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

FY 2013–2014 Site Review Report

for

Colorado Access CHP+ HMO and State Managed Care Network

April 2014

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

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ACKNOWLEDGMENTS AND COPYRIGHTS

Introduction

Public Law 111-3, The Children's Health Insurance Program Reauthorization Act (CHIPRA) 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 federal healthcare regulations and managed care contract 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 report documents results of the FY 2013–2014 site review activities for the review period of January 1, 2013, through December 31, 2013 for **Colorado Access** in its role as a contracted health maintenance organization (HMO) and as the State Managed Care Network (SMCN), the administrative service organization (ASO) for the State's CHP+ program. Although the two lines of business were reviewed concurrently with results reported in this combined compliance monitoring report, the results for the CHP+ HMO and the SMCN lines of business have been differentiated. This section contains summaries of the findings as evidence of compliance, strengths, findings resulting in opportunities for improvement, and required actions for each of the two standard areas reviewed this year for each line of business.[1-1] Section 2 contains graphical representation of results for all standards reviewed over the past two years and trending of required actions for the CHP+ HMO line of business. Section 3 describes the background and methodology used for the 2013–2014 compliance monitoring site review. Section 4 describes follow-up on the corrective actions required as a result of the 2012–2013 site review activities for the CHP+ HMO line of business. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the denials 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 CHP+ HMO will be required to complete for FY 2013–2014 (CHP+ HMO only) and the required template for doing so.

[1-1] The Department chose not to score the SMCN this year. HSAG has provided findings as evidence of compliance, strengths, and findings resulting in opportunities for improvement; however, the SMCN is not required to complete any required actions.

Summary of Results

Based on conclusions drawn from the review activities, HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. HSAG assigned required actions to any requirement within the compliance monitoring tool receiving a score of *Partially Met* or *Not Met*. HSAG assigned each SMCN requirement in the monitoring tool a result of *Implemented*, *Not Implemented*, or *Not Applicable* to provide an assessment of progress toward implementation of BBA requirements. Numerical scores were not assigned for the SMCN, and there were no accompanying required actions for the SMCN. HSAG also identified opportunities for improvement with associated recommendations for some elements, regardless of the score. Recommendations for requirements scored as *Met* did not represent noncompliance with contract requirements or federal health care regulations.

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

Table 1-1—Summary of Scores for the CHP+ HMO Standards

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
I Coverage and Authorization of Services	34	34	30	4	0	0	88%
II Access and Availability	22	22	20	2	0	0	91%
Totals	**56**	**56**	**50**	**6**	**0**	**0**	**89%**

Table 1-2 presents the scores for **Colorado Access** CHP+ HMO for the denials record review. Details of the findings for the record review are in Appendix B—Record Review Tool.

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

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Denials	70	42	40	2	28	95%
Totals	**70**	**42**	**40**	**2**	**28**	**95%**

Standard I—Coverage and Authorization of Services

The following sections summarize the findings applicable to both the CHP+ HMO and the SMCN. Any notable differences in compliance between the CHP+ HMO and the SMCN lines of business are identified.

Summary of Findings as Evidence of Compliance

The **Colorado Access** provider manuals (both SMCN and CHP+ HMO) included accurate and complete information about **Colorado Access**' utilization management (UM) program and informed providers how to access the list of services requiring authorization on the Web site. The Web site included the list of services requiring authorization, the provider manual, and preauthorization forms with clear instructions on how to complete these forms.

The **Colorado Access** UM program was comprehensive and clearly described the structure and scope of the UM program as well as staff responsibilities, philosophies of care, and processes for authorizing care and ensuring appropriate utilization control, and appropriateness of services furnished. **Colorado Access** provided evidence that appropriate personnel and committees routinely reviewed utilization reports and results of quality improvement studies and projects to evaluate appropriateness of services furnished and to detect over- and underutilization.

On-site denials record review demonstrated that:

- Individuals with appropriate clinical expertise made preauthorization and denial decisions.
- UM determinations with appropriate notices were made well within the required time frames, and often exceeded requirements.
- **Colorado Access** used standardized criteria to make authorization determinations.
- Documentation in the authorization system was complete and justified the determinations.
- Notice of action (NOA) letters were generally easy to understand, with few exceptions.
- NOA letters notified members in English and Spanish that the notice was available in another language.
- NOA letters included all required elements.

On-site review of the authorization system demonstrated that:

- **Colorado Access** had processes for consulting with the requesting provider when needed.
- The system included a dashboard which tracked timeliness and task lists to prompt staff members to complete reviews and provide notification well within/prior to time frame expiration.

Summary of Strengths

Policies addressed each of the requirements and described procedures rather than merely restating the regulations. Policies and procedures described processes for ensuring consistent application of utilization review criteria. During the on-site interview, **Colorado Access** staff members described extensive interrater reliability training and testing.

During the on-site interview, staff members described how they used the Health Literacy Advisor tool, pointing out unique benefits it offered that more commonly used tools lacked. Staff described documenting members' preferred language based on eligibility records and member contact and stated that **Colorado Access** purchased the capability to use both English and Spanish versions of the Health Literacy Advisor tool.

Colorado Access policies and procedures (applicable to all lines of business), as well as the SMCN and CHP+ HMO member handbooks and provider manuals, included accurate and complete information regarding how to obtain emergency, urgently needed, and poststabilization services. On-site discussion with staff members demonstrated that **Colorado Access** staff members had a clear understanding of poststabilization rules and requirements. Staff members reported that **Colorado Access** does not perform retroactive review of emergency claims, and that the claims payment system is configured to pay for all emergency services based on place of service (emergency department). Providers were informed via the contract and the provider manual that members may not be held liable for payment of mental health or emergency services.

Summary of Findings Resulting in Opportunities for Improvement

When more than one policy addressed the same activity (such as UM processes or grievance system), the language between the policies was not consistent; in some cases, the language was conflicting or not in compliance. HSAG recommended that **Colorado Access** review policies which include common content areas to ensure compliance across policies and consistency in how the information is presented.

While scores and required actions have not been assigned to the SMCN for this review, HSAG recommends that any changes to policies, templates, and processes applicable to the CHP+ HMO also apply to the SMCN to ensure consistency between programs and to ensure compliance with federal regulations.

Summary of Required Actions

The Medication Utilization Review Procedure policy stated that standard medication determinations are made within 10 calendar days of the receipt of information. Postponing determinations until after receipt of all information might cause determinations to be made beyond 10 calendar days of the receipt of the request for services (or medication). **Colorado Access** must revise the Medication Utilization Review Procedure policy to accurately depict the standard authorization decision time frame as being within 10 calendar days from the date of the request for service.

Two CHP+ HMO denial records and two SMCN denial records contained NOAs that were not easily understood due to the use of clinical or industry-specific language that members are not likely to understand. **Colorado Access** must develop processes to ensure that physician reviewers are cognizant of the requirement that NOAs and other member-specific communication is written at the sixth-grade reading level whenever possible.

The Utilization Review Determinations policy described the extension notice as an NOA and stated that the member had a right to appeal, treating the extension notice as an NOA. While the extension letter template included notification of the member's right to file a grievance, the template also

included a title header of "Notice of Action—Timeliness," which provides context of an action and inherent right to appeal rather than to file a grievance. The extension of the authorization timeline is not an action; therefore, the member has no appeal right in this circumstance but may file a grievance. **Colorado Access** must revise its applicable policies and templates to accurately describe the member's right to file a grievance (not an appeal) if he or she disagrees with the decision to extend the time frame for making the authorization determination.

Colorado Access must also clarify the Utilization Review Determinations policy to state that an NOA is not needed if the extension is used and that, although an NOA is required when the time frames expire, this notification period includes the extension time, if used.

Extension letter templates provided on-site for the CHP+ HMO and the SMCN provided evidence that **Colorado Access**/SMCN had a process to notify members when an extension of the authorization determination time frame is needed. Neither template, however, included language to notify the member of the right to file a grievance if he or she disagreed with the decision to extend the time frame. **Colorado Access** must ensure that, when members are notified that **Colorado Access** will extend the time frame for an authorization determination, the notice includes language informing the member of his or her right to file a grievance if the member does not agree with the decision to extend the time frame.

Standard II—Access and Availability

The following sections summarize the findings applicable to both the CHP+ HMO and the SMCN. Any notable differences in compliance between the CHP+ HMO and the SMCN lines of business are identified.

Summary of Findings as Evidence of Compliance

Network Adequacy reports for both CHP+ HMO and the SMCN documented analysis of primary care provider-to-member ratios, specialist-to-member ratios, and members' distance to providers. Reports indicated that the provider networks were adequate to meet member needs, including contracting with Essential Community Providers (ECPs), nurse midwives, and nurse practitioners. Within the CHP+ HMO service area, the same providers are contracted for both the CHP+ HMO and the SMCN. Staff stated that the CHP+ HMO and the SMCN have been actively pursuing contracts with nurse practitioners in rural areas, where physician availability is limited. During on-site interviews, staff described that the CHP+ HMO had expanded the number of counties within the network, thereby reducing the number of SMCN enrollees. The anticipation of member needs has been impacted by volatility in CHP+ HMO and SMCN enrollment during 2013 as a result of changes in eligibility requirements for Medicaid, as well as changes in the CHP+ HMO service area. CHP+ members now represent a slightly higher socioeconomic demographic, and the SMCN primarily includes prenatal care members and individuals who are transitioning into a CHP+ HMO within 45 days. The SMCN program volume has been reduced to less than 5,000 members. Policies specified that female members may have direct access to a women's health specialist or family planning services without authorization, and that members with special health care needs may maintain ongoing care from a network specialist. Evidence of Coverage (EOC) handbooks informed members, and provider manuals informed providers, of these requirements. Policies and procedures

also described that **Colorado Access** would arrange for necessary provider services, including second opinions, in network or out of network. Single case agreements (SCAs) were routinely used for out-of-network services, and they ensured that costs were appropriate and not billed to the member. **Colorado Access** provided coverage for emergency services and urgent care services in network or out of network, which was communicated to the member in the EOC. All appointment standards were communicated to the member in the EOCs, and provider manuals documented appointment standards that were more stringent than contract requirements. Staff members stated that **Colorado Access** is working to align appointment standards across all lines of business. **Colorado Access** monitored appointment availability through secret shopper calls and grievance data, and it stated that each appointment type was monitored annually, with feedback results shared with providers.

The Preventive Health Services policy stated **Colorado Access**' commitment to maintain a comprehensive program of preventive health services for members. The EOCs informed members that preventive services are covered, and they defined what types of preventive services are covered, including routine exams, immunizations, vision and hearing screening, and health education. The EOCs listed the well-child exam schedule. During on-site interviews, staff members stated that the higher socioeconomic levels of CHP+ beneficiaries would increase the demand for preventive health services. **Colorado Access** has also actively increased services for prenatal care members in both the SMCN and the CHP+ HMO. **Colorado Access** reported that it has been working with the Department and with Community Centered Boards (CCBs) to enable greater access to early intervention services for children in rural areas. Staff members stated that **Colorado Access** reviewed utilization trend reports, HEDIS measures, and input from member focus groups to attempt to evaluate the impact of preventive services and determine preventive health service priorities.

The 2013 Quality Assessment and Performance Improvement (QAPI) Evaluation report demonstrated that **Colorado Access** analyzed each of the required HEDIS measures for CHP+ HMO and described interventions for performance below the Medicaid 50th percentile. The report described that **Colorado Access** plans to continue interventions to increase the number of well-child visits. Interactive voice response (IVR) messages to members communicated the importance of preventive health visits and the frequency of visits recommended.

Colorado Access routinely monitored grievance data, CAHPS survey results, and other outreach study results (including focus groups), to determine member perceptions of accessibility and adequacy of services. Staff members stated that the legislative changes in eligibility requirements and the enrollment processes at the Department were very confusing to members and contributed to significant member dissatisfaction. **Colorado Access** worked regularly with the Department to remedy these problems during 2013. Staff members stated that it was necessary to prioritize the CAHPS results that were targeted for intervention, and that measures required additional analysis to determine underlying causes. **Colorado Access** conducted a mini-CAHPS survey with members in late 2013 which queried members regarding why they gave a low rating.

Colorado Access submitted multiple documents that demonstrated the organization's commitment to provide culturally sensitive services to members, including recruitment of network providers with diverse language capabilities, translation of written member materials, provision of interpreter services, and cultural competency training for providers. Staff members stated that many provider

sites have taken advantage of training programs. **Colorado Access** provided numerous services that addressed limited English proficiency, as well as speech, hearing, and visual impairments. **Colorado Access** also demonstrated an understanding of the need to identify and address cultural beliefs and behaviors beyond linguistic needs. During on-site interviews, staff discussed a variety of initiatives to enhance its cultural competency activities, including development of tools and mechanisms to collect updated and more detailed information on languages, cultural characteristics, and cultural specialties of providers. Staff members stated that individual out-of-network providers were contracted through SCAs to meet specific cultural needs of a member, and that culturally specialized providers were targeted for network recruitment. The Care Management and Customer Service departments were sources for identifying emerging patterns of members' cultural needs.

