, Credentialing staff can demonstrate this product if requested. Reviewers are welcome to visit the credentialing area where physical files are stored.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Credentialing and Recredentialing policy described the process for the credentialing program coordinator to review credentialing files for completeness and timeliness and for forwarding the file to the chief medical officer or the associate medical director for review. The Practitioner Review Classification policy described which files may be reviewed by the chief medical officer or the associate medical director physician designee, and which files are sent to the Credentials Committee for review. The policy stated that the Credentials Committee may also review any file designated as "meeting criteria." The Credentials Committee meeting minutes provided evidence that the Credentials Committee reviewed credentialing and recredentialing files as well as the list of providers who were approved by the medical director when providers met, without exception, all of the credentialing criteria.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.F. The process for delegating credentialing or recredentialing (if applicable). NCQA CR1—Element A6	**Documentation:** • CR301-Provider Credentialing and Recredentialing, Sections VI (pg 5), VIII (pg 6-7) • Provider Manual (pg 29) **Process Description:** The process for delegating credentialing and recredentialing is specified in CR301 ssections VI (pg 5)and VIII (p6-7). Currently, Colorado Access delegates credentialing and recredentialing to three entities: Denver Health, National Jewish, and University Physicians. These agreements are included in the "Delegation Agreements" folder. All three include CHP credentialed providers. The delegation of credentialing is also mentioned in the Provider Manual (pg 29).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Colorado Access staff members reported that Colorado Access delegated credentialing to Denver Health and Hospital Authority, National Jewish Health, and University Physicians, Incorporated, for those providers. Colorado Access staff stated that each delegate maintained a network of physicians who had an independent relationship with Colorado Access for provision of services to Colorado Access members. The Practitioner Credentialing and Recredentialing policy described the processes for the delegation, which included completion of a predelegation audit and Colorado Access' approval of the delegated entity's credentialing policies and procedures as well as subsequent oversight processes.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.G. The process for ensuring that credentialing and recredentialing are conducted in a non-discriminatory manner, (i.e., must describe the steps the Contractor takes to ensure that it does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes). NCQA CR1—Element A7	**Documents Submitted/Location Within Documents:** • CR301-Provider Credentialing and Recredentialing, Section III (pgs 4-5) • Provider Manual (pg 18) **Process Description:** The process for ensuring that credentialing and recredentialing are conducted in a non-discriminatory manner is specified in CR301 section III (p4-5). The CHP provider Manual also describes non-discrimination on page 18. If requested, the Credentials Committee signatures on the Non-Discrimination Acknowledgment can be made available during the site review.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Credentialing and Recredentialing policy stated that Colorado Access does not make credentialing and recredentialing decisions based solely on ethnic/national identity, gender, age, sexual orientation, type of practice, or types of patients the practitioner may specialize in treating. The policy also stated that Colorado Access will not discriminate—in terms of participation, reimbursement, or indemnification—against any health care professional who is acting within the scope of his or her license or certification under State law solely on the basis of that license or certification. In addition, the policy described the Credentials Committee process and described how the committee, the chief medical officer, and the associate medical director designee applied the criteria in the credentialing policies to each case prepared and reviewed for credentialing and recredentialing. The policy stated that all participating Credentials Committee members signed an acknowledgment form stating that they do not discriminate when making credentialing and recredentialing decisions. Signed nondiscrimination forms for committee members were reviewed on-site. The Provider Manual informed providers of Colorado Access' policy not to discriminate during the credentialing and recredentialing processes. During the on-site interview, staff members reported that, if complaints were received, the medical director would review the case. While Colorado Access had appropriate methods to prevent discrimination, there were no methods in place for periodic monitoring to ensure nondiscriminatory credentialing practices, as required by NCQA.		
Required Actions: Colorado Access must develop processes for monitoring to ensure nondiscriminatory credentialing practices.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.H. The process for notifying practitioners if information obtained during the Contractor's credentialing/recredentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A8	**Documents Submitted/Location Within Documents:** • CR301-Provider Credentialing and Recredentialing, Section V (pg 5) • CR312-Provider Rights, Section II.B (pg 3) • Colorado Health Care Professional Credentials Application (pg 23) • Provider Manual (pg 28) **Process Description:** Colorado Access policy CR301 states, "Practitioners have the right to review the information submitted in support of the credentialing application; be notified during the credentialing process if information obtained varies substantially from practitioner's information; correct any erroneous information submitted as a part of the credentialing process; and be informed, upon request, of the status of their credentialing or recredentialing application (Section V, pg 5)." Colorado Access policy CR312 details the rights afforded practitioners in the credentialing process (Section II.B, pg 3). The CHP Provider Manual on page 28 states; "To the extent permitted by law, the applicant has the right to review information obtained by Colorado Access to evaluate their credentialing application. Colorado Access is not required to allow applicants to review references, recommendations, or other information that is peer-review protected. Colorado Access is not required to reveal the source of information when the information is obtained to meet credentialing verification requirements, if disclosure is prohibited by law. In the event that credentialing information obtained from other sources varies substantially from that provided by the applicant, the Credentialing Department will notify the applicant of the process to correct erroneous information submitted by another party.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Credentialing and Recredentialing policy stated that if an application contained information that varied substantially from the information acquired during the credentialing process, the practitioner would be given the opportunity to correct the information and/or explain the discrepancy.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Providers were notified in the credentialing application that they would be notified if information received during the credentialing process varied from the information provided by the applicant and that the applicant had the right to correct any erroneous information. The Practitioner Rights policy stated that such notification would occur in writing using a standard form.		
Required Actions: None.		
2.I. The process for ensuring that practitioners are notified of credentialing and recredentialing decisions within 60 calendar days of the committee's decision. NCQA CR1—Element A9	**Documents Submitted/Location Within Documents:** • CR301-Provider Credentialing and Recredentialing, Section XVII (pg 16) **Process Description:** Colorado Access policy CR301 states, "Providers undergoing initial credentialing are notified in writing within ten (10) business days of the Senior Medical Director weekly reviews and Credentials Committee decisions." (Section XVII).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Credentialing and Recredentialing policy stated that practitioners undergoing initial credentialing are notified in writing within 60 calendar days of the committee's credentialing decision. On-site review of credentialing and recredentialing files demonstrated that notification was typically provided within the same week of the decision.		
Required Actions: None.		
2.J. The medical director's or other designated physician's direct responsibility and participation in the credentialing/ recredentialing program. NCQA CR1—Element A10	**Documents Submitted/Location Within Documents:** • CR301-Provider Credentialing and Recredentialing, Section IV (pg 5) and IX (pgs 7-8). **Process Description:** Colorado Access policy CR301 requires Medical Director responsibility for the credentialing program (Section IV p5 and IX p7-8 and). Credentialing Committee minutes (available during site review) are evidence that the Chief Medical Officer, or other Associate Medical Director designee, chairs the committee.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The Practitioner Credentialing and Recredentialing policy stated that the chief medical officer or the associate medical director designee is responsible for clinical aspects of the credentialing program and serves as chair of the Credentials Committee. The policy also stated that the chief medical officer or the associate medical director (designee) is authorized to approve practitioners for participation who meet criteria. The Credentials Committee meeting minutes reviewed on-site provided evidence of the medical director's involvement and participation in the committee. During the on-site interview, Colorado Access staff confirmed that the credentialing date for clean files is the medical director sign-off date and that for the files reviewed by the Credentials Committee, it is the committee date.		
Required Actions: None.		
2.K. The process for ensuring the confidentiality of all information obtained in the credentialing/ recredentialing process, except as otherwise provided by law. NCQA CR1—Element A11	**Documents Submitted/Location Within Documents:** • CR301-Provider Credentialing and Recredentialing, Section VII (pg 6) **Process Description:** Colorado Access policy CR301 (Sections noted above) specifies the process for ensuring the confidentiality of all credentialing information (p6). Confidentiality statements signed by the Credentials Committee can be produced upon request during the site review.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Credentialing and Recredentialing policy described the processes and procedures used for ensuring the confidentiality of information obtained during the credentialing and recredentialing processes. Processes included signed confidentiality statements by staff with access to credentialing and recredentialing materials, locked file cabinets for storage of hard copy files, shredding of copied materials, and password protection security of electronic files.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.L. The process for ensuring that listings in provider directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty. NCQA CR1—Element A12	**Documents Submitted/Location Within Documents:** • CR301-Provider Credentialing and Recredentialing, Section XVIII (pg 16-17) **Process Description:** Colorado Access policy CR301 specifies the process for listing practitioner information in provider directories. CR301 Section XVIII states; "Colorado Access verifies that the information pertaining to credentialed providers that is contained in member materials including provider directories is consistent with the information obtained during credentialing by conducting audits, at least annually. Examples of elements audited may include verification of the provider's name, education, training, certification, and specialty (p16)."	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Credentialing and Recredentialing policy described annual audits for accuracy of the provider directory information. Colorado Access staff stated that the claims system was used to query provider contact information, which was verified against the information contained in the credentialing database. Staff also stated that the online searchable database is updated within days of a change to the database. Hard copies used for mailings are printed annually by the vendor used for eligibility mailings.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.M. The right of practitioners to review information submitted to support their credentialing or recredentialing application, upon request. NCQA CR1—Element B1	**Documents Submitted/Location Within Documents:** • CR301-Provider Credentialing and Recredentialing, Section V (pg 5) • CR312-Provider Rights, All • Colorado Health Care Professional Credentials Application (#12, pg 23) • Provider Manual (pg 28) **Process Description:** Colorado Access policy CR301 states, "Providers have the right to review the information submitted in support of the credentialing application. Providers will be notified during the credentialing process if information obtained varies substantially from provider's information. Providers have the right to correct any erroneous information submitted as a part of the credentialing process, provide missing information during the verification process, and be informed, upon request, of the status of their credentialing or recredentialing application." (Section V). Colorado Access policy CR312 specifies the process practitioners need to follow to obtain information related to their credentialing application. The CO Health Care Professional Credentials Application used by Colorado Access informs practitioners of their right to review information submitted in support of their application (p23). Practitioners are also informed of this right within the Provider Manual (pg 28).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Credentialing and Recredentialing policy included the provision that practitioner applicants have the right to review information submitted in support of their credentialing/recredentialing application. The Practitioner Rights policy described Colorado Access' processes for allowing practitioners to access their information. Providers were informed of this right in the credentialing application and in the provider manual.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.N. The right of practitioners to correct erroneous information. NCQA CR1—Element B2	**Documents Submitted/Location Within Documents:** • CR301-Provider Credentialing and Recredentialing, Section V (pg 5) • CR312-Provider Rights, Section II (pg 3) • Colorado Health Care Professional Credentials Application (pg. 23) • Provider Manual (pg 28) **Process Description:** Colorado Access policy CR301 states, "Practitioners have the right to … correct any erroneous information submitted as a part of the credentialing process" (Section V, pg5). Colorado Access policy CR312 specifies the process practitioner's should follow to request that information within their application be corrected (Section II, pg 3).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Credentialing and Recredentialing policy included the provision that practitioners have the right to correct any erroneous information obtained during the credentialing/recredentialing process. The Practitioner Rights policy described Colorado Access' processes for correcting erroneous information. The policy included the link to find a correction form online.		
Required Actions: None.		
2.O. The right of practitioners, upon request, to receive the status of their application. NCQA CR1—Element B3	**Documents Submitted/Location Within Documents:** • CR301-Provider Credentialing and Recredentialing, Section V (pg 5) • CR312-Provider Rights, Section III (pg 3) • Colorado Health Care Professional Credentials Application (#12, pg 23) • Provider Manual (pg 28) **Process Description:** Colorado Access policy CR301 states, "Practitioners have the right to … be informed, upon request, of the status of their credentialing or recredentialing application" (Section V, pg 5).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Colorado Access policy CR312 specifies the process practitioner's should follow to request the status of their application (Section III, pg 3). Practitioners are informed of this right within the CO Health Care Professional Credentials Application (#12, pg 23). The Provider Manual also informs providers of this right (pg 28).	
