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

FY 2015–2016 Site Review Report

for

Colorado Access CHP+ HMO and State Managed Care Network

February 2016

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

HSAG HEALTH SERVICES ADVISORY GROUP

3133 East Camelback Road, Suite 100 ◆ Phoenix, AZ 85016-4545
Phone 602.801.6600 ◆ Fax 602.801.6051

HSAG HEALTH SERVICES ADVISORY GROUP

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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 health care regulations and managed care contract requirements. The Department of Health Care Policy & 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 fiscal year (FY) 2015–2016 site review activities for the review period of January 1, 2015 through December 31, 2015 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 **Colorado Access**' CHP+ HMO and the SMCN were reviewed concurrently, results are presented separately within this report. 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 four standard areas reviewed this year for each line of business. Section 2 contains graphical representation of results for all standards reviewed over the past three-year cycle and trending of required actions for the CHP+ HMO. Section 3 describes the background and methodology used for the 2015–2016 compliance monitoring site review. Section 4 describes follow-up on the corrective actions required as a result of the 2014–2015 site review activities for the CHP+ HMO. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the credentialing and recredentialing record reviews. Appendix C lists 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 2015–2016 and the required template for doing so. Appendix E contains a detailed description of HSAG's site review activities consistent with the Centers for Medicare & Medicaid Services (CMS) final protocol.

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* for the CHP+ HMO and for federal requirements for the SMCN. HSAG assigned required actions for any requirement receiving a score of *Partially Met* or *Not Met.* Recommendations assigned for requirements scored as *Met* did not represent noncompliance with contract requirements or federal healthcare regulations.

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

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

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
III Coordination and Continuity of Care	12	12	11	1	0	0	92%
IV Member Rights and Protections	5	5	4	0	1	0	80%
VIII Credentialing and Recredentialing	48	47	44	3	0	1	94%
X Quality Assessment and Performance Improvement	15	15	15	0	0	0	100%
Totals	**80**	**79**	**74**	**4**	**1**	**1**	**94%**

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

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

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Credentialing	90	83	83	0	7	100%
Recredentialing	90	90	88	2	0	98%
Totals	**180**	**173**	**171**	**2**	**7**	**99%**

Table 1-3 presents the scores for **Colorado Access** SMCN for each of the standards. Findings for all *Met* requirements are summarized in this section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* follow in Appendix A—Compliance Monitoring Tool.

Table 1-3—Summary of Scores for the Standards for SMCN

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
III Coordination and Continuity of Care	8	8	8	0	0	0	100%
IV Member Rights and Protections	5	5	4	0	1	0	80%
VIII Credentialing and Recredentialing	48	47	44	3	0	1	94%
X Quality Assessment and Performance Improvement	10	9	9	0	0	1	100%
Totals	**71**	**69**	**65**	**3**	**1**	**2**	**94%**

HSAG did not conduct record reviews for the SMCN.

Standard III—Coordination and Continuity of Care

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 are identified.

Summary of Strengths and Findings as Evidence of Compliance

Colorado Access policies and procedures outlined its processes for care coordination for members with intensive care coordination or special healthcare needs as including completion of a health risk assessment (HRA), member outreach, care planning and interventions, and coordinating with outside agencies and health plans. **Colorado Access** informed its primary care providers (PCPs) of their responsibility to coordinate care with specialists and that **Colorado Access** care managers are available to assist with members with complex needs. **Colorado Access** ensured that all CHP+ and SMCN members were assigned to PCPs within three days of enrollment and contacted each member within 30 days of enrollment to complete an HRA. **Colorado Access** did not require referrals or prior authorization for access to in-network specialist services and arranged for members to receive services out-of-network, as necessary, through single-case provider agreements. Staff stated that a member may see any type of provider at any time and may designate any provider, including a specialist, as his or her PCP. Care managers followed up with all members identified on the HRA who have special needs and/or potential transition of care needs to perform a more in-depth needs assessment, develop a care plan, connect the member to needed services, and ensure continuity of care with existing providers. The HRA for prenatal SMCN members screened members for pregnancy risk factors, mental illness or cognitive needs, and social needs, with follow-up as necessary to enroll the mother in the "Healthy Moms, Healthy Babies" program. In addition, **Colorado Access** monitored claims data to identify diagnosis-based special populations (e.g., diabetes, asthma) or members with multiple emergency room (ER) visits or hospital admissions and referred members to specialized disease management or care coordination teams.

Colorado Access' information systems enable sharing of member assessments, care plans, and care coordination activities across various internal programs and product lines such as the Regional Care Coordination Organization (RCCO) or behavioral health organization (BHO). During the on-site interview, staff presented case studies that demonstrated care coordination for members with multiple ER visits or post-delivery discharge needs. Case studies demonstrated that members received medication reconciliation, assistance with resolving eligibility issues, referrals to a PCP and dentist, and coordination with durable medical equipment (DME) providers and schools. Staff stated that, overall, CHP+ members tend to have fewer complex care coordination needs than the Medicaid population.

CHP+ HMO and the SMCN are two of **Colorado Access**' lines of business that provide care management services. Others lines of business include three RCCOs (northeast Colorado, Denver, and the surrounding metropolitan area), the single entry point (SEP) for Denver, and two BHOs (Denver and northeast Colorado). Most of the geographic regions for lines of business overlap. During 2015, **Colorado Access** developed and began implementing an enterprise-wide reorganization of care management services into teams that cross all product lines, rather than assigning staff to support individual product lines and programs. **Colorado Access** designed this

strategy to eliminate duplication of care coordination activities and to most efficiently use the multidisciplinary expertise available within various lines of business. In addition, **Colorado Access** configured teams to provide support and programs for categories of members such as those with special healthcare needs, children in foster care, and women who are pregnant. As a component of the reorganization, **Colorado Access** co-located community-based care managers at The Children's Hospital and Denver Health Medical Center to engage with and coordinate services for children and families. Staff stated that on-site engagement with members has been successful and the program will soon be expanded to University of Colorado Hospital. During on-site interviews, staff characterized care coordination processes as being in a continual state of evolution and estimated that the complete transformation of its care coordination program may require two to three years.

Summary of Findings Resulting in Opportunities for Improvement

Multiple policies, provider manuals, and the member handbooks describe the member's ability to have direct access to a specialist or receive ongoing care from a specialist with whom the member has a history of care. However, CHP+ and SMCN assessment tools do not include questions about any specialists a member may be seeing or may need. HSAG noted that this may be a missed opportunity to identify members needing direct access to a specialist and recommends that **Colorado Access** consider adding this element to its member needs assessments.

In general, **Colorado Access**' care coordination policies described the goals, objectives, and intent of integrated care management and collaboration with external providers and entities. The policies included very little description of actual procedures and accountabilities. Although **Colorado Access** can readily share the results of its member needs assessments with its internal programs and multiple lines of business, procedures did not require staff to share information with healthcare organizations outside of **Colorado Access**. The CHP+ and SMCN provider manuals also do not communicate this requirement. HSAG recommends that **Colorado Access** enhance efforts to define mechanisms for coordinating member care with external healthcare organizations and entities.

Staff stated that as **Colorado Access** continues reorganizing its care coordination program and better defines specialized care management teams it will revise its policies and procedures to be more specific. HSAG recommends that **Colorado Access** proceed as expeditiously as possible to detail care coordination policies and procedures and delineate accountabilities for care coordination. HSAG also recommends that **Colorado Access** expedite the internal care coordination transformation process to prevent inadequate, confusing, inefficient, or incomplete implementation of the reorganization plan.

Summary of Required Actions

The member handbook and provider manual informed members and providers of a new member's right to continue an ongoing course of treatment as required. However, the member handbook added, "as long as the provider works with us to transfer care" and "if the provider agrees to accept our reimbursement rates and work with us." This language may imply contingencies as to whether the member may continue care. Although staff members stated that these contingencies are not actually implemented, the health plan's contract does not allow for such contingencies and should

not be communicated to the member. **Colorado Access** must remove statements from the CHP+ member handbook that stipulate additional restrictions on when a member with special healthcare needs or a member in the second or third trimester of pregnancy may continue an ongoing course of treatment or services.

HSAG required no corrective actions for SMCN for this standard. (However, HSAG recommends that **Colorado Access** review the SMCN member handbook regarding the CHP+ required action and apply corrections, as applicable.)

Standard IV—Member Rights and Protections

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 are identified.

Summary of Strengths and Findings as Evidence of Compliance

The **Colorado Access** policies and procedures related to member rights and protections were applicable to all lines of business, including CHP+ HMO and SMCN. The Member Rights and Responsibilities policy affirmed **Colorado Access**' commitment to ensuring the rights of its members. The Nondiscrimination, Problem Reporting and Non-Retaliation, and Member Disability Rights Request and Complaint Resolution policies provided guidance to staff members on how to report suspected and alleged rights violations and described the process for investigating such reports. The Nondiscrimination policy identified the department responsible for developing and implementing training and education for staff, providers, and members with regard to member rights.

All **Colorado Access** customer service staff members participated in member rights training within the review period and were provided with a laminated list of member rights to be posted at their desks. All new providers were offered an introductory webinar training that included a review of member rights and how to report suspected and alleged rights violations. A list of member rights and how to report suspected and alleged rights violations was also included in the provider manual, which was accessible through the website along with the webinar training. Additionally, **Colorado Access** published and distributed member rights posters to be displayed in all service locations. **Colorado Access** included information about member rights in newsletters, annual mailings, on the website, and in both HMO and SMCN member handbooks. **Colorado Access** further ensured that members and providers are aware of member rights by requiring that its providers give each member a copy of the member rights and keep a signed acknowledgment form in the medical record.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to member rights and protections.

Summary of Required Actions

Rather than list the specific member rights, Policy CS212—Member Rights and Responsibilities referenced a specific section of the Colorado Code of Regulations (CCR). While this mechanism of reference is acceptable, the section of CCR referenced in the policy was incorrect. **Colorado Access** must revise its Member Rights and Responsibilities policy to either list the specific member rights or accurately reference a location where staff members can find specific rights.

Standard VIII—Credentialing and Recredentialing

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 are identified.

Summary of Strengths and Findings as Evidence of Compliance

The **Colorado Access** policies and procedures related to credentialing and recredentialing providers and organizations were applicable to all lines of business, including CHP+ HMO and SMCN. The policies were well-written, comprehensive, and compliant with National Committee for Quality Assurance (NCQA) credentialing and recredentialing standards and guidelines. During on-site interviews, credentialing staff members displayed extensive knowledge of NCQA requirements and **Colorado Access** policies and appeared confident discussing the processes and procedures used.

HSAG encountered various scenarios during on-site record reviews that demonstrated staff were credentialing and recredentialing providers in a manner consistent with the written procedures. Credentialing and recredentialing files included an application printed from the Council for Affordable Quality Healthcare (CAQH) Universal Credentialing Datasource (or an application that the provider mailed to **Colorado Access**) and documentation that demonstrated staff verified licensure, DEA or CDS certification (as applicable), board certification status, education and training, work history, and current malpractice insurance. Files also included documentation demonstrating that **Colorado Access** queried the National Practitioner Data Bank (NPDB) for history of professional liability claims and to ensure that the provider had not been excluded from federal participation. HSAG also found evidence that staff regularly followed up with providers to collect, as needed, additional information such as explanation for gaps in work history.

Colorado Access delegated credentialing and recredentialing to several of its contracted organizations. The delegation agreements described the activities, responsibilities, and reporting requirements and described the remedies available to **Colorado Access** should the delegate fall short of its obligations. **Colorado Access** retained the right to approve, suspend, or terminate providers approved by any of its delegated entities. HSAG reviewed annual audit findings for each delegated entity and found evidence that **Colorado Access** required corrective actions when necessary and followed up as appropriate.

HSAG reviewed credentialing committee meeting minutes that confirmed the credentialing committee met regularly, reviewed all credentialing and recredentialing files from **Colorado Access** and from delegates, and made appropriate determinations.

Summary of Findings Resulting in Opportunities for Improvement

Colorado Access' credentialing staff members indicated that they were in the process of consolidating the various policies and procedures related to credentialing and recredentialing into one document. HSAG suggested that **Colorado Access** could further strengthen its practice to ensure nondiscrimination by including a process to have a committee other than the credentialing committee review all denied provider applications.

Summary of Required Actions

The Provider Credentialing and Recredentialing policy and procedure listed the appropriate sources used to verify board certification for various levels of providers including mid-level providers such as certified nurse midwives (CNMs) and nurse practitioners (NPs). HSAG's on-site review of credentialing and recredentialing files demonstrated that **Colorado Access** verified board certification for all applicable providers in the sample except one CNM. **Colorado Access** does not list a practitioner's board certification in its provider directory, and therefore may not need to verify board certification on CNMs. However, **Colorado Access**' existing policy requires that this function be performed. **Colorado Access** must either revise its policies regarding verification of board certification of CNMs or ensure that it verifies board certification of CNMs in compliance with its policies.

