



CHP+

Child Health Plan *Plus*

Fiscal Year 2016–2017 Site Review Report *for* **Colorado Access CHP+ HMO and State Managed Care Network**

May 2017

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



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1. Executive Summary

Public Law 111-3, Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, requires that each state's Children's Health Insurance Program (CHIP) apply 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 (BBA), Public Law 105-33. The BBA requires that states conduct a periodic evaluation of their MCOs and PIHPs to determine compliance with federal healthcare regulations and managed care contract requirements. The Department of Health Care Policy & Financing (the Department) has elected to complete this requirement for Colorado's Child Health Plan *Plus* (CHP+) managed care health plans by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This report documents results of the FY 2016–2017 site review activities for the review period of January 1, 2016, through December 31, 2016 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 HSAG reviewed the two lines of business concurrently, the results for the CHP+ HMO and the SMCN lines of business are differentiated where applicable. For each of the two standard areas reviewed this year, this section contains summaries of: strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 2 contains (as available) graphical representations of results for all standards across two three-year cycles for the CHP+ HMO line of business. Section 3 describes the background and methodology used for the 2016–2017 compliance monitoring site review. Section 4 describes follow-up on the corrective actions required as a result of the 2015–2016 site review activities for the CHP+ HMO line of business. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the CHP+ HMO denials record reviews. Appendix C lists HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process the CHP+ HMO and SMCN will be required to complete for FY 2016–2017 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*. HSAG assigned required actions to any requirement within the compliance monitoring tool receiving a score of *Partially Met* or *Not Met*. HSAG also identified opportunities for improvement with associated recommendations for some elements, regardless of the score. Recommendations 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**' HMO line of business for each of the standards. Findings for requirements receiving a score of *Met* are summarized in this section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* follow in Appendix A—Compliance Monitoring Tool.

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

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I. Coverage and Authorization of Services	34	34	32	2	0	0	94%
II. Access and Availability	14	14	14	0	0	0	100%
Totals	48	48	46	2	0	0	96%

*The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements.

Table 1-2 presents the scores for **Colorado Access**' SMCN line of business for each of the standards. Findings for requirements receiving a score of *Met* are summarized in this section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* follow in Appendix A—Compliance Monitoring Tool.

Table 1-2—Summary of SMCN Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I. Coverage and Authorization of Services	31	31	29	2	0	0	94%
II. Access and Availability	13	13	13	0	0	0	100%
Totals	44	44	42	2	0	0	95%

*The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements.

Table 1-3 presents the scores for **Colorado Access** for the denials record review. The Department required no denial record reviews specific for the SMCN line of business. Details of the findings for the HMO record review are in Appendix B—Record Review Tool.

Table 1-3—Summary of Scores for the Record Review

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Denials	100	60	60	0	40	100%
Totals	100	60	60	0	40	100%

*The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements.

Standard I—Coverage and Authorization of Services

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

Summary of Strengths and Findings as Evidence of Compliance

Colorado Access had several documents that described and governed its utilization management (UM) program. The Utilization Review Determinations and Medical Criteria for Utilization Review policies described the process for making authorization decisions based on well-defined, established criteria. The policies described a three-level review process that allowed only clinically qualified physician reviewers to deny services. The Qualifications for Staff Engaged in Utilization Management policy delineated the minimum qualifications and roles and responsibilities for staff members at each level of review.

Colorado Access policies and procedures accurately specified the time frames for processing standard and expedited requests for authorization of services.

The Utilization Review Determinations policy described the processes for giving the requesting provider verbal notice of a decision to deny services and offering a peer-to-peer consultation. The Utilization Review Determinations policy also described processes for notifying the member of denial decisions, delineated required content of notice of action letters, and included the required time frames. **Colorado Access** ensured consistent application of review criteria by UM staff and medical directors using annual interrater reliability audits.

On-site review of 10 denial records demonstrated that **Colorado Access** staff members accurately implemented the policies and procedures. For all 10 cases reviewed, **Colorado Access** processed requests for services and appropriately provided notice to both the member and requesting provider well within the required time frames. The notice of action letters included the required content in an easy-to-understand language and format.

Summary of Findings Resulting in Opportunities for Improvement

Colorado Access defined “medical necessity” equivalent to the definition included in its contract; however, the definition of “medical necessity” outlined in 10 CCR 2505-10 8.076.1.8 (effective August 30, 2016) created a uniform definition of “medical necessity” to be used across all applicable medical assistance programs. Therefore, HSAG advises **Colorado Access** to immediately update the definition of “medical necessity” accordingly. Please reference 10 CCR 2505-10 8.076.1.8 (a–g) for guidance.

The Utilization Review Determinations policy stated that prospective reviews required would be made “within five (5) business days ... and no later than ten (10) calendar days after receipt of the request for service.” During the on-site interview, **Colorado Access** staff members stated that the correct time frame is 10 days. Although both time frames are compliant with federal and State requirements, HSAG cautions that the variation may cause confusion. HSAG recommends that **Colorado Access** revise its policy to clearly state the time frame for processing prospective review determinations.

As observed in on-site denial record reviews, all notices of action informed the member of the responsibility to request a State fair hearing within 30 days of the date of the denial letter. Although not formally processed to date as a revision to the Colorado Code of Regulations (CCR), the Department executed an emergency rule change effective September 2016 to specify that members may request a State fair hearing within 60 days of a notice of action. **Colorado Access** should immediately update applicable documents to reflect that each member has 60 days from the date of a notice of action to request a State fair hearing.

Summary of Required Actions

Colorado Access’ Emergency and Post-Stabilization Care policy addressed this requirement verbatim. The emergency room (ER) claims payment procedures stated that **Colorado Access** reviews each inpatient admission following an ER visit to ensure that an authorization was obtained for the admission. If authorization was granted, the claim is paid. If no authorization was granted, the claim is denied. However, during the on-site interview, staff members stated that **Colorado Access** had no process to review claims denied for no prior authorization in order to determine the presence of circumstances outlined in this requirement and as specified in the Emergency and Post-Stabilization Care policy. It is only after a member or provider files an appeal that staff members review to determine the presence of exceptions such as those related to post-stabilization care services (as well as continuity of care and access to women’s healthcare specialists). **Colorado Access** must develop a process to ensure that both the UM procedures and claims payment decisions are linked to the requirements for the Contractor’s financial responsibilities for post-stabilization care services not pre-approved, as outlined in the Emergency and Post-Stabilization Care policy.

Standard II—Access and Availability

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

Summary of Strengths and Findings as Evidence of Compliance

Colorado Access provided its Network Adequacy Report, Selection and Retention of Providers policy, and Provider Network Strategic Plan as evidence that it maintains and monitors a network appropriate in size and diversity to meet the needs of its CHP+ population—both current and anticipated. **Colorado Access** had policies and procedures that allowed female members direct access to a women’s health specialist and allowed members with special healthcare needs direct access to other specialists. **Colorado Access** also published these provisions in the member handbook and provider manual.

Policies stated that if covered and/or medically necessary services were not available within the required standard time frames, **Colorado Access** would arrange for members to receive services from out-of-network providers at a cost no greater than if the service was provided in network. **Colorado Access’** Reimbursement policy and procedure described use of single case agreements that prohibit providers from charging members for unpaid fees and listed mechanisms used to negotiate with providers who appeal for higher reimbursement rates.

During 2016, **Colorado Access** implemented an intensive three-hour cultural competency training program that all staff members were required to attend. In the future, **Colorado Access** will require that all new staff members attend the three-hour training as part of the new hire orientation. Additionally, continuing staff members are required to complete a less intensive, annual refresher course. In addition to the general cultural competency training, **Colorado Access** also offered periodic training programs that addressed cultural barriers and issues related to transgender and refugee populations. Trainings scheduled for 2017 will address black culture, poverty, and disabilities. **Colorado Access** makes all cultural competency trainings available to its providers.

Summary of Findings Resulting in Opportunities for Improvement

HSAG noted that CHP+ appointment standards listed in the provider manual were more restrictive than those listed in the policies and procedures and member handbook. HSAG cautions that the variance may cause confusion and recommends that **Colorado Access** revise its provider manual to include CHP+ appointment standards consistent with those listed in its policies.

Summary of Findings Resulting in Required Actions

HSAG required no corrective actions for this standard.

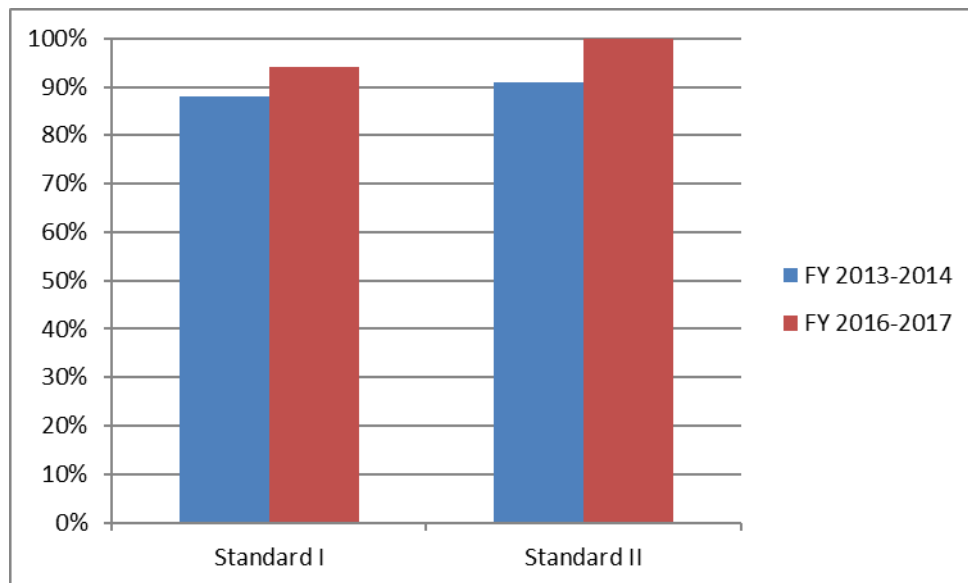
2. Comparison and Trending

Comparison of Results

Comparison of FY 2013–2014 Results to FY 2016–2017 Results

Figure 2-1 shows the scores from the FY 2013–2014 HMO site review (when Standard I and Standard II were previously reviewed) compared with the results from this year’s HMO 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. This is the first year HSAG assigned scores for the SMCN line of business; therefore, no comparison is available.