Findings: The Practitioner Credentialing and Recredentialing policy included the practitioner's right to receive the status of their credentialing application, upon request. The Practitioner Rights policy described Colorado Access' processes for informing practitioners of their application status, upon request. Providers were notified of this right in the credentialing application and in the provider manual.		
Required Actions: None.		
2.P. The right of the applicant to receive notification of their rights under the credentialing program. NCQA CR1—Element B4	**Documents Submitted/Location Within Documents:** • CR312-Provider Rights, Section IV (pg 3) • Colorado Health Care Professional Credentials Application (Schedule A, pgs 22-23) • Provider Manual (pg 28) **Process Description:** Colorado Access policy CR312 states, "Practitioners are notified of these rights by the Provider Manual and on Schedule A of the Colorado Health Professional Credentials Application" (Section IV, pg 4). Practitioners are notified of their rights when they sign Schedule A of the CO Health Care Professional Credentials Application. Providers are also notified of their rights within the Provider Manual (pg 28). This document is readily available on our website at http://www.coaccess.com/chp-offered-colorado-access-provider-information	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The Practitioner Rights policy stated that providers are notified of their rights via the provider manual and in the credentialing application. The credentialing application and the provider manual included each of the applicant rights.		
Required Actions: None.		
2.Q. How the Contractor accomplishes ongoing monitoring of practitioner sanctions, complaints, and adverse events between recredentialing cycles including: ◆ Collecting and reviewing Medicare and Medicaid sanctions. ◆ Collecting and reviewing sanctions or limitations on licensure. ◆ Collecting and reviewing complaints. ◆ Collecting and reviewing information from identified adverse events. ◆ Implementing appropriate interventions when it identified instances of poor quality related to the above. NCQA CR9—Element A	**Documents Submitted/Location Within Documents:** • CR301-Provider Credentialing and Recredentialing, Section XI (pg 9) • CR318-Ongoing Monitoring of Provider Sanctions, Grievances, and Occurrences of Adverse Events, All • QM201-Investigation of Potential Clinical Quality of Care Grievances and Concerns, All **Process Description:** Colorado Access policy CR301 states, "Colorado Access conducts ongoing monitoring of practitioners contracted to participate in the Colorado Access networks that fall within the scope of credentialing activities and will take appropriate action based on the findings. The ongoing monitoring activities conducted between recredentialing cycles will include Medicare and Medicaid sanctions or exclusions, practitioners who opt-out of Medicare, Colorado State licensing sanctions or limitations on licensure, and practitioner-specific member grievances, and occurrences of adverse events " (Section XI p9) . Colorado Access policy CR318 outlines the specific monitoring activities referred to in CR301, Section XI. • On a monthly basis, credentialing staff check the OIG exclusion database (CR318: Section II.A.1, pg 3) • Prior to each credentialing committee meeting, credentialing staff check the DORA Registrations Online Disciplinary report for all credentialed providers (CR318: Section II.B.1-2, pg 3). • Member quality of care concerns of adverse events are reviewed by a Medical Director. If warranted, cases are referred to the credentials committee for review (CR318: Section II.C, pg 4). This process is	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	specified within QM201 Section I.E-G. The summary report prepared by Quality Management will be available upon request.	
Findings: The Practitioner Credentialing and Recredentialing policy stated that ongoing monitoring activities between credentialing cycles included review for Medicare/Medicaid sanctions and Colorado State licensure sanctions, review of practitioner-specific member grievances, and review of occurrences of adverse events. The Ongoing Monitoring of Sanctions, Grievances, and Occurrences of Adverse Events policy (Ongoing Monitoring policy) stated that monitoring for State and Medicare/Medicaid sanctions occurred monthly. The Ongoing Monitoring policy also stated that if a provider had been disciplined, Colorado Access monitored compliance with the corrective actions. The Investigation of Potential Clinical Quality of Care (QOC) Grievances and Referrals policy described the processes for peer review and Colorado Access' response when practitioners were determined to have quality-of-care issues. The Sanction Monitoring Report, which was presented each month to the Credentials Committee, provided evidence that the health plan regularly monitored practitioner sanctions, licensure issues, Office of Inspector General (OIG) sanctions, and other adverse events for practitioners in the network and presented the information to the Credentials Committee for review. On-site review of the Credentials Committee meeting minutes provided evidence that the Sanction Monitoring Report was presented to and reviewed by the committee. On-site, Colorado Access provided evidence of the monthly search for sanctions using the appropriate online databases and crosscheck to determine if Colorado Access providers were on the list.		
Required Actions: None.		
2.R. The range of actions available to the Contractor against the practitioner (for quality reasons). NCQA CR10—Element A1	**Documents Submitted/Location Within Documents:** • CR213-Adverse Actions and Hearing and Appeals Process for Providers, All • CR318-Ongoing Monitoring of Providers Sanctions, Grievances, and Occurrences of Adverse Events, Section III (pgs 4-5) **Process Description:** Colorado Access policy CR213 outlines the action available to CHP if a provider does not meet quality standards. Colorado Access policy CR318 also outlines the actions available to the credentialing committee (Section III, pgs 4-5).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Adverse Actions and Hearing and Appeal Process for Practitioners policy (Adverse Actions policy) described the range of actions available to Colorado Access in response to an administrative action or a peer review action taken against a practitioner. Actions included imposition of a corrective		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
action plan (CAP) or reduction, suspension, or termination of the practitioner's network participation. The Credentials Committee meeting minutes provided evidence that the committee pended or denied credentialing to providers who did not meet the credentialing criteria for quality reasons.		
Required Actions: None.		
2.S. If the Contractor has taken action against a practitioner for quality reasons, the Contractor reports the action to the appropriate authorities (including State licensing agencies for each practitioner type and the National Practitioner Data Bank [NPDB]). NCQA CR10—Element A2 and B	**Documents Submitted/Location Within Documents:** • CR213-Adverse Actions and Hearing and Appeals Process for Providers, Section III (pg 6-7) **Process Description:** Colorado Access policy CR213 specifies the procedures to be followed when Colorado Access takes an action against a practitioner for quality reasons (Section IV, pgs 7-8).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Adverse Actions policy described Colorado Access' processes for reporting adverse actions to the appropriate agency, including the applicable State licensing board, the National Practitioners Data Bank (NPDB), and the Healthcare Integrity and Protection Data Bank (HIPDB), as applicable. Colorado Access staff stated that medical director approval is obtained prior to notification of authorities.		
Required Actions: None.		
2.T. A well-defined appeal process for instances in which the Contractor chooses to alter the conditions of a practitioner's participation based on issues of quality of care or service which includes: ◆ Providing written notification indicating that a professional review action has been brought against the practitioner, reasons for the action, and a summary of the appeal rights and process. ◆ Allowing the practitioner to request a hearing and the specific time period for submitting the request.	**Documents Submitted/Location Within Documents:** • CR213-Adverse Actions and Hearing and Appeals Process for Providers, Section I.A, Section II.C (pg 5), Section II.E, Section III.D, Attachment C (pgs 10-16), Attachment D • Provider Manual (pg 68) **Process Description:** CR213 Section I.A states, "For actions involving quality of care, professional competence and/or conduct, the Provider will be notified by certified mail within five (5) business days of the decision set forth in Section II below. (p5)" CR213 Section II.C describes the minimum contents of the written notice (5-6).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
◆ Allowing at least 30 days after the notification for the practitioner to request a hearing. ◆ Allowing the practitioner to be represented by an attorney or another person of the practitioner's choice. ◆ Appointing a hearing officer or panel of the individuals to review the appeal. ◆ Providing written notification of the appeal decision that contains the specific reasons for the decision. NCQA CR10—Element A3and C	CR213 Section II.C indicates as part of the written notification that a practitioner can request a hearing within 30 days of written notice. CR213 Section II.E states that practitioner has 30 days to request a hearing (p6). CR213 Attachment D states that practitioner can be represented by an attorney or any person of the practitioner's choice (p30). CR213 Attachment A III.F&G describe how a hearing panel and hearing officer are appointed (p13). CR213 Section III.D states; "The Appeal Panel may render its decision orally at the close of the Appeal Hearing. Within thirty (30) calendar days after rendering an oral decision, or within thirty (30) calendar days after the close of the Appeal Hearing if no oral decision has been rendered, the Appeal Hearing Panel shall issue a decision which shall be accompanied by a written report that contains findings of fact and conclusions that articulate the connection between the evidence produced at the Appeal Hearing and the decision rendered. The written decision and report shall be delivered to Colorado Access and the Provider within ten (10) business days."	
Findings: The Adverse Actions policy described the practitioner appeal and hearing processes. Practitioners were notified of the appeal and hearing process in the provider manual.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.U. Making the appeal process known to practitioners. NCQA CR10—Element A4	**Documents Submitted/Location Within Documents:** • CR213-Adverse Actions and Hearing and Appeals Process for Providers, Attachment A (pg 10) • Provider Manual, Section XI (pg 68) **Process Description:** Practitioners are notified of the appeal process in the Practitioner Termination for Professional Review Action letter (CR213, Attachment A p11). Practitioners are also made aware of the credentialing appeal process within the Provider Manual (pg 68)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Adverse Actions policy included a template letter that informed practitioners of the actions Colorado Access took, the reasons for the actions, and the practitioner's right to request a hearing.		
Required Actions: None.		
3. The Contractor designates a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions. The committee includes representation from a range of participating practitioners. NCQA CR2—Element A	**Documents Submitted/Location Within Documents:** • CR301-Provider Credentialing and Recredentialing, Section IX (pgs 7-8) • Credentialing Committee Roster 2012 **Process Description:** Colorado Access policy CR301 designates the existence of a credentialing committee (Section IX, pgs 7-8). This committee consists of participating network providers from all Colorado Access lines of business. The credentialing committee roster is included.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Credentialing and Recredentialing policy described the Colorado Access Credentials Committee and its responsibilities. The Credentials Committee roster listed the committee's membership, which consisted of a range of practicing physicians including a psychologist and medical doctors from several disciplines.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor provides evidence of the following: ◆ Credentialing committee review of credentials for practitioners who do not meet established thresholds. ◆ Medical director or equally qualified individual review and approval of clean files. NCQA CR2—Element B	**Documents Submitted/Location Within Documents:** • CR301-Provider Credentialing and Recredentialing, Section IX (pgs 7-8) • CR307-Credentialing and Recredentialing Provider Review Classification, Section I.B.1- 2 (pg 3) **Process Description:** Colorado Access policy CR301 stipulates that the credentialing committee will review, at a minimum, the status of practitioners who do not meet established credentialing criteria (Section IX, pg 7). Colorado Access policy CR307 specifies the process for reviewing practitioners who do not meet minimum standards and for review and approval of files by the Medical Director (Section I.B.1-2, pgs 2-3).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Review Classification policy described the criteria for applicants who met the criteria for clean files that may be reviewed by the chief medical officer, and for those files that must be reviewed by the committee. The Credentials Committee meeting minutes provided evidence that the Credentials Committee reviewed all files that did not cleanly meet the credentialing criteria.		
Required Actions: None.		
5. The Contractor conducts timely verification (at credentialing) of information, using primary sources, to ensure that practitioners have the legal authority and relevant training and experience to provide quality care. Verification is within the prescribed time limits and includes: ◆ A current, valid license to practice (verification time limit = 180 calendar days). ◆ A valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS)	**Documents Submitted/Location Within Documents:** • CR301-Provider Credentialing and Recredentialing, Section VIII (pgs 6-7) and XIV (pgs 10-15) **Process Description:** Colorado Access policy CR301 outlines the use of primary source verification and the deadlines for this verification to occur (Sections VIII, pgs 6-7 and XIV, pgs 9-13).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
certificate if applicable (effective at the time of the credentialing decision). ◆ Education and training, including board certification, if applicable (verification of the highest of graduation from medical/ professional school, residency, or board certification [board certification time limit = 180 calendar days]). ◆ Work history (verification time limit = 365 calendar days) (non-primary verification—most recent 5 years). ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (verification time limit = 180 calendar days). NCQA CR3—Elements A and B		
Findings: The Practitioner Credentialing and Recredentialing policy described the processes for primary source verification and for the time limits for verifying each element at the primary sources, all of which were NCQA-compliant.		
Required Actions: None.		
6. Practitioners complete an application for network participation (at initial credentialing and recredentialing) that includes a current and signed attestation and addresses the following: ◆ Reasons for inability to perform the essential functions of the position, with or without accommodation. ◆ Lack of present illegal drug use.	**Documents Submitted/Location Within Documents:** • CR301-Provider Credentialing and Recredentialing, Section X (pgs 8-9) • Colorado Health Care Professional Credentials Application (pgs 19-21, 24-26) **Process Description:** Colorado Access policy CR301 requires that all credentialing and recredentialing applications must include a current and signed attestation that includes the bullets listed to the left (Section X, pg 9).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