Colorado Access' policies and procedures required confirmation at least every three years that contracted organizations are in good standing with both State and federal regulatory agencies. On-site record review demonstrated that **Colorado Access** implemented this policy; however, two of the organizations had not been recredentialed within the three-year time frame. **Colorado Access** must develop and employ a process to ensure that organizations with which it contracts are recredentialed at least every three years.

The Organizational Provider Credentialing policy and procedure included the criteria used to assess unaccredited organizational providers, which included staff hiring and credentialing processes. On-site record review demonstrated that **Colorado Access** collected the organization's policies and procedures related to staff hiring and credentialing; however, some policies collected were not compliant with **Colorado Access**' credentialing standards. **Colorado Access** must ensure that unaccredited organizations with which it contracts credential practitioners in a manner consistent with **Colorado Access**' own policies, procedures, and standards.

The Organizational Provider Credentialing policy and procedure described the circumstances under which **Colorado Access** could substitute a CMS or State quality review in lieu of a site visit; however, the policy did not specify that **Colorado Access** would confirm that the survey conducted by CMS or the State meets its own quality assessment criteria or standards. HSAG did not find evidence in the records reviewed that **Colorado Access** confirmed the content of the CMS or State review. Some CMS and State reviews included with the records reviewed indicated the need for corrective action; however, **Colorado Access** did not document that it confirmed that the corrective actions had been completed. Furthermore, one of the State site reviews documented in the record as being used in lieu of a site visit was more than three years old at the time of the credentialing decision. **Colorado Access** must specify in its policies that it will confirm that CMS and State

quality reviews used in lieu of **Colorado Access** site visits include all criteria and standards identified in **Colorado Access**' policy. **Colorado Access** must ensure that CMS and State quality reviews used are no more than three years old at the time of the credentialing decision; and if the CMS or State quality review required that the organization complete any corrective actions, **Colorado Access** must document that the organization completed those corrective actions.

Standard X—Quality Assessment and Performance Improvement

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 are identified.

Summary of Strengths and Findings as Evidence of Compliance

Colorado Access' Quality Assessment and Performance Improvement (QAPI) program was applicable to all lines of business. The program description stated that quality monitoring encompasses access and availability; utilization management (UM); member satisfaction; clinical outcomes/performance measures; performance improvement projects (PIPs); and evaluation of internal operational performance, practice guidelines, and care management. The program evaluated quality for the combined businesses of **Colorado Access** as well as by product line, by provider, and by member population groups (e.g., asthma and other chronic conditions). **Colorado Access** used a variety of data from existing systems (e.g., claims/encounters, grievances and appeals, performance measures) for ongoing and periodic monitoring of services provided to members. **Colorado Access** staff provided reports demonstrating that its information systems can integrate data from multiple sources and produce reports for tracking, analysis, and profiling of quality performance within a variety of categories. **Colorado Access** developed practice guidelines for targeted populations, including those outlined in contract requirements. Practice guidelines were accessible to providers and members on the **Colorado Access** website. During on-site interviews, staff stated that **Colorado Access** is considering developing or purchasing clinical guidelines written in member-friendly terms for distribution to members. The Quality and Performance Advisory Committee reviews each practice guideline annually. **Colorado Access** reviews and analyzes CHP+ HEDIS measures and CAHPS results annually.

Colorado Access has a multi-layered committee and oversight structure for the analysis of quality data and outcomes. The Quality Management Department conducts in-depth internal analysis of quality data, studies, and indicators, and works with providers and the Executive Management Team regarding improvements required. Each administrative director for each product line has ongoing access to reports from claims-based data and special dashboard reports of defined performance indicators. The administrative management representatives from all lines of business met monthly to review quality performance data. **Colorado Access** reported outcomes of internal analysis and actions taken or recommended to the Quality Improvement Committee (QIC) (accountable to the Board of Directors). The QIC also received input from the Quality and Performance Advisory Committee (QPAC), the Pharmacy and Therapeutic Committee, the Member and Family Advisory Boards, and the Credentials Committee. **Colorado Access** incorporates most SMCN quality improvement processes and applicable data into the quality improvement program applied to CHP+ HMO. However, **Colorado Access** stated that, due to the limited number of

members in the SMCN and the short enrollment time frame for SMCN members, data results were too insignificant to provide either valid analysis of SMCN data or an annual evaluation of the effectiveness of the QAPI program. Therefore, Element 11 was scored *Not Applicable* for SMCN. All CHP+ quality activities were reported to the QIC through a well-designed and comprehensive annual report which presented an overview and summary data from all quality activities performed throughout the year. At the time of review, **Colorado Access** had recently reorganized and replaced management staff in the Quality Management Department. Quality management staff described a number of improvements in quality management processes, monitoring activities, and reports that it planned to implement in the future.

Summary of Findings Resulting in Opportunities for Improvement

Colorado Access' operational staff was responsible for analysis of quality data and providing conclusions and recommendations to improve quality performance. QIC meeting minutes, as well as the reports provided to the QIC, were documented at a high level with limited findings and recommendations reported. In addition, the QIC meeting minutes included limited evaluation of the effectiveness of the QAPI program per requirement 42CFR438.240(e). HSAG recommends that **Colorado Access** maintain a mechanism for documenting the results/conclusions of ongoing staff analysis activities in order to ensure a comprehensive and continuous stream of information (i.e., data, findings, conclusions, recommendations) regarding quality monitoring and improvements. HSAG also recommends that **Colorado Access** enhance the QIC meeting minutes to include an expanded statement of the committee's determination of the overall effectiveness of the CHP+ QAPI program (based on the annual CHP+ report).

Policy QM201 detailed the procedures for investigating and documenting quality of care concerns (QOCs) from members, providers, or staff members, and included specified time frames for resolution. The policy included time frames for accepting and resolving QOCs from members according to the required time frames for processing grievances. During on-site interviews, staff confirmed that QOCs are not processed as grievances but accepted from members at any time and processed using the QOC procedures. HSAG recommends that **Colorado Access** revise and clarify this policy to disassociate the QOC process from the member grievance process—i.e., QOCs are accepted from members at any time, are not necessarily associated with an "incident," and do not have to be processed within the time frames required for processing grievances.

Although **Colorado Access** has developed practice guidelines specific to the CHP+ and SMCN populations (e.g., prenatal/postpartum care, prominent chronic conditions, and well-child periodicity and immunization guidelines), the provider manual notes that guidelines are available for specific "mental health diagnoses." In addition, member handbooks do not inform members that guidelines are available and how to access them. HSAG recommends that **Colorado Access** inform members and providers of guidelines more applicable to the CHP+ population and how to access them.

During on-site interviews, staff members stated that **Colorado Access** has only informal mechanisms for ensuring that the guidelines are applied in internal processes (i.e., UM decisions, member education programs). Staff members explained that **Colorado Access** enforces compliance with guidelines primarily by "exception," such as when it identifies a grievance, QOC concern, or

other practice that may conflict with a practice guideline. HSAG recommends that **Colorado Access** enhance procedures to define accountabilities (e.g., UM medical directors, medical education staff) for confirming consistency with practice guidelines and/or define a more formal process—e.g., comparing the adopted guideline to other organizational materials during annual review of each guideline—for ensuring that covered services, UM decisions, and member education materials are consistent with adopted practice guidelines.

Summary of Required Actions

HSAG required no corrective actions for this standard.

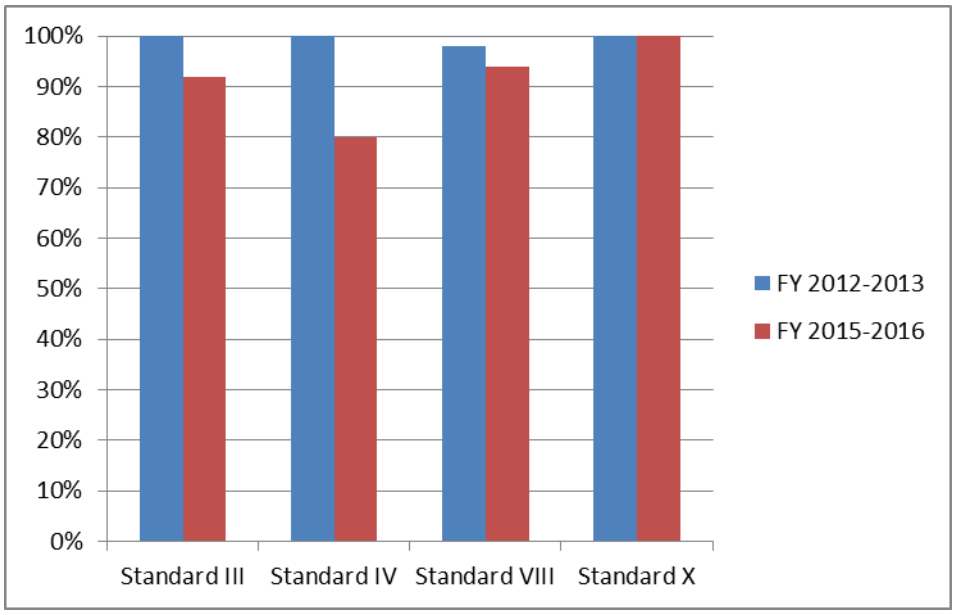
Comparison of Results

The Department elected to assign scores related to SMCN compliance with federal regulations beginning in FY 2015–2016. Therefore, no comparison data are available for previous years or standards for SMCN. The information presented in this section relates to **Colorado Access**' CHP+ HMO contract only.

Comparison of FY 2012–2013 Results to FY 2015–2016 Results

Figure 2-1 shows the scores from the FY 2012–2013 site review (when Standard III, Standard IV, Standard VIII, and Standard X were previously reviewed) compared with the results from this year's review. The results show the overall percent of compliance with each standard. Although the federal language did not change with regard to requirements, **Colorado Access**' contract with the State may have changed and may have contributed to performance changes.

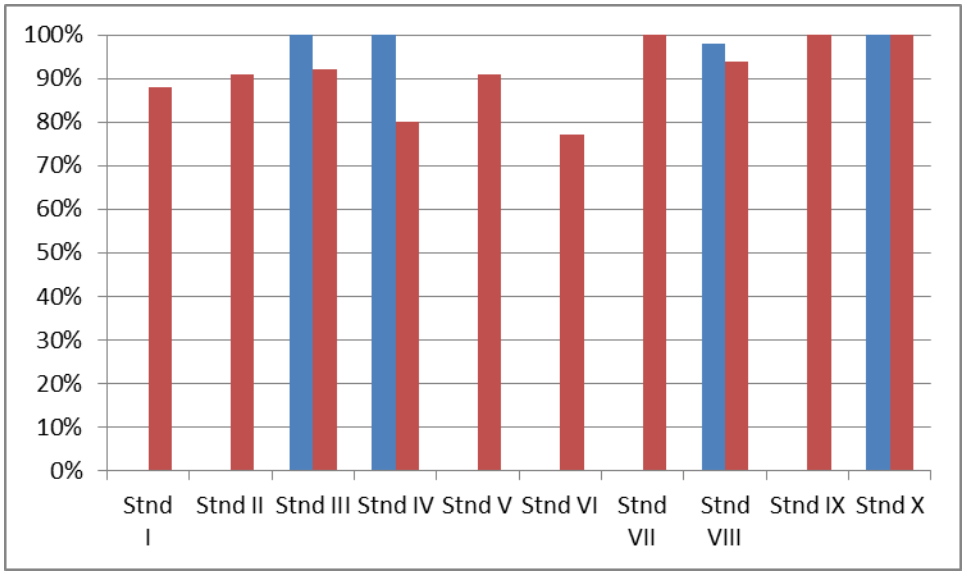
Figure 2-1—Comparison of FY 2012–2013 Results to FY 2015–2016 Results



Review of Compliance Scores for All Standards

Figure 2-2 shows the scores for all standards reviewed over the past four years of compliance monitoring. Table 2-1 shows which standards were reviewed each year. The figure compares the score for each standard across two review periods, as applicable, and may be an indicator of overall improvement.

Figure 2-2—Colorado Access' Compliance Scores for All Standards



Note: Results shown in blue are from FY 2012–2013. Results shown in red are from FY 2013–2014, FY 2014–2015, and FY 2015–2016.