Summary of Strengths

Colorado Access demonstrated a very active preventive services program for members through examples of health information and safety guidelines available on the member Web site, in member newsletters, and through IVR messages associated with CHP+ HEDIS measures and management of chronic illnesses (e.g., asthma, diabetes). In addition, **Colorado Access** anticipated an increased demand for preventive care services in the changing CHP+ population, and it has planned major program activities focused on preventive health for CHP+ members in 2014. **Colorado Access** has also improved programs for prenatal assessment and management of CHP+ HMO and SMCN members.

Colorado Access demonstrated that it has established a historical comprehensive base of services to meet the diverse linguistic needs of members. Nevertheless, **Colorado Access** has also recognized the need for **Colorado Access** and its providers to address the members' broader cultural behaviors and beliefs, which may affect access or effectiveness of care. Staff members described examples of activities directed toward specific cultural subpopulations, such as providing an SCA for a provider to work with a member's unique religious beliefs, as well as working to expand the provider network in rural areas to address the farming/rural culture. Staff stated that activities related to identifying and addressing members' cultural characteristics beyond linguistic needs was an ongoing and evolving effort, which was challenged by the shifting population base and variability of enrollment in the CHP+ program.

Colorado Access has initiated member focus groups to obtain qualitative feedback and evaluation of services instead of relying solely on quantitative measures. **Colorado Access** was also exploring additional mechanisms to obtain direct member input to guide its processes and services.

The CHP+ HMO and SMCN provider networks overlap significantly. **Colorado Access** has made efforts to align SMCN activities with CHP+ HMO activities whenever possible, and most **Colorado Access** policies and procedures applied to all lines of business. Therefore, despite the small SMCN population base, most of the efforts applied to the CHP+ HMO also benefit the SMCN population, such as provider contracting, provider and member communications, cultural competency and preventive services programs, and monitoring activities. When the SMCN population was too small or member characteristics were too distinct to warrant SMCN-specific activities (such as analysis of specific HEDIS measures or CAHPS results), any interventions applied to CHP+ HMO members were also applied to SMCN members. In addition, the majority of the SMCN population are

prenatal care members, so **Colorado Access** has focused on monitoring the prenatal care HEDIS measures and implemented improved prenatal programs for SMCN members.

Summary of Findings Resulting in Opportunities for Improvement

Staff stated that goals and activities related to meeting members' cultural needs beyond linguistic needs are ongoing and evolving; these activities are also being challenged by population shifts due to variability of eligibility and enrollment. Cultural competency initiatives were applicable to all **Colorado Access** lines of business; however, **Colorado Access** did not have a Cultural Competency Committee or a Cultural Competency Plan to guide its expanding efforts. If established, this committee would include provider involvement to examine ideas, establish priorities, and provide oversight for an organization-wide Cultural Competency Plan that represents expansion populations.

The SMCN provider manual did not address behavioral health appointment requirements. Staff acknowledged that, because the SMCN contract has not been updated to be consistent with BBA regulations, the SMCN provider manual also had not been updated. **Colorado Access** should consider adding the mental health and substance abuse appointment requirements to the SMCN provider manual in order to comply with 42CFR438.206(c)(1)(i).

Colorado Access policies and the Access to Care Plan accurately described that emergency and urgent care services are covered when the member is temporarily out of the service area, but the SMCN Evidence of Coverage (EOC) handbook described circumstances that were exceptions to coverage for out-of-area urgent care. **Colorado Access** should consider removing the description of exceptions to coverage for urgent care outside the service area from the SMCN EOC.

Neither the **Colorado Access** SMCN provider manual nor the Professional Services Agreement included a requirement that the provider maintain hours of operation for SMCN members that are no less than the hours of operation for commercial members. **Colorado Access** should consider requiring its providers to maintain hours of operation for SMCN members that are no less than hours of operation for commercial members, in order to be compliant with 42CFR438.206(c)(1)(ii).

Colorado Access submitted evidence of the analysis of the CHP+ HMO CAHPS results below the 50th percentile, and it proposed corrective actions, such as launching new Web site applications, implementing telemedicine, and continuing to measure and implement interventions designed to impact customer service and access to care performance. **Colorado Access** should consider continued analysis of CAHPS ratings below the 50th percentile and further development of corrective action plans based on results.

Summary of CHP+ HMO Required Actions

Colorado Access policies and the Access to Care Plan accurately described coverage of emergency and urgent care services when the member is temporarily out of the service area, but the CHP+ HMO member handbook described circumstances that were exceptions to coverage for out-of-area urgent care services. **Colorado Access** must remove any exceptions to coverage for urgent care outside the service area from the CHP+ HMO member handbook.

Neither the **Colorado Access** CHP+ HMO provider manual nor the Professional Services Agreement included a requirement that the provider maintain hours of operation for CHP+ members

that are no less than the hours of operation for commercial members. **Colorado Access** must require its providers to maintain hours of operation for CHP+ members that are no less than hours of operation for commercial members.

Comparison of Results

The Department has opted to not assign scores to the SMCN site reviews; therefore, no comparison data are available. The information presented in this section relates to Colorado Access' CHP+ HMO contract only.

Review of Compliance Scores for All Standards

Figure 2-1 shows the scores for all standards reviewed over the past two years of compliance monitoring. (The Department chose not to assign scores for the FY 2011–2012 site reviews.)

Figure 2-1—Compliance Scores for All Standards

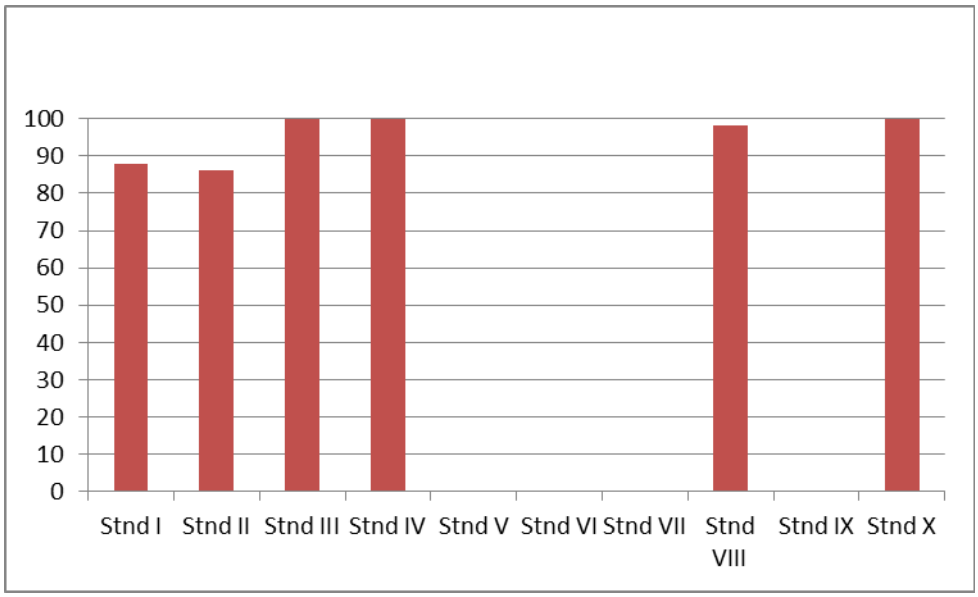


Table 2-1 presents the list of standards by review year.

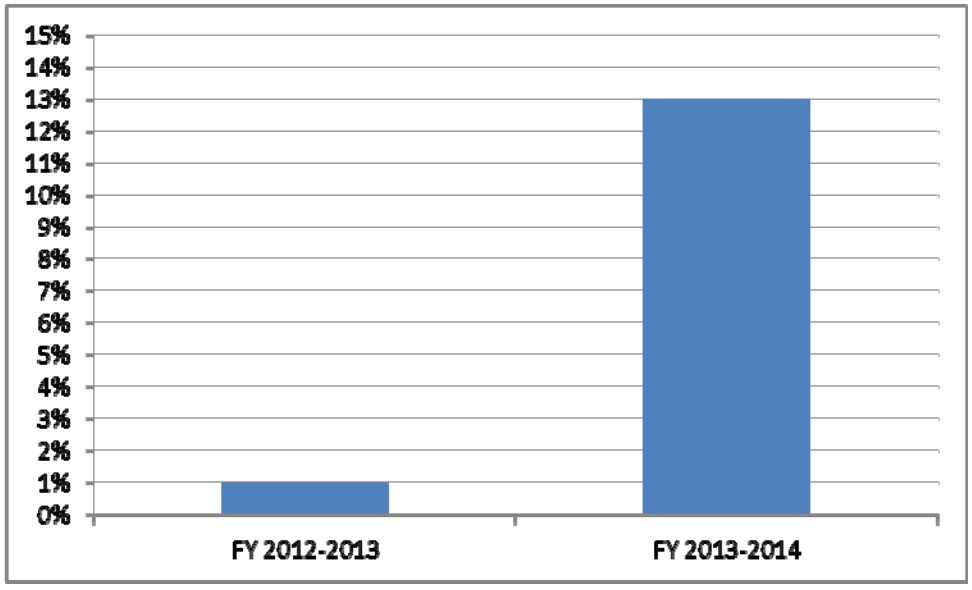
Table 2-1—List of Standards by Review Year			
Standard	**2011–12**	**2012–13**	**2013–14**
I—Coverage and Authorization of Services			X
II—Access and Availability			X
III—Coordination and Continuity of Care		X	
IV—Member Rights and Protections		X	
V—Member Information	X*		
VI—Grievance System	X*		
VII—Provider Participation and Program Integrity	X*		
VIII—Credentialing and Recredentialing		X	
IX—Subcontracts and Delegation	X*		
X—Quality Assessment and Performance Improvement		X	

*These standards were reviewed but were not scored.

Trending the Percentage of Required Actions

Figure 2-2 shows the percentage of requirements that resulted in required actions over the past two years of compliance monitoring. (The Department chose not to assign scores to the CHP+ plans during the FY 2011–2012 site reviews.) Each year represents the results for review of different standards.

Figure 2-2—Percentage of Required Actions—All Standards Reviewed



Overview of FY 2013–2014 Compliance Monitoring Activities

For the fiscal year (FY) 2013–2014 site review process, the Department requested a review of two areas of performance. HSAG developed a review strategy and monitoring tools consisting of two standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. Compliance with federal managed care regulations and managed care contract requirements was evaluated through review of the two standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the two standards, HSAG used the health plan's contract requirements 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 records, documents, and materials provided on-site; and on-site interviews of key health plan personnel to determine compliance with federal managed care regulations and contract requirements. Documents submitted for the desk review and on-site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to CHP+ service and claims denials. In addition, HSAG conducted a high-level review of the health plan's authorization processes through a demonstration of the health plan's electronic system used to document and process requests for CHP+ services.

A sample of the health plan's administrative records were reviewed to evaluate implementation of managed care regulations related to CHP+ service and claims denials and notices of action. Reviewers used standardized monitoring tools to review records and document findings. HSAG reviewed a sample of 15 records with an oversample of 5 records. Using a random sampling technique, HSAG selected the samples from all applicable health plan CHP+ service and claims denials that occurred between January 1, 2013, and December 31, 2013 (to the extent possible). For the record review, the health plan received a score of *C* (compliant), *NC* (not compliant), or *NA* (not applicable) for each of the required elements. Results of record reviews were considered in the scoring of applicable requirements in Standard I—Coverage and Authorization of Services. HSAG also separately calculated an overall record review score.

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The two standards chosen for the FY 2013–2014 site reviews represent a portion of the Medicaid managed care requirements. These standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, Standard VIII—

Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, and Standard X—Quality Assessment and Performance Improvement.

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 health care regulations and managed care contract requirements in the two 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 recommended to improve the quality of the health plan's services related to the standard areas reviewed.

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

for **Colorado Access**

FY 2012–2013 Corrective Action Methodology

As a follow-up to the FY 2012–2013 site review, each health plan that received one or more *Partially Met* or *Not Met* score was required to submit a corrective action plan (CAP) to the Department addressing those requirements found not to be fully compliant. If applicable, the health plan was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the health plan and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **Colorado Access** until it completed each of the required actions from the FY 2012–2013 compliance monitoring site review.

The SMCN was not required to complete a CAP in FY 2012–2013. The following summaries are related only to **Colorado Access**' HMO contract.

Summary of 2012–2013 Required Actions

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

Summary of Corrective Action/Document Review

Colorado Access submitted its CAP to HSAG and the Department in May 2013, as well as documents demonstrating that it had implemented the CAP. After careful review, HSAG and the Department determined that **Colorado Access** had successfully completed the required action.

Summary of Continued Required Actions

Colorado Access did not have any required actions continued from FY 2012–2013.