◆ History of loss of license and felony convictions. ◆ History of loss or limitation of privileges or disciplinary actions. ◆ Current malpractice/professional liability insurance coverage (minimums = physician—.5mil/1.5mil; facility—.5mil/3mil), ◆ The correctness and completeness of the application. NCQA CR4—Element A NCQA CR7—Element C C.R.S.—13-64-301-302	The CO Health Care Professional Credentials Application requires practitioners to attest to these requirements (pgs 19-21, 24-26).	
Findings: The Practitioner Credentialing and Recredentialing policy stated that Colorado Access requires all practitioners to complete the Colorado Health Care Professional Credentials Application. The application included each of the required attestations. On-site review of 10 credentialing and 10 recredentialing files provided evidence that each file contained a completed and signed application and attestation from the provider.		
Required Actions: None.		
7. The Contractor verifies the following sanction activities for initial credentialing and recredentialing: ◆ State sanctions, restrictions on licensure or limitations on scope of practice. ◆ Medicare and Medicaid sanctions. *42CFR438.610(b)(3)* NCQA CR5—Element A NCQA CR7—Element D	**Documents Submitted/Location Within Documents:** • CR301-Practitioner Credentialing and Recredentialing, Section XI (pg 9), XIV.A (pg 10), XV.H (pg 14) **Process Description:** Colorado Access policy CR301 requires that Colorado Access receive information on practitioner sanction before making a credentialing decision. This includes State and CMS sanctions. See specific sections noted above.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The Practitioner Credentialing and Recredentialing policy stated that in support of credentialing or recredentialing applications, State licensure sanctions, and Medicare/Medicare sanctions are researched using the required databases. On-site review of credentialing and recredentialing files confirmed review for sanctions at credentialing and recredentialing.		
Required Actions: None.		
8. The Contractor has a process to ensure that the offices of all practitioners meet its office-site standards. The organization sets standards and performance thresholds for: ◆ Physical accessibility. ◆ Physical appearance. ◆ Adequacy of waiting and examining room space. ◆ Adequacy of treatment record-keeping. NCQA CR6—Element A	**Documents Submitted/Location Within Documents:** • CR301-Provider Credentialing and Recredentialing, Section VIII (pg 7), XV.I (pg 15) • CR302-Office Site Visit for Providers Credentialing, All • Provider Manual (pg 28) **Process Description:** Colorado Access policy CR301specifies that a site visit will occur if a complaint is received related to the physical accessibility, appearance, or adequacy of waiting room or examining room space. If a site visit is required, Colorado Access policy CR302 outlines the process for practitioner site visits. Section II.A outlines what items will be assessed in a site visit (p2-3). Practitioner site review guidelines are also noted in the Provider Manual (pg 28).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Office Site Visit for Provider Credentialing policy delineated Colorado Access' criteria for office site visits. The policy stated that an office site assessment will include physical appearance, physical accessibility, appointment availability, and the adequacy of waiting room and exam/treatment room space. The policy also stated that the office site visit included assessment of medical record-keeping practices, including practices for confidentiality, file organization, and documentation. The site visit form, attached to the policy, included the specific requirements for each standard and included a review for all of the NCQA standards. Providers were informed of the site review standards via the provider manual. During the on-site interview, Colorado Access staff members reported that there had been no site visits based on office site quality during the review period.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor implements appropriate interventions by: ◆ Conducting site visits of offices about which it has received member complaints. ◆ Instituting actions to improve offices that do not meet thresholds. ◆ Evaluating effectiveness of the actions at least every six months, until deficient offices meet the thresholds. ◆ Continually monitoring member complaints for all practitioner sites and performing a site visit within 60 days of determining a complaint threshold was met. ◆ Documenting follow-up visits for offices that had subsequent deficiencies. NCQA CR6—Element B	**Documents Submitted/Location Within Documents:** • CR302-Office Site Visit for Provider Credentialing, All **Process Description:** Colorado Access policy CR302 outlines the process for practitioners site visits based on a member complaint. CR302 Section I describes how Colorado Access will conduct site visits when member complaints are received (p2) CR302 Section V.A&B describes actions that will be taken to improve offices that do not meet thresholds (p3). Section V.A also indicates that follow up site visits will occur every six months until the office meets the threshold (p3). Section VI describes how follow up visits are documented (p3).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Office Site Visit for Practitioner Credentialing policy included the process for determining office sites that require an office site visit. The policy contained the provision that two or more complaints or one Level 3 complaint (safety issue as defined by the Occupational Safety and Health Administration [OSHA]) in a 12-month period would trigger a site visit. The Colorado Access thresholds for what triggers a site visit were compliant with NCQA guidelines. The Office Site Visit for Practitioner Credentialing policy also stated that if an office did not meet Colorado Access' threshold for acceptability, a CAP would be developed and a follow-up site visit would be scheduled every six months until the performance standards were met. The Colorado Access Investigation of Potential Clinical and QOC Grievances and Referrals policy described Colorado Access' process for referring Level 3 complaints to the Credentials Committee for review and follow-up. The policy also stated that if the circumstances of the QOC incident precluded waiting for the next scheduled Credentials Committee meeting, the quality management department would notify the appropriate Colorado Access medical director or physician designee for immediate action. The policy also described the actions Colorado Access would take for a Level 3 incident (most serious), which included requesting a CAP from the involved provider or practitioner or termination of the provider.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor formally recredentials its practitioners (at least every 36 months) through information verified from primary sources. The information is within the prescribed time limits and includes: ◆ A current, valid license to practice (verification time limit = 180 calendar days). ◆ A valid DEA or CDS certificate (effective at the time of recredentialing). ◆ Board certification (verification time limit = 180 calendar days). ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (verification time limit = 180 calendar days). NCQA CR7—Elements A and B NCQA CR8— Element A	**Documents Submitted/Location Within Documents:** • CR301-Provider Credentialing and Recredentialing, Section IX (pg 8) Section VIII (pgs 6), Section XIV (pgs 11) • Provider Manual (pg 28) **Process Description:** Colorado Access policy CR301 specifies that practitioners are recredentialed at least every 36 months (Section IX, pg 8). This policy also outlines the information the recredentialing process must include (Section VIII, pgs 6 and XIV, pg 11).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Credentialing and Recredentialing policy stated that practitioners were recredentialed every 36 months and described the verification criteria required for recredentialing, which met NCQA requirements. Providers were informed in the provider manual that recredentialing occurred every three years. The recredentialing files reviewed on-site provided evidence that the above information was validated at the primary source, and that recredentialing occurred every three years.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of (organizational) providers with which it contracts, which include: 11.A. The Contractor confirms that the provider is in good standing with State and federal regulatory bodies. NCQA CR11—Element A1	**Documents Submitted/Location Within Documents:** • CR305-Organizational Provider Credentialing, Section IV (pgs 4) • Credentials Committee Roster 2012 **Process Description:** Colorado Access policy CR305 outlines the process for the initial and ongoing assessment of organizational providers. The Organizational Provider Credentialing meets monthly and is staffed by Colorado Access clinical staff (see Credentialing Committee Roster 2012). Minutes will be available for review during the site visit. CR305 specifies that Colorado Access will ensure all organizational providers are in good standing with State and Federal regulatory bodies (Section IV, pg 4-5).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Organizational Provider Credentialing policy included the procedures for assessment of organizational providers with which Colorado Access contracts. The procedures included the process for obtaining applicable State licenses or certifications, and evidence of eligibility to participate in federal health care programs, as evidenced by the federal OIG database query. Review of five organizational provider records on-site demonstrated that Colorado Access followed its procedures regarding assessment of organizational provider files.		
Required Actions: None.		
11.B. The Contractor confirms that the provider has been reviewed and approved by an accrediting body. NCQA CR11—Element A2	**Documents Submitted/Location Within Documents:** • CR305-Organizational Provider Credentialing, Section IV (pgs 4), Section V (Pgs 7) • Provider Manual (pgs 28-29) **Process Description:** Colorado Access policy CR305 specifies that Colorado Access confirms that each organizational provider has been reviewed and approved by an accrediting body (Section IV and V, pgs 4-9).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The Organizational Provider Credentialing policy included the process for obtaining a copy of any applicable accreditation certificates when contracting with and assessing organizational providers. The on-site review of organizational provider files provided evidence that the health plan collected accreditation information and certificates from organizational providers that were accredited.		
Required Actions: None.		
11.C. The Contractor conducts an on-site quality assessment if there is no accreditation status. NCQA CR11—Element A3	**Documents Submitted/Location Within Documents:** • CR305-Organizational Provider Credentialing, Section VII.E (pg 12) **Process Description:** Colorado Access policy CR305 specifies that Colorado Access will conduct an on-site assessment is the organization does not have accreditation status (Section VII.E, pg 12).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Organizational Provider Credentialing policy stated that nonaccredited facilities were subject to an on-site assessment by Colorado Access. Colorado Access provided an on-site assessment form used for non-accredited facilities not surveyed by the Division of Behavioral Health (DBH) or Colorado Department of Public Health and Environment (CDPHE).		
Required Actions: None.		
11.D. The Contractor confirms at least every three years that the organizational provider continues to be in good standing with State and federal regulatory bodies, and if applicable, is reviewed and approved by an accrediting body. The Contractor conducts a site visit every three years if the organizational provider has no accreditation status. NCQA CR11—Element A	**Documents Submitted/Location Within Documents:** • CR305-Organizational Provider Credentialing, Section II (pg 3), and VII.D (pg 11) **Process Description:** Colorado Access policy CR305 states, "Colorado Access conducts a pre-contractual assessment and re-assessment at least every three years. Reassessment includes confirmation that the organizational provider remains in good standing with State and Federal regulatory bodies. If not approved by an accrediting body, provisions for site review follow the same initial assessment procedures at reassessment (Section VII.D, pgs 11).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The Organizational Provider Credentialing policy contained the procedures for reassessment of organizational providers every three years, which included verifying that the provider was in good standing with State and federal regulatory agencies and whether the provider was accredited, and performing site visits for organizations not accredited. Although there was one organization in the file review that was reassessed at 37 months, Colorado Access provided evidence that it followed NCQA processes (multiple scheduled contacts with the provider and initiation of termination procedures for noncooperation with Colorado Access' policies for organizational provider reassessment/recredentialing).		
Required Actions: None.		
11.E. The Contractor's policies list the accrediting bodies the Contractor accepts for each type of organizational provider. (If the Contractor only contracts with organizational providers that are accredited, the Contractor must have a written policy that states it does not contract with nonaccredited facilities.) NCQA CR11—Element A	**Documents Submitted/Location Within Documents:** • CR305-Organizational Provider Credentialing, Section IV (pgs 4), V (pgs 6), and VII. E (pg10) **Process Description:** • Colorado Access policy CR305 (Section IV) specifies the Criteria and Verification Requirements used to evaluate organizational providers during initial credentialing and recredentialing and the verification requirements associated with each follow. • In the case of non-accredited organizational provider(s), Colorado Access will utilize the CMS site survey conducted by the Colorado Department of Public Health and Environment (CDHPE), the DMH site review conducted on behalf of the Department of Human Services (DHS) or the Alcohol and Drug Abuse Division (ADAD) Site Inspection in lieu conducting a site visit. • Colorado Access requires each organizational provider be accredited by one of the accreditation bodies listed in the CR 305 policy, Sct V. In lieu of accreditation, Colorado Access will accept the CMS site survey conducted by CDHPE, the DMH site review or the DBH Site Inspection Report, as applicable. If the organizational provider is not accredited by an entity recognized by Colorado Access or not subject to site reviews conducted by CMS, DMH or DBH, Colorado Access will perform a site visit.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The Organizational Provider Credentialing policy listed numerous appropriate accrediting bodies Colorado Access would accept. On-site review of organizational provider records included one facility accredited by The Joint Commission (TJC) and one accredited by the Council on Accreditation (COA).		
Required Actions: None.		
12. The Contractor has a selection process and assessment criteria for each type of nonaccredited organizational provider with which the Contractor contracts. NCQA CR11—Element A	**Documents Submitted/Location Within Documents:** • CR305-Organizational Provider Credentialing, Section IV (pgs 4), V (pgs 7), and VII. E (pg 12) **Process Description:** Colorado Access policy CR305 specifies the selection process and assessment criteria for each type of nonaccredited organizational provider. • In the case of non-accredited organizational provider(s), Colorado Access will utilize the CMS site survey conducted by the Colorado Department of Public Health and Environment (CDHPE), the DMH site review conducted on behalf of the Department of Human Services (DHS) or the Division of Behavioral Health (DBH) Site Inspection in lieu conducting a site visit. • If the organizational provider has not undergone a site visit by one of the above, Colorado Access will perform a site visit.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Facility Site Assessment form included a review of appointment availability, credentialing/recredentialing policies and practices, various aspects of clinical operations, safety policies and practices, office/site appearance, treatment record-keeping practices, confidentiality procedures, and medication safety practices. Colorado Access had a specific form for each type of organizational provider.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. Site visits for nonaccredited facilities include a process for ensuring that the provider credentials its practitioners. NCQA CR11—Element A	**Documents Submitted/Location Within Documents:** • CR305-Organizational Provider Credentialing, Section VII E (pg 12) **Process Description:** Colorado Access policy CR305 organizational site review survey procedures confirm that nonaccredited facilities include a process for ensuring that the provider credentials its practitioners.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Organizational Provider Assessment policy stated that the site visit for nonaccredited facilities included a review of staff hiring and credentialing processes. Review of organizational provider files on-site demonstrated that Colorado Access followed its policies for ensuring that nonaccredited facilities credential their practitioners.		
