Fiscal Year 2017–2018 Site Review Report

for

Colorado Access CHP+ HMO and State Managed Care Network

January 2018

This report was produced by Health Services Advisory Group, Inc., for the Colorado Department of Health Care Policy and 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 Code of Federal Regulations, Title 42—federal Medicaid managed care regulations published May 6, 2016. The Code of Federal Regulations requires that states conduct a periodic evaluation of their MCOs and PIHPs to determine compliance with federal healthcare regulations and managed care contract requirements. The Department of Health Care Policy and Financing (the Department) has elected to complete this requirement for Colorado's Child Health Plan *Plus* (CHP+) managed care health plans by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

In order to evaluate the health plan's progress toward compliance with new federal managed care regulations published May 2016, the Department determined that the review period for FY 2017–2018 was July 1, 2017, through December 31, 2017. This report documents results of the FY 2017–2018 site review activities 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 SMCN lines of business are differentiated where applicable. For each of the four 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 describes the background and methodology used for the 2017–2018 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the 2016–2017 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the appeals and grievances record reviews. Appendix C lists HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process the health plan will be required to complete for FY 2017–2018 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 applicable requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. HSAG assigned required actions for any requirement within the compliance monitoring tool receiving a score of *Partially Met* or *Not Met*. Revisions to federal Medicaid managed care regulations published May 6, 2016, do not become applicable to CHIP until July 1, 2018; therefore, HSAG assigned each **revised** federal requirement a score of *Met* or *Not Scored*. HSAG identified opportunities for improvement and associated recommendations for those requirements that do not become effective until July 2018.

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)
V. Member Information	24	12	12	0	0	12	100%
VI. Grievance System	35	22	21	1	0	13	95%
VII. Provider Participation and Program Integrity	16	15	15	0	0	1	100%
IX. Subcontracts and Delegation	4	0	0	0	0	4	NA
Totals	**79**	**49**	**48**	**1**	**0**	**30**	**98%***

Note: While the scoring of evidence related to individual, new federal requirements in the tool may indicate *Met* or *Not Scored*, all new requirements were scored *Not Applicable* in the total results; new federal requirements do not apply to CHP+ until July 1, 2018.

*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** HMO for the record reviews. Details of the findings for the record reviews are in Appendix B—Record Review Tools.

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

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Appeals	48	45	42	3	3	93%
Grievances	60	40	40	0	20	100%
Totals	**108**	**85**	**82**	**3**	**23**	**96%***

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

Table 1-3 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. The Department required no appeal or grievance record reviews for the SMCN line of business.

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

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
V. Member Information	24	12	12	0	0	12	100%
VI. Grievance System	35	22	22	0	0	13	100%
VII. Provider Participation and Program Integrity	16	15	15	0	0	1	100%
IX. Subcontracts and Delegation	4	0	0	0	0	4	NA
Totals	**79**	**49**	**49**	**0**	**0**	**30**	**100%***

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

Standard V—Member Information

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

HSAG reviewed the policies and procedure regarding member materials, which were generally the same between the CHP+ HMO and SMCN lines of business. HSAG found the policies inclusive of the requirements. **Colorado Access** used many of the same or similar member materials across both lines of business and made all vital member communication, including newsletters, available in Spanish. HSAG reviewed member materials, including the new member packets for **Colorado Access** members in both English and in Spanish. In addition, **Colorado Access** included in its website a translation function which made the website viewable in over 50 languages.

HSAG found that member materials, both printed and electronic, used simple, easy-to-understand language. **Colorado Access** HMO arranged its website in a user-friendly format that allows for intuitive use and member ease in finding important information. The **Colorado Access** SMCN website used an older format; however, it was easy to find and access important member information. For both lines of business, **Colorado Access** provided a wealth of information to its members on its websites, which serve as valuable resources.

Summary of Findings Resulting in Opportunities for Improvement

While present across written documents, **Colorado Access** did not include on its website notification that oral interpretation in any language and use of auxiliary aids are available free of charge. In addition, the website lacks information on how a member may access these services. While **Colorado Access** does provide oral interpretation and use of auxiliary aids to members free of charge as needed, HSAG suggests that **Colorado Access** include highly visible bylines on its website notifying members that these provisions are available and how to access them, particularly for members who are more likely to exclusively use electronic media for obtaining information. During the on-site review, HSAG and **Colorado Access** discussed prominent places on the **Colorado Access** website for disseminating this information.