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

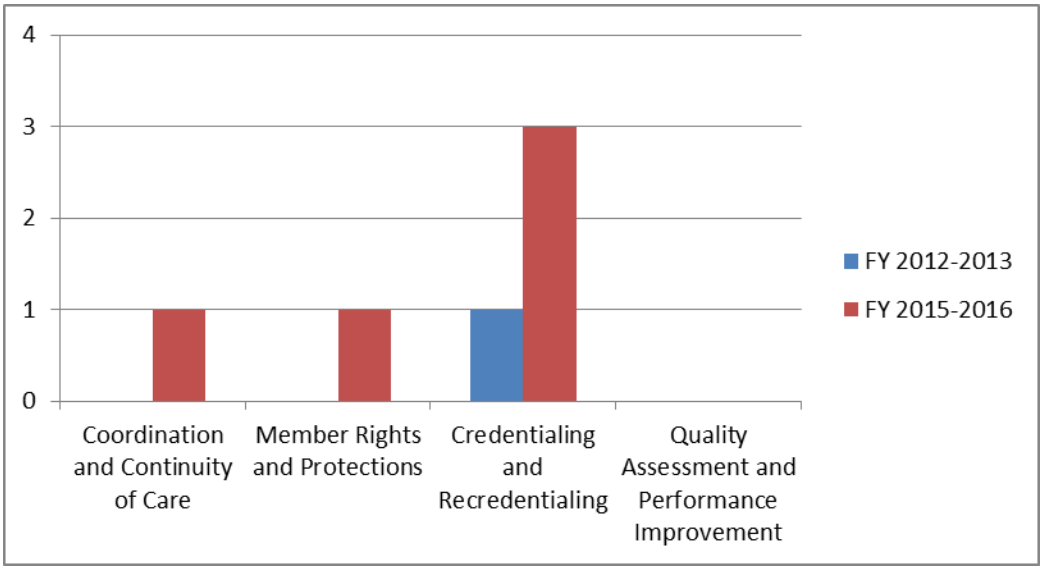
Table 2-1—List of Standards by Review Year

Standard	2012–13	2013–14	2014–15	2015–16
I—Coverage and Authorization of Services		X		
II—Access and Availability		X		
III—Coordination and Continuity of Care	X			X
IV—Member Rights and Protections	X			X
V—Member Information			X	
VI—Grievance System			X	
VII—Provider Participation and Program Integrity			X	
VIII—Credentialing and Recredentialing	X			X
IX—Subcontracts and Delegation			X	
X—Quality Assessment and Performance Improvement	X			X

Trending the Number of Required Actions

Figure 2-3 shows the number of requirements with required actions from the FY 2012–2013 site review (when Standard III, Standard IV, Standard VIII, and Standard X were previously reviewed) compared to the results from this year's review. Although the federal requirements did not change for the standards, **Colorado Access**' contract with the State may have changed and may have contributed to performance changes.

Figure 2-3—Number of FY 2012–2013 and FY 2015–2016 Required Actions per Standard

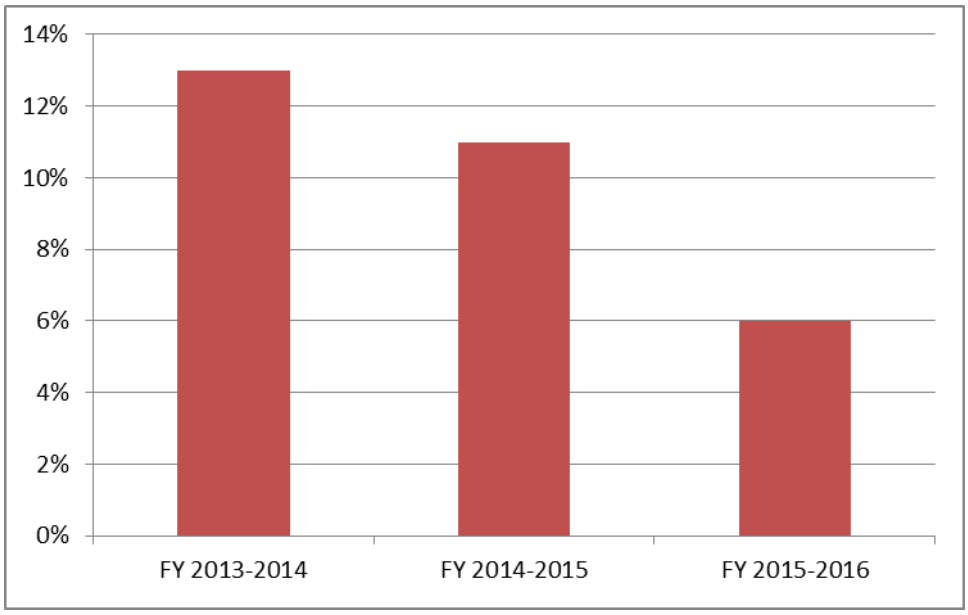


Note: **Colorado Access** had no required actions for Coordination and Continuity of Care, Member Rights and Protections, or Quality Assessment and Performance Improvement resulting from the FY 2012–2013 site review. **Colorado Access** also had no required actions for Quality Assessment and Performance Improvement resulting from the FY 2015–2016 site review.

Trending the Percentage of Required Actions

Figure 2-4 shows the percentage of requirements that resulted in required actions over the past three-year cycle of compliance monitoring. Each year represents the results for review of different standards, as indicated in Table 2-1.

Figure 2-4—Percentage of Required Actions—All Standards Reviewed



Overview of FY 2015–2016 Compliance Monitoring Activities

For the fiscal year (FY) 2015–2016 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement. Compliance with federal managed care regulations and CHP+ HMO managed care contract requirements was evaluated through review of the four standards. The SMCN was evaluated for compliance with federal managed care regulations only. SMCN contract-only requirements were not reviewed.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the health plan's CHP+ HMO 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+ HMO credentialing and recredentialing. HSAG documented detailed findings in the Compliance Monitoring Tool for any requirement receiving a score *Partially Met* or *Not Met* for each line of business.

A sample of the health plan's administrative records related to CHP+ HMO credentialing and recredentialing were also reviewed to evaluate implementation of federal healthcare regulations and compliance with National Committee for Quality Assurance (NCQA) requirements, effective July 2015. HSAG did not review a sample of SMCN credentialing and recredentialing records. HSAG used standardized monitoring tools to review records and document findings. Using a random sampling technique, HSAG selected a sample of 10 records with an oversample of five records from all CHP+ HMO credentialing and recredentialing records that occurred between January 1, 2015, and December 31, 2015, to the extent available at the time of the site-review request. HSAG reviewed a sample of 10 credentialing records and 10 recredentialing records, to the extent possible. For the record review, the health plan received a score of *M* (met), *N* (not met), or *NA* (not applicable) for each required element. Results of record reviews were considered in the review of applicable requirements in Standard VIII—Credentialing and Recredentialing. HSAG also separately calculated a credentialing record review score, a recredentialing record review score, and an overall record review score for CHP+ HMO.

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 four standards chosen for the FY 2015–2016 site reviews represent a portion of the CHP+ managed care requirements. These standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

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 four areas selected for review.
- Strengths, opportunities for improvement, and actions required to bring the health plan into compliance with federal health care regulations and contract requirements in the standard areas reviewed.
- The quality and timeliness of, and access to, services furnished by the health plan, as assessed by the specific areas reviewed.
- Possible interventions 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 2014–2015 Corrective Action Methodology

As a follow-up to the FY 2014–2015 site review, each health plan that received one or more *Partially Met* or *Not Met* scores 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 2014–2015 compliance monitoring site review.

The SMCN was not required to complete a CAP in FY 2014–2015. The following summaries are related only to **Colorado Access**' CHP+ HMO contract.

Summary of 2014–2015 Required Actions

As a result of the FY 2014–2015 site review, **Colorado Access** was required to address a total of eight *Partially Met* findings: two for Standard V—Member Information and six for Standard VI—Grievance System. For Standard V, **Colorado Access** was required to remove statements from the member handbook regarding the potential for members to be charged for missed appointments and the potential for members to be disenrolled for refusing to follow recommended treatment. The required actions for Standard VI were related to time frames for appeals and State fair hearings and timely resolution of grievances.

Summary of Corrective Action/Document Review

Colorado Access submitted its CAP to HSAG and the Department in April 2015. HSAG and the Department required a few minor revisions to the CAP plan before approving the proposed actions. **Colorado Access** began to submit documents that demonstrated implementation of its plan in August 2015. HSAG and the Department required periodic clarifications or enhancements to documents submitted and, in November 2015, determined that **Colorado Access** had successfully implemented all corrective actions.

Summary of Continued Required Actions

Colorado Access had no required actions continued from FY 2014–2015.