Appendix A. Compliance Monitoring Tool *for* Colorado Access

The completed compliance monitoring tool follows this cover page.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor ensures that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. *42CFR438.210(a)(3)(i)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.6.3 Exhibit K, 1.1	**1. Access to Care Plan 2014** Page 2; Paragraph 3: Access and Availability Standard Page 4; Paragraph 1–2 under Twenty-four Hour Availability of Services **2. CCS305 – Care Coordination** Page 3: Procedure I. A–J. Page 4–5: III Facilitation of Care Coordination A–C **3. CCS307 – Utilization Review Determinations** Page 6–7; Paragraph 7: Utilization Review (UR) A–J **4. CCS310 - Primary and Specialty Care Access** Page 2, Policy Statement Page 4–5: Access to Primary Care, Specialty and Ancillary Services Direct Access. **5. Initial Covered Services Report** Page 1; Paragraph 1 and 2 **6. PNS306 – Availability of After Hours Coverage** Page 2, Policy Statement: Page 3, II, A, B, C Page 4, C 2–3; D–H **7. FY2012-2013 COA CHP+ HMO QAPI Evaluation (Quality Assessment and Performance Improvement Program)** Page 3, Paragraph 4 -5; Mission and Philosophy Page 4, III, Goals and Objectives Page 10; A: Scope of Measurement Activities	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Paragraph 1-3 under this section Page 10, 4th Paragraph – Accessibility Page 10, 5th Paragraph – Provider Availability **8. UM Program Description** Page 3; Paragraphs 2,3,4 Co Acc Mission and Philosophy of the Utilization Management Program Page 3-4; Paragraph 5 Utilization Management Program Framework (entire section) Page 5; Goals and Objectives (all bullets) Page 6; Goals and Objectives cont. (all bullets) **9. Care Management** (not a live link) http://www.coaccess.com/care-management **SMCN:** All of the above except numbers 5, 7, and 9	
2. The Contractor provides the same standard of care for all Members regardless of eligibility category and makes all Covered Services as accessible in terms of timeliness, amount, duration and scope, to Members, as those services are to non-CHP+ Member recipients within the same area. *42CFR438.210(a)(2)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.6.3.9	**HMO:** **1. Access to Care Plan 2014** Page 3: B. Cultural and Linguistic Competency **2. ADM205 – Nondiscrimination** Page 2: Policy Statement **3. CS212 – Member Rights and Responsibilities** Page 2: Procedure I, II, III, IV **4. Evidence of Coverage (EOC)** Page 17: Members Rights and Responsibilities All bullets on this page (for SMCN, see page 15)	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	5. Provider Manual Page 7, Paragraph 1: Colorado Access Diversity Commitment Page 7, Paragraph 2: Cultural Competency Training Page 7, Paragraph 6: Culturally Sensitivity Services Page 8, Paragraph 1: Effective Communication with Limited English Proficient Persons & Sensory Impaired/Speech-Impaired Persons Page 8, Paragraph 2: Non-Discrimination (for SMCN, see pages 6 and 9) **6. PNS306** – Page 3, Procedure I—Service Availability A–D2 **PNS306** – Page 3; Procedure II – Evaluation A & B	
3. The Contractor has a Utilization Management Program that includes: ◆ Prospective, concurrent, and retrospective review ◆ Preauthorization system ◆ Medical Management Team oversight ◆ Transplant coordination ◆ On-site reviews ◆ Discharge planning ◆ Case management ◆ Appeals and grievances ◆ Mechanisms to detect over- and under-utilization CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.9.4.4 and Exhibit K, 1.1.1.2	**HMO:** **1. <u>Bullet 1: Prospective, concurrent and retro review</u>:** **CCS307 Utilization Review Determinations** Page 14: II. B-C. Prospective Review Request, Determination and Notification (Standard Request) Page 14, 3rd Paragraph: D. Concurrent Expedited Review Request, Determination and Notification (Urgent Care Requests) Page 16, Paragraph 7: E. Retrospective Review Determinations and Notifications **Access to Care Plan** Page 8, Paragraph 3: Utilization Review **CCS312 Medication Utilization Review Procedures** Page 17: II. A. CHP+ Pharmacy Utilization Review 1-6 **2. <u>Bullet 2; Preauthorization System</u>:** **CCS302 – Medical Criteria for Utilization Review**	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 2: Policy Statement Page 3: Procedure I. Development and Adoption of Criteria Used for Utilization Review; A-C Page 3: Procedure II. Application of Criteria; A-E Page 4: Procedure III Dissemination of the Criteria A-C **Interqual** Healthcare stakeholders have always wanted to ensure that care delivery is built on a solid, scientifically valid foundation of medical evidence, both to improve quality and to become more efficient. Over 30 years ago, the InterQual® product line was founded on the desire to establish that foundation and to empower providers, payors and others to more easily communicate, collaborate and ultimately determine what is best for patients. Today, McKesson's InterQual products are the undisputed gold standard in evidence-based clinical decision support. Our criteria cover the medical and behavioral health continuums of care, so they can be applied in a range of clinical situations. *Because Interqual is a licensed product we are unable to share their utilization information outside of our organization but can show you the details at the on-sight visit.* **3. <u>Bullet 3; Medical Management Team oversight</u>:** **UM Program Description FY13-14** Page 13- 15; Utilization Management Team A – L **4. <u>Bullet 4; Transplant Coordination</u>:** **UM Transplant Process** – Desktop Procedure	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	5. <u>Bullet 5; Onsight Reviews</u>: **Provider Manual** Page 13 Paragraph 3; Medical Record Documentation (for SMCN, see page 15) **CCS307 Utilization Review Determination** Page 7, section (g) Page 21, J. Patient Safety **QM201 Investigation of Potential Clinical Quality of Care Grievances and Referrals** Page 6, M **6. <u>Bullet 6; Discharge Planning</u>:** **CCS307 Utilization Review Determinations** Page 6, Paragraph 7: Utilization Review **UM Program Description** Page 14; H, bullet 2 Page 16; E & G **7. <u>Bullet 7; Case Management</u>:** **CCS307 Utilization Review Determination** Page 6; Paragraph 7: Utilization Review **UM Program Description** Page 17, Paragraph 1: Care Management **Access to Care Plan** Page 10; H - Care Management/Service/Resource Coordination	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	CCS305 Care Coordination Page 2 Policy Statement Page 3, Procedure I. The goals of Care Coordination are: A – J Page 4 - 6, Procedure III. Facilitation of Care Coordination A – E **8. <u>Bullet 8, Appeals and Grievances</u>:** **CCS307 Utilization Review Determination** Page 3, Paragraph 2, Definitions – Appeals Page 19, G. Appealing Adverse Determinations **ADM203 Member Grievance Process** Page 2 – 3 Procedure I, A. 1-9 **ADM204 Provider-Carrier Disputes** Page 1-2 Definitions (all) Page 2, Procedure I. A – H **ADM 219 Member Appeal Process** Page 2, Procedure I, A - H **Evidence of Coverage** Page 113 – 119; Grievance and Appeals **Provider Manual** Page 69 – 73; Definitions & CHP+ Appeals Process Page 119-123; Clinical Appeals & Grievances Page 123-125; Grievances (for SMCN, see Page 25: IV. Provider-Carrier Disputes and Pages 33-39: VII. Member Grievances & Clinical Appeals)	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	9. <u>Bullet 9; Mechanism to Detect Over and Under Utilization</u>: **Utilization Reporting Packages** Category of Service Reports Medical Trends Reports CHP+ Asthma Care Management Program: Goals of the Program CHP+ HMHB Care Management Program: Healthy Mom, Healthy Baby – Goals of the Program CHP+ Emergency Department Diversion Goals of the Program CHP+ CM Programs in Development Diabetes Prevention Program, Depression Screening Key Performance Indicator Dashboard (demo on sight)	
4. Utilization Management shall be conducted under the auspices of a qualified clinician. CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.8.1.	**1. CCS301 – <u>Qualifications</u> for Staff Engaged in Utilization Management** Page 2, Policy Statement Page 2-3, Sections I, II, III **2. CCS302 Medical Criteria for Review** Page 3, D. **3. Access to Care Plan 2014** Page 8, paragraph 3- A. Utilization Review **4. ADM226 – Staff Credentialing** Page 2, Policy Statement Page 2, Procedure I, New Hires Page 2, Procedure II, Continued Employment; A-C Page 2-3, Procedure III, Verification; A-B **5. UM Program Description** Page 4, paragraph 4 & 5	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor does not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42CFR438.210(a)(3)(ii)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.6.3.10	**1. CCS307 – Utilization Review Determination** Page 13, Process II, A. 6. **2. UM Processing with Interqual Desktop procedure** Page 2, all of Procedure I **3. Evidence of Coverage** Page 108: Paragraph 3–4: Time Limit on Certain Defenses **4. Provider Manual** Page 61, Paragraph 2 - Medical necessity determinations are based on the following: All three bullets (for SMCN, see page 40) **5. ADM205 Nondiscrimination** Page 2, Policy Statement Page 3, Procedure III, IV, V	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A
6. If the Contractor places limits on services, it is: ◆ On the basis of criteria applied under the State plan (medical necessity). ◆ For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose. *42CFR438.210(a)(3)(iii)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.6.2 and 2.6.3	**1. CCS307 – Utilization Review Determinations** Page 3, paragraph 1 – Adverse Service Determination Page 4, paragraph 3 – Medical Necessity; 1-4 Page 6, paragraph 7 – Utilization Review, (e) Page 19, #6, (e) **2. UM Program Description** Page 5, Goals and Objectives, bullet 6 Page 6, 9th bullet Page 17, K. **3. Provider Manual** Page 61, Medical Necessity, bullets 1-5 Page 61, Medical necessity determinations are based on the	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	following: Bullets 1-3 (for SMCN, see page 40) **4. CCS306 Delivering Continuity and Transition of Care** Page 3, Procedure II. B, C-2 & 3	