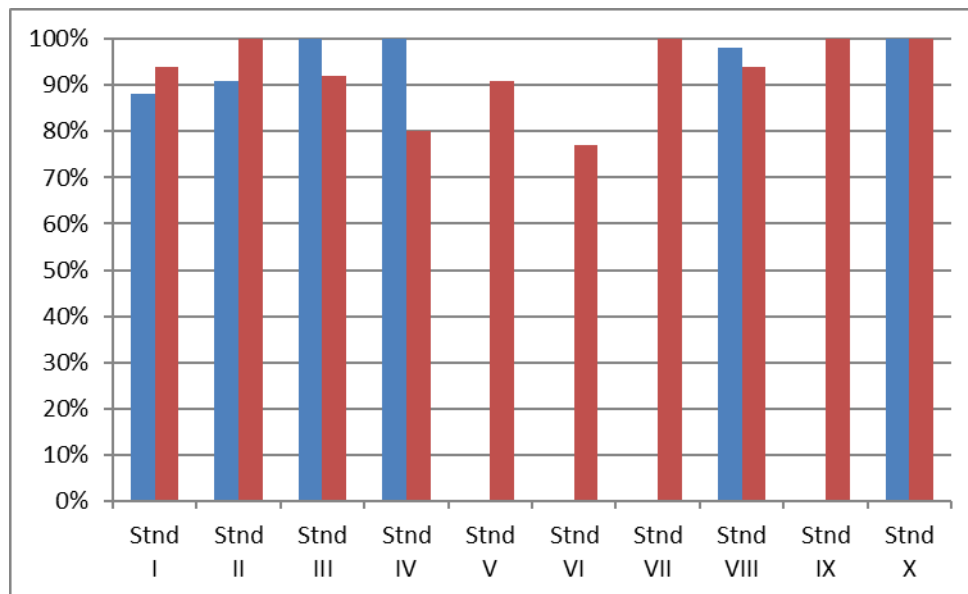
Figure 2-1—Comparison of FY 2013–2014 Results to FY 2016–2017 Results



Review of Compliance Scores for All Standards

Figure 2-2 shows the HMO scores for all standards reviewed over the past five years of compliance monitoring. The figure compares the score for each standard across two review periods, as available, and may be an indicator of overall improvement. This is the first year HSAG assigned scores for the SMCN line of business; therefore, no comparison is available.

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



Note: Results shown in blue are from FY 2012–2013 and FY 2013–2014. Results shown in red are from FY 2014–2015, FY 2015–2016, and FY 2016–2017.

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	2016–17
I—Coverage and Authorization of Services		X			X
II—Access and Availability		X			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	

3. Overview and Background

Overview of FY 2016–2017 Compliance Monitoring Activities

For the fiscal year (FY) 2016–2017 site review process, the Department requested a review of two areas of performance. HSAG developed a review strategy and monitoring tools consisting of two standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. Compliance with applicable federal managed care regulations and managed care contract requirements was evaluated through review of the two 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 two standards, HSAG used the health plan's contract requirements and regulations specified by the BBA, with revisions issued May 6, 2016. HSAG conducted a desk review of materials submitted prior to the on-site review activities: a review of records, documents, and materials provided on-site; and on-site interviews of key health plan personnel to determine compliance with federal managed care regulations and contract requirements. Documents submitted for the desk review and on-site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to CHP+ service and claims denials.

A sample of the health plan's administrative records related to CHP+ service and claims denials was reviewed to evaluate implementation of managed care regulations related to member denials and notices of action. The Department required no denial record reviews specific for the SMCN line of business. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records. Using a random sampling technique, HSAG selected the samples from all applicable CHP+ service and claims denials that occurred between January 1, 2016, and December 31, 2016. For the record review, the health plan received a score of *C* (compliant), *NC* (not compliant), or *NA* (not applicable) for each required element. Results of record reviews were considered in the scoring of applicable requirements in Standard I—Coverage and Authorization of Services. HSAG also separately calculated an overall record review score.

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.³⁻¹ Appendix E contains a detailed description of HSAG's site review

³⁻¹ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>. Accessed on: Aug 24, 2016.

activities consistent with those outlined in the CMS final protocol. The two standards chosen for the FY 2016–2017 site reviews represent a portion of the Medicaid managed care requirements. The following standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, and Standard X—Quality Assessment and Performance Improvement.

Objective of the Site Review

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

- The health plans compliance with federal health care regulations and managed care contract requirements in the three 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

FY 2015–2016 Corrective Action Methodology

As a follow-up to the FY 2015–2016 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 2015–2016 compliance monitoring site review.

Summary of FY 2015–2016 Required Actions

As a result of the FY 2015–2016 site review, **Colorado Access** was required to address one *Partially Met* element related to Coordination and Continuity of Care, one *Not Met* element for Member Rights and Protections, and three *Partially Met* elements for Credentialing and Recredentialing.

Summary of Corrective Actions/Document Review

Colorado Access submitted its proposed CAP to HSAG and the Department in April 2016. HSAG and the Department determined that, if implemented as written, **Colorado Access** would achieve full compliance with required actions. **Colorado Access** submitted evidence of having implemented corrective actions that addressed the elements related to Coordination and Continuity of Care and Member Rights and Protections in July 2016. **Colorado Access** submitted progress reports that demonstrated ongoing implementation of corrective actions related to the Credentialing and Recredentialing program in July and August 2016. HSAG and the Department determined in September 2016 that **Colorado Access** had fully implemented its CAP, having successfully addressed all required actions.

Summary of Continued Required Actions

Colorado Access had no required actions continued from FY 2015–2016.

Appendix A. Compliance Monitoring Tool

The completed compliance monitoring tool follows this cover page.



Appendix A. Colorado Department of Health Care Policy & Financing FY 2016–2017 Compliance Monitoring Tool for Colorado Access CHP+ and SMCN

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>1. The Contractor must ensure that the services provided are sufficient in amount, duration, or scope to reasonably be expected to achieve the purposes for which the services are furnished.</p> <p style="text-align: right;"><i>42 CFR 438.210(a)(3)(i)</i></p> <p>Contract: Amendment 6, Exhibit A-5—2.6.3</p>	<p>CCS 305 – Care Coordination Page 2 Procedure I. The goals of Care Coordination Page 2-3 III Facilitation of Care Coordination.</p> <p>CCS 307 – Utilization Review Determinations Page 3-4 Utilization Review (UR)</p> <p>CCS 310 - Primary and Specialty Care Access Page 1, Policy Statement Page 2 Procedure 1 Primary Care Page 2 Procedure 2 Specialty and Ancillary Service Referrals Page 3 Procedure 3 Direct Access.</p> <p>Covered Services Report Page 1; Paragraph 1 and 2</p> <p>PNS 306 – Availability of After Hours Coverage Page 1, Policy Statement: Page 2 Procedure 2 Evaluation Page 1, Procedure 1 Service Availability -C</p> <p>UM Program Description Page 3; Co Access Mission and Philosophy of the Utilization Management Program Page 3-4; Utilization Management Program Framework Page 5-6; Goals and Objectives</p> <p>Care Management http://www.coaccess.com/care-management</p>	<p>CHP+</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>SMCN</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy & Financing FY 2016–2017 Compliance Monitoring Tool for Colorado Access CHP+ and SMCN

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>2. The Contractor provides the same standard of care for all members regardless of eligibility category and furnishes services in an amount, duration, and scope no less than services provided to non-CHP+ recipients within the same area.</p> <p style="text-align: right;"><i>42 CFR 438.210(a)(2)</i> <i>(Requirement to be updated 7/2017—see appendix)</i></p> <p>Contract: Amendment 6, Exhibit A-5—2.6.3.9</p>	<p>ADM 205 – Nondiscrimination Page 2: Policy Statement</p> <p>CS 212 – Member Rights and Responsibilities Page 2: Procedure I, II, III, IV</p> <p>Evidence of Coverage (EOC) Page 15: Members Rights and Responsibilities All bullets on this page</p> <p>SMCN Page 14 Member Rights</p> <p>Provider Manual Page 3-4, 18-19 Provider Responsibilities</p> <p>SMCN Page 6 Primary Care Provider Responsibilities</p> <p>PNS 306 – Availability of After Hours Coverage Page 1; Procedure 1 Service Availability Page 2; Procedure 2 Evaluation</p>	<p>CHP+</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>SMCN</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy & Financing FY 2016–2017 Compliance Monitoring Tool for Colorado Access CHP+ and SMCN