Required Actions: None.		
14. If the Contractor chooses to substitute a CMS or State review in lieu of the required site visit, the Contractor must obtain the report from the organizational provider to verify that the review has been performed and that the report meets its standards. (CMS or State review or certification does not serve as accreditation of an institution.) A letter from CMS or the applicable State agency which shows that the facility was reviewed and indicates that it passed inspection is acceptable in lieu of the survey report if the organization reviewed and approved the CMS or State criteria as meeting the organization's standard. NCQA CR11—Element A	**Documents Submitted/Location Within Documents:** • CR305-Organizational Provider Credentialing, Section IV (pgs 4), V (pgs 7), and VII. E (pg 12) **Process Description:** Colorado Access policy CR305 outlines the requirements and terms for substituting a CMS or state review for the required site visit. The policy explains that if the organizational provider is not accredited or is accredited by an entity not recognized by Colorado Access, receipt of a copy of the report (survey), letter sent to the organizational provider from CMS, DMH or DBH that shows that the facility was reviewed and passed inspection.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: On-site review of organizational provider files demonstrated that Colorado Access obtained DBH and CDPHE survey reports for nonaccredited facilities surveyed by these State departments. Review of Credentials Committee meeting minutes demonstrated that the committee reviewed the applicable State survey during the organization's reassessment/recredentialing process.		
Required Actions: None.		
15. The Contractor's organizational provider assessment policies and process include assessment of at least the following medical providers: ◆ Hospitals. ◆ Home health agencies. ◆ Skilled nursing facilities. ◆ Free-standing surgical centers. NCQA CR11—Element B	**Documents Submitted/Location Within Documents:** • CR305-Organizational Provider Credentialing, Section I. A, B, C (pgs 2-3) **Process Description:** Per policy CR305 Colorado Access will conduct a pre-contractual credentialing of Physical and Behavioral health organizational providers for all lines of business. A full list is outlined in policy CR 305.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Organizational Provider Assessment policy stated that Colorado Access' organizational providers may include community mental health centers (CMHCs), hospitals, home health agencies, skilled nursing facilities, and other types of facilities. The provider directory provided evidence that Colorado Access contracted with these types of facilities. On-site record review included files for a hospital and a skilled nursing facility.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The Contractor's organizational provider assessment policies and process include assessment of at least the following behavioral health and substance abuse settings: ◆ Inpatient. ◆ Residential. ◆ Ambulatory. NCQA CR11—Element C	**Documents Submitted/Location Within Documents:** • CR305-Organizational Provider Credentialing, Section I. B (pg 2) **Process Description:** Colorado Access policy CR 305 outlines the list of medical and behavioral health providers for which pre-contractual credentialing will be performed on, for all lines of business. A full list is outlined in policy CR 305.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Organizational Provider Assessment policy stated that Colorado Access' organizational providers may include CMHCs, hospitals, residential treatment facilities, rehabilitation facilities, and other types of facilities. The provider directory provided evidence that Colorado Access contracted with inpatient facilities, residential treatment facilities, and ambulatory facilities. On-site record review included files for a residential treatment center, an alcohol and drug rehabilitation facility, and a community mental health center.		
Required Actions: None.		
17. The Contractor has documentation that it has assessed contracted medical and behavioral health care (organizational) providers. NCQA CR11—Element D	**Documents Submitted/Location Within Documents:** • CR305-Organizational Provider Credentialing, Section I. A, B, C (pgs 2-3) **Process Description:** Colorado Access policy CR305 explains the Scope of Credentialing Activities, including medical health care providers (Section I, A-C).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: On-site review of organization-specific files demonstrated that Colorado Access documented assessment and reassessment activities for organizational providers with which it contracts.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. If the Contractor delegates any NCQA-required credentialing activities, there is evidence of oversight of the delegated activities. NCQA CR12	**Documents Submitted/Location Within Documents:** • ADM223-Delegation, All • Executive Summaries for: (located in the Executive Summary and Audit Results uploaded folder) o Boulder Valley IPA o Denver Health and Hospital Authority o University Physician Inc o Northern Colorado IPA o National Jewish Health **Process Description:** Per policy ADM 223, Colorado Access will establish and maintain a pre-Delegation assessment process for Contractors with which Colorado Access desires Delegation and a process to accomplish Delegation oversight of Contractors awarded Delegation.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Delegation policy described ongoing monitoring and annual audit processes for oversight of delegates. Colorado Access provided audit reports for each delegate that demonstrated that Colorado Access conducted an on-site annual audit for each credentialing delegate. The Centura Health audit was a predelegation audit completed in July 2012, and all others were annual audits, also completed within 2012. On-site review of Credentials Committee meeting minutes demonstrated that the committee reviewed periodic reports of credentialing activities from each delegate.		
Required Actions: None.		
19. The Contractor has a written delegation document with the delegate that: ◆ Is mutually agreed upon. ◆ Describes the responsibilities of the Contractor and the delegated entity. ◆ Describes the delegated activities. ◆ Requires at least semiannual reporting by the delegated entity to the Contractor.	**Documents Submitted/Location Within Documents:** • Delegation Agreements for: (located in the Delegation Agreements uploaded folder) o Boulder Valley IPA o Denver Health and Hospital Authority o University Physician Inc o Northern Colorado IPA o National Jewish Health o Centura Health	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
◆ Describes the process by which the Contractor evaluates the delegated entity's performance. ◆ Describes the remedies available to the Contractor (including revocation of the contract) if the delegate does not fulfill its obligations. NCQA CR12—Element A	• Delegation Agreement template (located in the Delegation Agreements uploaded folder) **Process Description:** • Each credentialing delegation agreement: o Is mutually agreed upon o Describes the responsibilities of the Contractor and the delegated entity o Describes the delegated activities o Requires at least semiannual reporting to the Contractor o Describes the process by which the Contractor evaluates the delegated entity's performance o Describes the remedies available to the Contractor if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement	
Findings: Colorado Access provided signed Credentialing Delegation Agreements with Northern Colorado Individual Practice Association (IPA), Centura Health, Denver Health and Hospital Authority, University Physicians Incorporated, Boulder Valley IPA, and National Jewish Health. The delegation agreements described delegated activities and responsibilities for both parties, and reporting requirements. The agreements also specified how Colorado Access will monitor the delegate's performance of credentialing activities. The agreement specified several reports required monthly or annually, as appropriate. The agreement also provided for remedies if the delegate's performance is not adequate.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
20. If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes: ◆ A list of allowed use of PHI. ◆ A description of delegate safeguards to protect the information from inappropriate use or further disclosure. ◆ A stipulation that the delegate will ensure that subdelegates have similar safeguards. ◆ A stipulation that the delegate will provide members with access to their PHI. ◆ A stipulation that the delegate will inform the Contractor if inappropriate uses of the information occur. ◆ A stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends. NCQA CR12—Element B	**Documents Submitted/Location Within Documents:** • ADM223-Delegation, Section I.L (pg 4) • HIP203 Business Associate Agreement **Process Description:** Each credentialing delegation agreement includes: • Includes a list of allowed uses of PHI • Includes a description of delegate safeguards to protect the information (PHI) from inappropriate uses • Includes a stipulation that the delegate will ensure that subdelegates have similar safeguards • Includes a stipulation that the delegate will provide individuals with access to their PHI • Includes a stipulation that the delegate will inform the Contractor if inappropriate use of the information (PHI) occur • Includes a stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Business Associate Agreement included the required HIPAA-compliant provisions. During the on-site interview, Colorado Access staff confirmed that Colorado Access had a Business Associate Agreement with each delegate.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
21. The Contractor retains the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision making. This right is reflected in the delegation agreement. NCQA CR12—Element C	**Documents Submitted/Location Within Documents:** • Delegation Agreement Template, Section B.2 (pg 4) • Delegation Agreements – located in the Delegation Agreements uploaded folder **Process Description:** The delegation agreement Includes a stipulation that the Contractor has the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision-making.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Each of the delegation agreements included the provision that Colorado Access retains the right to approve, suspend, and terminate individual practitioners and providers. During the on-site interview, staff members confirmed that ongoing monitoring for sanctions included practitioners credentialed by delegates. In addition, the credentialing committee reviewed credentialing reports by delegates. If sanctions or other concerns are discovered, the process is to alert the delegate and begin appropriate Colorado Access committee review procedures to determine the appropriate action.		
Required Actions: None.		
22. For delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity before the delegation document was signed. NCQA CR12—Element D	**Documents Submitted/Location Within Documents:** • 2012 Centura Health Physician Group Pre-Delegation Documents **Process Description:** Colorado Access evaluated the delegate capacity, as identified in the uploaded pre-delegation documents, prior to signing the contract with Centura Health Physician Group.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Colorado Access provided the completed July 2012 Pre-Delegation Audit report for Centura Health Group and the October 2012 signed delegation agreement for review.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
23. For delegation agreements in effect 12 months or longer, the Contractor audits credentialing files against NCQA standards for each year that the delegation has been in effect. NCQA CR12—Element E	**Documents Submitted/Location Within Documents:** • 2012 Boulder Valley IPA Audit Results • 2012 Denver Health and Hospital Authority Audit Results • 2012 University Physician Inc. Audit Results • 2012 Northern Colorado IPA Audit Results • 2012 National Jewish Health Audit Results **Process Description:** Colorado Access has performed an audit for each of above listed facilities, whose delegation agreements have been in the effect longer than 12 months. The audit results for each have been uploaded to the Executive Summary and Audit Results folder.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Audit Reports submitted for each delegate demonstrated that Colorado Access' audit included a file review for compliance with NCQA standards.		
Required Actions: None.		
24. For delegation arrangements in effect 12 months or longer, the Contractor performs an annual substantive evaluation of delegated activities against NCQA standards and organization expectations. NCQA CR12—Element F	**Documents Submitted/Location Within Documents:** • 2012 Boulder Valley IPA Audit Results • 2012 Denver Health and Hospital Authority Audit Results • 2012 University Physician Inc. Audit Results • 2012 Northern Colorado IPA Audit Results • 2012 National Jewish Health Audit Results **Process Description:** Colorado Access has performed an audit for each of above listed facilities, whose delegation agreements have been in the effect longer than 12 months. The annual evaluation performs a comparison of NCQA standards against those of Colorado Access. The audit results for each have been uploaded to the Executive Summary and Audit Results folder.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: Audit Reports submitted for each delegate demonstrated that Colorado Access conducted a review of policies and procedures and reviewed for compliance with NCQA standards.		
Required Actions: None.		
25. For delegation arrangements in effect 12 months or longer, the Contractor evaluates regular reports (at least semiannually). NCQA CR12—Element G	**Documents Submitted/Location Within Documents:** • Boulder Valley IPA • Denver Health and Hospital Authority • University Physician Inc • Northern Colorado IPA • National Jewish Health **Process Description:** Colorado Access Credentialing staff receives monthly report from each organization delegated credentialing. These reports can be produced during the site visit if requested.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Review of Credentials Committee meeting minutes demonstrated that Colorado Access reviewed periodic reports of credentialing activities performed by each delegate. The frequency of reports varied based on the volume of credentialing activity, but all reports were produced at least semiannually.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
26. The Contractor identifies and follows up on opportunities for improvement, if applicable. NCQA CR12—Element H	**Documents Submitted/Location Within Documents:** • 2012 Boulder Valley IPA Audit Results • 2012 Denver Health and Hospital Authority Audit Results • 2012 University Physician Inc. Audit Results • 2012 Northern Colorado IPA Audit Results • 2012 National Jewish Health Audit Results **Process Description:** Colorado Access performs annual audits, per the audit results explanation any opportunities for improvement are identified and documented in the Recommendations for Improvement section as well as followed up on if applicable. Per the pre-delegation audit for Centura Health, the delegation recommendation was for Colorado Access to perform a 6-month delegation audit in order to assure the action plans listed in the audit results were implemented.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Centura Pre-delegation audit report demonstrated that Colorado Access identified opportunities for improvement and recommended corrective actions. Colorado Access accepted Centura for a six-month provisional period pending completion of corrective actions.		
Required Actions: None.		