7. The Contractor specifies what constitutes "medically necessary services" in a manner that: ◆ Is no more restrictive than that used in the State CHP+ program. ◆ Addresses the extent to which the Contractor is responsible for covering services related to the following: • The prevention, diagnosis, and treatment of health impairments. • The ability to achieve age-appropriate growth and development. • The ability to attain, maintain, or regain functional capacity. *42CFR438.210(a)(4)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.8.1.1 and 1.1.1.57	**1. CCS307 – Utilization Review Determinations** Page 4, paragraph 3: Definition of Medically Necessary 1 – 5 Page 5, paragraph 5 – Urgent Care Requests. I. A. Page 9, B. 4 **2. Evidence of Coverage** Page 13, Summary of Covered Benefits **Note in this table the "Benefit Adds" that Co Acc covers that are above the standard benefit limits. Page 39 & 40, Preventive Services covered Page 93, What Audiology Services are Covered Occupational therapy is a covered benefit of the CHP plan. The purpose of this therapy: improve a patient's functional ability to live independently. See Definitions of OT on page 130 (SMCN is on page 129). **3. Access to Care Plan** Page 1, Overview – Paragraph 2, 4 Page 8, paragraph 3 – A. Utilization Review Page 8, paragraph 4 – B. Referrals **4. QM308 Preventive Health Services** Page 2, Procedure I: Colorado Access identifies Preventive Services priorities through the use of: A–F	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 3, III. A. 1-10 Page 3 – 4, IV – IX **5. UM Early Intervention Process** Page 1 – Desktop Statement Page 5, Paragraph 2 **6. Provider Manual** Page 10, Benefits and Copays **Additional Co Acc Benefits Page 10, Special Services Page 23 – 24: Each patient record should contain the following information: All bullets Page 30, V. Provider Responsibility, all bullets For SMCN, see: Page 6: PCP Responsibilities Page 57, Copayments Page 15 Medical Record Documentation **7. CCS302 Medical Criteria for Utilization Review** Page 2, Definition – Medical Necessity Page 3, Procedure I. Development and Adoption of Criteria Used for Utilization Review Page 3, Procedure II. Application of Criteria	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor has written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42CFR438.210(b)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.8.1.2	**1. Evidence of Coverage** Page 23 - 24, Managed Care Sections: Preauthorization Tools or Process Adverse Service Determinations, Covered Benefit Decisions Page 24, Medically Necessary Health Services Sections: Medical Policy, Experimental/Investigational, Excluded Services Page 25 & 26, Appropriate Setting and Pre Authorization **2. CCS307 Utilization Review Determinations** Page 1, Policy Statement Page 13, II. General Procedure, A-E **3. CCS306 Delivering Continuity and Transition of Care** Page 4, C. 2. **4. UM Program Description** Page 16, D. Prospective Reviews Page 17, I. Drug Utilization and Review Program **5. Access to Care Plan** Page 7-8, IV. Coordinated Clinical Services, Paragraph 1 Page 9, D. Authorizations	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor has in place and follows written policies and procedures that include mechanisms to ensure consistent application of review criteria for authorization decisions. *42CFR438.210(b)(2)(i)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.8.1.3	**1. Access to Care Plan** Page 8, Paragraph 3, A. Utilization Review **2. CCS302 Medical Criteria for Utilization Review** Page 2, Policy Statement Page 3, Procedure I. Development and Adoption of Criteria Used for Utilization Review; A-C. Page 3, Procedure II. Application of Criteria, A-E. Page 4, Procedure III. Dissemination of Criteria, A-C **3. CCS307 Utilization Review Determination** Page 13, II. A. General Procedures. #6. **4. CCS301 Qualifications for Staff Engaged in Utilization Management Activities** Page 3, paragraph 4, IV. Page 3, paragraph 5, VI. **5. UM Program Description** Page 5, paragraph 3, Goals and Objectives Bullet 4, 6 Page 6, paragraph 1, bullet 9 **6. CCS314 Colorado Access Formulary Development and Maintenance** Page 2, Policy Statement Page 5, Procedure IV. Child Health Plan Plus (CHP+HMO and CHP+ SMCN) and Formulary Development and Maintenance. A-I. Page 6, V. CHP+ Formulary Publication and Postings A-C.	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	7. CCS312 Medication Utilization Review Page 2, Policy Statement Page 17, II. CHP+ (HMO & State Managed Care Network) Pharmacy Coverage Determinations, Paragraph 4. **8. Pharmacy and Therapeutic Committee Minutes** Page 2, II. Purpose and Function Page 2, IV. Decision Making Guidelines Page 3, V. Committee Structure, Membership, Term of Office **9. Inter-Rater Reliability (IRR) report results** Page 1, Purpose and Background Page 1, Methodology	
10. The Contractor has in place and follows written policies and procedures that include a mechanism to consult with the requesting provider when appropriate. *42CFR438.210(b)(2)(ii)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.8.1.3	**1. CCS307 Utilization Review Determination** Page 14, paragraph 1, d. Page 15, paragraph 5, #6. **2. UM Program Description** Page 16, paragraph 3, E. Prospective Review Page 17, paragraph 1, H. Care Management **3. CCS305 Care Coordination** Page 2, Policy Statement Page 3, Procedure I. Goals of Care Coordination, G. Page 4, Procedure III. Facilitation of Care Coordination C. 1 – 9.	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor has in place and follows written policies and procedures that include the provision that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease. *42CFR438.210(b)(3)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.8.1.6 and 2.8.1.3.1	**1. CCS302 Medical Criteria for Utilization Review** Page 3, II. Application of Criteria, D. **2. Provider Manual** Page 32 Colorado Access Responsibilities Bullet 5-9 Page 63, Bullet 3 - Adverse Service Determination ("Denied") Page 120, bullets 7 & 8 (for SMCN, see page 42, Adverse Service Determination) **3. CCS307 Utilization Review Determination** Page 13, II. A. 4. Page 18, 2 **4. CCS301 Qualifications for Staff Engaged in Utilization Management Activities** Page 2, Policy Statement Page 2, Procedure I. Page 2-3, Procedure II.	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A
12. The Contractor has in place and follows written policies and procedures that include processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested (notice to the provider need not be in writing). *42CFR438.210(c)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.8.1.3.2 and 2.8.1.3.3	**1. CCS307 – Utilization Review Determinations** Page 14, B. 3, 4, 6 Page 16, #3 Page 16, D. 4. Page 16, E. 2. Page 17, F. 1. A-F Page 19, 6. A-N **2. Evidence of Coverage** Denial of Services Page 24 - Adverse Service Determinations (Denial of Services) (for SMCN, see page 25) **3. Provider Manual – Denial of Services**	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 58, paragraph 5 (for SMCN, see page 42) **4. Notice of Action letter** **Additional Documents Submitted On-site:** • Notice of Action Templates	
13. The Contractor has in place and follows written policies and procedures that include the following time frames for making standard and expedited authorization decisions as expeditiously as the member's health condition requires not to exceed: ◆ For standard authorization decisions—10 calendar days. ◆ For expedited authorization decisions—3 business days. *42CFR438.210(d)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.8.1.3.3.1 and 2.8.1.3.3.2.1 10CCR2505—10, Sec 8.209.4.B	**1. CCS307 – Utilization Review Determinations** Page 10, B. 5 Page 14, B. 1-6 Page 15, C. 1-3 Page 16, D. 1-4 Page 16, E. 1-3 (a-e)	**HMO:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A
Findings: The Utilization Review Determinations policy accurately depicted the time frames for standard and expedited determinations. The Medication Utilization Review Procedure policy, however, stated that standard medication determinations are made within 10 calendar days of the receipt of information. Postponing determinations until after receipt of all information might cause determinations to be made beyond 10 calendar days of the receipt of the request for services (or medication). While scores and required actions have not been assigned to the SMCN for this review, HSAG recommends that the SMCN ensure that any changes to policies applicable to the CHP+ HMO apply to the SMCN as well, to ensure compliance with federal regulations. In practice, however, on-site review of the electronic authorization system as well as denials records demonstrated that, for both the CHP+ HMO and the SMCN, Colorado Access had successfully implemented processes which ensured that authorization decisions were made within the State-required time frames.		
Required Actions: Colorado Access must revise the Medication Utilization Review Procedure policy to accurately depict the standard authorization decision time frame as within 10 calendar days from the date of the request for service.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. Notices of action must meet the language and format requirements of 42CFR438.10 to ensure ease of understanding (6th grade reading level wherever possible and available in the prevalent non-English language for the service area). *42CFR438.404(a)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.4.3.1.6 10CCR2505—10, Sec 8.209.4.A.1	**1. ADM 207 – Effective Communication with LEP & SI/SI Persons** Page 2, Policy Statement Page 3, Procedure I. A-B Page 4, paragraph 3, #2 Page 4, II. B. **2. Language selection on Co Acc Website** Demo during on-sight visit **3. Health Literacy Advisor tool – English & Spanish** Demo available upon request **4. Evidence of Coverage** Page 1, Paragraph 2, 4, 5 (for SMCN, see page 8, Paragraph 5) **At the bottom of every page in the EOC:** *Have Questions? Need Help? We are here to help you in the language you speak!* Call us at (303) 751-9021, toll free 1-888-214-1101 TTY for the deaf or hard of hearing please call (720) 744-5126 or toll free at 1-888-803-4494. Email us at Customer.Service@coaccess.com	**HMO:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A