Colorado Access may wish to review all member documents to ensure that the general text of PDF versions of member materials is made available to members in at least a 12-point font. HSAG reviewed various member material available in PDF format; and while the font appeared to be in an acceptable range, HSAG was unable to directly confirm the font size due to the PDF format.

HSAG found that the taglines describing how to request auxiliary aids and services, including written translation and oral interpretation, while present, were not in 18-point font on both paper and electronic member materials, as required. **Colorado Access** should ensure that all member materials include taglines describing how to request auxiliary aids and services including written translation and oral interpretation in 18-point font.

During the desk review process, HSAG conducted an accessibility check on a few **Colorado Access** Web pages using the *Wave Web Accessibility Evaluation Tool*. Through use of the tool, HSAG discovered several general accessibility errors and contrast errors on various Web pages. HSAG also ran an accessibility check on PDF documents available for download from the **Colorado Access** website. Through use of the Adobe Acrobat Pro accessibility checker, HSAG discovered accessibility errors. HSAG repeated these accessibility checks during the on-site review for educational purposes, and the same outcomes were discovered. **Colorado Access** should enhance its process for reviewing its website to ensure that all information on its website is readily accessible (i.e., complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines).

HSAG was unable to locate notification on the **Colorado Access** website informing members that electronic information is available in paper form upon request without charge and is provided within five business days. During the on-site interview, HSAG and **Colorado Access** discussed possible placement on the website appropriate for displaying such messaging, especially considering that many members may not have a state-of-the-art cell phone or access to sufficient bandwidth to search the website for this notice or to download the available PDF documents. HSAG recommends that **Colorado Access** inform members on a prominent place of its website that information on the website is available in paper form upon request, without charge, and provided within five business days.

HSAG reviewed both the provider directory and the "Find A Provider" provider search feature on the **Colorado Access** website. While the provider directory did not contain all the required information, the

"Find A Provider" feature was a valuable resource that contained comprehensive information in a searchable format. As discussed on-site, the disability accommodation field did not define the accommodations available at each provider's location. Further research performed by **Colorado Access** during the on-site visit concluded that only one area of disability access, such as handicap parking or a nearby public transit line, could qualify a provider as having "disability access." The requirement, however, clarifies this to include accessible offices, exam rooms, and equipment. HSAG recommends that **Colorado Access** update its online "Find A Provider" provider search feature to better clarify what it defines as "disability access" in agreement with the requirement (e.g., presence of an adjustable exam table and/or a ceiling- or floor-based patient lift as described in Part 4 of the Americans with Disabilities Act publication, *Access To Medical Care For Individuals With Mobility Disabilities.*

Summary of Required Actions

HSAG identified no required actions for this standard.

Standard VI—Grievance System

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 stated that it will implement its updated grievance and appeal policies—revised for compliance with new federal and State requirements—for CHP+ members effective November 13, 2017. Prior to implementation of updated policies and procedures, CHP+ members remained subject to the grievance and appeal procedures outlined in **Colorado Access**' contract with the State. **Colorado Access** demonstrated that existing procedures for processing grievances and appeals complied with **Colorado Access**' contract with the State. In addition, the CHP+ HMO and SMCN member handbooks and provider manuals clearly outlined the procedures for filing grievances and appeals, including all essential time frames and information. Record reviews for CHP+ HMO demonstrated 100 percent compliance with requirements for processing grievances and 93 percent compliance with requirements for processing appeals. Staff demonstrated that the appeal manager contacts all members orally (and in writing) to acknowledge receipt of appeals, offer assistance, share all available pre- and post-appeal information in the files, and ensure that each member understands his or her appeal resolution. **Colorado Access** efficiently processes all grievances and appeals, rarely extending the time frame needed to issue a determination and rarely denying the request for an expedited decision. **Colorado Access** maintains records of appeals and grievances, including all required information, in the Altruista Health care management system for a period of 10 or more years.