Appendix A. Compliance Monitoring Tool *for* Colorado Access

The completed compliance monitoring tool follows this cover page.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
1. The Contractor has written policies and procedures to address the **coordination and provision of covered services** in conjunction with other medical and behavioral health plans and to promote: ◆ Service accessibility. ◆ Attention to individual needs. ◆ Continuity of care. ◆ Maintenance of health. ◆ Independent living. *42CFR438.208(b)(2)* CHP+ Contract: Exhibit A4—2.7.4.1	**Documents Submitted** **Both:** **CCS305- Care Coordination** All **CCS310- Access to Primary and Specialty Care** Page 4: Procedure I-III **CHP HMO:** **Provider Manual** Page 5, Mission Statement, Bullets 1-5 Page 22, Provider Responsibilities, Bullets 1-7 Page 23-4, Coverage; Specialty Care Providers, Bullets 2,4-5; Coverage Page 60-2, Authorization Categories Page 72, Continuity of Care Page 75-6, IX. Care Management Page 77, Paragraph 3 Page 112, Health Risk Assessment & Care Management **SMCN:** **Provider Manual** Page 6, Primary Care Responsibilities, Bullets 1-7 Page 17, Servicing Members with Special Healthcare Needs Page 43, 1st paragraph Page 52, Continuity of Care & Transition of Care for Members Page 57, Health Risk Assessment & Care Management	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor's procedures are designed to address those members who require complex coordination of benefits and services and may require services from multiple providers, facilities and agencies, ancillary or nonmedical services, including social services and other community resources.	**Documents Submitted** **Both:** **CCS305- Care Coordination** All **CCS310- Access to Primary and Specialty Care** Page 4, Procedure II. & III.	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
Procedures also address: ◆ Coordinating services for children with special healthcare needs with other agencies or entities such as those dealing with mental health and substance abuse, public health, home and community-based care, developmental disabilities, local school districts, child welfare, IDEA programs, Title V, families, caregivers, and advocates. ◆ Criteria for making referrals and coordinating care by specialists, subspecialists, and community-based organizations. CHP+ Contract: Exhibit A4—2.7.4.3.2; 2.7.4.3.3; 2.7.4.3.5; 2.7.5.5	*Example of complex case coordination available during on-site visit **Care Manager Desktop Procedure** Page 2, Definition: Intensive Care Management Page 3, Procedure I. G Page 5, Procedure V. D **CHP HMO:** **Provider Manual** Page 22, Provider Responsibilities, Bullets 5-6 Page 23, Specialty Care Providers, Bullets 4-5 Page 63, Specialist Referrals Page 68, Sub-Specialty Maternity Care Page 73, Telemedicine Page 75-6, IX. Care Management Page 112, Health Risk Assessment & Care Management **SMCN:** **Provider Manual** Page 6, PCP Responsibilities, Bullets 5-6 Page 17, Servicing Members with Special Healthcare Needs Page 45, Specialist Referrals Page 57, XI. Health Risk Assessment & Care Management	
3. The Contractor has a mechanism to ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating covered services furnished to the member. For CHP+ members— ◆ Upon enrollment, the Contractor makes at least one attempt to contact the member with information on	**Documents Submitted** **Both:** **CCS310- Access to Primary and Specialty Care** Page 2, Policy Statement Page 4, Procedure I-II. **CS311- Primary Care Assignment Changes** Page 3, Procedure II. **Comprehensive Provider Webinar Training Slides** Slide 66-68 Changing the PCP, PCP Reports (member PCP assignment)	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
options for selecting a PCP. ◆ If the member does not select a PCP within 10 days, the Contractor assigns the member to a PCP and notifies the member, by telephone or in writing, of his/her facility's or PCP's name, location, and office telephone number. ◆ The Contractor notifies the PCP of newly assigned members in a timely manner. ◆ The Contractor grants a member's request to change his/her PCP, as reasonable and practical. *42CFR438.208(b)(1)* CHP+ Contract: Exhibit A4—2.5.8.2	**AutoPCP Assignment Desktop Procedure** Page 2, Desktop Statement **Care Management Desktop Procedure** Page 4, Procedure IV. B **CHP HMO:** **CHPHMO_ID Card Mailing** PCP contact info **CHPHMO_EOC** Page 9-10, Choosing or Changing Your PCP **CHP HMO Annual Mailing** Page 6, Provider Information **Provider Manual** Page 25, Requesting a PCP Change Page 75, Care Management, Paragraph 2 **CHP+HRA Follow-Up Program Desktop Procedure** Page 3, Procedure III. B, 1 Page 4, Appendix A. Q1 and Q2 **SMCN:** **SMCN_ID Card Mailing** PCP contact info **SMCN Provider Manual** Page 53, Primary Care Provider **SMCN Member Handbook** Page 9-10, Primary Care Provider; Selecting or Changing your PCP	☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
4. The Contractor implements procedures to provide an individual needs assessment after enrollment and at any other necessary time, including the screening for special healthcare needs (e.g., mental health, high risk health problems, functional problems, language or comprehension barriers, and other complex health problems). The assessment mechanisms must use appropriate healthcare professionals. For CHP+ members— ◆ The Contractor will assess members with special healthcare needs within 30 days in order to identify ongoing conditions that require a course of treatment or regular care monitoring. *42CFR438.208(c)(2)* CHP+ Contract: Exhibit A4—2.7.4.3.1.1; 2.7.5.3	**Documents Submitted** **Both**: **QM308 – Preventive Health Services** Page 4, Procedure VI **CCS305 – Care Coordination** Page 4, Procedure III. B-C **CCS306 – Delivering Continuity and Transition of Care for Members** Page 3, Procedure I. A, II. A **Care Manager Desktop Procedure** Page 4, Procedure III. and IV. **CHP HMO:** **Provider Manual** Page 112, Health Risk Assessment and Care Management **CHP+ HRA Follow-Up Program** Page 2, Procedure I. Page 3, Procedure III. B **SMCN:** **SMCN_HRA_English** All **Initial Prenatal Assessment Script – welcome call list – weekly** All **Desktop Process_CHP+HMHB Program** Page 2, Paragraphs 1-2 **Provider Manual** Page 57, XI. Health Risk Assessment & Care Management	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
5. The Contractor shares with other healthcare organizations serving the member with special healthcare needs, the results of its identification and assessment of that member's needs, to prevent duplication of those activities. *42CFR438.208(b)(3)* CHP+ Contract: Exhibit A4—2.7.5.2	**Documents Submitted** **Both:** **CCS305 – Care Coordination** Page 2. Care Coordination definition Page 3, Procedure I. G-H Page 4, Procedure III. C. 2 **CHP HMO:** **Provider Manual** Page 112, Health Risk Assessment & Care Management **SMCN:** **Provider Manual** Page 57, XI. Health Risk Assessment & Care Management **Desktop Process_CHP+HMHB Program** Page 2, Paragraphs 1-2	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
6. The Contractor implements procedures to develop an individual treatment plan based on the needs assessment. The treatment plan addresses treatment objectives, treatment follow-up, monitoring of outcomes, and is revised as necessary. *42CFR438.208(c)(3)* CHP+ Contract: Exhibit A4—2.7.4.3.1.2; 2.7.4.3.1.3	**Documents Submitted** **Both:** **CCS305 – Care Coordination** Page 3, Procedure I. C Page 4, Procedure III. C. 2-5 **Care Manager Desktop Procedure** Page 5, Procedure V. **CHP HMO:** **Provider Manual** Page 112, Health Risk Assessment & Care Management, paragraph 3 **SMCN:** **Provider Manual** Page 57, XI. Health Risk Assessment & Care Management	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
7. The Contractor's procedures for individual needs assessment and treatment planning are designed to: ◆ Accommodate the specific cultural and linguistic needs of the members. ◆ Allow members with special healthcare needs direct access to a specialist as appropriate to the member's conditions and needs. *42CFR438.208(c)(3)(iii)* CHP+ Contract: Exhibit A4—2.7.4.3.1.4	**Documents Submitted** **Both:** **CCS306 – Delivering Continuity and Transition of Care for Members** Page 4, Procedure II. A,F,G **CCS305 – Care Coordination** Page 3, Procedure I. C **ADM206 – Culturally Sensitive Services for Diverse Populations** Page 2-3, Procedure I. A-B **ADM207 – Effective Communication with Limited English Proficient Persons and Sensory-Impaired/Speech-Impaired Persons** Page 2, Policy Statement Page 3, Procedure I. B-C Page 4, Procedure II. 2 **CCS310 – Access to Primary and Specialty Care** Page 4, Procedure II. D Page 5, Procedure III. A, F **Care Manager Desktop Procedure** Page 5, Procedure IV. B-C **CHP HMO:** **CHP+ HRA Follow-Up Program** Page 3, Procedure III. B, D **Provider Manual** Page 7, Culturally Sensitive Services; Effective Communication with Limited English Proficient Persons and SI/SI Persons Page 76, About the Colorado Access Care Management Team Page 113, Servicing Members with Special Healthcare Needs **CHP HMO EOC** Page 9-10, Primary Care Providers, last paragraph	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	SMCN: **Provider Manual** Page 17, Servicing Members with Special Healthcare Needs Page 57, XI. Health Risk Assessment & Care Management **Desktop Process_CHP+HMHB Program** Page 2, Paragraphs 1-2 **SMCN Member Handbook** Page 9-10, Primary Care Providers, 2nd to last paragraph	
8. The Contractor ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that they are applicable. In all other operations as well, the Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42CFR438.208(b)(4)* *42CFR438.224* CHP+ Contract: Exhibit A4—2.7.4.1, 3.1.4.3	**Documents Submitted** **Both:** **HIP201 – Protection of Member Individually Identifiable Health Information and Protected Health Information** All **HIP204 – Security of Electronic Protected Health Information** Page 4, Procedure I. E Page 10, Procedure X.-XI. **CCS305 – Care Coordination** Page 5, Procedure III., C. 6 **CMP204 - Corporate Compliance Program Education & Training** Page 2, Policy Statement **CMP201 – Problem Reporting and Non-Retaliation** Page 2, Policy Statement **HIPAA Training Roster** **CHP HMO:** **Provider Manual** Page 9, Privacy of Member Information **Notice of Privacy-HMO** sent out in welcome packet and annually	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	SMCN: **Provider Manual** Page 10, Confidentiality **Notice of Privacy_SMCN** sent out in welcome packet and annually	
9. The Contractor's procedures include a strategy to ensure that all members and/or authorized family members are involved in treatment planning and consent to medical treatment. CHP+ Contract: Exhibit A4—2.7.4.3.4	**Documents Submitted** **Both:** **CCS305 – Care Coordination** Page 4, Procedure III. A **CCS306 – Delivering Continuity and Transition of Care for Members** Page 3, Procedure II. A **Care Manager Desktop Procedure** Page 3, Procedure III. D **CHP HMO:** **Provider Manual** Page 112, Health Risk Assessment & Care Management **CHPHMO_EOC** Page 9, Primary Care Providers, 3rd to Last Paragraph **SMCN:** **Provider Manual** Page 57, Health Risk Assessment & Care Management **SMCN Member Handbook** Page 9-10, Primary Care Providers, Last Paragraph	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. The Contractor's **procedures** provide for continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services. ◆ The Contractor informs new members with special healthcare needs involved in an ongoing course of treatment that he/she:	**Documents Submitted** **Both:** **CCS306 – Delivering Continuity and Transition of Care for Members** Page 3, Procedure II. B-C	CHP+ ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
▪ May continue to receive covered services for 60 calendar days from his/her current provider. ▪ May continue to receive covered services from ancillary or non-network providers for a period of 75 calendar days. ◆ The Contractor informs a new member who is in her second or third trimester of pregnancy to continue to see their obstetrical provider until the completion of post-partum care directly related to the delivery. CHP+ Contract: Exhibit A4—2.7.4.3.6; 2.7.5.1.1; 2.7.5.1.2; 2.7.5.1.3	**CHP HMO:** **CHPHMO_EOC** Page 17-18, Rights and Responsibilities for Members with Special HealthCare Needs; Right and Responsibility for Members Who are More than Three Months Pregnant **Provider Manual** Page 117, Rights and Responsibilities for Members with Special HealthCare Needs; Right and Responsibility for Members Who are More than Three Months Pregnant **SMCN:** **SMCN EOC** Page 16, Rights and Responsibilities for Members with Special HealthCare Needs; Right and Responsibility for Members Who are More than Three Months Pregnant **Provider Manual** Page 13-14, Rights and Responsibilities for Members with Special HealthCare Needs; Rights and Responsibility for Members Who are More than Three Months Pregnant	

Findings:
The member handbook and provider manual informed members and providers of a new member's right to continue an ongoing course of treatment as specified in the requirement. However, the member handbook used language, "as long as the provider works with us to transfer care" and "if the provider agrees to accept our reimbursement rates and work with us," which may imply to the member contingencies as to whether the member may continue care according to the regulation. Although staff members stated that these contingencies are not actually implemented, the health plan's contract does not allow for such contingencies and should not be communicated to the member.

Required Actions:
Colorado Access must remove statements from the member handbook that stipulate additional restrictions on when a member with special healthcare needs or a member in the second or third trimester of pregnancy may continue an ongoing course of treatment or services.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
11. If necessary primary or specialty care cannot be provided to members with special healthcare needs within the Contractor's plan, the Contractor makes arrangements for members to access these providers outside the network. CHP+ Contract: Exhibit A4—2.7.5.2	**Documents Submitted** Both: **CCS306 – Delivering Continuity and Transition of Care for Members** Page 3, Procedure II.D **CCS310 – Access to Primary and Specialty Care** Page 4, Procedure II. D **Single Case Agreement Process Desktop** Page 1, Opening paragraph **CHP HMO:** **CHPHMO_EOC** Page 9, Paragraph 5 **SMCN:** **SMCN Member Handbook** Page 10, 4th Paragraph	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor allows members with special healthcare needs direct access to a specialist (for example, through a standing referral), as appropriate for the member's condition, and/or to maintain these types of specialists as PCPs. *42CFR438.208(c)(4)* CHP+ Contract: Exhibit A4—2.7.5.4	**Documents Submitted** **Both:** **CCS310 – Access to Primary and Specialty Care** Page 4, Procedure II. B **Care Management Desktop Procedure** Page 5, Procedure IV. B **HMO**: **CHP HMO_EOC** No referral necessary page 11 **Provider Manual** Page 112, Health Risk Assessment & Care Management, 2nd Paragraph **SMCN:** **SMCN Member Handbook** Page10, 3rd Paragraph **Provider Manual** Page 57, XI. Second Paragraph	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard III—Coordination and Continuity of Care CHP+ HMO							
Total	Met	=	11	X	1.00	=	11
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	12	**Total Score**		=	11

Total Score ÷ Total Applicable	=	92%

Results for Standard III—Coordination and Continuity of Care SMCN							
Total	Met	=	8	X	1.00	=	8
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	8	**Total Score**		=	8

Total Score ÷ Total Applicable	=	100%

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
1. The Contractor has written policies and procedures regarding member rights. *42CFR438.100(a)(1)* CHP+ Contract: Exhibit A4—3.1.1.1	**Documents Submitted** **Both:** **CS212- Member Rights and Responsibilities** All **Member Communications Plan** Page 7, VI. Member Rights and Responsibilities	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor ensures that its staff and affiliated and network providers take member rights into account when furnishing services to members. *42CFR 438.100(a)(2)* CHP+ Contract: Exhibit A4—3.1.1.1.1	**Documents Submitted** **Both:** **CS212- Member Rights and Responsibilities** All **Comprehensive Webinar Training Slides** Slides 78-81 **Desktop Laminate_CHP Member Rights and Responsibilities** -this placard is displayed at the desks of COA Staff **Member Communications Plan** Page 7, VI. Member Rights and Responsibilities **CHP HMO:** **Provider manual** Page 116, Member Rights **SMCN:** **Provider manual** Page 12, Member Rights and Responsibilities	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IV—Member Rights and Protections

Requirement	Evidence as Submitted by Health Plan	Score
3. The Contractor's policies and procedures ensure that each member is treated by staff and affiliated providers in a manner consistent with the following specified rights: ◆ Receive information in accordance with information requirements (42CFR438.10). ◆ Be treated with respect and with due consideration for his or her dignity and privacy. ◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. ◆ Participate in decisions regarding his or her healthcare, including the right to refuse treatment. ◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. ◆ Request and receive a copy of his or her medical records and request that they be amended or corrected. ◆ Obtain family planning services from any duly licensed provider in or out of network without a referral. ◆ Be furnished healthcare services in accordance with federal healthcare regulations for access and availability, care coordination, and quality. *42CFR438.100(b)(2) and (3)* CHP+ Contract: Exhibit A4—3.1.1.1.2–3.1.1.1.6; 3.1.1.3.2	**Documents Submitted** **Both:** **CS212 – Member Rights and Responsibilities** All **Member Rights and Responsibilities_Staff Training** All **Desktop Laminate_CHP Member Rights and Responsibilities** This placard is displayed at the desks of COA Staff **Member Communications Plan** Page 2, Procedure II Page 6, Procedure IV, Last paragraph **Comprehensive Provider Webinar Training Slides** Slides 79 **CHP HMO:** **Provider Manual** Page 9, Requests from Members to Access Information Page 116, Member Rights **CHP HMO Annual Mailing** Page 1, Your Rights **CHPHMO_EOC** Page 16, Member Rights & Responsibilities **SMCN:** **Provider Manual** Page 12, Member Rights & Responsibilities **SMCN Member Handbook** Page 15, Member Rights & Responsibilities	CHP+ ☐ Met ☐ Partially Met ☒ Not Met ☐ N/A SMCN ☐ Met ☐ Partially Met ☒ Not Met ☐ N/A

Findings:
Rather than list the specific member rights, Policy CS212—Member Rights and Responsibilities referenced a specific section of the Colorado Code of Regulations (CCR) and the contract between Colorado Access and the Department. While this mechanism of reference is acceptable, the section of CCR referenced in the policy was incorrect and the contract routing number was outdated.