Findings:
Policies and procedures clearly described Colorado Access/SMCN's processes for ensuring that notices of action are easy to understand. During the on-site review, staff members described how they used the Health Literacy Advisor tool, pointing out unique benefits it offered that more commonly used tools lacked. Staff members described documenting members' preferred language based on eligibility records and member contact. During the on-site record review, however, there were two CHP+ HMO denial records and two SMCN denial records that contained notices of action (NOAs) that were not easily understood due to the use of clinical or industry-specific language that members are not likely to understand. In addition, the template used in one SMCN record was from another line of business and did not have the required information regarding appeal and State fair hearing rights. It was clear however, through record review, that Colorado Access had successfully implemented processes for its SMCN that were consistent with the CHP+ HMO and were compliant with federal regulations.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: Colorado Access must develop processes to ensure that physician reviewers are cognizant of the requirement that NOAs and other member-specific communication is written at the sixth-grade reading level whenever possible.		
15. Notices of action must contain: ◆ The action the Contractor (or its delegate) has taken or intends to take. ◆ The reasons for the action. ◆ The member's, authorized representative's, and provider's (on behalf of the member) right to file an appeal and procedures for filing. ◆ The date the appeal is due. ◆ The member's right to a State fair hearing. ◆ The procedures for exercising the right to a State fair hearing. ◆ The circumstances under which expedited resolution is available and how to request it. ◆ The member's right to have benefits continue pending resolution of the appeal and how to request that the benefits be continued. ◆ The circumstances under which the member may have to pay for the costs of services (if continued benefits are requested). *42CFR438.404(b)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.5.5 10CCR2505—10, Sec 8.209.4.A.2	**1. ADM219 - Member Appeal Process** Page 2, Policy Statement Page 4, Definition: Appeal Page 15, Clinical Appeal Process A – S (S. 1-9) **2. ADM203 – Member Grievance Process** Page 2, Policy Statement Page 3, procedure I. A. 1-9 **3. CCS307 – Utilization Review Determinations** Page 14, B. 1, 3, 4(a) Page 15, C - Prospective Expedited Review Request, Determination and Notification (Urgent Care Requests) 1-3. Page 19, #6. a. – n. Page 20, l **4. Evidence of Coverage** Page 11, paragraph 1 (for SMCN, see Page 21) Page 26 - You may have to pay (be held financially responsible) for all charges linked to an inpatient stay that is not authorized by CHP+ HMO. (for SMCN, see page 27) Page 113 – Grievance and Appeal, paragraph 1-3 Page 113 - What is a Designated Client Representative (DCR) Page 116, paragraph 3 Page 118 - Expedited ("Rush") Appeals Page 118 - How to Request a State Fair Hearing Page 119 – paragraph 4 (under address)	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The notices of action must be mailed within the following time frames: ◆ For termination, suspension, or reduction of previously authorized covered services, within the time frames specified in 431.211: • The notice of action must be mailed at least 10 days before the date of the intended action unless exceptions exist (see 42CFR431.213 and 214). ◆ For denial of payment, at the time of any action affecting the claim. ◆ For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires but within 10 calendar days following receipt of the request for services. ◆ For service authorization decisions not reached within the required time frames on the date time frames expire. ◆ For expedited service authorization decisions, as expeditiously as the member's health condition requires but within 3 business days after receipt of the request for services. *42CFR438.404(c)* *42CFR438.400(b)(5)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.8.1.3.3.1 and 2.8.1.3.3.2.1 10CCR2505—10, Sec 8.209.4.A.3	**1. CCS307 Utilization Review Determination** Page 14, B. 2 Page 15, C. 1 Page 18, 2. (b) **2. Notice of Action Letter** Page 3, The Expedited Appeals Process	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The Contactor may extend the authorization decision time frame if the enrollee requests an extension, or if the Contractor justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest. The Contractor's written policies and procedures include the following time frames for possible extension of time frames for authorization decisions: ◆ Standard authorization decisions—up to 14 calendar days. ◆ Expedited authorization decisions—up to 14 calendar days. *42CFR438.210(d)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.8.1.3.3.1 and 2.8.1.3.3.2. 10CCR2505—10, Sec 8.209.4.A.3	**1. CCS307 Utilization Review Determination** Page 14, B. 5 Page 15, C. 2 **2. Provider Manual** Page 118, Service Change, Bullet 3	**HMO:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **SMCN** ☐ Implemented ☒ Not Implemented ☐ N/A
Findings: The Utilization Review Determinations policy included the processes for accepting member requests for extension and for requesting extension if Colorado Access determined it to be in the member's best interest. The policy, however, described the extension notice as an NOA and stated that the member had a right to appeal, treating the extension notice as an NOA. The CHP+ HMO and the SMCN extension letter templates also included "Notice of Action – Timeliness" title headers. The extension of the authorization timeline in not an action; therefore, the member has no appeal right in this circumstance but may file a grievance. While scores and required actions have not been assigned to the SMCN for this review, HSAG recommends that the SMCN develop templates and processes consistent to those developed for the CHP+ HMO to ensure compliance with federal regulations.		
Required Actions: Colorado Access must revise its applicable policies and templates to accurately describe the member's right to file a grievance (not an appeal) if he or she disagrees with the decision to extend the time frame for making the authorization determination. Colorado Access must also clarify the Utilization Review Determinations policy to state that an NOA is not needed if the extension is used and that, although an NOA is required when the time frames expire, this notification period includes the extension time, if used.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. If the Contractor extends the time frame for making a service authorization decision, it: ◆ Provides the member written notice of the reason for the decision to extend the time frame. ◆ Informs the member of the right to file a grievance if the member disagrees with the decision to extend the time frame. ◆ Carries out the determination as expeditiously as the member's health condition requires and no later than the date the extension expires. *42CFR438.404(c)(4) and 438.210(d)(2)(ii)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.8.1.3.3 10CCR2505—10, Section 8.209.4.A.3	**1. CCS307 Utilization Review Determinations** Page 14, B. 5. a-d Page 15, C. 2. Page 16, E. 3. a-e Page 16, C. 2. **2. Provider Manual** Page 120 bullet 4 Page 120– 125 Appeal and Grievance (for SMCN, see pages 35 and 33) **3. Evidence of Coverage** Page 113 – 115 Grievance and Appeals **4. Notice of Action letter & Appeal Info** See denial letter and attached appeals rights	**HMO:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **SMCN** ☐ Implemented ☒ Not Implemented ☐ N/A
Findings: Extension letter templates provided on-site for the CHP+ HMO and the SMCN provided evidence that Colorado Access/SMCN had a process to notify members when an extension of the authorization determination time frame is needed. Neither template, however, included language to notify the member of the right to file a grievance if he or she disagreed with the decision to extend the time frame.		
Required Actions: Colorado Access must ensure that, when members are notified that Colorado Access will extend the time frame for an authorization determination, the notice includes language informing the member of his or her right to file a grievance if the member does not agree with the decision to extend the time frame.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
19. The Contractor has in place and follows written policies and procedures that provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42CFR438.210(e)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.8.1.1	**1. Evidence of Coverage** Page 24, Covered Benefit Decisions, paragraph 3. (for SMCN, see page 25) **2. CCS301 – Qualifications for Staff Engaged in Utilization Management Activities** Page 3. IV.	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A
20. The Contractor provides pharmacy medical management. CHP+ HMO Contract: Amendment 02, Exhibit K, 1.1	**1. CCS312 – Medication Utilization Review Procedure** Page 17. II. CHP+ (HMO & State Managed Care Network) Pharmacy Coverage Determinations A-G **2. CCS314 – Co Access Formulary Development & Maintenance** Page 2. Policy Statement Page 4. IV. A-I Page 6. V. CHP+ Formulary Publication and Postings A-C **3. Website formulary** http://www.coaccess.com/index.php/chp-prior-authorization-request-forms (for SMCN, use http://www.chpplusproviders.com/pharmacy.asp) **4. CHP+ Asthma Care Management Program** Program Goals	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	5. Evidence of Coverage Page 88–92: Member Benefits – Covered Services Outpatient Pharmacy and Prescription Medications (for SMCN, see page 87–92)	
21. The Contractor defines Emergency Medical Condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: ◆ Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. ◆ Serious impairment to bodily functions. ◆ Serious dysfunction of any bodily organ or part. *42CFR438.114(a)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 1.1.1.27	**1. Evidence of Coverage** Page 56 - What Emergency Care Services are Covered? Bullet 1. **2. Provider Manual** Page 65: Definition of an Emergency Medical Condition **3. CCS309 –Emergency and Post-Stabilization Care** Page 2. Definitions: Emergency Medical Condition Page 3. Procedure IV. **4. CCS 307 – Utilization Review Determinations** Page 3 – Definition: Emergency Medical Condition	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A
22. The Contractor defines Emergency Services as inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title, and are needed to evaluate or stabilize an emergency medical condition. *42CFR438.114(a)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 1.1.1.28	**1. CCS309 –Emergency and Post-Stabilization Care** Page 2. Definitions – Emergency Services, A & B **2. CCS307 – Utilization Review Determinations** Page 3. Definitions – Emergency Services, 1 & 2 **3. Provider Manual** Page 65 - Definition of an Emergency Medical Condition (for SMCN, see page 43, last paragraph)	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
23. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. *42CFR438.114(c)(1)(i)* CHP+ HMO Contract: Amendment 02, Exhibit A-2,2.6.6.1.4	**1. CCS309 –Emergency and Post-Stabilization Care** Page 3, Procedure III. **2. Evidence of Coverage** Page 48 - Where can I get Inpatient Hospital Services? Bullet 1. Page 55 - Covered Services: Urgent/After-Hours Care, Emergency Care and Travel Outside of the Country Page 56 -Where can I get Emergency Care? Bullet 2. **3. Provider Manual** Page 65–Emergency and Urgent Care for SMCN: Page 42–Participating vs Non-Participating Providers Page 43–Emergency and Urgent Care: Page 61–Covered Services: Emergency Room and Urgent/After-Hours Care.	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A
24. The Contractor does not require prior authorization for emergency or urgently needed services. *42CFR438.10(f)(6)(viii)(B)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.6.6.1.3	**1. CCS309 –Emergency and Post-Stabilization Care** Page 2. Definition - Prior Authorization Page 3. Procedure II. **2. Evidence of Coverage** Page 23 - Pre-authorization Tools or Processes Paragraph 1. Page 56 - Where can I get Emergency Care? Bullet 4. For SMCN: Page 55 – What emergency care services are covered? Page 56 – Where can I get emergency care? **3. Provider Manual** Page 65: Emergency and Urgent Care	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	For SMCN: Page 42–Participating vs Non-Participating Providers Page 43–Emergency and Urgent Care	
25. The Contractor may not deny payment for treatment obtained under the following circumstances: ◆ A member had an emergency medical condition, and the absence of immediate medical attention would ***have*** had the following outcomes: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. • Serious impairment to bodily functions. • Serious dysfunction of any bodily organ or part. ◆ Situations which a reasonable person outside the medical community would perceive as an emergency medical condition but the absence of immediate medical attention would ***not*** have had the following outcomes: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. • Serious impairment to bodily functions. • Serious dysfunction of any bodily organ or part. ◆ A representative of the Contractor's organization instructed the member to seek emergency services. *42CFR438.114(c)(1)(ii)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.6.6.1.4, 2.6.6.3.1, and 2.6.6.4.1.3	**1. CCS309 –Emergency and Post-Stabilization Care** Page 2. Definition – Emergency Medical Condition A - C **2. Evidence of Coverage** Page 55 – 56 Emergency Care *Emergency care is a sudden and unexpected health condition that needs immediate medical attention. It means that if you do not get medical attention immediately you could have a serious injury to your bodily functions, organs, or you would put your health in serious jeopardy.* Page 56 - What Emergency Care Services Are Covered? Bullets 1 & 2 (all 4 sub-bullets) **3. Provider Manual** Page 65 Definition of Emergency Medical Condition Paragraph 2, 3, and 4 For SMCN Page 43-44 Definition of Emergency Medical Condition, Last Paragraph **4. CCS307 – Utilization Review Determinations** Page 3. Definition: Emergency Medical Condition Page 5. Urgent Care Requests. 1. A.	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
26. The Contractor does not: ◆ Limit what constitutes an emergency medical condition on the basis of a list of diagnoses or symptoms. ◆ Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the Contractor or State agency of the member's screening and treatment within 10 days of presentation for emergency services. *42CFR438.114(d)(1)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.6.6.6.2.1 and 2.6.6.1.6	**1. CCS309 –Emergency and Post-Stabilization Care** Page 2 - Emergency Medical Condition Page 2 - Emergency Services: Covered inpatient and outpatient services that are: A. Furnished by a qualified provider under 42 CFR 438 B. Needed to evaluate or stabilize an Emergency Medical Condition. Page 3, Procedure IV. **2. Evidence of Coverage** Page 55& 56 - Urgent/After-Hours Care, Emergency Care Page 56, bullet 1 - What Emergency Care Services are Covered? Page 104 - Out-of-Network Billing Procedures for Covered Services For SMCN Page 55 – Where can I get emergency care? Page 61 - Urgent/After-Hours Care, Emergency Care Page 31 – Services from Out-of-Network Providers **3. Provider Manual** Page 61 - Authorization Categories Bullet 1. Page 65 - Definition of an Emergency Medical Condition For SMCN Page 40 - Authorization Categories Page 43-44 Definition of Emergency Medical Condition, Last Paragraph **4. CCS307 – Utilization Review Determinations** Page 3 – Definition: Emergency Medical Condition	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
27. The Contractor will be responsible for Emergency Services when: ◆ The member's primary diagnosis is medical in nature, even when the medical diagnosis includes some psychiatric conditions or procedures. ◆ The primary diagnosis is psychiatric in nature even when the psychiatric diagnosis includes some procedures to treat a secondary medical diagnosis. CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.6.6.6.2	**1. CCS309 –Emergency and Post-Stabilization Care** Page 3. IV. **2. Evidence of Coverage** Page 129 - Mental health condition (for SMCN, see page 83) **3. Provider Manual** Page 61 – Medical Necessity, bullet 1. (for SMCN, see page 40) **4. CCS307 – Utilization Review Determinations** Page 2. Definitions – Medical Necessity, 1. **5. ADM205 – Nondiscrimination** Policy Statement **6. Claims Payment Processes** CHP claims do not process based on diagnosis. All CHP claims are processed based on covered benefit, place of service, provider and eligibility on the date of service.	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A
28. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42CFR438.114(d)(2)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.6.6.1.7	**1. CCS309 –Emergency and Post-Stabilization Care** Page 4. VIII. **2. Evidence of Coverage** Page 56 - What Emergency Care Services are Covered? Bullets 1 and 2 (all 4 sub-bullets) (for SMCN, see page 55) **3. Provider Manual** Page 55- Hold Harmless Clause	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
29. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment. *42CFR438.114(d)(3)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.6.6.1.5	**1. CCS309 –Emergency and Post-Stabilization Care** Page 3. Procedure V. **2. Evidence of Coverage** Page 56 - What Emergency Care Services are Covered? Bullet 1 & 2, and 4 sub-bullets (for SMCN, see p 55) **3. Provider Manual** Page 63 Paragraph 2 Page 65 Definition of an Emergency Medical Condition, Last sentence (for SMCN, see page 44, paragraph 3)	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A
30. The Contractor defines Poststabilization Care as covered services, related to an emergency medical condition, that are provided after a member is stabilized in order to maintain the stabilized condition, or provided to improve or resolve the member's condition. *42CFR438.114(a)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 1.1.1.67	**1. CCS309 –Emergency and Post-Stabilization Care** Page 2. Definition – Post Stabilization Care **2. Evidence of Coverage** Page 56 - What Emergency Care Services are Covered? Bullet 1 & 2, and 4 sub-bullets (for SMCN, see p 55, paragraph 2) **3. Provider Manual** Page 62 - Post-Stabilization Care Services (for SMCN, see page 44, paragraph 2 and 3)	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A
31. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that ***have been*** pre-approved by a plan provider or other organization representative. *42CFR438.114(e)* *42CFR422.113(c)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.6.6.4.1.4	**1. Evidence of Coverage** Page 57 - What Emergency Care Services are Covered? Bullet 2 (and all sub bullets) (for SMCN, see Page 55 Paragraph 2) **2. Provider Manual** Page 62 - Post-Stabilization Care Services: Page 94 – Post-Stabilization Services (for SMCN, see Page 44, Paragraph 2, 3) **3. CCS309 – Emergency & Post-Stabilization Care** Page 3. VI.	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
32. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that ***have not been*** pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition under the following circumstances: ◆ Within 1 hour of a request to the organization for pre-approval of further poststabilization care services. ◆ The Contractor does not respond to a request for pre-approval within 1 hour. ◆ The Contractor cannot be contacted. ◆ The Contractor's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a plan physician, and the treating physician may continue with care of the patient until a plan physician is reached, or the Contractor's financial responsibility for poststabilization care services it ***has not*** pre-approved ends. *42CFR438.114(e)* *42CFR422.113(c)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.6.6.4.1.5 and 6	**1. CCS309 –Emergency and Post-Stabilization Care** Page 3. VI. B. Page 3. VI. C. 1, 2, 3 **2. Evidence of Coverage** Page 56 - What Emergency Care Services are Covered? Bullet 1 -2, and 4 sub-bullets (for SMCN, see p 55) **3. Provider Manual** Page 62 - Post-Stabilization Care Services: Page 94 – Post-Stabilization Services (For SMCN, see page 44)	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
33. The Contractor's financial responsibility for poststabilization care services it ***has not*** pre-approved ends when: ◆ A plan physician with privileges at the treating hospital assumes responsibility for the member's care. ◆ A plan physician assumes responsibility for the member's care through transfer. ◆ A plan representative and the treating physician reach an agreement concerning the member's care, ◆ The member is discharged. *42CFR438.114(e)* *42CFR422.113(c)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.6.6.4.1.8	**1. CCS309 –Emergency and Post-Stabilization Care** Page 4. VII. A – D **2. Evidence of Coverage** Page 56 - What Emergency Care Services are Covered? Bullet 2, and 4 sub-bullets (SMCN see page 55) **3. Provider Manual** Page 62 - Post-Stabilization Care Services: Page 94 – Post-Stabilization Services (for SMCN, see page 44)	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A
34. The Contractor must limit charges to members for poststabilization care services to an amount no greater than what the Contractor would charge the member if he or she had obtained the services through the Contractor. *42CFR438.114(e)* *42CFR422.113(c)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.6.6.4.1.7	**1. CCS309 –Emergency and Post-Stabilization Care** Page 4, VIII. **2. Evidence of Coverage** Page 56 - What Emergency Care Services are Covered? Bullet 2, sub-bullet 4 (SMCN see page 55) **3. Provider Manual** Page 62-63 - Post-Stabilization Care Services, Paragraph 2	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A