HSAG also reviewed **Colorado Access**' revised appeals and grievances policies and procedures proposed to be implemented for CHP+ members beginning November 13, 2017. The Member Grievance Process policy and Member Appeals Process policy thoroughly addressed and were largely compliant

with new federal and State regulations. Staff members stated that applicable changes in the federal regulations effective July 1, 2018, largely reflected processes already in place and operationally applied in processing of appeals and grievances by **Colorado Access**. To assist CHP+ HMO and SMCN in complying with new requirements following the implementation of its updated policies and procedures, HSAG offers recommendations in the "Summary of Findings Resulting in Opportunities for Improvement" section following.

Summary of Findings Resulting in Opportunities for Improvement

Staff members stated that **Colorado Access** intends to implement for CHP+ members the updated corporate policies related to grievances and appeals effective November 13, 2017. However, neither the CHP+ HMO or SMCN member handbooks nor provider manuals include the updated regulatory information. **Colorado Access** should ensure that member handbooks for CHP+ and SMCN and provider manuals for CHP+ and SMCN are updated to coincide with implementation of revised grievance and appeal policies and procedures, and should alert members and providers of these changes. Necessary changes specifically include time frames for filing and processing grievances and appeals, such as: member may file a grievance *at any time;* members may file an appeal *within 60 days* of adverse benefit determination; members must *complete the health plan appeal process before requesting a State fair hearing (SFH);* members may request an SFH *within 120 days* of the appeal resolution notice; and expedited appeals must be processed *within 72 hours.*

Colorado Access should ensure that the Quality of Care Concern (QOCC) Investigations policy is updated to reflect that a quality of care grievance may be filed by a member at any time. In addition, as QOCCs are a component of the member grievance process, the QOCC policy should more specifically reference the time frames and procedures for processing a grievance.

HSAG recommends the following improvements in the Member Grievance Process policy:

- Delete language that states "decisions shall take into account all information submitted by a member without regard to whether such information was submitted or considered in the *initial adverse benefit determination,*" as this requirement pertains to appeals, not grievances.

HSAG recommends the following improvements in the Member Appeals Process policy:

- Delete "until the time period or service limits of the previously authorized service has been met" as a criterion for the length of time that benefits would continue during an appeal or State fair hearing.
- Expand language—per requirements and as practiced by **Colorado Access**—that indicates that **Colorado Access** informs members of their rights to and how to request an SFH through the notice of adverse benefit determination and *the appeal resolution notice* (if not in favor of the member).
- Include in written appeal procedures a description of the process for obtaining a member signature on a written appeal and the processing of appeals when a signature cannot be obtained.

The CHP+ section of the existing provider manual includes detailed information concerning grievances and appeals. **Colorado Access** described the language proposed to be included in the revised provider manual (with an anticipated completion date of early 2018), which generally describes the member's right to file grievances and appeals and the provider's participation in doing so, and will include links to the detailed grievance and appeal policies on the provider website. HSAG advises that **Colorado Access** consider maintaining essential grievance and appeal information for providers directly in the member handbook as well as providing links to the policies and procedures.

Summary of Required Actions

The Member Materials policy stated that notices of action as well as grievance, appeal, and SFH information must use easily-understood language and format. However, in three of eight CHP+ record reviews, the appeal resolution letter was written in language not easy to understand and another three records were determined to be borderline regarding ease of understanding. In all cases, the explanation of the appeal decision included clinical jargon documented by the professional reviewer. **Colorado Access** must ensure that appeal resolution letters to CHP+ members are written in language that may be easily understood by the member.

Standard VII—Provider Participation and Program Integrity

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

HSAG found that **Colorado Access**' policies for the selection and retention of providers were well written and clearly described methods used to identify a specific area of need and then to recruit providers to fill the gap. **Colorado Access** staff members described methods for provider retention which aligned well with the policy.

HSAG reviewed the template letter related to declining a prospective provider from participation and found it to be appropriate. **Colorado Access** provided a description of its process for assessing which relationships result in an individual's inclusion in or exclusion from federal healthcare programs, both prior to hiring the individual and monthly ongoing. **Colorado Access** supplied HSAG with reports evidencing that a process is in place, as described in policies, for reviewing the LEIE and SAM monthly for current providers, employees, board members, and consultants. **Colorado Access** clearly described what would happen should an applicant or current provider, employee, or other relationship be found to be excluded from participation in federal programs.