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
Required Actions: Colorado Access must revise its Member Rights and Responsibilities policy to either list the specific member rights or accurately reference a location where staff members can find specific rights.		
4. The Contractor ensures that each member is free to exercise his or her rights and that exercising those rights does not adversely affect the way the Contractor or its providers treat the member. *42CFR438.100(c)* CHP+ Contract: Exhibit A4—3.1.1.1.7	**Documents Submitted** **Both:** **ADM203 – Member Grievance Process** Page 3, Procedure I. A **CHP HMO:** **CHPHMO_EOC** Page 17, 1: Member Rights and Responsibilities, 1st sentence Page 17, 6th bullet from the bottom Page 104 Grievances, 1st paragraph **Provider Manual** Page 116, Member Rights 3rd and 14th Bullet Page 120, CHP+ Appeal Process, Bullet 4 **SMCN:** **SMCN Member Handbook** Page 16, 1: Member Rights and Responsibilities, 1st sentence Page 16, 16th Bullet **Provider Manual** Page 12, Member Rights 3rd and 14th Bullet Page 34, Bullet 3	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. The Contractor complies with any other federal and State laws that pertain to member rights including Title VI of the Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act, and titles II and III of the Americans with Disabilities Act. *42CFR438.100(d)* CHP+ Contract: 21.A	**Documents Submitted** **Both**: **ADM205 – Nondiscrimination** All **ADM229 – Member Disability Rights Request and Complaint Resolution** Page 4, Procedure I, A.	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	CHP HMO: **Provider Manual** Page 8, Non-Discrimination **SMCN**: **Provider Manual** Page 10, Non-Discrimination	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard IV—Member Rights and Protections CHP+ HMO							
Total	Met	=	4	X	1.00	=	4
	Partially Met	=	0	X	.00	=	0
	Not Met	=	1	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	5	**Total Score**		=	4

Total Score ÷ Total Applicable	=	80%

Results for Standard IV—Member Rights and Protections SMCN							
Total	Met	=	4	X	1.00	=	4
	Partially Met	=	0	X	.00	=	0
	Not Met	=	1	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	5	**Total Score**		=	4

Total Score ÷ Total Applicable	=	80%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. ◆ The Contractor's credentialing program shall comply with the standards of the National Committee for Quality Assurance (NCQA) for initial credentialing and recredentialing of participating providers. NCQA CR1 CHP+ Contract: Exhibit A4—3.2.1.1; 3.2.1.3 SMCN Contract—II.A.9.1	**Documents Submitted** **Both:** **CR301- Provider Credentialing and Recredentialing** All **CR302- Office Site Visit for Provider Credentialing** All **CR307- Credentialing/Recredentialing Provider Classification and Credentials Committee Determination Process** All **CR312 – Provider Rights** All **CR318 – Ongoing Monitoring of Provider Sanctions, Grievances and Occurrences of Adverse Actions** All **PNS202 – Selection and Retention of Providers** All **CMP206- Sanction, Exclusion, Prohibited Affiliations and Opt-Out Screening** Page 4, Procedure I. B. 4 **ADM223 – Delegation** Page 4, Procedure I. H Page 5, Procedure I. L Page 5, Procedure II. D **ADM301- Adverse Actions Hearing and Appeal Process for Providers** Page 10, Procedure II, III **QM201 – Investigation of Potential Clinical Quality of Care Grievances and Referrals** All	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners to credential and recredential. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. (Examples include MDs, DOs, podiatrists, nurse practitioners, and each type of behavior health provider.) *42CFR438.214(a)* NCQA CR1—Element A1	**Documents Submitted** **Both:** **CR301 – Provider Credentialing and Recredentialing** Page 3, Procedure I. 4, a	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.B. The verification sources used. NCQA CR1—Element A2	**Documents Submitted** **Both:** **CR301 – Provider Credentialing and Recredentialing** Page 12-14, Procedure XV.	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	**Documents Submitted** **Both:** **CR301 - Provider Credentialing and Recredentialing** Page 7, Procedure VIII **CR307 – Credentialing and Recredentialing Provider Review Classification** All **Credentialing Provider Checklist**	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	**Documents Submitted** **Both:** **CR301 - Provider Credentialing and Recredentialing** Page 9-10, Procedure IX. Page 16-17, Procedure XVI **CR307 – Credentialing and Recredentialing Provider Review Classification** All	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
2.E. The process for managing credentialing/ recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	**Documents Submitted** **Both:** **CR301 - Provider Credentialing and Recredentialing** Page 7, Procedure VII. File Maintenance and Confidentiality **Process:** Credentialing files are maintained using the Apogee Managed Care Credentialing System (Morrisey Associates, Inc.). Apogee software is a web-based comprehensive membership management system. During the site review, Credentialing staff can demonstrate this product if requested. Reviewers are welcome to visit the credentialing area where physical files are stored.	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.F. The process for delegating credentialing or recredentialing (if applicable). NCQA CR1—Element A6	**Documents Submitted** **Both:** **CR301 - Provider Credentialing and Recredentialing** Page 6, Procedure VI. Delegation Page 7-8, Procedure VIII. Credentialing/Recredentialing Criteria and Verification Time Limits **ADM223 – Delegation** Page 4, Procedure I, H Page 5, Procedure I, L Page 5, Procedure II, D **See Folder: Delegation Agreements**	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
2.G. The process for ensuring that credentialing and recredentialing are conducted in a nondiscriminatory manner, (i.e., must describe the steps the Contractor takes to ensure that it does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes; and that it takes proactive steps to prevent and monitor discriminatory practices). NCQA CR1—Element A7	**Documents Submitted** **Both:** **CR301 - Provider Credentialing and Recredentialing** Page 5, Procedure III, Non-Discrimination	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.H. The process for notifying practitioners if information obtained during the Contractor's credentialing/recredentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A8	**Documents Submitted** **Both:** **CR301 - Provider Credentialing and Recredentialing** Page 6, V. Provider Rights **CR312 – Provider Rights** Procedure II. Correcting Erroneous Information **CO Health Care Professional Credentials Application** Page 23, #12 **Practitioner Rights Form** All	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
2.I. The process for ensuring that practitioners are notified of credentialing and recredentialing decisions within 60 calendar days of the credentialing committee's decision. NCQA CR1—Element A9	**Documents Submitted** **Both**: **CR301 - Provider Credentialing and Recredentialing** Page 17, Procedure XVII. Credentialing Determination Notification	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.J. The medical director or other designated physician's direct responsibility and participation in the credentialing/ recredentialing program. NCQA CR1—Element A10	**Documents Submitted** **Both**: **CR301 – Provider Credentialing and Recredentialing** Page 6, Procedure IV. Program Resources Page 9-10, Procedure IX. Credentials Committee	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.K. The process for ensuring the confidentiality of all information obtained in the credentialing/ recredentialing process. NCQA CR1—Element A11	**Documents Submitted** **Both**: **CR301 – Provider Credentialing and Recredentialing** Page 7, Procedure VII. File Maintenance and Confidentiality	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
		SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.L. The process for ensuring that listings in provider directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty. NCQA CR1—Element A12	**Documents Submitted** **Both:** **CR301 – Provider Credentialing and Recredentialing** Page 17-18, Procedure XVIII. Provider Listings in the Directories	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.M. The Contractor notifies practitioners about their rights: ◆ The right to review information submitted to support their credentialing or recredentialing application. NCQA CR1—Element B1	**Documents Submitted** **Both**: **CO Health Care Professional Credentials Application** Page 23, 12 **CR301 – Provider Credentialing and Recredentialing** Page 6, Procedure V. Provider Rights **CR312 – Provider Rights** All **CHP HMO**: **Provider Manual** Page 19, Paragraph 2 **SMCN**: **Provider Manual** Page 8, last paragraph	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
2.N. The right to correct erroneous information. NCQA CR1—Element B2	**Documents Submitted** **Both**: **CO Health Care Professional Credentials Application** Page 23, 12 **CR301 – Provider Credentialing and Recredentialing** Page 6, Procedure V. Provider Rights **CR312 – Provider Rights** Page 3, Procedure II. Correcting Erroneous Information **CHP HMO:** **Provider Manual** Page 19, Paragraph 2 **SMCN**: **Provider Manual** Page 8-9, last/first paragraph	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.O. The right to receive the status of their credentialing or recredentialing application, upon request. NCQA CR1—Element B3	**Documents Submitted** **Both**: **CO Health Care Professional Credentials Application** Page 23, 12 **CR301 – Provider Credentialing and Recredentialing** Page 6, Procedure V. Provider Rights **CR312 – Provider Rights** Page 3, Procedure III. Provider Request for Information on Application Status **CHP HMO**: **Provider Manual** Page 20, Paragraph 3 **SMCN**: **Provider Manual** Page 9, 1st paragraph	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
2.P. How the Contractor accomplishes ongoing monitoring of practitioner sanctions, complaints, and adverse events between recredentialing cycles including: ◆ Collecting and reviewing Medicare and Medicaid sanctions. ◆ Collecting and reviewing sanctions or limitations on licensure. ◆ Collecting and reviewing complaints. ◆ Collecting and reviewing information from identified adverse events. ◆ Implementing appropriate interventions when it identified instances of poor quality related to the above. NCQA CR6—Element A	**Documents Submitted** **Both**: **CR301 – Provider Credentialing and Recredentialing** Page 10-11, Procedure XI. Ongoing Monitoring of Sanctions **CR318 – Ongoing Monitoring of Provider Sanctions, Grievances and Occurrences of Adverse Actions** All **QM201 – Investigation of Potential Clinical Quality of Care Grievances and Referrals** Page 6, M-O	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.Q. The range of actions available to the Contractor against the practitioner (for quality reasons). NCQA CR7—Element A1	**Documents Submitted** **Both**: **ADM301 – Adverse Action Hearing and Appeal Process for Providers** All **QM201 – Investigation of Potential Clinical Quality of Care Grievances and Referrals** Page 6, M-O.	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
2.R. If the Contractor has taken action against a practitioner for quality reasons, the Contractor reports the action to the appropriate authorities (including State licensing agencies for each practitioner type and the National Practitioner Data Bank [NPDB]). NCQA CR7—Elements A2 and B	**Documents Submitted** **Both**: **ADM301 – Adverse Action Hearing and Appeal Process for Providers** Page 10-11, Procedure III. A, 2	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.S. A well-defined appeal process for instances in which the Contractor has taken action against a practitioner for quality reasons, which includes: ◆ Providing written notification indicating that a professional review action has been brought against the practitioner, reasons for the action, and a summary of the appeal rights and process. ◆ Allowing the practitioner to request a hearing and the specific time period for submitting the request. ◆ Allowing at least 30 days after the notification for the practitioner to request a hearing. ◆ Allowing the practitioner to be represented by an attorney or another person of the practitioner's choice. ◆ Appointing a hearing officer or panel of the individuals to review the appeal. ◆ Providing written notification of the appeal decision that contains the specific reasons for the decision. NCQA CR7—Elements A3and C	**Documents Submitted** **Both**: **ADM301 – Adverse Action Hearing and Appeal Process for Providers** Page 5, Procedure II. C Page 16, Attachment B **QOC Notice of Action Letter Template** All **HMO**: **Provider Manual** Page 125, Provider Rights Regarding Quality of Care, Competency, or Professional Conduct Actions **SMCN:** **Provider Manual** Page 39, Provider Rights Regarding Quality of Care, Competency, or Professional Conduct Actions	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
2.T. Making the appeal process known to practitioners. NCQA CR7—Elements A4 and C	**Documents Submitted** **Both:** **QOC Notice of Action Letter Template** All **CHP HMO:** **Provider Manual** Page 125, Provider Rights Regarding Quality of Care, Competency, or Professional Conduct Actions **SMCN:** **Provider Manual** Page 39, Provider Rights Regarding Quality of Care, Competency, or Professional Conduct Actions	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
3. The Contractor designates a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions. The committee includes representation from a range of participating practitioners. NCQA CR2—Element A1	**Documents Submitted** **Both**: **CR301 – Provider Credentialing and Recredentialing** Page 9, Procedure IX, Credentials Committee	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
4. The credentialing committee: ◆ Reviews credentials for practitioners who do not meet established thresholds. ◆ Ensures that files which meet established criteria are reviewed and approved by a medical director or designated physician. NCQA CR2—Elements A2 and A3	**Documents Submitted** **Both**: **CR301 – Provider Credentialing and Recredentialing** Page 8, Procedure IX, Credentials Committee **CR307 - Credentialing/Recredentialing Provider Classification and Credentials Committee Determination Process** Page 2, Procedure I. Pre-credentials File Review and Credentials Committee Preparation Process	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. The Contractor conducts timely verification (at credentialing) of information, using primary sources, to ensure that practitioners have the legal authority and relevant training and experience to provide quality care. Verification is within the prescribed time limits and includes: ◆ A current, valid license to practice (verification time limit is 180 calendar days). ◆ A valid Drug Enforcement Administration (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (effective at the time of the credentialing decision). ◆ Education and training, including board certification, if applicable (verification of the highest of graduation from medical/ professional school, residency, or board certification—board certification time limit is 180 calendar days). ◆ Work history (verification time limit is 365 calendar days; nonprimary verification is most recent five years).	**Documents Submitted** **Both**: **CR301 – Provider Credentialing and Recredentialing** Page 7-8, Procedure VIII. Credentialing/Recredentialing Criteria and Verification Time Limits Page 12, Procedure XV. Verification Process	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (verification time limit is 180 calendar days). NCQA CR3—Element A		
6. Practitioners complete an application for network participation (at initial credentialing and recredentialing) that includes a current and signed attestation and addresses the following: ◆ Reasons for inability to perform the essential functions of the position, with or without accommodation. ◆ Lack of present illegal drug use. ◆ History of loss of license and felony convictions. ◆ History of loss or limitation of privileges or disciplinary actions. ◆ Current malpractice/professional liability insurance coverage (minimums= physician—0.5mil/1.5mil; facility—0.5mil/3mil). ◆ The correctness and completeness of the application. NCQA CR3—Element C CHP+ Contract: Exhibit A4—3.2.2.1.1; 3.2.2.1.2	**Documents Submitted** **Both**: **CR301 – Provider Credentialing and Recredentialing** Page 10, Procedure X. B **CO Health Care Professional Credentials Application** Page 20, XII. Attestation Questions Page 25, Supplemental A, 3-4 Page 26, Supplemental B, 1-2 Page 16, X. Professional Liability Insurance	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
7. The Contractor verifies the following sanction activities for initial credentialing and recredentialing: ◆ State sanctions, restrictions on licensure, or limitations on scope of practice. ◆ Medicare and Medicaid sanctions. NCQA CR3—Element B	**Documents Submitted** **Both**: **CR301-Provider Credentialing and Re-credentialing** Page 10-11, Procedure XI. A Page 15-16, Procedure XV. I, 2-3	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. The Contractor has a process to ensure that the offices of all practitioners meet its office-site standards. The organization sets standards and performance thresholds for: ◆ Physical accessibility. ◆ Physical appearance. ◆ Adequacy of waiting and examining room space. ◆ Adequacy of treatment record-keeping. NCQA CR5—Element A	**Documents Submitted** **Both**: **CR301-Provider Credentialing and Re-credentialing** Page 16, J. 1 **CR302-Office Site Visit for Providers Credentialing** All	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor implements appropriate interventions by: ◆ Conducting site visits of offices about which it has received member complaints. ◆ Instituting actions to improve offices that do not meet thresholds. ◆ Evaluating effectiveness of the actions at least every six months, until deficient offices meet the thresholds.	**Documents Submitted** **Both**: **CR302-Office Site Visit for Providers Credentialing** All	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
◆ Continually monitoring member complaints for all practitioner sites and performing a site visit within 60 days of determining a complaint threshold was met. ◆ Documenting follow-up visits for offices that had subsequent deficiencies. NCQA CR5—Element B		SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. The Contractor formally recredentials its practitioners at least every 36 months. NCQA CR4	**Documents Submitted** **Both**: **CR301-Provider Credentialing and Re-credentialing** Page 9, Procedure IX. F	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of (organizational) providers with which it contracts, which include: 11.A. The Contractor confirms—initially and at least every three years—that the provider is in good standing with state and federal regulatory bodies. NCQA CR8—Element A1	**Documents Submitted** **Both**: **CR305 – Organizational Provider Credentialing** Page 4, Procedure IV. Criteria and Verification Requirements **CMP206 – Sanction, Exclusion, Prohibited Affiliations & Opt-Out Screening** Page 3-5, Procedure I., B, 4 **CR318 – Ongoing Monitoring of Provider Sanctions, Grievances and Occurrences of Adverse Actions** All	CHP+ ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A SMCN ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
Findings: The Organizational Provider Credentialing policy described the process for confirming that a provider is in good standing with State and federal agencies, and HSAG found evidence of compliance in the record reviews. While the policy also stated that this process would be performed at least every three years, two of the five organizational records reviewed did not document that the organization had been recredentialed within the three-year time frame.		
Required Actions: Colorado Access must implement a process to ensure that organizations with which it contracts are recredentialed at least every three years.		
11.B. The Contractor confirms—initially and at least every three years—that the provider has been reviewed and approved by an accrediting body. NCQA CR8—Element A2	**Documents Submitted** **Both**: **CR305 – Organizational Provider Credentialing** Page 3-4, Procedure II, C Page 6, Procedure V. Accreditation or Site Visit by CMS, DMH, OBH or Colorado Access	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11.C. The Contractor conducts—initially and at least every three years—an on-site quality assessment if there is no accreditation status. NCQA CR8—Element A3	**Documents Submitted** **Both**: **CR305 – Organizational Provider Credentialing** Page 6, Procedure V. Accreditation or Site Visit by CMS, DMH, OBH or Colorado Access Page 10, Procedure VII. E	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
11.D. The Contractor's policies specify the sources used to confirm: ◆ That providers are in good standing with state and federal requirements. ◆ The provider's accreditation status. (Includes applicable state or federal agency or applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, copies of credentials—e.g., licensure, accreditation report or letter—from the provider.) NCQA CR8—Element A, Factors 1 and 2	**Documents Submitted** **Both**: **CR305 – Organizational Provider Credentialing** Page 6, Procedure V. Accreditation or Site Visit by CMS, DMH, OBH or Colorado Access Page 10, Procedure VII. D-E	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11.E. The Contractor's policies and procedures include: ◆ On-site quality assessment criteria for each type of unaccredited organizational provider. ◆ A process for ensuring that the provider credentials its practitioners. NCQA CR8—Element A, Factor 3	**Documents Submitted** **Both**: **CR305 – Organizational Provider Credentialing** Page 11, Procedure VII. E – Last paragraph	CHP+ ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A SMCN ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The Organizational Provider Credentialing policy and procedure included the criteria used to assess unaccredited organizational providers, which included staff hiring and credentialing processes. While on-site record review demonstrated that Colorado Access collected the organization's policies and procedures related to staff hiring and credentialing, some of the policies collected were not compliant with Colorado Access' credentialing standards.		
Required Actions: Colorado Access must be sure that unaccredited organizational providers are credentialing practitioners in a manner consistent with Colorado Access policies, procedures, and standards.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
12. The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: ◆ The CMS or state review is no more than three years old. ◆ The organization obtains a survey report or letter from CMS or the state, from either the provider or from the agency, stating that the facility was reviewed and passed inspection. ◆ The report meets the organization's quality assessment criteria or standards. NCQA CR8—Element A, Factor 3	**Documents Submitted** **Both**: **CR305 – Organizational Provider Credentialing** Page 11, Procedure VII. E	CHP+ ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A SMCN ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Findings:
The Organizational Provider Credentialing policy and procedure described the circumstances under which Colorado Access could substitute a CMS or State quality review in lieu of a site visit; however, the policy did not specify that Colorado Access would confirm that the survey conducted by CMS or the State meets its own quality assessment criteria or standards. HSAG did not find evidence in the records reviewed that Colorado Access confirmed the content of the CMS or State review. Some CMS and State reviews included with the records reviewed indicated the need for corrective action; however, Colorado Access did not document that it confirmed that the corrective actions had been completed. Furthermore, one of the State site reviews documented in the record as being used in lieu of a site visit was more than three years old at the time of the credentialing decision.