Results for Standard I—Coverage and Authorization of Services (CHP+ HMO)							
Total	Met	=	30	X	1.00	=	30
	Partially Met	=	4	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	34	**Total Score**		=	30

Total Score ÷ Total Applicable	=	88%

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
The Contractor ensures that all covered services are available and accessible to members through compliance with the following requirements:		
1. The Contractor maintains and monitors a network of providers that is supported by written agreements and is sufficient to provide adequate access to all covered services. In order for the Contractor's plan to be considered to provide adequate access, the Contractor includes the following provider types and ensures a minimum provider-to-member caseload ratio as follows: ◆ Appropriate access to certified nurse practitioners and certified nurse midwives. ◆ 1:2000 primary care physician-to-member ratio. PCP includes physicians designated to practice family medicine and general medicine. ◆ 1:2000 physician specialist-to-members ratio. Physician specialist includes physicians designated to practice cardiology, otolaryngology/ENT, endocrinology, gastroenterology, neurology, orthopedics, pulmonary medicine, general surgery, ophthalmology, and urology. ◆ Physician specialists designated to practice internal medicine, infectious disease, OB/GYN and pediatrics shall be counted as either PCP or physician specialist, but not both. *42CFR438.206(b)(1)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.7.1.1.5, 2.7.1.1.6, and 2.7.1.1.9	**1. Quarterly Report** HMO Network Adequacy Report FY14 Q1 Network Adequacy Report CHP SMCN FY 12-13 Network Adequacy Report CHP SMCN FY14 Q1 **2. PNS202 Selection & Retention of Providers** Page 2, Policy Statement Page 2, I. B. Page 2 – 3, C. 1. a-f Page 3, C. 4. Page 4, G. **3. Provider Network Strategic Plan FY 13-14** Page 2, Network Adequacy (all bullets) **4. CHP Provider Directory** http://www.chpplusproviders.com/ProviderDirectory/dsp_ProviderDirectoryPrint.asp (hard copy available upon request) See Certified Nurse Midwives under: Aurora, Colorado Springs, Commerce City, Englewood, Evergreen, Ft Collins, Greeley, Greenwood Village, Lamar, Loveland, New Castle, Pueblo, Sheridan, Sterling, Denver, Thornton, Nurse Practitioners—Colorado Access comments: Nurse practitioners have been included as contracted providers in our networks for years, though we just began credentialing NPs individually last year so they could be included/listed individually in our provider directories. Prior to 2013 we did not credential NPs, though many of our	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	contracted providers did employ NPs who provided services to our members. **5. CHP HMO & SMCN Midwife Network Report** (see report in reports folder)	
2. In establishing and maintaining the network, the Contractor considers: ◆ The anticipated CHP+ enrollment. ◆ The expected utilization of services, taking into consideration the characteristics and health care needs of specific CHP+ populations represented in the Contractor's service area. ◆ The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted CHP+ services. ◆ The numbers of network providers who are not accepting new CHP+ patients. ◆ The geographic location of providers and CHP+ members, considering distance, travel time, the means of transportation ordinarily used by CHP+ members, and whether the location provides physical access for CHP+ members with disabilities. *42CFR438.206(b)(1)(i) through (v)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.5.10.1	**1. PNS202 Selection & Retention of Providers** Page 1, Policy Statement Page 2, C. 1. a-f Page 2, C. 2. **2. Provider Network Strategic Plan** Page 1, paragraph 3, Provider Network Strategic Planning **3. Access to Care Plan** Page 4, B. Choosing and Changing a Provider Page 13, A. Monitoring, Evaluation and Reporting, Paragraph 1. Page 15, Geographic Accessibility Standards Table 1 – see CHP HMO column. **4. Network Adequacy Reports** FY Quarter 4 report (HMO) Network Adequacy Report CHP SMCN FY 12-13 Network Adequacy Report CHP SMCN FY14 Q1	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor ensures that its members have access to a provider within 30 miles or 30 minutes travel time, whichever is larger, to the extent such services are available and providers are qualified and willing to contract on reasonable terms. CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.7.1.3.1	**1. Quarterly Report** HMO Network Adequacy Report FY14 Q1 See example document in Standard II Reports folder Includes - Essential Community Provider Network Adequacy Report CHP SMCN FY 12-13 Network Adequacy Report CHP SMCN FY14 Q1 **2. Access to Care Plan** Page 15, Geographic Accessibility Standards Table 1 – see CHP HMO column **3. Provider Network Strategic Plan** Page 2, Network Adequacy **4. CS311 – PCP Assignment** Page 2, C. 2.	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A
4. The Contractor ensures that members have access to an Essential Community Provider, to the extent such services are available: ◆ Within 30 minutes or 30 miles in urban counties. ◆ Within 45 minutes or 45 miles in suburban counties. ◆ Within 90 minutes or 90 miles in rural counties. CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.7.1.3.2	The following are Network Adequacy Reports specific to ECP providers. **1. CHP ECP Access Annual Rural FY 2013** See in reports folder **2. CHP ECP Access Annual Suburban FY 2013** See in reports folder **3. CHP ECP Access Annual Urban FY 2013** See in reports folder **4. Provider Manual** Page 118—Essential Community Provider **5. PNS202 Selection and Retention of Providers** Page 3. D. **6. ECP Provider List – By provider type**	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor provides female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health care specialist. *42CFR438.206(b)(2)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.7.1.1.7	**1. Evidence of Coverage** Page 41 - Who Should I see for Family Planning/Reproductive Health Services – bullet 1 & 2. Page 43 - Who Should I see for Maternity and Newborn Care? – bullet 2. Page 45 - You do not need to get approval from CHP+ HMO when you get care from: bullet 1 (for SMCN, see pages 41, 42, and 44) **2. Provider Manual** Page 62 – Clinical Referrals (p 40 for SMCN) Page 64 – Specialist Referrals (p 42 for SMCN) Page 66 - Women's Health - OB/GYN Services (p 44 for SMCN) Page 67 – Maternity Care (p 45 for SMCN) Page 68 – Postpartum Ambulatory Maternity Care (p 46 for SMCN) Page 68 - Amniocentesis and Chorionic Villus Sampling Villus Sampling (p 46 for SMCN) **3. CCS310 – Access to Primary and Specialty Care** Page 3, III. Direct Access. A-J	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor allows persons with special health care needs who use specialists frequently to maintain these types of specialists as PCPs or be allowed direct access/standing referrals to specialists. *42CFR438.208(c)(4)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.7.5.4	**1. Access to Care Plan** Page 10, H. Care Management/Service/Resource Coordination. Paragraph 1: Intensive Care Management provides care coordination primarily for individuals with special healthcare needs that are medically complex. The goal of providing care coordination is to reduce fragmentation in care delivery among providers for members with complex or serious medical and social needs and to promote member self-management of medical, emotional and personal issues. Page 11, I. 2. (page 12 also): new members with special healthcare needs may continue to receive medically necessary covered services at the level of care received prior to enrollment from their providers for a transition period of up to sixty (60) days from the date of enrollment, and from ancillary providers for up to seventy-five (75) days. **2. CCS310 Access to Primary and Specialty Care** Page 3 - Special Healthcare Needs Page 4, III. Direct Access, A.	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A
7. The Contractor has a mechanism to allow members to obtain a second opinion from a qualified health care professional within the network, or arranges for the member to obtain one outside the network, at no cost to the member. *42CFR438.206(b)(3)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.7.1.1.8	**1. Evidence of Coverage** Page 46 - What Provider Office Services are Covered, Bullet 3. (p 45–46 for SMCN) Page 107 - Refusal to Follow Recommended Treatment (p 108 for SMCN) Page 134 – Glossary; Second Opinion (p 133 for SMCN) **2. CCS310 – Primary & Specialty Care Access** Page 4, II. C. Page 5, III. I.	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. If the Contractor is unable to provide necessary primary or specialist services to a member in-network, the Contractor must make special arrangements for members to access out-of-network providers for as long as the Contractor is unable to provide them. *42CFR438.206(b)(4)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.7.1.2.1	**1. Access to Care Plan** Page 8, B. Referrals, paragraph 2. **2. CCS310 Access to Primary and Specialty Care** Page 5, J. **3. HMO Single Case Agreement** Page 2, B. 3. Hold Member Harmless **4. Evidence of Coverage** Page 10, paragraph 3. (p 20, paragraph 4 for SMCN)	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A
9. The Contractor works with out-of-network providers with respect to payment and ensures that the cost to the member is no greater than it would be if the services were furnished within the network. *42CFR438.206(b)(5)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.7.1.2.2.1	**1. PNS215 Reimbursement** Page 3, II. Reimbursement for Non-Participating Providers Page 6, paragraph 1 Page 8, V. Single Case Agreements Page 9, Paragraph 2 SMCN state approval of SCA **2. Access to Care Plan** Page 11, 2. New Members with Transition-of-Care Needs Cont on page 12: paragraph 1. **3. HMO Single Case Agreement document** Page 2, B. 3. Hold Member Harmless **4. CHP SMCN Single Case Agreement Template** Page 2, B. 3. Hold Member Harmless	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor ensures that members within the service area have access to emergency services on a 24-hour, 7 days-a-week basis. *42CFR438.206(c)(1)(iii)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.6.3.5	**1. Access to Care Plan** Page 2, II. A. Access and Availability Standard **2. Evidence of Coverage** Page 84, bullet 4. Emergency Services **3. CCS 309 – Emergency & Post-Stabilization Care** Page 2, Policy Statement Page 3, Procedure I. **4. QAPI Evaluation 12/13** Page 6, Service Accessibility Page 6, Results and Analysis Page 7, See After Hours Access chart **5. After Hours Access Survey Report 2013**	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A
11. Members temporarily out of the service area may receive out-of-area emergency services and urgently needed services. CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.6.3.5	**1. CCS309 –Emergency and Post-Stabilization Care** Page 2 - Urgently Needed Services (AA and CHP+) A & B Page 3, Procedure III **2. Evidence of Coverage** Page 55 - Where Can I Get Urgent/After-Hours Care Bullet 3. (page 54 for SMCN) **3. Access to Care Plan** Page 9, bullet 4.	**HMO:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **SMCN** ☐ Implemented ☐ Not Implemented ☒ N/A

Findings:
The Emergency and Poststabilization Services policy, as well as the Access to Care Plan, stated that Colorado Access covers emergency and urgent care in or out of the network, and described "urgent care" as services which are provided when a member is temporarily absent from the service area or provided when the in-network provider is not available. Both the CHP+ HMO and SMCN Evidence of Coverage (EOC)/member handbooks informed members that emergency services were covered in network or out of network and that urgent care is covered in network or when temporarily out of the service area. However, both EOC handbooks communicated that urgent care was not covered if the member was "more than 50 miles from the service area if you knew you might need care before you left," or for maternity care within five weeks of delivery. This language is out of compliance with the contract requirement, as well as Colorado Access' policies.