During the on-site review, **Colorado Access** staff members thoroughly described the compliance program, specifically as it relates to **Colorado Access**' compliance organizational structure, chain of command, and processes. **Colorado Access** noted the compliance training that takes place upon hire (a

live half-day session which occurs monthly) and then annually (through the electronic learning system). The compliance officer also noted the educational programs and professional organizations with which she maintains membership to ensure that she is up-to-date on topics in corporate compliance and fraud, waste, and abuse. **Colorado Access** described its processes for monitoring for and reporting fraud, waste, and abuse. The process included collecting and investigating issues brought forward from various sources for validation, termination of the provider when allegations are confirmed, collection and reimbursement of paid funds, and notification of appropriate entities, including the Department.

Summary of Findings Resulting in Opportunities for Improvement

During the on-site review, the compliance officer described a future edition of **Colorado Access**', provider manual anticipated to be released in the first half of 2018. **Colorado Access** is redesigning its manual to be web-based and to link providers directly to policies and procedures as well as other resources. This process will allow **Colorado Access** to incorporate updates in real time and should transform the provider manual into a more dynamic tool for provider communication. HSAG suggests that **Colorado Access** continue its work on developing the new version of its provider manual so that it can be made available as soon as possible.

Summary of Required Actions

HSAG identified no required actions for this standard.

Standard IX—Subcontracts and Delegation

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

Although the CHP+ program does not have subcontractors or delegates specific to the CHP+ program, some CHP+ processes are subcontracted as a component of **Colorado Access** corporate agreements. No notable differences in findings existed between CHP+ HMO and SMCN. **Colorado Access** subcontracted with entities for the following services: provider credentialing, claims systems, pharmacy management, after-hours crisis calls, fulfillment of member identification cards, fulfillment of member materials, review of clinical appeals, specialist clinical review, and after-hours utilization management (UM). Policies described the delegation program, accountable to the compliance officer, and addressed **Colorado Access**' ultimate accountability for all delegated activities, pre-delegation assessment of the subcontractor, and ongoing oversight and monitoring of delegated functions—with corrective actions and potential revocation of the subcontract if necessary. The subcontractor agreement template and existing subcontractor agreements had been updated to include all information described in the requirements of this standard as well as a detailed description of delegated activities and related

reporting requirements. All agreements had been previously executed several years prior to the on-site review. **Colorado Access** had designated internal "business owners" for oversight of each subcontractor, including ongoing monitoring and management of corrective actions, and provided sample documentation of monthly performance tracking and annual audit of delegate requirements. Monitoring reports were provided monthly to the **Colorado Access** Quality Assurance Committee. HSAG found that **Colorado Access**' subcontractor written agreements and processes met the requirements outlined in this standard.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to subcontracts and delegation.

Summary of Required Actions

All requirements for subcontracts and delegation were scored as not applicable for CHP+ due to an effectiveness date of July 1, 2018, for new federal regulations. As such, HSAG identified no required actions for this standard.

2. Overview and Background

Overview of FY 2017–2018 Compliance Monitoring Activities

For the fiscal year (FY) 2017–2018 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation. Compliance with applicable federal managed care regulations and managed care contract requirements was evaluated through review of all four standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the health plan's contract requirements and regulations specified by the federal Medicaid/CHP+ managed care regulations published May 6, 2016. The SMCN was evaluated for compliance with federal managed care regulations only. SMCN contract-only requirements were not reviewed. 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+ appeals and grievances.

HSAG also reviewed a sample of the health plan's administrative records related to CHP+ HMO appeals and grievances to evaluate implementation of managed care contract requirements for processing grievances and appeals. The Department required no denial record reviews specific to 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 (to the extent that a sufficient number existed). Using a random sampling technique, HSAG selected the samples from all applicable CHP+ appeals and grievances that occurred between July 1, 2017, and December 31, 2017. For the record review, the health plan received a score of *M* (met), *NM* (not met), or *NA* (not applicable) for each required element. Results of record reviews were considered in the review of applicable requirements in Standard VI—Grievance System. HSAG also separately calculated a grievances record review score, an appeals record review score, and 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.[2-1] Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The four standards chosen for the FY 2017–2018 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement.

Objective of the Site Review

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

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

[2-1] 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: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Sep 26, 2017.

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

FY 2016–2017 Corrective Action Methodology

As a follow-up to the FY 2016–2017 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 2016–2017 compliance monitoring site review.