Required Actions:
Colorado Access must specify in its policies that it will confirm that CMS and State quality reviews used in lieu of Colorado Access site visits include all criteria and standards identified in Colorado Access' policy. Colorado Access must ensure that CMS and State quality reviews used are no more than three years old at the time of the credentialing decision. Additionally, if the CMS or State quality review required that the organization complete any corrective actions, Colorado Access must document that the organization completed all corrective actions.

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
13. The Contractor's organizational provider assessment policies and process include assessment of at least the following medical providers: ◆ Hospitals. ◆ Home health agencies. ◆ Skilled nursing facilities. ◆ Free-standing surgical centers. NCQA CR8—Element B	**Documents Submitted** **Both**: **CR305 – Organizational Provider Credentialing** Page 2, Procedure I. Scope of Credentialing Activities	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
14. The Contractor's organizational provider assessment policies and process include assessment of at least the following behavioral health and substance abuse settings: ◆ Inpatient. ◆ Residential. ◆ Ambulatory. NCQA CR8—Element C	**Documents Submitted** **Both**: **CR305 – Organizational Provider Credentialing** Page 2, Procedure I. B	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
15. The Contractor has documentation that it has assessed contracted medical healthcare (organizational) providers. NCQA CR8—Element D	**Documents Submitted** **Both**: **CR305 Organizational Provider Credentialing** Page 2, Procedure I. B	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
		SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
16. The Contractor has documentation that it has assessed contracted behavioral healthcare (organizational) providers. NCQA CR8—Element E	**Documents Submitted** **Both**: **CR305 Organizational Provider Credentialing** Page 2, Procedure I. B	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
17. If the Contractor delegates any NCQA-required credentialing activities, there is evidence of oversight of the delegated activities. NCQA CR9	**Documents Submitted** **Both**: **ADM223 - Delegation** All **See Delegate Audits Folder** Boulder Valley IPA – BVIPA Credentialing Audit Findings Denver Health and Hospital Authority- DHHA Credentialing Audit Findings University Physician Inc – UPI Credentialing Audit Findings Northern Colorado IPA – NCIPA Credentialing Audit Findings National Jewish Health – NJH Credentialing Audit Findings	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
18. The Contractor has a written delegation document with the delegate that: ◆ Is mutually agreed upon. ◆ Describes the delegated activities and responsibilities of the Contractor and the delegated entity. ◆ Requires at least semiannual reporting by the delegated entity to the Contractor. ◆ Describes the process by which the Contractor evaluates the delegated entity's performance. ◆ Describes the remedies available to the Contractor (including revocation of the delegation agreement) if the delegate does not fulfill its obligations. NCQA CR 9—Element A	**Documents Submitted** **Both**: **See Delegation Agreement Folder:** Template_Credentialing Delegation Agreement Credentialing Delegation Agreement_NCIPA - Northern Colorado IPA Credentialing Delegation Agreement_UPI - University Physician Inc Credentialing Delegation Agreement_Boulder Valley IPA Credentialing Delegation Agreement_National Jewish Credentialing Delegation Agreement_DHHA- Denver Health	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
19. If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes: ◆ A list of allowed use of PHI. ◆ A description of delegate safeguards to protect the information from inappropriate use or further disclosure. ◆ A stipulation that the delegate will ensure that subdelegates have similar safeguards. ◆ A stipulation that the delegate will provide members with access to their PHI. ◆ A stipulation that the delegate will inform the Contractor if inappropriate uses of the information occur.	**Documents Submitted** **Both**: **HIP203- Business Associate Agreements** All **ADM223 - Delegation** Page 5, Procedure I. M **Template_Credentialing Delegation Agreement** Page 3, Table Row 2 HIPAA Security/Privacy Issues **See BAA Agreement Folder:** Boulder Valley IPA Denver Health and Hospital Authority University Physician Inc Northern Colorado IPA National Jewish Health Centura Health	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
◆ A stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends. NCQA CR9—Element B		
20. The Contractor retains the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision making. This right is reflected in the delegation agreement. NCQA CR9—Element C	**Documents Submitted** **Both**: **Template_Credentialing Delegation Agreement** Page 5, Article Two, B.2 Page 5, Article Three, C.1 **See Delegation Agreement Folder:** Credentialing Delegation Agreement_NCIPA - Northern Colorado IPA Credentialing Delegation Agreement_UPI - University Physician Inc Credentialing Delegation Agreement_Boulder Valley IPA Credentialing Delegation Agreement_National Jewish Credentialing Delegation Agreement_DHHA- Denver Health	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
21. For delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity before the delegation document was signed. NCQA CR9—Element D	**Documents Submitted** **Both**: **See Delegate AuditsFolder:** Centura_Pre-Delegation Audit_2012 COA does not have any delegation agreements that have been in effect for less than 12 months. This document is an example of a pre-delegation desk audit.	CHP+ ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A SMCN ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
22. For delegation agreements in effect 12 months or longer, the Contractor audits credentialing files against NCQA standards for each year that the delegation has been in effect. NCQA CR9—Element E1	**Documents Submitted** **Both**: **See Delegate Audits Folder:** Boulder Valley IPA – BVIPA Credentialing Audit Findings Denver Health and Hospital Authority- DHHA Credentialing Audit Findings University Physician Inc – UPI Credentialing Audit Findings Northern Colorado IPA – NCIPA Credentialing Audit Findings National Jewish Health – NJH Credentialing Audit Findings	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
23. For delegation arrangements in effect 12 months or longer, the Contractor performs an annual substantive evaluation of delegated activities against NCQA standards and organization expectations. NCQA CR9—Element E2	**Documents Submitted** **Both**: **See Delegate Audits Folder:** Boulder Valley IPA – BVIPA Credentialing Audit Findings Denver Health and Hospital Authority- DHHA Credentialing Audit Findings University Physician Inc – UPI Credentialing Audit Findings Northern Colorado IPA – NCIPA Credentialing Audit Findings National Jewish Health – NJH Credentialing Audit Findings	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
24. For delegation arrangements in effect 12 months or longer, the Contractor evaluates regular reports (at least semiannually). NCQA CR9—Element E3	**Documents Submitted** **Both**: **See Delegate Audits Folder:** Boulder Valley IPA – BVIPA Credentialing Audit Findings Denver Health and Hospital Authority- DHHA Credentialing Audit Findings University Physician Inc – UPI Credentialing Audit Findings	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
	Northern Colorado IPA – NCIPA Credentialing Audit Findings National Jewish Health – NJH Credentialing Audit Findings Colorado Access Credentialing staff receives monthly report from each organization delegated credentialing. Upon request, these reports can be produced during the site visit.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
25. The Contractor identified and followed up on opportunities for improvement (at least once in each of the past two years), if applicable. NCQA CR9—Element F	**Documents Submitted** **Both**: **See Delegate Audits Folder:** Boulder Valley IPA – BVIPA Credentialing Audit Findings Denver Health and Hospital Authority- DHHA Credentialing Audit Findings University Physician Inc – UPI Credentialing Audit Findings Northern Colorado IPA – NCIPA Credentialing Audit Findings National Jewish Health – NJH Credentialing Audit Findings	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard VIII—Credentialing and Recredentialing CHP+HMO							
Total	Met	=	44	X	1.00	=	44
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	N/A	=	1	X	NA	=	0
Total Applicable		=	47	**Total Score**		=	44