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	49	X	1.00	=	49
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	50	**Total Score**		=	49

Total Score ÷ Total Applicable	=	98%

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an ongoing Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. *42CFR438.240(a)* Contract: Exhibit A—2.9	**Documents Submitted/Location Within Documents:** 1. CY12 COA QAPI Program Description 2. FY13 COA CHP+ HMO Work Plan 3. CY12 MBQIC Minutes 4. CY12 QIC Minutes **Description of Process** Colorado Access has an ongoing QAPI Program described in detail in the QAPI Program Description which is updated annually and approved by the Board of Directors. An annual QAPI Work Plan outlines specific activities and goals for the year. The Work Plan also includes dates the activities will be reported to the QIC (Quality Improvement Committee including multidisciplinary representation from all areas of the company) and MBQIC (external Quality Improvement Committee including members and providers) committees.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:

The Colorado Access Quality Improvement (QI) Program Description (applicable to all lines of business) defined the objectives and the organizational structure for the QI program. The Board of Directors has ultimate accountability for the program and delegates responsibility for oversight of the program to the corporate-wide Quality Improvement Committee (QIC). The Medical/Behavioral Quality Improvement Committee (MBQIC) is a provider subcommittee of the QIC responsible for recommending strategies to monitor and improve the clinical quality of health care delivered to members. The description stated that results of activities and measures are analyzed and addressed through the implementation of action plans to improve performance or correct identified problems. Program components included analysis of accessibility, provider availability, clinical practice guidelines, care management, Healthcare Effectiveness Data and Information Set (HEDIS) clinical performance measures, member satisfaction, performance improvement projects (PIPs), grievances and appeals, utilization management, medication utilization, member education, and medical record documentation. The QI Program Description was updated and approved annually. The CHP+ QI Work Plan documented the QI program activities, metrics, and measurable goals for the year. Both the QIC and MBQIC meeting minutes documented review and approval of the Colorado Access QI Program Description and the CHP+ Work Plan. Meeting minutes also included discussions and recommendations related to reported QI outcomes and activities.

During the on-site interview, staff stated that the review of detailed quality monitoring data was routinely performed by various management staff and work groups prior to reporting the outcomes to the MBQIC and QIC committees. Staff stated that these reviews and discussions are inherent to business operations and, as such, are not formally documented. HSAG recommended that Colorado Access consider increasing the formality of the reviews and documentation of pertinent findings to substantiate that Colorado Access performs ongoing monitoring of QI data.