Summary of FY 2016–2017 Required Actions

For FY 2016–2017, HSAG reviewed Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. HSAG found **Colorado Access** 100 percent compliant with the requirements in the access and availability standard. **Colorado Access** was required to develop a process to ensure that both the UM procedures and claims payment decisions are linked to the requirements for the contractors' financial responsibilities for post-stabilization care services not pre-approved, as outlined in the Emergency and Post-Stabilization Care policy. Additionally, **Colorado Access** was required to develop a process to ensure that contractors' financial responsibilities for post-stabilization care services not pre-approved are integrated into claims payment decisions.

Summary of Corrective Action/Document Review

Colorado Access submitted a proposed plan of corrective actions in September 2017. After reviewing the proposed plan, HSAG and the Department required that **Colorado Access** revise its proposed interventions. **Colorado Access** was allowed until March 1, 2017, to submit evidence of having implemented its corrective actions. HSAG completed this 2017–2018 compliance monitoring report prior to receiving and processing **Colorado Access**' 2016–2017 CAP submission and is unable to comment on the completeness of the corrective actions.

Summary of Continued Required Actions

HSAG will review **Colorado Access**' CAP submission with the Department when received and work with the health plan to ensure full implementation of all corrective actions.

Appendix A. Compliance Monitoring Tool

The completed compliance monitoring tool follows this cover page.

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor provides all required member information to members in a manner and format that may be easily understood **and is readily accessible by members.** *(Note: Readily accessible means electronic information which complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines.)* *42 CFR 438.10(b)(1)* Contract: Section 21.A.	**HMO and SMCN** • ADM208 Member Materials • ADM 207 Effective Communication with LEP & SI/SI Persons • MKT203 Website Design, Maintenance and Oversight • MKT201 Printing/Marketing Information and Corporate Branding Materials • CHP+ Communications Plan • Language selection on Website http://www.coaccess.com/child-health-plan-plus	**CHP+** ☒ Met ☐ Not Scored **SMCN** ☒ Met ☐ Not Scored
2. The Contractor has in place a mechanism to help members understand the requirements and benefits of the plan. *42 CFR 438.10(c)(7)* Contract: Exhibit B—6.3.1.15	**HMO** • CHP HMO Welcome Letter • HMO Evidence of Coverage • HMO Website Income guidelines, summary of benefits. http://www.coaccess.com/chp-member-information **SMCN** • SMCN Evidence of coverage • CHP SMCN_Welcome Letter • CHP SMCN_Choose an HMO • SMCN Website https://www.chpplusproviders.com/members.asp	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. **For consistency in the information provided to members, the Contractor uses the following as developed by the State:** • **Definitions for managed care terminology, including appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care.** • **Model member handbooks and member notices.** *42 CFR 438.10(c)(4)*	**HMO and SMCN** CHP and SMCN use the definitions provided by the state contracts or other communications from the state. At this time the state has not provided any updated definitions.	**CHP+** ☐ Met ☒ Not Scored **SMCN** ☐ Met ☒ Not Scored
Findings: HSAG is aware and the Department acknowledges that, for the 2017–2018 compliance review period, the State has neither developed nor communicated to health plan contractors a consensus list of managed care definitions to be used in information provided to members. HSAG has therefore scored this element *Not Applicable.* HSAG recommends that all contractors maintain awareness of this requirement and, when received, incorporate State-defined managed care definitions into all applicable member communications, as directed by the Department.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • Written materials must use easily understood language and format. *42 CFR 438.10(d)(3) and (d)(6)(i)* Contract: Exhibit B—10.8.2.5	**HMO and SMCN** • ADM208 Member Material • MKT201 Printed Marketing/Informational and Corporate Branding Materials • ADM207 Effective Communication with Limited English Proficient Persons and SI/SI Persons • CHP+ Communications Plan **HMO** • Evidence of Coverage – English & Spanish Page 1, Do You Need Special Help with This Booklet? Page 1, Tenemos este libro disponible en espanol • Language selection on Co Access Website http://www.coaccess.com/child-health-plan-plus **SMCN** • Evidence of Coverage –English & Spanish Page 4, Do You Need Special Help with This Booklet? Page 5, Tenemos este libro disponible en espanol	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. **Written materials that are critical to obtaining services include: provider directories, member handbooks, appeal and grievance notices, and denial and termination notices.** **All written materials for members must:** • **Use a font size no smaller than 12 point.** • Be available in alternative formats **and through provision of auxiliary aids and service** that takes into consideration the	**HMO and SMCN** • ADM208 Member Material • MKT201 Printed Marketing/Informational and Corporate Branding Materials • ADM207 Effective Communication with Limited English Proficient Persons and SI/SI Persons • CHP+ Communications Plan **HMO** • Evidence of Coverage – English & Spanish	**CHP+** ☐ Met ☒ Not Scored **SMCN** ☐ Met ☒ Not Scored