Total Score ÷ Total Applicable	=	94%

Results for Standard VIII—Credentialing and Recredentialing SMCN							
Total	Met	=	44	X	1.00	=	44
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	N/A	=	1	X	NA	=	0
Total Applicable		=	47	**Total Score**		=	44

Total Score ÷ Total Applicable	=	94%

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
1. The Contractor has an ongoing Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. 42CFR438.*240*(a) CHP+ Contract: Exhibit A4—2.9.1	**Documents Submitted** **Both**: **2015 COA QAPI Program Description** All	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42CFR438.240(b)(3)* CHP+ Contract: Exhibit A4—2.9.4.4.1	**Documents Submitted** **Both**: **2015 COA QAPI Program Description** Page 8, Utilization Management	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
3. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care for persons with special healthcare needs. *42CFR438.240(b)(4)* CHP+ Contract: Exhibit A4—None	**Documents Submitted** **Both**: **2015 CoA QAPI Program Description** Page 9, Quality, Safety and Appropriateness of Care	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
		SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. The Contractor adopts practice guidelines for the following: ◆ Perinatal, prenatal, and postpartum care for women. ◆ Conditions related to persons with a disability or special healthcare needs. ◆ Well child care. CHP+ Contract: Exhibit A4—2.9.2.1.1	**Documents Submitted** **Both**: **QM311: Clinical Practice Guidelines** Page 2, Procedure III. A-C **Copies of all guidelines can be found here:** http://www.coaccess.com/practice-guidelines	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. The Contractor ensures that practice guidelines comply with the following requirements: ◆ Are based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field. ◆ Consider the needs of the Contractor's members. ◆ Are adopted in consultation with contracting healthcare professionals. ◆ Are reviewed and updated annually. *42CFR438.236(b)* CHP+ Contract: Exhibit A4—2.9.2.1.2	**Documents Submitted** **Both**: **QM311: Clinical Practice Guidelines** Page 2, Procedure I. A-C **Copies of all guidelines can be found here:** http://www.coaccess.com/practice-guidelines	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
6. The Contractor disseminates the guidelines to all affected providers, and upon request to members, the Department, other nonmembers, and the public, at no cost. *42CFR438.236(c)* CHP+ Contract: Exhibit A4—2.9.2.1.3	Documents Submitted **Both**: **QM311: Clinical Practice Guidelines** Page 3, Procedure V. Guideline availability on website for providers: http://www.coaccess.com/practice-guidelines	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	Guideline availability on website for members/public http://www.coaccess.com/practice-guidelines-members **HMO**: **Provider Manual** Page 77, Clinical Practice Guidelines **SMCN:** **Provider Manual** Page 64, Clinical Practice Guidelines	SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
7. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42CFR438.236(d)* CHP+ Contract: Exhibit A4—2.9.2.1.4	**Documents Submitted** **Both**: **QM311- Clinical Practice Guidelines** Page 3, Procedure VI. **CCS302- Medical Criteria for Utilization Review** Page 3, Procedure I. A	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. The Contractor calculates and submits specified HEDIS measures determined by collaboration between the Department and the Contractors quality improvement committee. The Contractor: ◆ Analyzes and responds to results indicated in the HEDIS measures. ◆ Calculates additional mandatory federal performance measures when they are required by CMS. CHP+ Contract: Exhibit A4—2.9.4.1.1; 2.9.4.1.2; 2.9.4.2.1	**Documents Submitted** **HMO**: **FY2015 COA CHP+HMO Annual Quality Report** Page 25-29 **HEDIS Submission_CHPHMO_2014** All **SMCN**: No HEDIS measurements for SMCN in 2014 See E-mail "HEDIS prenatal and postpartum care question"	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
9. The Contractor monitors member perceptions of accessibility and adequacy of services provided. Tools shall include: ◆ Member Surveys (CAHPS). ◆ Anecdotal information. ◆ Grievance and appeals data. ◆ Enrollment and disenrollment information. CHP+ Contract: Exhibit A4—2.9.4.3.2	**Documents Submitted** **CHP HMO**: **FY2015 COA CHP+HMO Annual Quality Report** Page 12-13, CAHPS Page 14-15, Grievances Page 35, Appeals **Quarterly Report Q3-FY 14-15** Page 3, Disenrollment Report Page 8, Appeal Reporting Page 11, Grievance Reporting Page 15, Quality of Care Issues **SMCN**: **SMCN Grievance Detail Reports Q1-Q4 (FY2014-2015)** **SMCN Quarterly Report FY14-15 Q3** Page 7, E. Third quarter Provider Health Plan Disputes (Claim Appeals) Page 29, XV. Grievance Reports	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. The Contractor investigates any alleged quality of care concerns. ◆ Upon request, the Contractor shall submit a letter (within 10 business days) to the Department that includes a brief but clear description of the issue, the efforts that the Contractor took to investigate the issue, the outcome of the review, and what action the Contractor intends to take with the providers involved. CHP+ Contract: Exhibit A4—2.9.4.5.1; 2.9.4.5.2	**Documents Submitted** **Both**: **QM201- Investigation of Potential Clinical Quality of Care Grievances and Referrals** Page 4, Procedure I. F	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
11. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis. For CHP+— ◆ The Contractor has a Quality Improvement Committee to assess and implement measures of quality, access, and customer satisfaction. ◆ The annual QAPI report includes: ▪ Specific preventive care priorities, and services covered in and goals of the program over the prior 12-month period. ▪ Status and results of each performance improvement project (PIP) started, continuing, or completed during the prior 12-month period. ▪ Results of member satisfaction surveys completed during the prior 12-month period. ▪ Detailed description of the findings of the program impact analysis. ▪ Techniques used by the Contractor to improve performance. ▪ Overall impact and effectiveness of the QAPI Program during the prior 12-month period. ◆ Upon request, this information shall be made available to providers and members at no cost. *42CFR438.240(e)(2)* CHP+ Contract: Exhibit A4—2.9.4.7; 2.9.4.6.1	**Documents Submitted** **HMO:** **FY2015 COA CHP+HMO Annual Quality Report** **CHP HMO_EOC** Page 17, Member rights, last bullet **Provider Manual** Page 17, Paragraphs 1-2 **SMCN:** Not relevant to SMCN – no QAPI requirement	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
12. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data, including, but not limited to, information on utilization, grievances and appeals, encounters, and disenrollment. *42CFR438.242(a)* CHP+ Contract: Exhibit A4—2.9.4.10.1	**Documents Submitted** **Both**: **IT Data Flow Diagram** All **Process:** Colorado Access has multiple systems that collect various types of provider and member data. This data is brought together into our enterprise data base and used for reporting.	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. The Contractor collects data on member and provider characteristics and on services furnished to members. *42CFR438.242(b)(1)* CHP+ Contract: Exhibit A4—2.9.4.10.2	**Documents Submitted** **Both**: **IT Data Flow Diagram** All **Process:** Colorado Access has multiple systems that contain utilization data, grievance and appeal data and TPL. Colorado Access is able to pull the data from these systems and report the information as requested. Colorado Access receives daily and monthly eligibility files from the State that include additions and terminations (disenrollments). These additions and terminations/deletes are loaded into our systems accordingly. Colorado Access does not terminate/disenroll any Medicaid member unless they come across on the eligibility files as a termination.	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
14. The Contractor's health information system includes a mechanism to ensure that data received from providers are accurate and complete by: ◆ Verifying the accuracy and timeliness of reported data. ◆ Screening the data for completeness, logic, and consistency. ◆ Collecting service information in standardized formats to the extent feasible and appropriate. *42CFR438.242(b)(2)* CHP+ Contract: None	**Documents Submitted** **Both**: **Configuration and Rule Settings_Trizetto** All **Process:** Colorado Access' claims payment system has various edits in place that aid in verifying the accuracy and timeliness of the data. The requirements from the HCPF Uniform Services Coding Manual are configured in both the claims payment system and in the COA Encounter Process. If claims/encounters are submitted with incomplete data, the claims are sent back to the provider for correction. If claims/encounters are missing a modifier for example, the claim/encounter would be rejected in the COA Encounter Process. All encounter data is submitted to HCPF on a monthly basis in two formats, a proprietary flat-file and an ANSI ASC X12N 837 format.	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A SMCN ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
15. The Contractor submits immunization information for all covered members to the Colorado Immunization Information System (CIIS) monthly. CHP+ Contract: Exhibit A4—2.9.4.10.6	**Documents Submitted** **HMO**: **CIIS FTP Server Access and Tracking** All **Monthly Childhood Immunization Report_File History** All	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard X—Quality Assessment and Performance Improvement CHP+ HMO							
Total	Met	=	15	X	1.00	=	15
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	N/A	=	0	X	NA	=	0
Total Applicable		=	15	**Total Score**		=	15

Total Score ÷ Total Applicable	=	100%

Results for Standard X—Quality Assessment and Performance Improvement for SMCN							
Total	Met	=	9	X	1.00	=	9
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	N/A	=	1	X	NA	=	0
Total Applicable		=	9	**Total Score**		=	9

Total Score ÷ Total Applicable	=	100%

The completed record review tools follow this cover page.