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>3. Utilization Management shall be conducted under the auspices of a qualified clinician.</p> <p>Contract: Amendment 6, Exhibit A-5—2.8.1.1</p>	<p>CCS 301 – Qualifications for Staff Engaged in Utilization Management Page 1, Policy Statement Page 1-2, Procedure I, II, III</p> <p>CCS 302 Medical Criteria for Utilization Review Page 2, Application of Criteria Procedure 2-D</p> <p>ADM 226 – Staff Credentialing Page 1, Policy Statement Page 1, Procedure 1, New Hires Page 1, Procedure 2, Continued Employment Page 1-2, Procedure 3, Verification</p> <p>UM Program Description Page 4-5 Utilization Management Program framework, paragraph 6 & 7</p>	<p>CHP+</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>4. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.</p> <p style="text-align: right;"><i>42 CFR 438.210(a)(3)(ii)</i></p> <p>Contract: Amendment 6, Exhibit A-5—2.6.3.10</p>	<p>CCS 307 – Utilization Review Determination Page 4 Procedure 1-A General Procedure Bullet 6.</p> <p>Evidence of Coverage Page 29, Time Limit on Certain Defenses</p> <p>SMCN Page 95, Time Limit on Certain Defenses</p> <p>Provider Manual Page 55 Medical Necessity</p> <p>SMCN Page 40 Submitting an Authorization Request (Paragraph 5)</p> <p>ADM 205 Nondiscrimination Page 2, Policy Statement Page 3, Section II, III, IV</p>	<p>CHP+</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>SMCN</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>

Appendix A. Colorado Department of Health Care Policy & Financing FY 2016–2017 Compliance Monitoring Tool for Colorado Access CHP+ and SMCN

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>5. The Contractor may place appropriate limits on a service:</p> <ul style="list-style-type: none"> On the basis of criteria applied under the State plan (medical necessity). For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose. <p style="text-align: right;"><i>42 CFR 438.210(a)(3)(iii)</i> (Requirement to be updated 7/2017—see appendix)</p> <p>Contract: Amendment 6, Exhibit A-5—2.8.1.1</p>	<p>CCS 307 – Utilization Review Determinations Page 1, Adverse Determination Page 2, Medical Necessity; bullets 1-4 Page 4, Utilization Review, bullet 5 Page 9, Procedure 1-F Adverse determinations #6, Notice of Action Elements for Adverse Determinations, bullet 5</p> <p>UM Program Description Page 5, Goals and Objectives, bullet 6 & bullet 9 Page 16, K. -Inter-rater Reliability</p> <p>Provider Manual Page 55 Medical Necessity</p> <p>SMCN Page 40 Submitting an Authorization Request (Paragraph 5)</p> <p>CCS 306 Delivering Continuity and Transition of Care Page 2 Procedure 2 Continuity of Care and Transition of Care ... B, C bullet 2 & 3</p>	<p>CHP+</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>SMCN</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>6. The Contractor specifies what constitutes “medically necessary services” in a manner that:</p> <ul style="list-style-type: none"> Is no more restrictive than that used in the State Medicaid program. <ul style="list-style-type: none"> Is consistent with the symptoms, diagnosis, and treatment of a member’s medical condition. Is widely accepted by the practitioner’s peer group as effective and reasonably safe based upon scientific evidence. 	<p>CCS 307 – Utilization Review Determinations Page 2, Definition of Medically Necessary bullets 1 – 5 Page 3– Urgent Care Requests. Bullet 1</p> <p>Evidence of Coverage Page 11, Summary of Covered Benefits Page 108 Definition Occupational Therapy</p> <p>SMCN Page 12 Summary of Covered Benefits Page 115 Definition Occupational Therapy</p>	<p>CHP+</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>SMCN</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy & Financing FY 2016–2017 Compliance Monitoring Tool for Colorado Access CHP+ and SMCN

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<ul style="list-style-type: none"> – Is not experimental, investigational, unproven, unusual, or uncustomary. – Is not solely for cosmetic purposes. – Is not solely for the convenience of the member, subscriber, physician, or other provider. – Is the most appropriate level of care that can be safely provided to the member. – Failure to provide the covered service would adversely affect the member’s health. – When applied to inpatient care, “medically necessary” further means that covered services cannot be safely provided in an ambulatory setting. <ul style="list-style-type: none"> • Addresses the extent to which the Contractor is responsible for covering services related to the following: <ul style="list-style-type: none"> – The prevention, diagnosis, and treatment of health impairments. – The ability to achieve age-appropriate growth and development. – The ability to attain, maintain, or regain functional capacity. <p style="text-align: right;"><i>42 CFR 438.210(a)(5)</i> <i>(Requirement to be updated 7/2017—see appendix)</i></p> <p>Contract: Amendment 6, Exhibit A-5—1.1.1.58</p>	<p>Provider Manual Page 55 Medical Necessity</p> <p>SMCN Page 40 Submitting an Authorization Request (Paragraph 5)</p> <p>CCS 302 Medical Criteria for Utilization Review Page 1, Definition – Medical Necessity Page 2, Procedure 1. Development and Adoption of Criteria Used for Utilization Review Page 2, Procedure 2. Application of Criteria</p> <p>Evidence of Coverage Page 83-84, Medically Necessary Health Care Services Sections: Medical Policies, Experimental/ Investigational and/or Cosmetic Procedures, Excluded Services Page 84, Appropriate Setting</p> <p>SMCN Page 24-25, Medically Necessary Health Care Services Sections: Medical Policies, Experimental/ Investigational and/or Cosmetic Procedures, Excluded Services Page 25, Appropriate Setting</p>	



Appendix A. Colorado Department of Health Care Policy & Financing FY 2016–2017 Compliance Monitoring Tool for Colorado Access CHP+ and SMCN

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>Findings:</p> <p>Colorado Access defined “medical necessity” equivalent to the definition included in its contract and outlined in this requirement. However, the definition of “medical necessity” outlined in 10 CCR 2505-10 8.076.1.8 (effective August 30, 2016) created a uniform definition of “medical necessity” to be used across all applicable Medical Assistance programs. Therefore, HSAG advises Colorado Access to immediately update the definition of “medical necessity” accordingly. Please reference 10 CCR 2505-10 8.076.1.8 (a–g) for guidance:</p> <p>8.076.1.8. Medical necessity means a Medical Assistance program good or service:</p> <ul style="list-style-type: none">a. Will, or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all.b. Is provided in accordance with generally accepted professional standards for health care in the United States.c. Is clinically appropriate in terms of type, frequency, extent, site, and duration.d. Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider.e. Is delivered in the most appropriate setting(s) required by the client's condition.f. Is not experimental or investigational.g. Is not more costly than other equally effective treatment options.		
<p>7. The Contractor has in place written policies and procedures that address the processing of requests for initial and continuing authorization of services.</p> <p style="text-align: right;"><i>42 CFR 438.210(b)</i></p> <p>Contract: Amendment 6, Exhibit A-5—2.8.1.2</p>	<p>CCS 307 Utilization Review Determinations Page 1, Policy Statement Page 4-5 Procedure 1. A&B</p> <p>CCS 306 Delivering Continuity and Transition of Care Page 2, Procedure 2 Continuity of Care and Transition of Care ... C.bullet 2.</p> <p>UM Program Description Page 16, D. Prospective Reviews Page 17, I. Drug Utilization and Review Program</p>	<p>CHP+</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p> <p>SMCN</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



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Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>8. The Contractor has in place and follows written policies and procedures that include effective mechanisms to ensure consistent application of review for authorizing decisions.</p> <p style="text-align: right;"><i>42 CFR 438.210(b)(2)(i)</i></p> <p>Contract: Amendment 6, Exhibit A-5—2.8.1.3</p>	<p>CCS 302 Medical Criteria for Utilization Review</p> <p>Page 1, Policy Statement</p> <p>Page 2, Procedure 1. Development and Adoption of Criteria Used for Utilization Review</p> <p>Page 2, Procedure 2. Application of Criteria</p> <p>Page 2, Procedure 3. Dissemination of Criteria</p> <p>CCS 307 Utilization Review Determination</p> <p>Page 5 Procedure 1 A General Procedure bullet 6.</p> <p>Inter-Rater Reliability (IRR) report results</p> <p>Page 1, Purpose and Background</p> <p>Page 1, Methodology</p>	<p>CHP+</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p> <p>SMCN</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>
<p>9. The Contractor has in place and follows written policies and procedures that include a mechanism to consult with the requesting provider when appropriate.</p> <p style="text-align: right;"><i>42 CFR 438.210(b)(2)(ii)</i></p> <p>Contract: Amendment 6, Exhibit A-5—2.8.1.3</p>	<p>CCS 307 Utilization Review Determination</p> <p>Page 5, Procedure 1-A General Procedure bullet 6.D</p> <p>Page 6, Procedure 1-B Prospective Review Request bullet 6</p>	<p>CHP+</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p> <p>SMCN</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



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Requirement	Evidence as Submitted by the Health Plan	Score
<p>10. The Contractor's UM Program ensures that any decision to deny a service authorization request or to authorize a service in the amount, duration, or scope that is less than requested, be made by a healthcare professional who has appropriate clinical expertise in treating the member's condition or disease.</p> <p style="text-align: right;"><i>42 CFR 438.210(b)(3)</i> <i>(Requirement to be updated 7/2017—see appendix)</i></p> <p>Contract: Amendment 6, Exhibit A-5—2.8.1.3.1</p>	<p>CCS 302 Medical Criteria for Utilization Review Page 2, Procedure 2. Application of Criteria, D.</p> <p>CCS 301 Qualifications for Staff Engaged in Utilization Management Activities Page 1, Policy Statement</p>	<p>CHP+</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p> <p>SMCN</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>
<p>11. The Contractor has processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested (notice to the provider need not be in writing).</p> <p style="text-align: right;"><i>42 CFR 438.210(c)</i></p> <p>Contract: Amendment 6, Exhibit A-5—2.8.1.3.3</p>	<p>CCS 307 – Utilization Review Determinations Page 7-9, Procedure 1 F Adverse Determinations</p> <p>HMO Denial Letter</p> <p>SMCN Denial Letter</p>	<p>CHP+</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p> <p>SMCN</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