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
special needs of members **with disabilities** or limited English proficiency. • **Include taglines in large print (18 point) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service number, and availability of materials in alternative formats.** *42 CFR 438.10(d)(3) and (d)(6)(ii–iv)*	Page 1, Do You Need Special Help with This Booklet? Page 1, Tenemos este libro disponible en espanol • Language selection on Co Acc Website http://www.coaccess.com/child-health-plan-plus **SMCN** • Evidence of Coverage –English & Spanish Page 4, Do You Need Special Help with This Booklet? Page 5, Tenemos este libro disponible en espanol	
Findings: HSAG found that the taglines describing how to request auxiliary aids and services including written translation and oral interpretation, while present, were not in 18-point font on either paper or electronic member materials, as required.		
Recommendations: HSAG recommends that Colorado Access ensure that member materials include taglines describing how to request auxiliary aids and services, including written translation and oral interpretation, in 18-point font.		
6. **If the Contractor makes information available electronically—Information provided electronically must meet the following requirements:** • **The format is readily accessible (see definition of readily accessible above).** • **The information is placed in a Web site location that is prominent and readily accessible.**	**HMO & SMCN** • MKT203 Website Design, Maintenance and Oversight • ADM207 Effective Communication with Limited English Proficient Persons and SI/SI Persons • CHP+ Communications Plan	**CHP+** ☐ Met ☒ Not Scored **SMCN** ☐ Met ☒ Not Scored

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• **The information can be electronically retained and printed.** • **The information complies with content and language requirements.** • **The member is informed that the information is available in paper form without charge upon request, and is provided within five (5) business days.** *42 CFR 438.10(c)(6)*		
Findings: During the desk review process, HSAG conducted an accessibility check on a few Colorado Access Web pages using the WAVE Web Accessibility Evaluation Tool. Through use of the tool, HSAG discovered several general accessibility errors and contrast errors on various Web pages. HSAG also ran an accessibility check on several PDF documents available for download from the Colorado Access website. Through use of the Adobe Acrobat Pro accessibility checker, HSAG discovered accessibility errors. HSAG repeated these accessibility checks during the on-site review for educational purposes, and the same outcomes were discovered. HSAG was unable to locate notification on the Colorado Access website informing members that electronic information is available in paper form upon request without charge and is provided within five business days. During the on-site interview, HSAG and Colorado Access discussed possible placement on the website appropriate for displaying such messaging, especially considering that many members may not have state-of-the-art cell phones or access to sufficient bandwidth to search the website for this notice or to download the available PDF documents.		
Recommendations: HSAG recommends that Colorado Access develop a process to ensure that all information on its website is readily accessible (i.e., complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines). HSAG recommends that Colorado Access inform members in a prominent place on its website that information on the website is available in paper form upon request, without charge, and provided within five business days.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. **The Contractor makes available to members in electronic or paper form information about its formulary:** • **Which medications are covered (both generic and name brand).** • **What tier each medication is on.** • **Formulary drug list must be available on the Contractor's Web site in a machine readable file and format.** *42 CFR 438.10(i)*	**HMO** • http://www.coaccess.com/documents/CHPHMO_FL.pdf **SMCN** • http://www.coaccess.com/documents/CHPSMCN_FL.pdf	**CHP+** ☒ Met ☐ Not Scored **SMCN** ☒ Met ☐ Not Scored
8. The Contractor makes interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and how to access them. *42 CFR 438.10(d)(4) and (d)(5)* Contract: Exhibit B—7.5, 14.1.3.4, 14.1.7.4–6	**HMO and SMCN** • ADM207 Effective Communication with Limited English Proficient Persons and SI/SI Persons • CHP+ Communications Plan **HMO** • Provider Manual, Page 3-4, 9 • Evidence of Coverage Footer of every page: *Have Questions? Need Help? We are here to help you in the language you speak! For free interpretation services:* Call us at (303) 751-9021, toll free 1-888-214-1101 TTY for the deaf or hard of hearing please call (720) 744-5126 or toll free at 1-888-803-4494 Email us at Customer.Service@coaccess.com	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	SMCN • SMCN Provider Manual Page 9 • Evidence of Coverage Page 4, last paragraph Footer of every page: Have questions? Need help? We are here to help you in the language you speak! 14 Call us at 303-751-9051 or 800-414-6198 (toll free) TTY users should call 720-744- 5126 or 888-803-4494 (toll free)	
9. **Interpretation services include oral interpretation and use of auxiliary aids such as TTY/TDY and American Sign Language.** • The Contractor notifies members that **auxiliary aids and services are available upon request and at no cost for members with disabilities**, and how to access them. *42 CFR 438.10(d)(4) and (d)(5)*	**HMO and SMCN** • ADM207 Effective Communication with Limited English Proficient Persons and SI/SI Persons • CHP+ Communications Plan **HMO** • Provider Manual, Page 3-4, 9 • Evidence of Coverage Footer of every page: *Have Questions? Need Help? We are here to help you in the language you speak! For free interpretation services:* Call us at (303) 751-9021, toll free 1-888-214-1101 TTY for the deaf or hard of hearing please call (720) 744-5126 or toll free at 1-888-803-4494 Email us at Customer.Service@coaccess.com **SMCN** • SMCN Provider Manual Page 9 • Evidence of Coverage Page 4, last paragraph	**CHP+** ☒ Met ☐ Not Scored **SMCN** ☒ Met ☐ Not Scored