Appendix B. Colorado Department of Health Care Policy & Financing
2015–2016 Credentialing Record Review Tool
for Colorado Access

Review Period:	January 1, 2013–November 30, 2015
Date of Review:	December 1, 2015
Reviewer:	Katherine Bartilotta
Participating Plan Staff Member:	Jean Barker and Gary Grindley

SAMPLE	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Provider ID#	***47	***44	***58	***73	***05	OMIT	***82	**92	**05	OMIT
Provider Type (MD, PhD, NP, PA, MSW)	OT	PT	MD	PT	LPC		DO	MD	LPC	
Application/Attestation Date	2/27/13	9/16/13	7/2/14	7/8/14	11/12/14		7/9/15	3/3/14	9/18/14	
Credentialing Date (Committee/Medical Director Approval Date)	2/28/13	10/24/13	9/11/14	10/19/14	1/12/15		10/16/15	7/31/14	10/19/14	
The Contractor, using primary sources, verifies that the following are present:										
◆ A current, valid license to practice (with verification that no State sanctions exist)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐
◆ A valid DEA or CDS certificate (if applicable)	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☒ N☐ NA☐	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☐ N☐ NA☒	Y☐ N☐ NA☐
◆ Education and training, including board certification (if the practitioner states on the application that he or she is board certified)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐
◆ Work history	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐
◆ History of professional liability claims	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐
◆ Current malpractice insurance in required amount	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐
◆ Verification that the provider has not been excluded from federal participation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐
◆ Signed application and attestation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐
◆ The provider credentialing was completed within verification time limits (see specific verification element—180/365 days)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐
# Applicable elements	**8**	**8**	**9**	**8**	**8**		**9**	**9**	**8**	
# Compliant elements	**8**	**8**	**9**	**8**	**8**		**9**	**9**	**8**	
Percentage compliant	**100%**	**100%**	**100%**	**100%**	**100%**		**100%**	**100%**	**100%**	

OVERSAMPLE	1	2	3	4	5
Provider ID#	***31	***38			
Provider Type (MD, PhD, NP, PA, MSW)	Optometry	SP			
Application/Attestation Date	12/26/12	4/2/14			
Credentialing Date (Committee/Medical Director Approval Date)	2/21/13	7/14/14			
The Contractor, using primary sources, verifies that the following are present:					
◆ A current, valid license to practice (with verification that no State sanctions exist)	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
◆ A valid DEA or CDS certificate (if applicable)	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☐	Y☐ N☐ NA☐	Y☐ N☐ NA☐
◆ Education and training, including board certification (if the practitioner states on the application that he or she is board certified)	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
◆ Work history	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
◆ History of professional liability claims	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
◆ Current malpractice insurance in required amount	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
◆ Verification that the provider has not been excluded from federal participation	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
◆ Signed application and attestation	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
◆ The provider credentialing was completed within verification time limits (see specific verification element—180/365 days)	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
# Applicable elements	**8**	**8**			
# Compliant elements	**8**	**8**			
Percentage compliant	**100%**	**100%**			

Total Record Review Score					**Total Applicable: 83**	**Total Compliant: 83**	**Total Percentage: 100%**

Comments:
HSAG eliminated Files 6 and 10 because the providers were recredentialed, rather than initially credentialed.

Review Period:	January 1, 2013–November 30, 2015
Date of Review:	December 1–3, 2015
Reviewer:	Katherine Bartilotta
Participating Plan Staff Member:	Jean Barker and Gary Grindley

SAMPLE	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Provider ID#	**48	**21	**38	**44	**90	**49	*60	**68	**16	**38
Provider Type (MD, PhD, NP, PA, MSW)	MD	MD	Podiatry	MD	MD	MD	MD	MD	MD	CNM
Application/Attestation Date	2/15/13	10/10/13	4/22/14	3/11/14	4/10/14	11/13/14	12/18/14	5/19/14	11/3/14	5/11/15
Last Credentialing/Recredentialing Date	4/6/10	2/24/11	4/21/11	6/7/11	7/7/11	1/19/12	4/13/12	10/27/11	4/19/12	1/26/12
Recredentialing Date (Committee/Medical Director Approval Date)	5/7/13	2/16/14	4/30/14	6/22/14	6/31/14	12/28/14	2/28/15	10/19/14	3/8/15	6/21/15
The Contractor, using primary sources, verifies that the following are present:										
◆ A current, valid license to practice (with verification that no State sanctions exist)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ A valid DEA or CDS certificate (if applicable)	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐
◆ Board certification status (verifies status only if the practitioner states on the application that he/she is board certified)	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☐ N☒ NA☐
◆ History of professional liability claims	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Current malpractice insurance in the required amount	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Verification that the provider has not been excluded from federal participation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Signed application and attestation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ The provider recredentialing was completed within verification time limits (see specific verification element—180/365 days)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Recredentialing was completed within 36 months of last credentialing/recredentialing date	Y☐ N☒	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
# Applicable elements	**8**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**8**
# Compliant elements	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**
Percentage compliant	**89%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**89%**

Total Record Review Score					**Total Applicable: 90**		**Total Point Score: 88**		**Total Percentage: 98%**	

Comments: For Record Number 1, the recredentialing date exceeded the 36-month time frame; however, Colorado Access staff documented multiple attempts to obtain necessary information from the provider. The provider responded to the requests too late for the monthly credentialing committee meeting and the file was held until the next monthly meeting.

The provider in Record Number 10 indicated that she was a board-certified nurse midwife. Although Colorado Access' policies require verification for board-certified nurse midwives, this file did not document that staff verified the certification.

Appendix C. Site Review Participants for Colorado Access

Table C-1 lists the participants in the FY 2015–2016 site review of **Colorado Access** (CHP+ HMO and SMCN).

Table C-1—HSAG Reviewers and Health Plan Participants

HSAG Review Team	Title
Katherine Bartilotta, BSN	Senior Project Manager
Rachel Henrichs	External Quality Review Compliance Auditor
Colorado Access Participants	**Title**
Alexis A. Giese, MD	Senior Vice President, Behavioral Health
Beth Neuhalfen	Manager, RCCO/CHP; Director, Physical Engagement
Bethany Himes	Executive Director, CHP+, SMCN
Bill Elswick	Credentialing Coordinator
Christine E. Gillespie	Clinical Appeals Manager
Claudine McDonald	Director, Office of Member and Family Affairs
Dave Rastatter	Director, NE Colorado Medicaid
Elizabeth Strammiello	Chief Compliance Officer
Gary Grindley	Credentialing Manager
Janet Milliman	Operations Manager, CHP/SMCN
Jean Barker	Vice President of Commercial Products, Provider Network Services
John Kiekhaefer	Clinical Director, Colorado Access
Kelsey Byars	Credentialing Coordinator
Kristin Brown	Behavioral Health Operations Manager
Landon Palmer	Compliance
Lindsay Cowee	Clinical Quality Manager (Interim Quality Director)
Michelle Tomsche	Behavioral Health Operations Director
Mikhail Babayev	Care Manager
Paula Jung	Manager, ABC Community Based Care Management
Raeanna Wuestner	Care Manager II, ABC
Regina Fetterolf	Manager, BHI and ABC NE Care Management
Renee Fletter	Manager, Provider Relations
Reyna Garcia	Senior Director, Customer Service and Claim Appeals
Rob Bremer	Executive Director, Access Behavioral Care
Shelby Kiernan	Director, Integrated Care/Communications
Shawna Marshall	Care Manager
Stephanie Dohrman	Grievance Manager
Department Observers	**Title**
Melissa Eddleman	Behavioral Health Unit Supervisor
Russ Kennedy	Quality Specialist
Teresa Craig	Program and Contract Manager, CHP+

Appendix D. Corrective Action Plan Template for FY 2015–2016 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

For this step,	HSAG completed the following activities:
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, persons responsible, 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.

For this step,	HSAG completed the following activities:
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 healthcare regulations and managed care contract requirements.

The template for the CAP follows.

Table D-2—FY 2015–2016 Corrective Action Plan *for* Colorado Access

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
This requirement applies to HMO only. 10. The Contractor's **procedures** provide for continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services. ◆ The Contractor informs new members with special healthcare needs involved in an ongoing course of treatment that he/she: ▪ May continue to receive covered services for 60 calendar days from his/her current provider. ▪ May continue to receive covered services from ancillary or non-network providers for a period of 75 calendar days. ◆ The Contractor informs a new member who is in her second or third trimester of pregnancy to continue to see their obstetrical provider until the completion of post-partum care directly related to the delivery.	The member handbook and provider manual informed members and providers of a new member's right to continue an ongoing course of treatment as specified in the requirement. However, the member handbook used language, "as long as the provider works with us to transfer care" and "if the provider agrees to accept our reimbursement rates and work with us," which may imply to the member contingencies as to whether the member may continue care according to the regulation. Although staff members stated that these contingencies are not actually implemented, the health plan's contract does not allow for such contingencies and should not be communicated to the member.	Colorado Access must remove statements from the member handbook that stipulate additional restrictions on when a member with special healthcare needs or a member in the second or third trimester of pregnancy may continue an ongoing course of treatment or services.
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:		

Standard IV—Member Rights and Protections		
Requirement	**Findings**	**Required Action**
This requirement applies to HMO and SMCN. 3. The Contractor's policies and procedures ensure that each member is treated by staff and affiliated providers in a manner consistent with the following specified rights: ◆ Receive information in accordance with information requirements (42CFR438.10). ◆ Be treated with respect and with due consideration for his or her dignity and privacy. ◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. ◆ Participate in decisions regarding his or her healthcare, including the right to refuse treatment. ◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. ◆ Request and receive a copy of his or her medical records and request that they be amended or corrected. ◆ Obtain family planning services from any duly licensed provider in or out of network without a referral. ◆ Be furnished healthcare services in accordance with federal healthcare regulations for access and availability, care coordination, and quality.	Rather than list the specific member rights, Policy CS212—Member Rights and Responsibilities referenced a specific section of the Colorado Code of Regulations (CCR) and the contract between Colorado Access and the Department. While this mechanism of reference is acceptable, the section of CCR referenced in the policy was incorrect and the contract routing number was outdated.	Colorado Access must revise its Member Rights and Responsibilities policy to either list the specific member rights or accurately reference a location where staff members can find specific rights.

Standard IV—Member Rights and Protections		
Requirement	**Findings**	**Required Action**
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:		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Findings**	**Required Action**
This requirement applies to HMO and SMCN. 11. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of (organizational) providers with which it contracts, which include: 11.A. The Contractor confirms—initially and at least every three years—that the provider is in good standing with state and federal regulatory bodies.	The Organizational Provider Credentialing policy described the process for confirming that a provider is in good standing with State and federal agencies, and HSAG found evidence of compliance in the record reviews. While the policy also stated that this process would be performed at least every three years, two of the five organizational records reviewed did not document that the organization had been recredentialed within the three-year time frame.	Colorado Access must implement a process to ensure that organizations with which it contracts are recredentialed at least every three years.
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:		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Findings**	**Required Action**
This requirement applies to HMO and SMCN. 11.E. The Contractor's policies and procedures include: ◆ On-site quality assessment criteria for each type of unaccredited organizational provider. ◆ A process for ensuring that the provider credentials its practitioners.	The Organizational Provider Credentialing policy and procedure included the criteria used to assess unaccredited organizational providers, which included staff hiring and credentialing processes. While on-site record review demonstrated that Colorado Access collected the organization's policies and procedures related to staff hiring and credentialing, some of the policies collected were not compliant with Colorado Access' credentialing standards.	Colorado Access must be sure that unaccredited organizational providers are credentialing practitioners in a manner consistent with Colorado Access policies, procedures, and standards.
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:		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Findings**	**Required Action**
This requirement applies to HMO and SMCN. 12. The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: ◆ The CMS or state review is no more than three years old. ◆ The organization obtains a survey report or letter from CMS or the state, from either the provider or from the agency, stating that the facility was reviewed and passed inspection. ◆ The report meets the organization's quality assessment criteria or standards.	The Organizational Provider Credentialing policy and procedure described the circumstances under which Colorado Access could substitute a CMS or State quality review in lieu of a site visit; however, the policy did not specify that Colorado Access would confirm that the survey conducted by CMS or the State meets its own quality assessment criteria or standards. HSAG did not find evidence in the records reviewed that Colorado Access confirmed the content of the CMS or State review. Some CMS and State reviews included with the records reviewed indicated the need for corrective action; however, Colorado Access did not document that it confirmed that the corrective actions had been completed. Furthermore, one of the State site reviews documented in the record as being used in lieu of a site visit was more than three years old at the time of the credentialing decision.	Colorado Access must specify in its policies that it will confirm that CMS and State quality reviews used in lieu of Colorado Access site visits include all criteria and standards identified in Colorado Access' policy. Colorado Access must ensure that CMS and State quality reviews used are no more than three years old at the time of the credentialing decision. Additionally, if the CMS or State quality review required that the organization complete any corrective actions, Colorado Access must document that the organization completed all corrective actions.
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 healthcare 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 email delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards 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 lists of all CHP+ HMO credentialing and recredentialing records that occurred between January 1, 2015, and December 31, 2015, to the extent available at the time of the site-review request. 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.

For this step,	HSAG completed the following activities:
	◆ HSAG reviewed a sample of administrative records to evaluate implementation of Medicaid managed care regulations related to CHP+ HMO credentialing and recredentialing. ◆ 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 2015–2016 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.