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
During on-site interviews, staff stated that COA does not retroactively review or deny coverage for urgent care services outside the service area. Staff acknowledged that the language in the EOCs regarding exceptions for coverage of urgent care services outside the services area appeared to be erroneously retained from prior contract language. Colorado Access should consider removing the description of urgent care coverage exceptions from the SMCN EOC.		
Required Actions: Colorado Access must remove the description of exceptions to coverage for urgent care outside the service area from the CHP+ HMO EOC.		
12. The Contractor must require its providers to offer hours of operation that are no less than the hours of operation offered to commercial members. *42CFR438.206(c)(1)(ii)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.5.1	**1. Provider Manual** Page 21, III. Provider Responsibility, Bullet 2 (see p 6 for SMCN) Page 22, Paragraph 2 - PCP Responsibilities; Coverage Bullet 1 (see p 7 for SMCN) Paragraph 4 – Specialty Care Providers; Coverage (see p 7 for SMCN) Bullet 1 **2. Access to Care Plan** Page 2, II. A. **3. PNS306 Availability of After Hours Coverage** Page 2, Policy Statement Page 4, Procedure I. B. Page 4, Procedure I. D. 1. a – c	**HMO:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **SMCN** ☐ Implemented ☒ Not Implemented ☐ N/A
Findings: Neither the CHP+ or SMCN provider manuals nor the Professional Services Agreement specified that hours of office operation for CHP+ HMO or SMCN members must be no less than the hours of operation offered to commercial members. Recommendation: Colorado Access should consider requiring SMCN providers to maintain hours of operation for SMCN members that are no less than hours of operation for commercial members.		
Required Actions: Colorado Access must require its CHP+ HMO providers to maintain hours of operation for CHP+ members that are no less than hours of operation for commercial members.		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services taking into account the urgency of the need for services: ◆ Urgently needed services are provided within 48 hours of notification of the primary care physician or the Contractor. *42CFR438.206(c)(1)(i)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.7.1.5.2.1	**1. Access to Care plan** Appendix A. Page 2. Table 2. Table 2: Appointment Availability Standard See Urgent under CHP HMO column **2. Provider Manual** Page 12 Appointment Standards, Urgent Care (p 14 for SMCN) See Physical Health table **3. Evidence of Coverage** Page 10- 11; Going to see your PCP (see table on page 11) (p 20 for SMCN) **4. FY14 Secret Shopper Report: Pediatric Urgent Care**	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A
14. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services taking into account the urgency of the need for services: ◆ Non-urgent, symptomatic health care is scheduled within two weeks. ◆ Non-emergent, non-urgent care for a medical problem is provided within 30 calendar days. ◆ Non-symptomatic well care physical examinations are scheduled within 4 months. *42CFR438.206(c)(1)(i)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.7.1.5.2–4	**1. Access to Care Plan** Appendix A. Page 2. Table 2. Table 2: Appointment Availability Standard See Routine/Non-Urgent under CHP HMO column **2. Provider Manual** Page 12 - Appointment and Services Standards (p 14 for SMCN) See Physical Health table **3. Evidence of Coverage** Page 11 – see table (p 20 for SMCN) **4. FY13 Ped Routine Care Secret Shopper**	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services taking into account the urgency of the need for services: ◆ Diagnosis and treatment of non-emergency, non-urgent mental health condition scheduled within 30 calendar days. ◆ Diagnosis and treatment of a non-emergent, non-urgent substance abuse condition scheduled within 2 weeks. *42CFR438.206(c)(1)(i)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.7.1.5.2.5 and 2.7.1.5.2.6	**1. QAPI Work Plan** P. 4 "Service Accessibility" **2.** A survey was conducted to investigate whether our providers were meeting these standards. Below are the supporting documents: **A. Mental Health-Substance Abuse ATC Script** **B. Email form for electronic responses** *Results from access study will be available for audit visit **3. Provider Manual** Page 12 Appointment Standards (Behavioral Health)	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☐ Implemented ☒ Not Implemented ☐ N/A
Findings: The SMCN provider manual did not address behavioral health appointment requirements. Staff stated that the SMCN population consists primarily of pregnant women and members who are transitioning into a CHP+ HMO within 45 days. In addition, the SMCN contract has not been updated to be consistent with BBA regulations, including this requirement. Therefore, the SMCN provider manual had also not been updated. Recommendation: Colorado Access should consider adding mental health and substance abuse appointment requirements to the SMCN provider manual to be consistent with 42CFR438.206(c)(1)(i)		
16. The Contractor communicates all scheduling guidelines to participating providers and members. CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.7.1.5.4	**1. Evidence of Coverage** Page 10 & 11 - Going to see your PCP (p 20 for SMCN) **2. Provider Manual** Page 12 & 13 Tables (p 14 & 15 for SMCN) **3. Access to Care Plan** Page 2, II. A. Access and Availability Standards	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☐ Implemented ☐ Not Implemented ☒ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The Contractor maintains an effective organizational process for monitoring scheduling and wait times, identifying scheduling and wait time issues that do not comply with its guidelines, and takes appropriate action. The Contractor has mechanisms to ensure compliance by providers regarding timely access to services, has mechanisms to monitor providers regularly to determine compliance, and to take corrective action if there is failure to comply. *42CFR438.206(c)(1)(iv) through (vi)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.7.1.4.1.1.1, and 2.7.1.5.4	**1. FY14 Ped Urgent Care Secret Shopper** **2. FY13 Ped Routine Care Secret Shopper** **3. QAPI Evaluation Appointment Availability** Page 6 & 7 **4. QAPI Work Plan** Page 3 – Service and Accessibility **5. Access to Care Plan** Page 2, II. A. Page 13, paragraph 2, 4, Page 13-14, B. **6. Provider Manual –Access to Care Standards** Page 12-13 – Tables (p 14 & 15 for SMCN) **7. Grievance Report CHP HMO**	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Implemented ☐ Not Implemented ☐ N/A
18. The Contractor maintains a comprehensive program of preventive health services for members that includes written policies and procedures, involves providers and members in their development and ongoing evaluation, and includes: ◆ Risk assessment by a member's PCP or other qualified professionals specializing in risk prevention who are part of the Contractor's participating providers or under contract to provide such services, to identify members with chronic or high-risk illnesses, a disability, or the potential for such condition. ◆ Health education and promotion of wellness	**1. CCS305 – Care Coordination** Page 2, Care Coordination Page 2, Care Management Page 3, Procedure I. A-J Page 3-4, Procedure II. A. 1-6 Page 4, Procedure III. A-C Page 6, E. 1-4 **2. CCS310 – Access to Primary & Specialty Care** Page 3 - Special Healthcare Needs **3. QM308 - Preventive Health Services** Page 2, Policy Statement Page 2-3, Procedure I. – VII.	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☐ Implemented ☐ Not Implemented ☒ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
programs, including the development of appropriate preventive services for members with a disability to prevent further deterioration. The Contractor will also include distribution of information to members to encourage member responsibility for following guidelines for preventive health. ◆ Evaluation of the effectiveness of health preventive services, including monitoring and evaluation of the use of select preventive health services by at-risk members. ◆ Procedures to identify priorities and develop guidelines for appropriate preventive services. ◆ Processes to inform and educate participating providers about preventive services, involve participating providers in development of programs, and evaluate the effectiveness of participating providers in providing such services. CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.7.8.1	**4. QM311 Clinical guidelines** Page 2, Policy Statement Page 2, Procedure I. II. III **5. Access to Care Plan** Page 14, C. **6. Evidence of Coverage** Page 13–Summary of Benefits Page 39 – Preventive Care Services Including immunization chart **7. Provider Manual** Page 16 – Quality Management, bullet 3 Page 21 – Provider Responsibility, bullet 5 Page 77 - Prevention Perks Program Page 78-79 – Measurable Goals of Care Management All bullets Page 101, 8 (for SMCN, see p 18, 29, and 60) **8. QAPI Evaluation** Page 15 – Focus Group Results and Analysis Page 21 – 23 – Population Health Programs High Risk Assessment IVR Outreach Asthma High Risk OB; 1-6 Depression Diabetes Page 26 – Prevention Perks Page 28 - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents Performance	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Improvement Project (PIP) and Healthy Living Initiative Page 31 – Dental Health Improvement Plan **9. http://www.coaccess.com/safe-t-tiger-program** **10. http://www.coaccess.com/health-and-wellness** **11. Access Kids Health Quarterly Newsletter**	
19. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner, to all members including those with limited English proficiency or reading skills including those with diverse cultural and ethnic backgrounds by: ◆ Maintaining policies to reach out to specific cultural and ethnic members for prevention, health education, and treatment for diseases prevalent in those groups. ◆ Maintaining policies to provide health care services that respect individual health care attitudes, beliefs, customs, and practices of members related to cultural affiliation. ◆ Making a reasonable effort to identify members whose cultural norms and practices may affect their access to health care. Such efforts may include: • Inquiries conducted by the Contractor of the language proficiency of members during the Contractor's orientation calls. • Being served by participating providers. • Improving access to health care through community outreach and Contractor publications. ◆ Developing and/or providing cultural competency training programs, as needed, to the network	**1. ADM206 – Culturally Sensitive Services for Diverse** Page 2, Policy Statement Page 2-3, Procedure I. A – F Page 3, Procedure II Page 3, Procedure III Page 3, Procedure IV **2. ADM207 – Effective Communication with LEP & SI/SI** Page 2, Policy Statement Page 3, Procedure I. A & B Page 4, Procedure II. 2. Page 4, Procedure II (should be III, correcting under way). A-H. **3. QM308 – Preventive Health Services** Page 2, Policy Statement Page 3, III. A. 1-10 **4. Evidence of Coverage – English and Spanish** Page 1—Do You Need Special Help with This Booklet? (p 6 for SMCN) Footer on every page: Have Questions? Need Help? We are here to help you in the language you speak! Call us at (303) 751-9021, toll free 1-888-214-1101 TTY for the deaf or	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☐ Implemented ☐ Not Implemented ☒ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
providers and Contractor staff regarding: • Health care attitudes, values, customs, and beliefs that affect access to and benefit from health care services, • The medical risks associated with the Client population's racial, ethnic, and socioeconomic conditions. ◆ Making available written translation of Contractor materials, including member handbook, correspondence and newsletters. Written member information and correspondence shall be made available in languages spoken by prevalent non-English-speaking member populations within the Contractor's service area. ◆ Developing policies and procedures, as needed, on how the Contractor shall respond to requests from participating providers for interpreter services by a qualified interpreter. This shall occur particularly in service areas where language may pose a barrier so that Participating Providers can: • Conduct the appropriate assessment and treatment of non-English-speaking members (including Members with a communication disability), • Promote accessibility and availability of covered services, at no cost to Members. ◆ Developing policies and procedures on how the Contractor shall respond to requests from members for interpretive services by a qualified interpreter or publications in alternative formats. ◆ Making a reasonable effort, when appropriate, to develop and implement a strategy to recruit and	hard of hearing please call (720) 744-5126 or toll free at 1-888-803-4494 Email us at Customer.Service@coaccess.com Page 2, paragraph 4 **5. Access to Care Plan** Page 1, Overview, paragraph 4 Page 2, II. B. Page 3, paragraph 2 Page 3, paragraph 4 (all 10 bullets) Page 6, D. Member Communication Page 12, V. **6. CHP HMO Newsletter – English and Spanish** (not applicable to SMCN) **7. Language Interpretation Request Form** **8. Member communications plan** Page 5, paragraph 4 (not applicable to SMCN) **9. PNS202 Selection and Retention of Providers** Page 2, I. B. Page 3, C. 1. b, f **10. Access to Care Plan** Page 8, B. Referrals, paragraph 2. **11. CCS310 Access to Primary and Specialty Care** Page 5, J. **12. HMO Single Case Agreement**	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
retain qualified, diverse, and culturally competent clinical providers that represent the racial and ethnic communities being served, ◆ Providing access to interpretative services by a qualified interpreter for members with a hearing impairment in such a way that it shall promote accessibility and availability of covered services, ◆ Developing and maintaining written policies and procedures to ensure compliance with requirements of the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973, ◆ Arranging for Covered Services to be provided through agreements with non-participating providers when the Contractor does not have the direct capacity to provide covered services in an appropriate manner, consistent with independent living, to members with disabilities, ◆ Providing access to TDD or other equivalent methods for members with a hearing impairment in such a way that it will promote accessibility and availability of covered services, ◆ Making member information available upon request for members with visual impairments, including, but not limited to, Braille, large print, or audiotapes. For members who cannot read, member information shall be available on audiotape. *42CFR438.206(c)(2)* CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.7.7.2	Page 2, B. 3. Hold Member Harmless **13. CHP+ SMCN Single Case Agreement** Page 2, B. 3. Hold Member Harmless **14. Evidence of Coverage** Page 10, paragraph 3. (p 20 for SMCN) **15. Prenatal Assessment (SMCN only)** **16. IVR Prevention Call Scripts_CHP** See question 15 **17. CS Desktop Flagging Member Accounts** Page 2, Procedure – Example; bullet 2 **18. ADM205 Nondiscrimination** Page 3, Procedure II, III, IV	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
20. The Contractor analyzes and responds to results of the following HEDIS measures: ◆ Well-Child Visits in the First 15 Months of Life ◆ Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life ◆ Adolescent Well-Care Visits CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.9.4.1.2	**1. QAPI Evaluation** Page 24 – 26, Results and Analysis **2. QAPI Work Plan** Page 2, Work Plan table, row 3. **3. IVR Prevention Call Scripts** Page 3-4 **4. QM308 - Preventive Health Services** Page 2, Policy Statement Page 3, Procedure I. Colorado Access identifies Preventive Services priorities through the use of: A – F. Page 3, Procedure II. A. 1-10 Page 3-4, Procedure IV. A-D **5. Birthday cards** This is sent two months prior to the child's birthday to remind their families to schedule a well child visit. Copy of the card will be available at the on-site visit	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☐ Implemented ☐ Not Implemented ☒ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
21. The Contractor monitors member perceptions of accessibility and adequacy of services provided by the Contractor. The Contractor uses tools including member surveys, anecdotal information, grievance and appeals data, and enrollment and disenrollment information. CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.9.4.3.2	**1. HMO QAPI Evaluation** Page 6 – 9; Service Accessibility Page 15-18; Grievance Page 13 – 14; Consumer Assessment of Health Plans Survey (CAHPS) **2. HMO Quarterly Disenrollment Report** **3. Network Adequacy Report; FY14 Q1** **4. CHP/SMCN/ABC Grievance Workflow Desktop** **5. Procedure** Page 3, Process 6. **6. Grievance Report** Page 2, Analysis **7. Call Monitoring Report** Page 3 – Customer Service Call Reasons Report	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☐ Implemented ☐ Not Implemented ☒ N/A
22. The Contractor develops and implements a corrective action plan for all areas of the CAHPS survey that report a score that is less than the 50th percentile. CHP+ HMO Contract: Amendment 02, Exhibit A-2, 2.9.4.3.5	**1. 2013 CHP+ CAHPS Summary CAP** See page 10 for the corrective action topics	**HMO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☐ Implemented ☐ Not Implemented ☒ N/A

Results for Standard II—Access and Availability							
Total	Met	=	20	X	1.00	=	20
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	22	**Total Score**		=	20

Total Score ÷ Total Applicable	=	91%

The completed record review tools follow this cover page.

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2013–2014 Denials Record Review Tool
for Colorado Access (CHP+ HMO)

Review Period:	January 1, 2013–December 31, 2013
Date of Review:	February 18, 2014
Reviewer:	Kathy Bartilotta
Participating Plan Staff Member:	Laura Coleman

Requirement	File 1	File 2	File 3	File 4	File 5
1. Member ID	******	******	******	******	******
2. Date of initial request	3/14/13	10/4/13	10/4/13	3/5/13	4/23/13
3. What type of denial? (termination [T], new request [NR], or claim [CL])	NR	NR	NR	NR	NR
4. Standard (S) or Expedited (E)	S	S	S	S	S
5. Date notice of action sent	3/18/13	10/4/13	10/4/13	3/12/13	4/30/13
6. Notice sent to provider and member? (C or NC)	C	C	C	C	C
7. Number of days for decision/notice	4	3	1	7	7
8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before)	C	C	C	C	C
9. Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
a. If extended, extension notification sent to member? (C or NC, or NA)	NA	NA	NA	NA	NA
b. If extended, extension notification includes required content? (C or NC, or NA)	NA	NA	NA	NA	NA
10. Notice of Action includes required content? (C or NC)	C	C	C	C	C
11. Authorization decision made by qualified clinician? (C or NC, or NA)	C	C	C	C	C
12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA)	NA	NA	NA	NA	NA
13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA)	NA	NA	NA	NA	NA
14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C	C	C	C
15. Was correspondence with the member easy to understand? (C or NC)	C	C	C	C	NC
Total Applicable Elements	6	6	6	6	6
Total Compliant Elements	6	6	6	6	5
Score (Number Compliant / Number Applicable) = %	100%	100%	100%	100%	83%

Comments:

Record 5—The reason for denial included clinical information that a member is not likely to understand.

Record 7—The reason for denial used utilization management terminology (e.g., severity of illness, level of care) that a member would not understand.