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<p>12. The Contractor provides notice of standard authorization decisions as expeditiously as the member's health condition requires and not to exceed 10 calendar days from receipt of the request for service.</p> <p style="text-align: right;"><i>42 CFR 438.210(d)(1)</i></p> <p>10CCR2505—10, Sec 8.209.4.A.3(c) Contract: Amendment 6, Exhibit A-5—2.8.1.3.3.1</p>	<p>CCS 307 – Utilization Review Determinations Page 8-9, F. Adverse Determination 3 & 5</p> <p>CCS DP 56- Medication Utilization Review Page 15 Procedure II A CHP+ Pharmacy Utilization Review-Standard Coverage Determination Request #3</p>	<p>CHP+</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p> <p>SMCN</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>
<p>13. For cases in which a provider indicates, or the Contractor determines, that the standard authorization timeframe could seriously jeopardize a member's life or health or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization decision and provides notice as expeditiously as the member's health condition requires and not to exceed 3 working days from receipt of the request for service.</p> <p style="text-align: right;"><i>42 CFR 438.210(d)(2)</i> <i>(Requirement to be updated 7/2017—see appendix)</i></p> <p>10CCR2505—10, Sec 8.209.4.A.3(c) Contract: Amendment 6, Exhibit A-5—2.8.1.3.3.2 and 2.8.1.3.3.2.1</p>	<p>CCS 307 – Utilization Review Determinations Page 6 Procedure 1 C Prospective Expedited Review Request, Determination and Notification (Urgent Care Requests)</p> <p>CCS DP 56- Medication Utilization Review Page 15 Procedure II A.CHP+ Pharmacy Utilization Review-Standard Coverage Determination Request #5</p>	<p>CHP+</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p> <p>SMCN</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



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<p>14. Notices of action must meet the language and format requirements of 42 CFR 438.10 to ensure ease of understanding (6th-grade reading level wherever possible and available in the prevalent non-English language for the service area).</p> <p style="text-align: center;"><i>42 CFR 438.404(a); 438.10 (b) and (c)(2) (Requirement to be updated 7/2017—see appendix)</i></p> <p>10CCR2505—10, Sec 8.209.4.A.1 Contract: Amendment 6, Exhibit A-5—2.4.3.1.6</p>	<p>ADM 207 – Effective Communication with LEP & SI/SI Persons Page 2, Policy Statement Page 3, Procedure I. A</p> <p>CCS 307 – Utilization Review Determinations Page 9 Procedure 1 F Adverse Determinations #6. Notice of Action Elements for Adverse Service Determination. Page 10, Procedure 1 G. Monitoring Compliance</p> <p>HMO Denial Letter</p> <p>SMCN Denial Letter</p>	<p>CHP+ <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>SMCN <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>15. Notices of action must contain:</p> <ul style="list-style-type: none"> The action the Contractor (or its delegate) has taken or intends to take. The reasons for the action. The member's or provider's (on behalf of the member) right to file an appeal and procedures for filing. The date the appeal is due. The member's right to request a State fair hearing. The procedures for exercising the right to a State fair hearing. The circumstances under which expedited resolution is available and how to request it. 	<p>CCS 307 – Utilization Review Determinations Page 9 Procedure 1 F Adverse Determinations #6. Notice of Action Elements for Adverse Service Determination. Page 10, Procedure 1 G. Monitoring Compliance</p> <p>HMO Denial Letter</p> <p>SMCN Denial Letter</p>	<p>CHP+ <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>SMCN <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



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<ul style="list-style-type: none"> The member’s right to have benefits continue pending resolution of the appeal and how to request that the benefits be continued. The circumstances under which the member may have to pay for the costs of services (if continued benefits are requested). <p style="text-align: right;"><i>42 CFR 438.404(b)</i> <i>(Requirement to be updated 7/2017—see appendix)</i></p> <p>10CCR2505—10, Sec 8.209.4.A.2 Contract: Amendment 6, Exhibit A-5—2.8.1.3.3</p>		
<p>16. The notices of action must be mailed within the following time frames:</p> <ul style="list-style-type: none"> For termination, suspension, or reduction of previously authorized CHP+-covered services, the notice of action must be mailed at least 10 days before the date of the intended action except— <ul style="list-style-type: none"> In as few as 5 days prior to the date of action if the Contractor has verified information indicating probable beneficiary fraud. No later than the date of action when: <ul style="list-style-type: none"> The member has died. The member submits a signed written statement requesting service termination. The member submits a signed written statement including information that requires termination or reduction and indicates that the member understands 	<p>CCS 307 Utilization Review Determination Page 7-10, Procedure 1 F. Adverse Determination 1-5</p> <p>HMO Denial Letter</p> <p>SMCN Denial Letter</p>	<p>CHP+ <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>SMCN <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



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<p>that service termination or reduction will occur.</p> <ul style="list-style-type: none">○ The member has been admitted to an institution in which the member is ineligible for CHP+ services.○ The member's address is determined unknown based on returned mail with no forwarding address.○ The member is accepted for CHP+ services by another local jurisdiction, state, territory, or commonwealth.○ A change in the level of medical care is prescribed by the member's physician.○ The notice involves an adverse determination with regard to preadmission screening requirements. <ul style="list-style-type: none">● For denial of payment, at the time of any action affecting the claim.● For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires but within 10 calendar days following receipt of the request for services.● For expedited service authorization decisions, as expeditiously as the member's health condition requires but within 3 working days after receipt of the request for services.		



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<ul style="list-style-type: none">For service authorization decisions not reached within the required time frames on the date time frames expire.If the Contractor extends the timeframe, as expeditiously as the member's health condition requires, and no later than the date the extension expires. <p><i>42 CFR 438.210 (d)</i> <i>42 CFR 438.404(c)</i> <i>42 CFR 431.211, 431.213, and 431.214</i></p> <p>10CCR2505—10, Sec 8.209.4.A.3(a-c) Contract: Amendment 6, Exhibit A-5—2.8.1.3.3</p>		
<p>17. The Contractor may extend the standard or expedited authorization decision time frame up to 14 calendar days if the member requests an extension, or if the Contractor justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest.</p> <p><i>42 CFR 438.210(d)(1)(2)</i></p> <p>Contract: Amendment 6, Exhibit A-5—2.8.1.3.3.2</p>	<p>CCS 307 Utilization Review Determination Page 5, Procedure 1 B. Prospective Review Request, determination and Notification (Standard Request). Bullet 5 Page 6, Procedure 1 C. Prospective Expedited Review Request, Determination and Notification (Urgent Care Requests) bullet 2</p> <p>HMO Notice of Extension</p> <p>SMCN Notice of Extension</p>	<p>CHP+ <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>SMCN <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>

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Requirement	Evidence as Submitted by the Health Plan	Score
<p>18. If the Contractor extends the time frame for making a service authorization decision, it:</p> <ul style="list-style-type: none"> Provides the member written notice of the reason for the decision to extend the time frame. Informs the member of the right to file a grievance if the member disagrees with the decision to extend the time frame. <p style="text-align: right;"><i>42 CFR 438.404(c)(4)(i)</i></p> <p>10CCR2505—10, Section 8.209.4.A.3(c)(i) Contract: Amendment 6, Exhibit A-52.8.1.3.3</p>	<p>CCS 307 Utilization Review Determinations Page 5, Procedure 1 B. Prospective Review Request, determination and Notification (Standard Request). Bullet 5 Page 6, Procedure 1 C. Prospective Expedited Review Request, Determination and Notification (Urgent Care Requests) bullet 2 Page 6-7 Procedure 1, D. Concurrent Expedited Review Request, Determination and Notification (Urgent Care Requests). Bullet 7. A-E Evidence of Coverage Page 92 –98 Grievance and Appeals SMCN Page 99- 105 Complaints, Appeals, & Grievances HMO Notice of Extension SMCN Notice of Extension</p>	<p>CHP+ <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>SMCN <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>19. The Contractor provides that compensation to individuals or entities that conduct utilization management (UM) activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member.</p> <p style="text-align: right;"><i>42 CFR 438.210(e)</i></p> <p>Contract: Amendment 6, Exhibit A-5—2.8.1.1</p>	<p>Evidence of Coverage Page 83, Covered Benefit Decisions SMCN Page 24, Covered Benefit Decisions CCS301 – Qualifications for Staff Engaged in Utilization Management Activities Page 3 Procedure IV</p>	<p>CHP+ <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>SMCN <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



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Requirement	Evidence as Submitted by the Health Plan	Score
<p>20. The Contractor defines “emergency medical condition” as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following:</p> <ul style="list-style-type: none"> Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. Serious impairment to bodily functions. Serious dysfunction of any bodily organ or part. <p style="text-align: right;"><i>42 CFR 438.114(a)</i> <i>(Requirement updated 7/2016—as shown)</i></p> <p>Contract: Amendment 6, Exhibit A-5—1.1.1.28</p>	<p>Evidence of Coverage Page 42 - What Emergency Care Services are Covered? SMCN Page 49 What Emergency Care Services are Covered?</p> <p>CCS309 -Emergency and Post-Stabilization Care Page 2 Definitions: Emergency Medical Condition</p> <p>CCS 307 - Utilization Review Determinations Page 2- Definition: Emergency Medical Condition</p>	<p>CHP+ <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>SMCN <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>21. The Contractor defines “emergency services” as covered inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title and needed to evaluate or stabilize an emergency medical condition.</p> <p style="text-align: right;"><i>42 CFR 438.114(a)</i> <i>(Requirement updated 7/2016—as shown)</i></p> <p>Contract: Amendment 6, Exhibit A-5—1.1.1.29</p>	<p>CCS 309 –Emergency and Post-Stabilization Care Page 2 Definitions – Emergency Services</p> <p>CCS 307 – Utilization Review Determinations Page 2 Definitions – Emergency Services</p>	<p>CHP+ <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>SMCN <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