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: None.		
2. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42CFR438.240(b)(3)* Contract: Exhibit A—2.9.4.4	**Documents Submitted/Location Within Documents:** 1. CY12 COA QAPI Program Description-p 10-13 2. FY13 COA UM Program Description- p 15-18 3. FY13 COA Access to Care Plan-p 8 Sect. IV. A; p 9 Sect IV. D; p. 10 Sect. IV. G; p 13 Sect. V. A) 4. FY13 COA CHP+ HMO Work Plan 5. CCS307-Utilization Review Determinations 6. CCS302-Medical Criteria for Utilization Review 7. CHP+ HMO Provider Manual-p 21 Mis-utilization definition; p 26 UM program and last paragraph, p 31, p 51-64 8. CHP+ HMO Trend Report (Category of Service) 9. CHP+ HMO Dashboard (Medical Trends) 10. CHP+ HEDIS 2012 QIC Report 11. CY12 Q3 CHP+ HMO Pharmacy Report 12. Daily Census Report 12 07 12 NO PHI 13. CHC ER Report 12 06 12 NO PHI **Description of Process** Colorado Access QAPI and UM Program has mechanisms to detect under and overutilization. The QAPI and UM Program Descriptions scope sections and Access to Care Plan outlines the various areas monitored including all levels of service. The CHP+ HMO QAPI Work Plan outlines specific areas monitored and dates the activities are reported to QIC. Colorado Access policies CCS307-Utilization Review Determination and CCS302-Medical Criteria for Utilization Review outline the UM review process which helps manage utilization. The Provider Manual educates providers on the utilization and quality oversight programs and encourages providers to be partners in helping members access appropriate services. Various reports are reviewed by the QIC, Senior Staff Team, work groups and clinical/quality staff. These include reports at summary and patient	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	detail levels including Category of Service, Medical Trends, HEDIS reporting, Pharmacy Utilization and Daily Inpatient and ER reports.	
Findings: The QI Program Description and the Utilization Management (UM) Program Description stated that potential over- and underutilization is managed through UM Program authorizations, as well as the case management and disease management programs. Utilization is monitored through utilization trending reports and HEDIS measures. The QI Program Description also stated that medication utilization and cost profiles are monitored through the pharmacy program. The CHP+ QI work plan included goals related to specific utilization measures. Colorado Access submitted several sample reports used to monitor CHP+ utilization, including HEDIS measures of underutilization and a dashboard report of multiple measures of potential overutilization. During the on-site interview, staff stated that utilization and dashboard trending reports are reviewed by senior staff regularly, and a staff summary is presented to the QIC. Staff stated that reports were being modified to address the expanded CHP+ requirements.		
Required Actions: None.		
3. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis. The annual QAPI report describes: ◆ The specific preventive care priorities, and services covered in and goals of the program over the prior 12-month period. ◆ The status and results of each PIP started, continuing, or completed during the prior 12-month period. ◆ The results of member satisfaction surveys completed during the prior 12-month period. ◆ A detailed description of the findings of the program impact analysis. ◆ Techniques used by the Contractor to improve performance. ◆ The overall impact and effectiveness of the QAPI Program during the prior 12-month period. *42CFR438.240(e)(2)*	**Documents Submitted/Location Within Documents:** 1. CY12 COA QAPI Program Description-p 5-, 8 IV A, B, D Responsibilities; p 10-13 Scope; p 20 X 2. FY13 COA CHP+ HMO Work Plan-All and p 4 Impact Analysis 3. 2011 CHP+ CAHPS Summary 4. Weight Assessment PIP Remeasurement 1 **Description of Process** Colorado Access has a process in place for evaluating the impact and effectiveness of the QAPI Program at least annually. The QAPI Program Description and Work Plan describe the scope specific activities monitored throughout the year including Preventive Care measurement, goals and priorities, PIPs, and member satisfaction surveys. The QAPI Program Description also describes the techniques used to improve performance. Activities monitored all year long are combined into the annual QAPI Evaluation which includes a detailed description of the findings and an analysis of overall impact and effectiveness. The QAPI Program Description also describes the process by which the evaluation will be reviewed by the various committees including the cross functional QIC and external (member and provider) input from the MBQIC.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract: Exhibit A—2.9.4.7, 4.7.2.1 (RMHP—4.6.2.1)	Since this is the first FY of the requirement, a QAPI Evaluation will be produced for FY13 at the end of the FY (July 2013). Previous QAPI Evaluations for other Colorado Access lines of business are available to demonstrate capability to meet this requirement if needed.	
Findings: Since this is the first contract year for this requirement, the annual report is not due until after July 2013. The CHP+ Work Plan targeted September 2013 for the first annual evaluation of the CHP+ QI program. Colorado Access submitted examples of annual reporting, analysis of the most recent Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction survey, and the weight assessment PIP. During the on-site interview, staff stated that Colorado Access anticipated that the CHP+ annual evaluation report would be similar in format and content to the ABC annual evaluation report, which documented results of each QI program activity. Staff stated that the report will also be designed to include the specific CHP+ content defined in the requirement.		
Required Actions: None.		
4. The Contractor shall adopt practice guidelines for the following: ◆ Perinatal, prenatal, and postpartum care for women. ◆ Conditions related to persons with a disability or special health care needs. ◆ Well child care. Contract: Exhibit A—2.9.2.1	**Documents Submitted/Location Within Documents:** 1. QM311 Clinical Practice Guidelines-p 2, #3 2. CY12 COA QAPI Program Description-p 10-11 last bullet 3. FY13 COA CHP+ HMO Work Plan-p 3 Practice Guidelines 4. FY13 COA UM Program Description- p 16 B and C 5. Guideline Track 2012-2013 6. Prenatal Care Guideline (includes peri and post partum) 7. Childhood Obesity Guideline 8. Adolescent Depression Guideline 9. ADHD Guideline 10. Bipolar Disorder Treatment Guideline 11. SBIRT (Alcohol and Substance Abuse) Guideline 12. Asthma Guideline 13. Diabetes Guideline 14. Child/Adolescent Health Schedule 15. Child Immunization Schedule 16. Influenza Guideline	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Description of Process Colorado Access adopts practice guidelines as outlined in policy QM311 Clinical Practice Guidelines and the Quality Program Description. The QAPI Work Plan also ensures the activity is completed each year. Guidelines include Perinatal/ prenatal/postpartum care for women, Well child care (Child/Adolescent Health Schedule, Child Immunization Schedule, Influenza Guideline) and guidelines for conditions related to persons with a disability or special health care needs including Obesity, Depression, ADHD, Bipolar Disorder, Alcohol and Substance Abuse, Asthma and Diabetes.	
Findings: The CHP+ Work Plan identified nine clinical practice guidelines (CPGs) for review, approval, and dissemination per the scheduled annual review date. The work plan specified guidelines related to each of the topics outlined in the requirement. Colorado Access submitted copies of each of the adopted CHP+ clinical guidelines. The Guideline Tracking tool documented the MBQIC annual approval dates for all CPGs. During the on-site interview, staff stated that Colorado Access uses CPGs primarily as a reference for providers in the delivery of care to members.		
Required Actions: None.		
5. The Contractor ensures that practice guidelines comply with 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 contracting health care professionals. ◆ Are reviewed and updated annually. *42CFR438.236(b)* Contract: Exhibit A—2.9.2.1.2	**Documents Submitted/Location Within Documents:** 1. QM311 Clinical Practice Guidelines-p 2 I 2. CY12 COA QAPI Program Description-p 10-11 last bullet 3. FY13 COA UM Program Description- p 16 B and C 4. MBQIC Minutes 03 06 12-p 2, #5 11 5. MBQIC Minutes 09 04 12- p 2, #4 6. MBQIC Minutes 11 06 12-p 4-5, #6 7. FY13 COA CHP+ HMO Work Plan-p 3 Practice Guidelines 8. Guideline Track 2012-2013 **Description of Process** Colorado Access ensures that practice guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field as stated in policy QM311. Most guidelines are adopted	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	from HealthTeamWorks, Colorado's consensus based clinical guideline task force. Topics that do not have HealthTeamWorks guidelines are adopted from reliable clinical sources based on research and oversight from internal medical directors and external contracting health care professionals through the MBQIC. Guidelines are tracked in the QAPI Work Plan and Guideline Track to ensure they are reviewed and updated annually. MBQIC minutes demonstrate adoption in consultation with contracted providers and annual review.	
Findings: The Clinical Practice Guidelines policy stated that Colorado Access would adopt CPGs that meet all of the criteria outlined in the requirement. The policy stated that guidelines are approved by the MBQIC, which was confirmed through MBQIC meeting minutes. The CHP+ Work Plan and the Guidelines Tracking tool documented annual review of the CHP+ guidelines. During the on-site interview, staff stated that many of the CHP+ guidelines originated from HealthTeamWorks, which publishes guidelines based on nationally recognized standards. A provider subcommittee reviewed the proposed guidelines prior to approval by the MBQIC.		
Required Actions: None.		
6. The Contractor disseminates the guidelines to all affected providers, and upon request, to members, potential members, and the public, at no cost. *42CFR438.236(c)* Contract: Exhibit A—2.9.2.1.3	**Documents Submitted/Location Within Documents:** 1. QM311 Clinical Practice Guidelines-p 3 V 2. CHP+ HMO Provider Manual-p 26 3. CHP+ HMO Provider Bulletin June 2012-p. 4-5 4. Provider Website Screenshot Guidelines-p 1 5. CHP+ HMO EOC (Member Benefits Handbook)- p 24 6. Member Website Screenshot Guidelines-p 1 **Description of Process** As stated in QM311 Clinical Practice Guidelines, Colorado Access disseminates guidelines to providers, members, potential members, and the public. This is done through various mechanisms. The guidelines are posted to the Colorado Access website both in the member health and wellness and provider areas. Providers are also informed of updated guidelines through the Provider Bulletin. Providers and Members are also notified of guideline availability in the Provider Manual and Member Benefits Handbook.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The Clinical Practice Guidelines policy stated that CPGs would be disseminated to Colorado Access providers through the Colorado Access Web site, to members upon request, and to the public at no cost. The Preventive Health Services policy stated that Colorado Access develops and maintains preventive services guidelines, which follow nationally accepted standards and are available to providers and members at no cost. Colorado Access submitted a sample provider bulletin that informed providers of the adoption of specific practice guidelines (listed) and directed providers to the Colorado Access provider Web site to obtain the guidelines. The Colorado Access provider tab on the Web site included all practice guidelines. The CHP+ Provider Manual did not reference CPGs. HSAG recommended that Colorado Access also consider informing providers in the CHP+ Provider Manual about CPGs and how to access them. The member tab on the Colorado Access Web site also provided access to CPGs; however, HSAG staff noted that accessing CPGs on the member Web site was not easy, and that the CHP+ Member Benefits Handbook did not reference CPGs. HSAG recommended that Colorado Access clarify the availability of CPGs on the member Web site and develop a mechanism to inform members of the availability of CPGs and how to access them.		