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Footer of every page: Have questions? Need help? We are here to help you in the language you speak! 14 Call us at 303-751-9051 or 800-414-6198 (toll free) TTY users should call 720-744-5126 or 888-803-4494 (toll free)	
10. **The Contractor provides each member with a member handbook within a reasonable time after receiving notification of the member's enrollment.** *42 CFR 438.10(g)(1)*	**HMO and SMCN** • CHP+ HMO, SMCN Member Materials Mailing Desktop Procedure	**CHP+** ☒ Met ☐ Not Scored **SMCN** ☒ Met ☐ Not Scored
11. The Contractor gives members written notice of any significant change (as defined by the State) in the information required at 438.10(g) at least 30 days before the intended effective date of the change. *42 CFR 438.10(g)(4)* Contract: Exhibit B—14.1.3.13	**HMO and SMCN** • MKT201 Printed Marketing/Informational & Corporate Branding Materials **HMO** • Evidence of Coverage Page 6, Attention Members CHP HMO Website http://www.coaccess.com/chp-member-information **SMCN** • Evidence of Coverage Page 6, Attention Members	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. *42 CFR 438.10(f)(1)* Contract: Exhibit B—7.12.2, 14.1.8.1	**HMO and SMCN** • ADM300 Provider Terminations	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. The Contractor makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals**, pharmacies, and behavioral health providers, and long-term services and supports (LTSS) providers:** • The provider's name and **group affiliation**, street address(es), telephone number(s), **Web site URL, specialty (as appropriate),** and whether the providers will accept new members. • **The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training.**	**HMO** • *Provider Directory https://providers.coaccess.com/ProviderSearch/home.jsf • Pharmacy Directory http://www.coaccess.com/documents/NVCHPH-CO-Pharmacy-Listing.pdf **SMCN** • Provider Directory https://providers.coaccess.com/ProviderSearchSMCN/home.jsf • Pharmacy Directory-Also in the folder as an excel document https://www.chpplusproviders.com/members.asp *Directory will be updated in the next few weeks. Demo should be available at the on-site visit.	**CHP+** ☐ Met ☒ Not Scored **SMCN** ☐ Met ☒ Not Scored