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Requirement	Evidence as Submitted by the Health Plan	Score
<p>22. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor.</p> <p style="text-align: right;"><i>42 CFR 438.114(c)(1)(i)</i> (Requirement updated 7/2016—as shown)</p> <p>Contract: Amendment 6, Exhibit A-5—2.6.6.1.4</p>	<p>CCS 309 –Emergency and Post-Stabilization Care Page 2 Procedure 3</p> <p>Evidence of Coverage Page 42 -Where can I get Emergency Care? SMCN Page 49 What Emergency Care Services are Covered?</p>	<p>CHP+ <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>SMCN <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>23. Members temporarily out of the service area may receive out-of-area emergency services and urgently needed services.</p> <p>Contract: Amendment 6, Exhibit A-5—2.6.6.1.2</p>	<p>CCS 309 –Emergency and Post-Stabilization Care Page 1 - Urgently Needed Services (CHP+) Page 2, Procedure 3</p> <p>Evidence of Coverage Page 41- Where Can I Get Urgent/After-Hours Care SMCN Page 48- What urgent/after-hours care is covered?</p>	<p>CHP+ <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>24. The Contractor shall not require prior authorization for emergency services or urgently needed services.</p> <ul style="list-style-type: none"> The Contractor informs members that prior authorization is not required for emergency services. <p style="text-align: right;"><i>42 CFR 438.10(f)(6)(viii)(B)</i></p> <p>Contract: Amendment 6, Exhibit A-5—2.6.6.1.3</p>	<p>CCS 309 –Emergency and Post-Stabilization Care Page 1 Definition - Prior Authorization Page 2 Procedure 2</p> <p>Evidence of Coverage Page 82 - Pre-authorization for Health Care Services Page 42- Where can I get Emergency Care? SMCN Page 49 What Emergency Care Services are Covered?</p>	<p>CHP+ <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>SMCN <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



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Requirement	Evidence as Submitted by the Health Plan	Score
<p>25. The Contractor may not deny payment for treatment obtained under the following circumstances:</p> <ul style="list-style-type: none"> A member had an emergency medical condition, as defined in 42 CFR 438.114(a) (see #20 above). Situations which a prudent layperson who possesses an average knowledge of health and medicine would perceive as an emergency medical condition but the absence of immediate medical attention would <i>not</i> have had the following outcomes: <ul style="list-style-type: none"> Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. Serious impairment to bodily functions. Serious dysfunction of any bodily organ or part. A representative of the Contractor’s organization instructed the member to seek emergency services. <p style="text-align: right;"><i>42 CFR 438.114(c)(ii)</i> <i>(Requirement updated 7/2016—as shown)</i></p> <p>Contract: Amendment 6, Exhibit A-5—2.6.6.4.1.3 and 2.6.6.1.4</p>	<p>CCS309 –Emergency and Post-Stabilization Care Page 2 Definition – Emergency Medical Condition A C</p> <p>Evidence of Coverage Page 42 - What Emergency Care Services Are Covered?</p> <p>SMCN Page 49 What Emergency Care Services are Covered?</p> <p>Provider Manual Page 57 Post-Stabilization Care Services</p> <p>SMCN Page 43 Emergency and Urgent Care</p> <p>CCS 307 – Utilization Review Determinations Page 2 Definition: Emergency Medical Condition Page 3. Urgent Care Requests. Bullet 1. A.</p>	<p>CHP+</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p> <p>SMCN</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



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Requirement	Evidence as Submitted by the Health Plan	Score
<p>26. The Contractor does not:</p> <ul style="list-style-type: none"> Limit what constitutes an emergency medical condition on the basis of a list of diagnoses or symptoms. Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member’s primary care provider, the Contractor, or State agency of the member’s screening and treatment within 10 days of presentation for emergency services. <p style="text-align: center;"><i>42 CFR 438.114(d)(1)(i) and (ii)</i> <i>(Requirement updated 7/2016—as shown)</i></p> <p>Contract: Amendment 6, Exhibit A-5—2.6.6.3.1, 2.6.6.6.2.1, and 2.6.6.1.6</p>	<p>CCS 309 –Emergency and Post-Stabilization Care Page 1 - Emergency Medical Condition Page 1 - Emergency Services</p> <p>Evidence of Coverage Page 41-42 - Urgent/After-Hours Care, Emergency Care Page 42 - What Emergency Care Services are Covered?</p> <p>SMCN Page 49 What Emergency Care Services are Covered?</p> <p>Provider Manual Page 57 Post-Stabilization Care Services</p> <p>SMCN Page 43 Emergency and Urgent Care</p> <p>CCS 307 – Utilization Review Determinations Page 2 – Definition: Emergency Medical Condition</p>	<p>CHP+</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>SMCN</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>27. The Contractor will be responsible for emergency services:</p> <ul style="list-style-type: none"> When the primary diagnosis is medical in nature, even when the medical diagnosis includes some psychiatric conditions and procedures. When the primary diagnosis is psychiatric in nature, even when the psychiatric diagnosis includes some procedures to treat a secondary medical diagnosis. <p>Contract: Amendment 6, Exhibit A-5—2.6.6.6.2.1.1–2</p>	<p>CCS 309 –Emergency and Post-Stabilization Care Page 2 Procedure 4</p> <p>Evidence of Coverage Page 108 - Mental health condition</p> <p>SMCN Page 115- Mental health condition</p> <p>Provider Manual Page 55 Medical Necessity, bullet 1.</p> <p>SMCN Page 40 Submitting an Authorization Request (Paragraph 5)</p>	<p>CHP+</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy & Financing FY 2016–2017 Compliance Monitoring Tool for Colorado Access CHP+ and SMCN

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>CCS 307 – Utilization Review Determinations Page 2 Definition: Medical Necessity, bullet 1.</p> <p>ADM 205 – Nondiscrimination Policy Statement</p> <p>Claims Payment Processes CHP claims do not process based on diagnosis. All CHP claims are processed based on covered benefit, place of service, provider and eligibility on the date of service</p>	
<p>28. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.</p> <p style="text-align: right;"><i>42 CFR 438.114(d)(2)</i> <i>(Requirement updated 7/2016—as shown)</i></p> <p>Contract: Amendment 6, Exhibit A-5—2.6.6.1.7</p>	<p>CCS 309 –Emergency and Post-Stabilization Care Page 3 Procedure 8</p> <p>Evidence of Coverage Page 42 - What Emergency Care Services are Covered?</p> <p>SMCN Page 49 What Emergency Care Services are Covered?</p>	<p>CHP+</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p> <p>SMCN</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy & Financing FY 2016–2017 Compliance Monitoring Tool for Colorado Access CHP+ and SMCN

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>29. The Contractor allows the attending emergency physician or the provider actually treating the member to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor, who is responsible for coverage and payment.</p> <p style="text-align: right;"><i>42 CFR 438.114(d)(3)</i> (Requirement updated 7/2016—as shown)</p> <p>Contract: Amendment 6, Exhibit A-5—2.6.6.1.5</p>	<p>CCS 309 –Emergency and Post-Stabilization Care Page 2 Procedure 5</p> <p>Evidence of Coverage Page 42 - What Emergency Care Services are Covered?</p> <p>SMCN Page 49 What Emergency Care Services are Covered?</p> <p>Provider Manual Page 57 Post-Stabilization Care Services</p> <p>SMCN Page 43 Emergency and Urgent Care</p>	<p>CHP+ <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>SMCN <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>30. The Contractor defines “poststabilization care services” as covered services, related to an emergency medical condition, that are provided after a member is stabilized to maintain the stabilized condition or provided to improve or resolve the member’s condition.</p> <p style="text-align: right;"><i>42 CFR 438.114(a)</i> (Requirement updated 7/2016—as shown)</p> <p>Contract: Amendment 6, Exhibit A-5—1.1.1.69</p>	<p>CCS 309 –Emergency and Post-Stabilization Care Page 1. Definition – Post Stabilization Care</p> <p>Evidence of Coverage Page 42 - What Emergency Care Services are Covered?</p> <p>SMCN Page 49 What Emergency Care Services are Covered?</p> <p>Provider Manual Page 57 Post-Stabilization Care Services</p> <p>SMCN Page 43 Emergency and Urgent Care</p>	<p>CHP+ <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>SMCN <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>

Appendix A. Colorado Department of Health Care Policy & Financing FY 2016–2017 Compliance Monitoring Tool for Colorado Access CHP+ and SMCN

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>31. The Contractor is financially responsible for post-stabilization care services obtained within or outside the network that <i>have been</i> pre-approved by a plan provider or other organization representative.</p> <p style="text-align: right;"><i>42 CFR 438.114(e)</i> <i>42 CFR 422.113(c)(i)</i> <i>(Requirement updated 7/2016—as shown)</i></p> <p>Contract: Amendment 6, Exhibit A-5—2.6.6.4.1.4</p>	<p>Evidence of Coverage Page 42 - What Emergency Care Services are Covered?</p> <p>SMCN Page 49 What Emergency Care Services are Covered?</p> <p>CCS 309 – Emergency & Post-Stabilization Care Page 2 Procedure 6.A</p>	<p>CHP+ <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>SMCN <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>32. The Contractor is financially responsible for post-stabilization care services obtained within or outside the network that <i>have not been</i> pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition under the following circumstances:</p> <ul style="list-style-type: none"> • Within 1 hour of a request to the organization for pre-approval of further post-stabilization care services. • The Contractor does not respond to a request for pre-approval within 1 hour. • The Contractor cannot be contacted. • The Contractor's representative and the treating physician cannot reach an agreement concerning the member's care, and a plan physician is not available for consultation. In this situation, the Contractor must give the treating physician the 	<p>CCS 309 –Emergency and Post-Stabilization Care Page 2 Procedure 6. B. Page 2 Procedure 6. C.</p> <p>Evidence of Coverage Page 42 - What Emergency Care Services are Covered?</p> <p>SMCN Page 49 What Emergency Care Services are Covered?</p>	<p>CHP+ <input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>SMCN <input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