Required Actions: None.		
7. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42CFR438.236(d)* Contract: Exhibit A—2.9.2.1.4	**Documents Submitted/Location Within Documents:** 1. QM311 Clinical Practice Guidelines-p 3 VI 2. QM308 Preventive Health Services-p 2-3 I.C and V 3. CCS307 Utilization Review Determinations 4. CCS 302 Medical Criteria for Utilization Review p 3 I A **Description of Process** As stated in QM311 Clinical Practice Guidelines, Colorado Access ensures that decisions for utilization management, member education, coverage of services and other areas to which the guidelines apply are consistent with the guidelines. QM308 discusses assuring member education is aligned with guidelines and CCS 302 and CCS 307 discusses utilization management and coverage of services. As guidelines are reviewed annually at the MBQIC, discussions around benefits coverage for the services recommended are always integral to determining guideline approval.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The Clinical Practice Guidelines policy stated that Colorado Access will ensure that decisions regarding utilization management, member education, covered services, and other areas to which the CPGs apply are consistent with adopted CPGs. The Preventive Health Services policy stated that Colorado Access maintains appropriate preventive services guidelines and that Colorado Access informed members about preventive health initiatives through member newsletters, member calls, and health education materials. Colorado Access submitted policies that confirmed that UM decisions are based on nationally recognized InterQual guidelines. During the on-site interview, staff stated that CPGs are used to educate providers regarding performance measures, as a reference for case management decisions, and to provide the basis for member education regarding disease management topics (e.g., asthma). Staff stated that CPGs are reviewed by QI staff, the medical director, and line of business managers to ensure consistency with other operational decisions; and a summary of recommendations is presented to the MBQIC during the annual approval process. Staff provided an example of a required modification to a national guideline based on inconsistency with covered member benefits.		
Required Actions: None.		
8. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42CFR438.242(a)* Contract: Exhibit A—2.9.4.10	**Documents Submitted/Location Within Documents:** 1. 2012 CoA QAPI Program Description-p 10 V A 2nd paragraph 2. IT Data Flow 3. FY13 COA CHP+ HMO Work Plan 4. FY13 Q1 Appeals Report 5. FY13 Q1 Grievance Report 6. FY13 Q1 Call Reporting 7. FY12 Q4 Denials Report 8. CHP+ HEDIS 2012 QIC 9. Monthly Membership Report November 2012 **Description of Process** Colorado Access maintains a robust health information system that collects, integrates, reports and analyzes data as outlined in the QAPI Program Description. The IT Data Flow depicts many of the systems used to collect data and how it is integrated into the data warehouse for reporting. Reports are generated by Decision Support Services and various business owners. Data is analyzed and reported to the QIC regularly. The	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	CHP+ HMO Work Plan describes specific reporting activities and examples of reports and analysis include monthly membership reports; quarterly service monitoring such as grievances, appeals, denials and calls and the annual HEDIS report.	
Findings: The IT Data Flow diagram provided an overview of multiple source systems for collecting and processing data related to claims from multiple provider systems (e.g., laboratory, pharmacy), eligibility, customer services, case management, and authorizations. All data were integrated and maintained in the Enterprise Database, which provided reporting and electronic output to the Colorado Access Web site, operating departments, the Department, and other external recipients. Reporting can be customized online or through programmed routine reports. Colorado Access submitted numerous examples of reports used in the QAPI program that demonstrated integration of heath information system (HIS) data.		
Required Actions: None.		
9. The Contractor collects data on member and provider characteristics and on services furnished to members. *42CFR438.242(b)(1)* Contract: Exhibit A—2.9.4.10.2	**Documents Submitted/Location Within Documents:** 1. 2012 CoA QAPI Program Description-p 10-13 Scope 2. FY13 COA CHP+ HMO Work Plan 3. Monthly Membership Report November 2012 4. FY13 Pediatric Routine Secret Shopper Report 5. FY13 Pediatric Non Urgent Secret Shopper Report 6. FY13 Q1 CHP+ Network Adequacy 7. 2011 CHP+ CAHPS Summary 8. CHP+ HEDIS 2012 QIC 9. CHP+ HMO Trend Report (Category of Service) 10. CHP+ HMO Dashboard (Medical Trends) **Description of Process** Colorado Access collects data on member and provider characteristics and services furnished to members as outlines in the QAPI Program Description scope; specific activities are listed in the Work Plan. Examples of data on member characteristics include the monthly membership and CAHPS reporting. Examples of data on provider characteristics include the Secret Shopper access to care testing and quarterly network adequacy reports. Examples of data collected on services furnished to members include the CAHPS, HEDIS, Trend Report and Dashboards	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: Colorado Access submitted several examples of reports that demonstrated collection of data related to member characteristics, provider characteristics, and services furnished to members. During the on-site interview, staff explained that Colorado Access collects data on member characteristics from claims and enrollment databases, as well as updates from the customer service, care management, and utilization management systems. Colorado Access collected provider characteristics through the provider contracting and credentialing databases, and integrated provider characteristics into the claims payment system. Colorado Access collected data on services provided to members primarily through the claims database.		
Required Actions: None.		
10. The Contractor monitors member perceptions of accessibility and adequacy of services provided. Tools shall include: ◆ Member surveys (Consumer Assessment of Healthcare Providers and Systems [CAHPS]). ◆ Anecdotal information. ◆ Grievance and appeals data. ◆ Enrollment and disenrollment information. Contract: Exhibit A—2.9.4.3.2, 2.9.4.3.1	**Documents Submitted/Location Within Documents:** 1. 2012 CoA QAPI Program Description-p 10-13 Scope 2. FY13 COA CHP+ HMO Work Plan 3. 2011 CHP+ CAHPS Summary 4. FY13 Q1 Appeals Report 5. FY13 Q1 Grievance Report 6. CHP+ Focus Group Results 7. Monthly Membership Report November 2012 **Description of Process** Colorado Access monitors member perceptions of accessibility and adequacy of services provided through a variety of mechanisms and tools as outlined in the QAPI Program Description scope; specific activities are listed in the Work Plan. Tools include member surveys including the annual CAHPS survey; grievance and appeals data can be seen in the quarterly grievance and appeals reporting to QIC; enrollment/disenrollment information is monitored in the monthly membership reports and anecdotal information includes focus groups, call reasons and member/family input on the MBQIC. Regarding member disenrollment information, the files Colorado Access currently receives (with disenrollment codes) only identify disenrollment reasons due to loss of eligibility. These disenrollment files are sent from Maximus, the Eligibility broker for the state.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The CHP+ QI Work Plan included review of member grievance data, review of 2013CAHPS member satisfaction data, and conducting of member focus groups to obtain feedback on improving services. Colorado Access submitted examples of reports that monitored member satisfaction with access and		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
adequacy of services and that included analysis of results and opportunities for improvement. The sample Quarterly Grievance Monitoring report included trended data by type of grievance (access, quality, customer service) for each Colorado Access line of business. During the on-site interview, staff stated that disenrollment data from the State does not provide adequate data to identify reasons for termination. However, the Customer Service tracking system monitors member complaints related to enrollment. Staff reported that there have been recent significant issues with the State's eligibility and enrollment processes that resulted in significant confusion among CHP+ providers and members. Staff stated that Colorado Access anticipates this incident will result in high levels of member dissatisfaction with access to services in the upcoming CAHPS survey and will also impact HEDIS results.		
Required Actions: None.		
11. The Contractor develops a corrective action plan when members report statistically significant levels of dissatisfaction, when a pattern of complaint is detected, or when a serious complaint is reported. Contract: Exhibit A—2.9.4.3.5	**Documents Submitted/Location Within Documents:** 1. 2012 CoA QAPI Program Description-p 10-13 Scope 2. ADM 203 Member Grievance Process- p 3 I A 3 3. 2011 CHP+ CAHPS Summary 4. FY13 Q1 Grievance Report **Description of Process** Colorado Access develops corrective actions plans when a pattern of complaint or statistically significant dissatisfaction is identified as outlined in the QAPI Program Description scope. ADM 203 discusses the grievance process including resolution of serious complaints and quarterly monitoring to detect patterns. Example quarterly grievance monitoring and annual CAHPS reporting are included.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Colorado Access QI Program Description stated that results of activities and measures are analyzed and addressed through the implementation of action plans to improve performance or correct identified problems. The sample Quarterly Grievance Monitoring report documented that grievances are tracked, if categories of grievances contain a higher number of grievances than typical, or if trends are noted, Colorado Access performs further analysis and investigation. Colorado Access also submitted an example of the most recent (2011) CAHPS member satisfaction survey, which documented opportunities for improvement and follow-up actions. During the on-site interview, staff confirmed that there were no patterns of grievances or serious complaints that required corrective action during the review period. However, staff described that a recent incident with the State enrollment system for CHP+ is anticipated to result in a significant level of member dissatisfaction in the upcoming CAHPS survey. Staff stated that Colorado Access immediately implemented corrective actions with the State, providers, and members related to the problem.		
Required Actions: None.		