C = Compliant; NC = Not Compliant (scored items)
Y= Yes; N = No (Not a scored item—informational only)
NA = Not Applicable
Cal = Calendar days/Bus = business days

Requirement	File 6	File 7
1. Member ID	******	******
2. Date of initial request	8/15/13	7/30/13
3. What type of denial? (termination [T], new request [NR], or claim [CL])	NR	NR
4. Standard (S) or Expedited (E)	S	S
5. Date notice of action sent	8/16/13	7/30/13
6. Notice sent to provider and member? (C or NC)	C	C
7. Number of days for decision/notice	4	1
8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before)	C	C
9. Was authorization decision timeline extended? (Y or N)	N	N
a. If extended, extension notification sent to member? (C or NC, or NA)	NA	NA
b. If extended, extension notification includes required content? (C or NC, or NA)	NA	NA
10. Notice of Action includes required content? (C or NC)	C	C
11. Authorization decision made by qualified clinician? (C or NC, or NA)	C	C
12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA)	NA	NA
13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA)	NA	NA
14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C
15. Was correspondence with the member easy to understand? (C or NC)	C	NC
Total Applicable Elements	6	6
Total Compliant Elements	6	5
Score (Number Compliant / Number Applicable = %)	100%	83%

Total Record Review Score	Total Applicable Elements: 42	Total Compliant Elements: 40	Total Score: 95%

C = Compliant; NC = Not Compliant (scored items)
Y= Yes; N = No (Not a scored item—informational only)

NA = Not Applicable
Cal = Calendar days/Bus = business days

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2013–2014 Denials Record Review Tool
for Colorado Access (State Managed Care Network)

Review Period:	January 1, 2013–December 31, 2013
Date of Review:	February 18, 2014
Reviewer:	Rachel Henrichs
Participating Plan Staff Member:	Laura Coleman

Requirement	File 1	File 2	File 3	File 4	File 5
1. Member ID	*****	*****	*****	*****	*****
2. Date of initial request	NA	3/18/13	1/30/13	2/11/13	2/13/13
3. What type of denial? (termination [T], new request [NR], or claim [CL])	Retro CL	NR	NR	NR	NR
4. Standard (S) or Expedited (E)	S	E	S	S	S
5. Date notice of action sent	4/25/13	3/19/13	2/1/13	2/13/13	2/18/13
6. Notice sent to provider and member? (C or NC)	C	C	C	C	C
7. Number of days for decision/notice	NA	1	2	2	5
8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before)	C	C	C	C	C
9. Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
a. If extended, extension notification sent to member? (C or NC, or NA)	NA	NA	NA	NA	NA
b. If extended, extension notification includes required content? (C or NC, or NA)	NA	NA	NA	NA	NA
10. Notice of Action includes required content? (C or NC)	C	C	C	C	C
11. Authorization decision made by qualified clinician? (C or NC, or NA)	C	C	C	C	C
12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA)	NA	NA	NA	NA	NA
13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA)	NA	NA	NA	NA	NA
14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C	C	C	C
15. Was correspondence with the member easy to understand? (C or NC)	C	C	C	C	NC
Total Applicable Elements	6	6	6	6	6
Total Compliant Elements	6	6	6	6	5
Score (Number Compliant / Number Applicable) = %	100%	100%	100%	100%	83%

C = Compliant; NC = Not Compliant (scored items)
Y= Yes; N = No (Not a scored item—informational only)
NA = Not Applicable
Cal = Calendar days/Bus = business days

Requirement	File 6	File 7
1. Member ID	*****	*****
2. Date of initial request		
3. What type of denial? (termination [T], new request [NR], or claim [CL])		
4. Standard (S) or Expedited (E)		
5. Date notice of action sent		
6. Notice sent to provider and member? (C or NC)		
7. Number of days for decision/notice		
8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before)		
9. Was authorization decision timeline extended? (Y or N)		
a. If extended, extension notification sent to member? (C or NC, or NA)		
b. If extended, extension notification includes required content? (C or NC, or NA)		
10. Notice of Action includes required content? (C or NC)		
11. Authorization decision made by qualified clinician? (C or NC, or NA)		
12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA)		
13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA)		
14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)		
15. Was correspondence with the member easy to understand? (C or NC)		
Total Applicable Elements		
Total Compliant Elements		
Score (Number Compliant / Number Applicable = %)		

C = Compliant; NC = Not Compliant (scored items)
Y= Yes; N = No (Not a scored item—informational only)
NA = Not Applicable
Cal = Calendar days/Bus = business days

Requirement	OS 1	OS 2	OS 3	OS 4	OS 5
1. Member ID	*****	*****	*****	*****	*****
2. Date of initial request		1/29/13	8/6/13		
3. What type of denial? (termination [T], new request [NR], or claim [CL])		NR	NR		
4. Standard (S) or Expedited (E)		S	S		
5. Date notice of action sent		1/31/13	8/7/13		
6. Notice sent to provider and member? (C or NC)		C	NC		
7. Number of days for decision/notice		2	1		
8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before)		C	C		
9. Was authorization decision timeline extended? (Y or N)		N	N		
a. If extended, extension notification sent to member? (C or NC, or NA)		NA	NA		
b. If extended, extension notification includes required content? (C or NC, or NA)		NA	NA		
10. Notice of Action includes required content? (C or NC)		C	NC		
11. Authorization decision made by qualified clinician? (C or NC, or NA)		C	C		
12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA)		NA	NA		
13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA)		NA	NA		
14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)		C	C		
15. Was correspondence with the member easy to understand? (C or NC)		C	NC		
Total Applicable Elements		6	6		
Total Compliant Elements		6	3		
Score (Number Compliant / Number Applicable = %)		100%	50%		

Total Record Review Score	**Total Applicable Elements: 42**	**Total Compliant Elements: 38**	**Total Score: 90%**

C = Compliant; NC = Not Compliant (scored items)
Y= Yes; N = No (Not a scored item—informational only)
NA = Not Applicable
Cal = Calendar days/Bus = business days

Comments:

Record 5: The NOA contained language such as “non-formulary,” “contraindication,” and “formulary alternatives” in the notice of action letter. The reviewer believed that these words increased the level of readability beyond the sixth-grade requirement.

Record 6: This service was denied because the member was not eligible for services on the date services were rendered; therefore, this record was removed from the sample.

Record 7 and Oversample 1: These services were denied based on provider procedural issues; therefore, these records were removed from the sample.

Oversample #2: Colorado Access mistakenly used a Medicare template when relaying the decision to deny services to the member. This template included incorrect time frames and appeal rights, making it difficult to understand. Furthermore, the reviewer was unable to determine if the decision to deny services was also relayed to the provider.

Appendix C. Site Review Participants for Colorado Access

Table C-1 lists the participants in the FY 2013–2014 site review of **Colorado Access** (CHP+ HMO and SMCN).

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, Quality Management
Robert Bremer	Executive Director, Access Behavioral Care, CO Access
Laura Coleman	Director, Clinical Services
Jen Conrad	Manager, Care Management
Irene Girgus	Pharmacy Director
Bethany Himes	Colorado Access
John Kiekhaefer	ABC Operations Manager
Suzanne Kinney	Behavioral Health Quality Program Manager
Gretchen McGinnis	Senior VP, Public Policy and Performance Improvement
Janet Milliman	CHP+ Program Manager, CO Access
Marina Osovskaya	CHP+ Program Specialist, CO Access
Terri Travis	Provider Liaison
Chris Gillespie	Clinical Appeals Manager
Department Observers	**Title**
Teresa Craig	CHP+ HMO Contract Manager
Russell Kennedy	Quality and Health Improvement Unit
Alan Kislowitz	CHP+ SMCN Contract Manager

Appendix D. Corrective Action Plan Template for FY 2013–2014 *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 compliance monitoring site review report via e-mail or through the file transfer protocol (FTP) site, with an e-mail notification to HSAG and the Department. The health plan must submit the CAP using the template provided. For each element receiving a score of *Partially Met* or *Not Met*, the CAP must describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training 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 health care regulations and managed care contract requirements.

The template for the CAP follows.

Table D-2—FY 2013–2014 Corrective Action Plan *for* Colorado Access		
Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
13. The Contractor has in place and follows written policies and procedures that include the following time frames for making standard and expedited authorization decisions as expeditiously as the member's health condition requires not to exceed: ◆ For standard authorization decisions—10 calendar days. ◆ For expedited authorization decisions—3 business days.	The Medication Utilization Review Procedure policy stated that standard medication determinations are made within 10 calendar days of the receipt of information. Postponing determinations until after receipt of all information might cause determinations to be made beyond 10 calendar days of the receipt of the request for services (or medication). HSAG recommends that the SMCN ensure that any changes to policies applicable to the CHP+ HMO apply to the SMCN as well, to ensure compliance with federal regulations.	Colorado Access must revise the Medication Utilization Review Procedure policy to accurately depict the standard authorization decision time frame as within 10 calendar days from the date of the request for service.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Table D-2—FY 2013–2014 Corrective Action Plan *for* Colorado Access		
Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
14. Notices of action must meet the language and format requirements of 42CFR438.10 to ensure ease of understanding (6th grade reading level wherever possible and available in the prevalent non-English language for the service area).	During the on-site record review, there were two CHP+ HMO denial records and two SMCN denial records that contained notices of action (NOAs) that were not easily understood due to the use of clinical or industry-specific language that members are not likely to understand. In addition, the template used in one SMCN record was from another line of business and did not have the required information regarding appeal and State fair hearing rights. It was clear however, through record review, that Colorado Access had successfully implemented processes for its SMCN that were consistent with the CHP+ HMO and were compliant with federal regulations.	Colorado Access must develop processes to ensure that physician reviewers are cognizant of the requirement that NOAs and other member-specific communication is written at the sixth-grade reading level whenever possible.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Table D-2—FY 2013–2014 Corrective Action Plan *for* Colorado Access		
Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
17. The Contactor may extend the authorization decision time frame if the enrollee requests an extension, or if the Contractor justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest. The Contractor's written policies and procedures include the following time frames for possible extension of time frames for authorization decisions: ◆ Standard authorization decisions—up to 14 calendar days. ◆ Expedited authorization decisions—up to 14 calendar days.	The CHP+ HMO and the SMCN extension letter templates included "Notice of Action – Timeliness" title headers. The extension of the authorization timeline in not an action; therefore, the member has no appeal right in this circumstance but may file a grievance. HSAG recommends that the SMCN develop templates and processes consistent to those developed for the CHP+ HMO to ensure compliance with federal regulations.	Colorado Access must revise its applicable policies and templates to accurately describe the member's right to file a grievance (not an appeal) if he or she disagrees with the decision to extend the time frame for making the authorization determination. Colorado Access must also clarify the Utilization Review Determinations policy to state that an NOA is not needed if the extension is used and that, although an NOA is required when the time frames expire, this notification period includes the extension time, if used.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Table D-2—FY 2013–2014 Corrective Action Plan *for* Colorado Access		
Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
18. If the Contractor extends the time frame for making a service authorization decision, it: ◆ Provides the member written notice of the reason for the decision to extend the time frame. ◆ Informs the member of the right to file a grievance if the member disagrees with the decision to extend the time frame. ◆ Carries out the determination as expeditiously as the member's health condition requires and no later than the date the extension expires.	Extension letter templates provided on-site for the CHP+ HMO and the SMCN provided evidence that Colorado Access/SMCN had a process to notify members when an extension of the authorization determination time frame is needed. Neither template, however, included language to notify the member of the right to file a grievance if he or she disagreed with the decision to extend the time frame.	Colorado Access must ensure that, when members are notified that Colorado Access will extend the time frame for an authorization determination, the notice includes language informing the member of his or her right to file a grievance if the member does not agree with the decision to extend the time frame.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Table D-3—FY 2013–2014 Corrective Action Plan *for* Colorado Access		
Standard II—Access and Availability		
Requirement	**Findings**	**Required Action**
11. Members temporarily out of the service area may receive out-of-area emergency services and urgently needed services.	Both the CHP+ HMO and SMCN Evidence of Coverage (EOC)/member handbooks informed members that emergency services were covered in network or out of network and that urgent care is covered in network or when temporarily out of the service area. However, both EOC handbooks communicated that urgent care was not covered if the member was "more than 50 miles from the service area if you knew you might need care before you left," or for maternity care within five weeks of delivery. This language is out of compliance with the contract requirement, as well as Colorado Access' policies. Colorado Access should consider removing the description of urgent care coverage exceptions from the SMCN EOC.	Colorado Access must remove the description of exceptions to coverage for urgent care outside the service area from the CHP+ HMO EOC.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Table D-3—FY 2013–2014 Corrective Action Plan *for* Colorado Access		
Standard II—Access and Availability		
Requirement	**Findings**	**Required Action**
12. The Contractor must require its providers to offer hours of operation that are no less than the hours of operation offered to commercial members.	Neither the CHP+ or SMCN provider manuals nor the Professional Services Agreement specified that hours of office operation for CHP+ HMO or SMCN members must be no less than the hours of operation offered to commercial members. Colorado Access should consider requiring SMCN providers to maintain hours of operation for SMCN members that are no less than hours of operation for commercial members.	Colorado Access must require its CHP+ HMO providers to maintain hours of operation for CHP+ members that are no less than hours of operation for commercial members.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review Protocol Activities for Colorado Access

The following table describes the activities performed throughout the compliance monitoring process. The activities listed below are consistent with CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal health care regulations and managed care contract requirements: ◆ HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. ◆ HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, on-site agendas; and set review dates. ◆ HSAG submitted all materials to the Department for review and approval. ◆ HSAG conducted training for all site reviewers to ensure consistency in scoring across plans.
Activity 2:	**Perform Preliminary Review**
	◆ HSAG attended the Department's Medical Quality Improvement Committee (MQuIC) meetings and provided group technical assistance and training, as needed. ◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the health plan in writing of the request for desk review documents 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 two standards and on-site activities. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. ◆ Documents submitted for the desk review and on-site 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. The health plans also submitted a list of all CHP+ service and claims denials that occurred between January 1, 2013, and December 31, 2013 (to the extent possible). HSAG used a random sampling technique to select records for review during the site visit. ◆ 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 3:	**Conduct Site Visit**
	◆ 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. ◆ HSAG reviewed a sample of administrative records to evaluate implementation of managed care regulations related to CHP+ service denials and notices of action.

Table E-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG completed the following activities:**
	◆ Also while on-site, 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 confidential or proprietary, or were requested as a result of the pre-on-site document review.) ◆ At the close of the on-site portion of the site review, HSAG met with health plan staff and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	◆ HSAG used the FY 2013–2014 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, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the State**
	◆ HSAG populated the report template. ◆ 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.