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Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>opportunity to consult with a plan physician; and the treating physician may continue with care of the patient until a plan physician is reached or the Contractor’s financial responsibility for poststabilization care services it <i>has not</i> pre-approved ends.</p> <p style="text-align: right;"><i>42 CFR 438.114(e)</i> <i>42 CFR 422.113(c)(ii) and (iii)</i> <i>(Requirement updated 7/2016—as shown)</i></p> <p>Contract: Amendment 6, Exhibit A-5—2.6.6.4.1.5 and 2.6.6.4.1.6.1–3</p>		
<p>Findings: Colorado Access’ Emergency and Post-Stabilization Care policy addressed this requirement verbatim. The emergency room (ER) claims payment procedures stated that Colorado Access reviews each inpatient admission following an ER visit to ensure that an authorization was obtained for the admission. If authorization was granted, the claim is paid. If no authorization was granted, the claim is denied. However, during the on-site interview, staff members stated that Colorado Access had no process to review claims denied for no prior authorization in order to determine the presence of circumstances outlined in this requirement and as specified in the Emergency and Post-Stabilization Care policy. It is only after a member or provider files an appeal that staff members review to determine the presence of exceptions such as those related to post-stabilization care services, continuity of care, or access to women’s healthcare specialists.</p>		
<p>Required Actions: Colorado Access must develop a process to ensure that both the UM procedures and claims payment decisions are linked to the requirements for the Contractor’s financial responsibilities for post-stabilization care services not pre-approved, as outlined in the Emergency and Post-Stabilization Care policy.</p>		

Appendix A. Colorado Department of Health Care Policy & Financing FY 2016–2017 Compliance Monitoring Tool for Colorado Access CHP+ and SMCN

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>33. The Contractor’s financial responsibility for poststabilization care services it <i>has not</i> pre-approved ends when:</p> <ul style="list-style-type: none"> • A plan physician with privileges at the treating hospital assumes responsibility for the member's care. • A plan physician assumes responsibility for the member's care through transfer. • A plan representative and the treating physician reach an agreement concerning the member’s care. • The member is discharged. <p style="text-align: right;"><i>42 CFR 438.114(e)</i> <i>42 CFR 422.113(c)(2)</i> <i>(Requirement updated 7/2016—as shown)</i></p> <p>Contract: Amendment 6, Exhibit A-5—2.6.6.4.1.8.1–4</p>	<p>CCS 309 –Emergency and Post-Stabilization Care Page 2. Procedure 7 Evidence of Coverage Page 42 - What Emergency Care Services are Covered? SMCN Page 49 What Emergency Care Services are Covered?</p>	<p>CHP+ <input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>SMCN <input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>Findings: The Emergency and Post-Stabilization Care policy addressed this requirement verbatim. The ER claims payment procedures stated that Colorado Access reviews inpatient admissions following an ER visit to ensure that an authorization was obtained for the admission. If authorization was granted, the claim is paid. If no authorization was granted, the claim is denied. However, it was unclear in written procedures and during on-site interviews whether or not the circumstances outlined in this requirement and specified in Colorado Access’ Emergency and Post-Stabilization Care policy were integrated into claims payment decisions.</p>		
<p>Required Actions: Colorado Access must develop a process to ensure that the Contractor’s financial responsibilities for post-stabilization care services not pre-approved, as outlined in the Emergency and Post-Stabilization Care policy, are integrated into claims payment decisions.</p>		



Appendix A. Colorado Department of Health Care Policy & Financing FY 2016–2017 Compliance Monitoring Tool for Colorado Access CHP+ and SMCN

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
34. The Contractor must limit charges to members for post-stabilization care services to an amount no greater than what the Contractor would charge the member if he or she had obtained the services through the Contractor. <i>42 CFR 438.114(e)</i> <i>42 CFR 422.113(c)</i> <i>(Requirement updated 7/2016—as shown)</i> Contract: Amendment 6, Exhibit A-5—2.6.6.4.1.7	CCS 309 –Emergency and Post-Stabilization Care Page 3, Procedure 8 Evidence of Coverage Page 42 - What Emergency Care Services are Covered? SMCN Page 49 What Emergency Care Services are Covered?	CHP+ <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A SMCN <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A

Results for CHP+ Standard I—Coverage and Authorization of Services					
Total	Met	=	32	X	1.00 = 32
	Partially Met	=	2	X	.00 = 0
	Not Met	=	0	X	.00 = 0
	Not Applicable	=	0	X	NA = 0
Total Applicable		=	34	Total Score	= 32

Total Score ÷ Total Applicable		=	94%
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Results for SMCN Standard I—Coverage and Authorization of Services					
Total	Met	=	29	X	1.00 = 29
	Partially Met	=	2	X	.00 = 0
	Not Met	=	0	X	.00 = 0
	Not Applicable	=	0	X	NA = 0
Total Applicable		=	31	Total Score	= 29

Total Score ÷ Total Applicable		=	94%
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Appendix A. Colorado Department of Health Care Policy & Financing FY 2016–2017 Compliance Monitoring Tool for Colorado Access CHP+ and SMCN

Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
The Contractor ensures that all covered services are available and accessible to members through compliance with the following requirements:		
<p>1. The Contractor maintains and monitors a network of appropriate providers sufficient to provide adequate access to all services covered under the contract. In order for the Contractor’s network to be considered to provide adequate access, the Contractor includes the following provider types and ensures a minimum provider-to-member caseload ratio as follows:</p> <ul style="list-style-type: none"> • 1:2,000 primary care physician (PCP) provider-to-members ratio. PCP includes physicians designated to practice family medicine and general medicine. • 1:2,000 physician specialist-to-members ratio. Physician specialist includes physicians designated to practice cardiology, otolaryngology, endocrinology, gastroenterology, neurology, orthopedics, pulmonary medicine, general surgery, ophthalmology, and urology. • Appropriate access to certified nurse practitioners and certified nurse midwives. • Physician specialists designated to practice internal medicine, gerontology, obstetrics and gynecology (OB/GYN), and pediatrics shall be counted as either PCP or physician specialist, but not both. <p style="text-align: right;"><i>42 CFR 438.206(b)(1)</i> <i>(Requirement to be updated 7/2018—see appendix)</i></p> <p>Contract: Amendment 6, Exhibit A-5—2.5.10, 2.7.1.1.5, and 2.7.1.1.9</p>	<p>HMO Network Adequacy Report FY17 Q1</p> <p>PNS 202 Selection & Retention of Providers Page 1, Policy Statement Page 1, Procedure I. Provider selection B. Page 1, Procedure I. Provider selection C. 1. Page 2, Procedure I. Provider selection C. 4. Page 2-3, Procedure I. Provider selection. H.</p> <p>Provider Network Strategic Plan FY 16-17 Page 2, Network Adequacy (all bullets)</p> <p>CHP HMO & SMCN Midwife Network Report</p>	<p>CHP+</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>SMCN</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>

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Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>2. In establishing and maintaining the network, the Contractor considers:</p> <ul style="list-style-type: none"> The anticipated CHP+ enrollment. The expected utilization of services, taking into consideration the characteristics and healthcare needs of specific CHP+ populations represented in the Contractor’s service area. The numbers, types, and specialties of providers required to furnish the contracted CHP+ services. The number of network providers accepting/not accepting new members. The geographic location of providers in relationship to where CHP+ members live, considering distance, travel time, and means of transportation used by members. <ul style="list-style-type: none"> Members have access to a provider within 30 miles or 30 minutes’ travel time, whichever is larger, to the extent such services are available. Physical access to locations for members with disabilities. <p style="text-align: right;"><i>42 CFR 438.206(b)(1)(i) through (v) (Requirement to be updated 7/2018—see appendix)</i></p> <p>Contract: Amendment 6, Exhibit A-5—2.7.1.3.1 and 2.7.1.1.3.1</p>	<p>PNS 202 Selection & Retention of Providers Page 1, Policy Statement Page 1, Procedure I. Provider selection C. 1. Page 2, Procedure I. Provider selection C. 2.</p> <p>Provider Network Strategic Plan Page 1, Provider Network Strategic Planning</p> <p>COA FY16 CHP+ HMO Annual Quality Report Page 8-9 Network Adequacy</p> <p>Network Adequacy Reports FY16 Quarter 4 report</p> <p>SMCN FY 16 Quarter 3 report</p>	<p>CHP+</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p> <p>SMCN</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



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Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>3. The Contractor provides female members with direct access to a women’s health specialist within the network for covered care necessary to provide women’s routine and preventive healthcare services. This is in addition to the member’s designated source of primary care if that source is not a women’s healthcare specialist.</p> <p style="text-align: right;"><i>42 CFR 438.206(b)(2)</i></p> <p>Contract: Amendment 6, Exhibit A-5—2.7.1.1.7</p>	<p>Evidence of Coverage</p> <p>Page 31 - Who Should I see for Family Planning/Reproductive Health Services</p> <p>Page 32 - Who Should I see for Maternity and Newborn Care?</p> <p>Page 34 – (Who should I see for provider office service?)</p> <p>You do not need to get approval from CHP+ HMO when you get care from: Bullet 1</p> <p>SMCN</p> <p>Page 38 Who Should I see for Family Planning/Reproductive Health Services?</p> <p>Page 39 Who Should I see for Maternity and Newborn Care?</p> <p>Page 41 (Who should I see for provider office service?) You do not need to get approval from CHP+ HMO when you get care from: Bullet 1</p> <p>CCS310 – Access to Primary and Specialty Care</p> <p>Page 5, III. Direct Access. A-J</p>	<p>CHP+</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p> <p>SMCN</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>
<p>4. The Contractor allows persons with special healthcare needs who use specialists frequently to maintain these types of specialists as PCPs or be allowed direct access/standing referrals to specialists.</p> <p style="text-align: right;"><i>42 CFR 438.208(c)(4)</i></p> <p>Contract: Amendment 6, Exhibit A-5— 2.7.5.4</p>	<p>CCS310 Access to Primary and Specialty Care</p> <p>Page 3 - Special Healthcare Needs</p> <p>Page 5, III. Direct Access, A.</p>	<p>CHP+</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p> <p>SMCN</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