Results for Standard X—Quality Assessment and Performance Improvement							
Total	Met	=	11	X	1.00	=	11
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	11	**Total Score**		=	11

Total Score ÷ Total Applicable	=	100%

The completed record review tools follow this cover page.

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix B. Colorado Department of Health Care Policy and Financing
Credentialing Record Review Tool
for Colorado Access

Review Period:	January 1, 2012–December 31, 2012	**Reviewer:**	Rachel Henrichs
Date of Review:	February 12, 2013	**Participating Plan Staff Member:**	Jennifer Rogers

SAMPLE	**1**		**2**		**3**		**4**		**5**		**6**		**7**		**8**		**9**		**10**	
Provider ID#	013492		005439		016445		016486		035570		021197		010584		011182		017153		020143	
Provider Type (MD, PhD, NP, PA, MSW, etc.)	MD		MD		MD		LCSW		MD		MD		MD		MD		CNM		DO	
Application Date	9/20/11		1/31/11		6/21/11		7/11/12		2/17/10		3/21/11		2/16/10		2/16/10		2/1/10		1/19/12	
Specialty	OBGYN		Neurology		Psychiatry		Social Work		Infect Disease		Fam Medicine		Infect Disease		Oncology		Midwife		Fam Medicine	
Credentialing Date (Committee/Medical Director Approval Date)	9/22/11		6/16/11		6/30/11		9/21/12		2/24/10		4/5/11		3/11/10		7/6/10		7/26/12		5/18/12	
Item	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Initial Credentialing Verification: The contractor, using primary sources, verifies that the following are present:																				
♦ A current, valid license to practice (with verification that no State sanctions exist)	X		X		X		X		X		X		X		X		X		X	
♦ A valid DEA or CDS certificate (if applicable)	X		X		X		NA		X		X		X		X		X		X	
♦ Credentials (i.e., education and training, including board certification if the practitioner states on the application that he or she is board certified)	X		X		X		X		X		X		X		X		X		X	
♦ Work history	X		X		X		X		X		X		X		X		X		X	
♦ Current malpractice insurance in the required amount (with history of professional liability claims)	X		X		X		X		X		X		X		X		X		X	
♦ Verification that the provider has not been excluded from federal participation	X		X		X		X		X		X		X		X		X		X	
♦ Signed application and attestation	X		X		X		X		X		X		X		X		X		X	
♦ The provider's credentialing was completed within verification time limits (see specific verification element—180/365 days)	X		X		X		X		X		X		X		X		X		X	
Applicable Elements	**8**		**8**		**8**		**7**		**8**		**8**		**8**		**8**		**8**		**8**	
Point Score	**8**		**8**		**8**		**7**		**8**		**8**		**8**		**8**		**8**		**8**	
Percentage Score	**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**	

Total Record Review Score					**Total Applicable: 79**		**Total Point Score: 79**		**Total Percentage: 100%**	

Notes:

Appendix B. Colorado Department of Health Care Policy and Financing
Recredentialing Record Review Tool
for Colorado Access

Review Period:	January 1, 2012–December 31, 2012	**Reviewer:**	Rachel Henrichs
Date of Review:	February 12, 2013	**Participating Plan Staff Member:**	Jennifer Rogers

SAMPLE	1		2		3		4		5		6		7		8		9		10	
Provider ID#	015295		004795		019722		017906		021613		013532		006700		012574		012662		012729	
Provider Type (MD, PhD, NP, PA, MSW, etc.)	MD		MD		MD		MD		LMFT		MD		PhD		DPM		MD		MD	
Application/Attestation Date	8/16/12		1/5/12		2/22/12		12/15/10		1/19/12		11/15/11		11/10/11		11/23/11		5/12/11		11/4/11	
Specialty	Physical Med		Oncology		Internal Med		Family Med		Therapy		Family Med		Psychology		Podiatry		Family Med		Ortho Surgery	
Last Credentialing/Recredentialing Date	1/14/10		6/24/09		6/24/09		6/16/08		8/12/09		2/11/09		3/12/09		3/12/09		11/26/08		2/9/09	
Recredentialing Date (Committee/Medical Director Approval Date)	12/20/12		5/18/12		5/18/12		4/7/11		7/15/12		12/29/11		3/22/12		1/12/12		9/29/11		12/22/11	
Item	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Recredentialing Verification: The contractor, using primary sources, verifies that the following are present:																				
♦ A current, valid license to practice (with verification that no State sanctions exist)	X		X		X		X		X		X		X		X		X		X	
♦ A valid DEA or CDS certificate (if applicable)	X		X		X		X		NA		X		NA		X		X		X	
♦ Credentials (i.e., verified board certification only if the practitioner states on the recredentialing application that there is new board certification since last credentialing/recredentialing date)	X		X		X		X		NA		X		NA		X		X		X	
♦ Current malpractice insurance in the required amount (with history of professional liability claims)	X		X		X		X		X		X		X		X		X		X	
♦ Verification that the provider has not been excluded from federal participation	X		X		X		X		X		X		X		X		X		X	
♦ Signed application and attestation	X		X		X		X		X		X		X		X		X		X	
♦ The provider's recredentialing was completed within verification time limits (see specific verification element—180/365 days)	X		X		X		X		X		X		X		X		X		X	
♦ Recredentialing was completed within 36 months of last credentialing/recredentialing date	X		X		X		X		X		X		X		X		X		X	
Applicable Elements	**8**		**8**		**8**		**8**		**6**		**8**		**6**		**8**		**8**		**8**	
Point Score	**8**		**8**		**8**		**8**		**6**		**8**		**6**		**8**		**8**		**8**	
Percentage Score	**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**	

Total Record Review Score					**Total Applicable: 76**	**Total Point Score: 76**	**Total Percentage: 100%**
Notes:							

Appendix C. Site Review Participants for Colorado Access

Table C-1 lists the participants in the FY 2012–2013 site review of **Colorado Access**.

Table C-1—HSAG Reviewers and Health Plan Participants	
HSAG Review Team	**Title**
Barbara McConnell, MBA, OTR	Director, State & Corporate Services
Katherine Bartilotta, BSN	Project Manager
Rachel Henrichs	Project Coordinator
Colorado Access Participants	**Title**
Carrie Bandell	Director of Quality Management
Robert Bremer	Executive Director, ABC
Laura Coleman	Director of Clinical Services
Rodonda DeLoach	Health Coach
Rich Duncan	Manager of CHP+ Care Management
Sandy Gahagan	Care Manager II
Bethany Himes	Executive Director, CHP+
John Kickhaefer	Operations Manager, ABC
Suzanne Kinney	Behavioral Health Quality Program Manager
Claudine McDonald	Director, Office of Member and Family Affairs
Suzanne Nelson	Care Manager II
Marina Osovskaya	CHP+ Program Specialist
Irina Pomirchy	CHP+ Senior Program Manager
Jennifer Rogers	Manager, Credentialing Program
Robin Walker	Care Manager II
Department Observers	**Title**
Teresa Craig	Contract Manager
Alan Kislowitz	Health Plan Manager
Russell Kennedy	Quality Compliance Specialist

Appendix D. Corrective Action Plan Process for FY 2012–2013 for Colorado Access

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

Table D-1—Corrective Action Plan Process

Step 1	**Corrective action plans are submitted**
	If applicable, the health plan will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final external quality review site review report via e-mail or through the file transfer protocol (FTP) site, with an e-mail notification regarding the FTP posting to HSAG and the Department. The health plan will submit the CAP using the template provided. For each of the elements receiving a score of *Partially Met* or *Not Met*, the CAP must describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training and follow-up activities, and documents to be sent following the completion of the planned interventions.
Step 2	**Prior approval for timelines exceeding 30 days**
	If the health plan is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.
Step 3	**Department approval**
	Following review of the CAP, the Department or HSAG will notify the health plan via e-mail whether: ◆ The plan has been approved and the health plan should proceed with the interventions as outlined in the plan. ◆ Some or all of the elements of the plan must be revised and resubmitted.
Step 4	**Documentation substantiating implementation**
	Once the health plan has received Department approval of the CAP, the health plan should implement all the planned interventions and submit evidence of such implementation to HSAG via e-mail or the FTP site, with an e-mail notification regarding the posting. The Department should be copied on any communication regarding CAPs.
Step 5	**Progress reports may be required**
	For any planned interventions requiring an extended implementation date, the Department may, based on the nature and seriousness of the noncompliance, require the health plan to submit regular reports to the Department detailing progress made on one or more open elements of the CAP.

Table D-1—Corrective Action Plan Process	
Step 6	**Documentation substantiating implementation of the plans is reviewed and approved**
	Following a review of the CAP and all supporting documentation, the Department or HSAG will inform the health plan as to whether: (1) the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements or (2) the health plan must submit additional documentation. The Department or HSAG will inform each health plan in writing when the documentation substantiating implementation of all Department-approved corrective actions is deemed sufficient to bring the health plan into full compliance with all the applicable federal Medicaid managed care regulations and contract requirements.

The template for the CAP follows.

Table D-2—FY 2012–2013 Corrective Action Plan *for* Colorado Access					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
Standard VIII—Credentialing and Recredentialing 2.G. The process for ensuring that credentialing and recredentialing are conducted in a non-discriminatory manner, (i.e., must describe the steps the Contractor takes to ensure that it does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes).	While Colorado Access had appropriate methods to prevent discrimination, there were no methods in place for periodic monitoring to ensure nondiscriminatory credentialing practices, as required by NCQA. Colorado Access must develop processes for monitoring to ensure nondiscriminatory credentialing practices.				

Appendix E. Compliance Monitoring Review Activities for Colorado Access

The following table describes the activities performed throughout the compliance monitoring process. The activities listed below are consistent with CMS' final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)*, February 11, 2003.

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Planned for Monitoring Activities**
	Before the compliance monitoring review: ◆ HSAG and the Department held teleconferences to determine the content of the review. ◆ HSAG coordinated with the Department and the health plan to set the dates of the review. ◆ HSAG coordinated with the Department to determine timelines for the Department's review and approval of the tool and report template and other review activities. ◆ HSAG staff attended Medical Quality Improvement Committee (MQUIC) meetings to discuss the FY 2012–2013 compliance monitoring review process and answer questions as needed. ◆ HSAG assigned staff to the review team. ◆ Prior to the review, HSAG representatives also responded to questions via telephone contact or e-mails related to federal managed care regulations, contract requirements, the request for documentation, and the site review process to ensure that the health plans were prepared for the compliance monitoring review.
Activity 2:	**Obtained Background Information From the Department**
	◆ HSAG used the federal Medicaid managed care regulations, NCQA Credentialing and Recredentialing Standards and Guidelines, and the health plan's managed care contract with the Department, to develop HSAG's monitoring tool, on-site agenda, record review tools, and report template. ◆ HSAG submitted each of the above documents to the Department for its review and approval. ◆ HSAG submitted questions to the Department regarding State interpretation or implementation of specific Managed Care regulations or contract requirements. ◆ HSAG considered the Department responses when determining compliance and analyzing findings.
Activity 3:	**Reviewed Documents**
	◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the health plan in writing of the desk review request via e-mail delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. ◆ Documents submitted for the desk review and during the on-site document review consisted of the completed desk review form, the compliance monitoring tool with the health plan's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials.

Table E-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG completed the following activities:**
	◆ The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.
Activity 4:	**Conducted Interviews**
	◆ During the on-site portion of the review, HSAG met with the health plan's key staff members to obtain a complete picture of the health plan's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan's performance.
Activity 5:	**Collected Accessory Information**
	◆ During the on-site portion of the review, HSAG collected and reviewed additional documents as needed. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were of a confidential or proprietary nature or were requested as a result of the pre-on-site document review.)
Activity 6:	**Analyzed and Compiled Findings**
	◆ Following the on-site portion of the review, HSAG met with health plan staff to provide an overview of preliminary findings. ◆ HSAG used the FY 2012–2013 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. ◆ HSAG analyzed the findings. ◆ HSAG determined opportunities for improvement and recommendations based on the review findings.
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 2012–2013 Site Review Report. ◆ HSAG submitted the site review report to the health plan and the Department for review and comment. ◆ HSAG incorporated the health plan's and Department's comments, as applicable and finalized the report. ◆ HSAG distributed the final report to the health plan and the Department.