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Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>5. The Contractor provides for a second opinion from a qualified healthcare professional within the network or arranges for the member to obtain one outside the network if there is no other qualified health care professional within the network, at no cost to the member.</p> <p style="text-align: right;"><i>42 CFR 438.206(b)(3)</i></p> <p>Contract: Amendment 6, Exhibit A-5—2.7.1.1.8</p>	<p>Evidence of Coverage Page 34 - What Provider Office Services are Covered? Bullet 1.(sub-bullet1) Page 134 – Glossary; Second Opinion</p> <p>SMCN Page 41 What Provider Office Services are Covered? Page 119 Definition- Second opinion</p> <p>CCS310 – Primary & Specialty Care Access Page 4, II Specialty and Ancillary Service Referrals. C. Page 5, III. Direct Access I.</p>	<p>CHP+ <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>SMCN <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>6. If the Contractor is unable to provide covered services to a particular member within its network, the Contractor adequately and timely provides the covered services out of network for as long as the Contractor is unable to provide them.</p> <p style="text-align: right;"><i>42 CFR 438.206(b)(4)</i></p> <p>Contract: Amendment 6, Exhibit A-5—2.7.1.2</p>	<p>CCS310 Access to Primary and Specialty Care Page 5, III Direct Access. J.</p>	<p>CHP+ <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>SMCN <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



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Requirement	Evidence as Submitted by the Health Plan	Score
<p>7. The Contractor coordinates with out-of-network providers with respect to payment and ensures that the cost to the member is no greater than it would be if the services were furnished within the network.</p> <p style="text-align: right;"><i>42 CFR 438.206(b)(5)</i></p> <p>Contract: Amendment 6, Exhibit A-5—2.7.1.2.2.1</p>	<p>PNS215 Reimbursement Page 5-6, Procedure II. Reimbursement for Non-Participating Providers, Child Health Plan Plus (CHP+) Page 6, Child Health Plan Plus (CHP+) Page 7-9, Procedure V. Single Case Agreements</p>	<p>CHP+ <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>SMCN <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>8. The Contractor ensures that covered services are available 24 hours a day, 7 days a week when medically necessary.</p> <p style="text-align: right;"><i>42 CFR 438.206(c)(1)(iii)</i></p> <p>Contract: Amendment 6, Exhibit A-5—2.6.3.1, 2.6.3.4, and 2.7.1.4.1.1</p>	<p>PNS306 Availability of After Hours Coverage Page 1, Policy Statement Page 4 Procedure 3 Notification</p> <p>CCS 309 – Emergency & Post-Stabilization Care Page 1, Policy Statement</p> <p>Provider Manual Page 18 Coverage</p> <p>SMCN Page 7 PCP Coverage</p> <p>COA FY16 CHP+ HMO Annual Quality report Page 4-5</p>	<p>CHP+ <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>SMCN <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



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Requirement	Evidence as Submitted by the Health Plan	Score
<p>9. The Contractor must require its providers to offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to other CHP+ providers.</p> <p style="text-align: right;"><i>42 CFR 438.206(c)(1)(ii)</i></p> <p>Contract: Amendment 6, Exhibit A-5—2.5.1</p>	<p>Provider Manual Page 17, Provider Responsibilities bullet 3</p> <p>SMCN Page 6, Provider Responsibilities bullet 3</p>	<p>CHP+ <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>SMCN <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>10. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services, taking into account the urgency of the need for services:</p> <ul style="list-style-type: none">• Within 48 hours for urgently needed services.• Within 30 calendar days for:<ul style="list-style-type: none">– Non-emergent, non-urgent medical problems.– Non-urgent, symptomatic medical problems.– Non-symptomatic well-care physical examinations. <p style="text-align: right;"><i>42 CFR 438.206(c)(1)(i)</i></p> <p>Contract: Amendment 6, Exhibit A-5—2.6.3.2 and 2.6.3.3.1–4</p>	<p>Provider Manual Page 8-9 Appointment and Service Standards</p> <p>SMCN Page 14-15 Appointment and Service Standards</p> <p>COA FY16 CHP+ HMO Annual Quality Report Page 4-5</p>	<p>CHP+ <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>SMCN <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



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Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>11. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services, taking into account the urgency of the need for services:</p> <ul style="list-style-type: none"> Within 14 calendar days for: <ul style="list-style-type: none"> Diagnosis and treatment of a non-emergent, non-urgent substance use disorder. Diagnosis and treatment of a non-emergent, non-urgent mental health condition. <p style="text-align: right;"><i>42 CFR 438.206(c)(1)(i)</i></p> <p>Contract: Amendment 6, Exhibit A-5—2.7.1.5.2.5–6</p>	<p>Provider Manual Page 8-9 Appointment and Service Standards</p> <p>SMCN Page 14-15 Appointment and Service Standards</p>	<p>CHP+ <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>SMCN <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>12. The Contractor communicates all scheduling guidelines in writing to participating providers.</p> <p>Contract: Amendment 6, Exhibit A-5—2.7.1.5.4</p>	<p>Provider Manual Page 8-9 Appointment and Service Standards</p> <p>SMCN Page 14-15 Appointment and Service Standards</p>	<p>CHP+ <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>13. The Contractor has mechanisms to ensure compliance by providers with standards for timely access, monitors providers regularly to determine compliance with standards for timely access, and takes corrective action if there is a failure to comply with standards for timely access.</p> <p style="text-align: right;"><i>42 CFR 438.206(c)(1)(iv) through (vi)</i></p> <p>Contract: Amendment 6, Exhibit A-5—2.7.1.5.4</p>	<p>Quality Assessment and Performance Improvement Program Description Page 6</p> <p>COA FY 16CHP+HMO Annual Quality Report Page 10-11CAHPS Survey Page 12-13 Grievance monitoring Page 25-27 Clinical denials and appeals Page 6-7 Telephone Monitoring Page 4-5 Service Accessibility Page 8-9 Network Adequacy Analysis</p> <p>Behavioral Health Access to Care</p>	<p>CHP+ <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>SMCN <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy & Financing FY 2016–2017 Compliance Monitoring Tool for Colorado Access CHP+ and SMCN

Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>14. The Contractor participates in the State’s efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds.</p> <p>(Includes policies and procedures, training, and member communications.)</p> <p style="text-align: right;"><i>42 CFR 438.206(c)(2)</i> <i>(Requirement to be updated 7/2018—see appendix)</i></p> <p>Contract: Amendment 6, Exhibit A-5—2.7.7.2</p>	<p>ADM206 – Culturally Sensitive Services for Diverse</p> <p style="padding-left: 20px;">Page 2, Policy Statement</p> <p style="padding-left: 20px;">Page 2-3, Procedure I. A – F</p> <p style="padding-left: 20px;">Page 3, Procedure II</p> <p style="padding-left: 20px;">Page 3, Procedure III</p> <p style="padding-left: 20px;">Page 3, Procedure IV</p> <p>ADM207 – Effective Communication with LEP & SI/SI</p> <p style="padding-left: 20px;">Page 2, Policy Statement</p> <p style="padding-left: 20px;">Page 3, Procedure I. A & B</p> <p style="padding-left: 20px;">Page 4, Procedure II. 2.</p> <p style="padding-left: 20px;">Page 4-5, Procedure III A-H.</p> <p>Evidence of Coverage – English and Spanish (HMO & SMCN)</p> <p>Evidence of Coverage</p> <p style="padding-left: 20px;">Page 1 Do You Need Special Help with This Booklet?</p> <p>SMCN</p> <p style="padding-left: 20px;">Page 4 Do You Need Special Help with This Booklet?</p> <p>Language Interpretation Request Form</p> <p>ADM 205 Nondiscrimination</p> <p style="padding-left: 20px;">Page 3, Procedure II, III, IV</p> <p>Provider Manual</p> <p style="padding-left: 20px;">Page 3-4 Colorado Access Policies</p> <p>SMCN</p> <p style="padding-left: 20px;">Page 6 Primary Care Provider Responsibilities bullet 9</p>	<p>CHP+</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p> <p>SMCN</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>

Appendix A. Colorado Department of Health Care Policy & Financing FY 2016–2017 Compliance Monitoring Tool for Colorado Access CHP+ and SMCN

Results for CHP+ Standard II—Access and Availability						
Total	Met	=	14	X	1.00	= 14
	Partially Met	=	0	X	.00	= 0
	Not Met	=	0	X	.00	= 0
	Not Applicable	=	0	X	NA	= 0
Total Applicable		=	14	Total Score	=	14

Total Score ÷ Total Applicable		=	100%
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Results for SMCN Standard II—Access and Availability						
Total	Met	=	13	X	1.00	= 13
	Partially Met	=	0	X	.00	= 0
	Not Met	=	0	X	.00	= 0
	Not Applicable	=	0	X	NA	= 0
Total Applicable		=	13	Total Score	=	13

Total Score ÷ Total Applicable		=	100%
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Appendix B. Record Review Tool

The completed record review tool follows this cover page.



Appendix B. Colorado Department of Health Care Policy & Financing FY 2016–2017 Denials Record Review Tool for Colorado Access

Review Period:	January 1, 2016–December 31, 2016
Date of Review:	March 21, 2017
Reviewer:	Rachel Henrichs
Participating Plan Staff Member:	Bethanie Tran and Carol Wilde

Requirements	File 1	File 2	File 3	File 4	File 5
Member	MP	RR	AS	KT	JS
Date of initial request	12/19/16	01/14/16	03/30/16	03/31/16	05/31/16
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	NR	NR	NR	NR
Standard (S), Expedited (E), or Retrospective (R)	S	S	S	E	S
Date notice of action sent	12/21/16	01/15/16	04/01/16	04/01/16	06/01/16
Notice sent to provider and member? (C or NC)	C	C	C	C	C
Number of days for decision/notice	2	1	2	1	1
Notice sent within required time frame? (C or NC) (S = 10 Cal days after; E = 3 Bus days after; T = 10 Cal days before)	C	C	C	C	C
Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
If extended, extension notification sent to member? (C, NC, or NA)	NA	NA	NA	NA	NA
If extended, extension notification includes required content? (C, NC, or NA)	NA	NA	NA	NA	NA
Notice of Action includes required content? (C or NC)	C	C	C	C	C
Authorization decision made by qualified clinician? (C, NC, or NA)	C	C	C	C	C
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (C, NC, or NA)	NA	NA	NA	NA	NA
If denied due to <i>not a covered service</i> but covered by Medicaid Fee-for-Service/wraparound service, did the notice of action include clear information about how to obtain the service? (C, NC, or N/A)	NA	NA	NA	NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C	C	C	C
Was correspondence with the member easy to understand? (C or NC)	C	C	C	C	C
Total Applicable Elements	6	6	6	6	6
Total Compliant Elements	6	6	6	6	6
Score (Number Compliant / Number Applicable) = %	100%	100%	100%	100%	100%

C = Compliant **NC** = Not Compliant **NA** = Not Applicable **Y** = Yes **N** = No (not scored—informational only)
Cal = Calendar **Bus** = Business



**Appendix B. Colorado Department of Health Care Policy & Financing
FY 2016–2017 Denials Record Review Tool
for Colorado Access**

Requirements	File 6	File 7	File 8	File 9	File 10
Member	ZH	JB	KM	SH	JH
Date of initial request	08/18/16	12/09/16	05/16/16	12/12/16	12/23/16
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	NR	NR	NR	NR
Standard (S), Expedited (E), or Retrospective (R)	S	S	S	S	S
Date notice of action sent	08/22/16	12/16/16	05/20/16	12/15/16	12/23/16
Notice sent to provider and member? (C or NC)	C	C	C	C	C
Number of days for decision/notice	4	7	4	3	1
Notice sent within required time frame? (C or NC) (S = 10 Cal days after; E = 3 Bus days after; T = 10 Cal days before)	C	C	C	C	C
Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
If extended, extension notification sent to member? (C, NC, or NA)	NA	NA	NA	NA	NA
If extended, extension notification includes required content? (C, NC, or NA)	NA	NA	NA	NA	NA
Notice of Action includes required content? (C or NC)	C	C	C	C	C
Authorization decision made by qualified clinician? (C, NC, or NA)	C	C	C	C	C
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (C, NC, or NA)	NA	NA	NA	NA	NA
If denied due to <i>not a covered service</i> but covered by Medicaid Fee-for-Service/wraparound service, did the notice of action include clear information about how to obtain the service? (C, NC, or N/A)	NA	NA	NA	NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C	C	C	C
Was correspondence with the member easy to understand? (C or NC)	C	C	C	C	C
Total Applicable Elements	6	6	6	6	6
Total Compliant Elements	6	6	6	6	6
Score (Number Compliant / Number Applicable) = %	100%	100%	100%	100%	100%

C = Compliant NC = Not Compliant NA = Not Applicable Y = Yes N = No (not scored—informational only)
Cal = Calendar Bus = Business

Total Record Review Score	Total Applicable Elements: 60	Total Compliant Elements: 60	Total Score: 100%
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Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2016–2017 site review of **Colorado Access**.

Table C-1—HSAG Reviewers and Colorado Access and Department Participants

HSAG Review Team	Title
Rachel Henrichs	External Quality Review (EQR) Compliance Auditor
Colorado Access Participants	Title
Bethanie Tran	Clinical Pharmacist
Bethany Hines (telephonic)	Executive Director, CHP+ and SMCN
Carol Wilde	Manager, Utilization Management
Elizabeth Strammiello	Chief Compliance Officer
Janet Milliman	Director, CHP+
Julie McNamara	Director, Systems Operations and Vendor Management
Lindsay Cowee	Director, Quality Improvement
Mo Armstrong	Contract Coordinator
Department Observers	Title
Teresa Craig	Contract Manager

Appendix D. Corrective Action Plan Template for FY 2016–2017

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

Table D-1—Corrective Action Plan Process

Step	Action
Step 1	Corrective action plans are submitted
	<p>If applicable, the health plan will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final compliance site review report via email or through the file transfer protocol (FTP) site, with an email notification to HSAG and the Department. The health plan must submit the CAP using the template provided.</p> <p>For each element receiving a score of <i>Partially Met</i> or <i>Not Met</i>, the CAP must describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training and follow-up activities, and documents to be sent following the completion of the planned interventions.</p>
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
	<p>Following review of the CAP, the Department or HSAG will notify the health plan via email whether:</p> <ul style="list-style-type: none"> • 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 email or the FTP site, with an email 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.

Step	Action
Step 6	Documentation substantiating implementation of the plan is reviewed and approved
	<p>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.</p> <p>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 healthcare regulations and managed care contract requirements.</p>

The CAP template follows.

Table D-2—FY 2016–2017 Corrective Action Plan for Colorado Access

Standard I—Coverage and Authorization of Services		
Requirement	Findings	Required Action
<p>32. The Contractor is financially responsible for post-stabilization care services obtained within or outside the network that <i>have not been</i> pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition under the following circumstances:</p> <ul style="list-style-type: none"> • Within 1 hour of a request to the organization for pre-approval of further post-stabilization care services. • The Contractor does not respond to a request for pre-approval within 1 hour. • The Contractor cannot be contacted. • The Contractor's representative and the treating physician cannot reach an agreement concerning the member's care, and a plan physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a plan physician; and the treating physician may continue with care of the patient until a plan physician is reached or the Contractor's financial responsibility for poststabilization care services it <i>has not</i> pre-approved ends. <p style="text-align: right;">42 CFR 438.114(e) 42 CFR 422.113(c)(ii) and (iii)</p>	<p>Colorado Access' Emergency and Post-Stabilization Care policy addressed this requirement verbatim. The emergency room (ER) claims payment procedures stated that Colorado Access reviews each inpatient admission following an ER visit to ensure that an authorization was obtained for the admission. If authorization was granted, the claim is paid. If no authorization was granted, the claim is denied. However, during the on-site interview, staff members stated that Colorado Access had no process to review claims denied for no prior authorization in order to determine the presence of circumstances outlined in this requirement and as specified in the Emergency and Post-Stabilization Care policy. It is only after a member or provider files an appeal that staff members review to determine the presence of exceptions such as those related to post-stabilization care services, continuity of care, or access to women's healthcare specialists.</p>	<p>Colorado Access must develop a process to ensure that both the UM procedures and claims payment decisions are linked to the requirements for the Contractor's financial responsibilities for post-stabilization care services not pre-approved, as outlined in the Emergency and Post-Stabilization Care policy.</p>

Standard I—Coverage and Authorization of Services		
Requirement	Findings	Required Action
<i>(Requirement updated 7/2016—as shown)</i> Contract: Amendment 6, Exhibit A-5—2.6.6.4.1.5 and 2.6.6.4.1.6.1–3		
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 I—Coverage and Authorization of Services		
Requirement	Findings	Required Action
<p>33. The Contractor’s financial responsibility for poststabilization care services it <i>has not</i> pre-approved ends when:</p> <ul style="list-style-type: none"> • A plan physician with privileges at the treating hospital assumes responsibility for the member’s care. • A plan physician assumes responsibility for the member’s care through transfer. • A plan representative and the treating physician reach an agreement concerning the member’s care. • The member is discharged. <p style="text-align: right;"><i>42 CFR 438.114(e)</i> <i>42 CFR 422.113(c)(2)</i> <i>(Requirement updated 7/2016—as shown)</i></p> <p>Contract: Amendment 6, Exhibit A-5—2.6.6.4.1.8.1–4</p>	<p>The Emergency and Post-Stabilization Care policy addressed this requirement verbatim. The ER claims payment procedures stated that Colorado Access reviews inpatient admissions following an ER visit to ensure that an authorization was obtained for the admission. If authorization was granted, the claim is paid. If no authorization was granted, the claim is denied. However, it was unclear in written procedures and during on-site interviews whether or not the circumstances outlined in this requirement and specified in Colorado Access’ Emergency and Post-Stabilization Care policy were integrated into claims payment decisions.</p>	<p>Colorado Access must develop a process to ensure that the Contractor’s financial responsibilities for post-stabilization care services not pre-approved, as outlined in the Emergency and Post-Stabilization Care policy, are integrated into claims payment decisions.</p>
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

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
	<p>Before the site review to assess compliance with federal Medicaid managed care regulations and contract requirements:</p> <ul style="list-style-type: none"> • 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
	<ul style="list-style-type: none"> • 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 three standards and on-site activities. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. • Documents submitted for the desk review and on-site review consisted of the completed desk review form, the compliance monitoring tool with the health plan's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The health plans also submitted a list of all CHP+ service and claims denials that occurred between January 1, 2016, and December 31, 2016. 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.

For this step,	HSAG completed the following activities:
Activity 3:	Conduct Site Visit
	<ul style="list-style-type: none"> During the on-site portion of the review, HSAG met with the health plan's key staff members to obtain a complete picture of the health plan's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan's performance. HSAG reviewed a sample of administrative records to evaluate implementation of Medicaid managed care regulations related to health plan service and claims denials and notices of action. 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
	<ul style="list-style-type: none"> HSAG used the FY 2016–2017 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
	<ul style="list-style-type: none"> HSAG populated the report template. HSAG submitted the draft 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.