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• **Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment.** *(Note: Information included in a paper provider directory must be updated at least monthly, and electronic provider directories must be updated no later than 30 calendar days after the Contractor receives updated provider information.)* *42 CFR 438.10(h)(1–3)*		
Findings: HSAG reviewed both the provider directory and the "Find A Provider" feature on the Colorado Access website. While the provider directory did not contain all required information, the "Find A Provider" was a valuable resource that contained comprehensive information in a searchable format. As discussed on-site, the disability accommodation field did not define the accommodations available at each provider's location. Further research performed by Colorado Access during the on-site visit concluded that only one area of disability access, such as handicap parking or a nearby public transit line, could qualify a provider as having "disability access." The requirement, however, clarifies this to include accessible offices, exam rooms, and equipment.		
Recommendations: HSAG recommends that Colorado Access update its provider directory and online "Find A Provider" provider search feature to better clarify what it defines as "disability access" in agreement with the requirement (e.g., presence of an adjustable exam table and/or a ceiling- or floor-based patient lift as described in Part 4 of the Americans with Disabilities Act publication, *Access To Medical Care For Individuals With Mobility Disabilities.*		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. **Provider directories are made available on the Contractor's Web site in a machine readable file and format.** *42 CFR §438.10(h)(4)*	**HMO & SMCN** • MKT203 Website Design, Maintenance and Oversight **HMO** • Provider Directory https://providers.coaccess.com/ProviderSearch/home.jsf **SMCN** • Provider Directory https://providers.coaccess.com/ProviderSearchSMCN/home.jsf	**CHP+** ☒ Met ☐ Not Scored **SMCN** ☒ Met ☐ Not Scored
15. The member handbook provided to members following enrollment includes: • The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled. • Procedures for obtaining benefits, including authorization requirements and/or referrals for specialty care and for other benefits not furnished by the member's primary care provider. • Any restrictions on the member's freedom of choice among network providers. • In the case of a counseling or referral service that the Contractor does not cover due to moral or religious objections, the Contractor informs the member that the service is not covered and	**HMO** • Evidence of Coverage Page 13, Summary of Benefits Page 20, Primary Care Providers Page 23, Referrals Page 26, Services from Out-of-Network providers Page 84, Preauthorization for health care services Page 88, UM- Moral or religious objections **SMCN** • Evidence of Coverage Page 12, Summary of Benefits Page 37, Member Benefits – Covered Services Page 25, Pre-Authorization Page 18, Primary Care Providers Page 27, UM - Moral or religious objections Page 30, Services from Out-of-Network providers	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
how the member can obtain information from the State about how to access such services. *42 CFR 438.10 (g)(2)(iii, iv, vi) and (g)(ii)(A-B)* Contract: Exhibit B—14.1.3.13.1–3, 14.1.3.14.4, Exhibit K—1.1.4.1–3, 1.1.7, 1.1.16.3.11, 1.1.28		
16. The member handbook provided to members following enrollment includes: • The extent to which and how members may obtain benefits, including family planning services, from out-of-network providers. **This includes an explanation that the Contractor cannot require the member to obtain a referral before choosing family planning provider.** • **The process of selecting and changing the member's primary care provider.** *42 CFR 438.10(g)(2)(vii, x)*	**HMO** • Evidence of Coverage Page 31, Member benefits – Family Planning Page 21, Choosing or changing your PCP **SMCN** • Evidence of Coverage Page 38, Member benefits – Family Planning Page 19, Selecting a PCP	**CHP+** ☒ Met ☐ Not Scored **SMCN** ☒ Met ☐ Not Scored
17. The member handbook provided to members following enrollment includes the following member rights and protections as specified in 42 CFR 438.100. Each member has the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for his or her dignity and privacy.	**HMO** • Evidence of Coverage Page 17, Member Rights **SMCN** • Evidence of Coverage Page 14, Member Rights	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding his or her healthcare, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. • Request and receive a copy of his or her medical records, and request that they be amended or corrected. • Be furnished healthcare services in accordance with requirements for access, coverage, and coordination of medically necessary services. • Freely exercise his or her rights; and the exercising of those rights will not adversely affect the way the Contractor, its network providers, or the State agency treats the member. *42 CFR 438.10(g)(2)(ix)* Contract: Exhibit B—14.1.3.6.1, Exhibit K—1.1.2		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. The member handbook provided to members following enrollment includes the following information regarding the grievance, appeal, and fair hearing procedures and timeframes: • The right to file grievances and appeals. • The requirements and timeframes for filing a grievance or appeal. • The right to a request a State fair hearing after the Contractor has made a determination on a member's appeal which is adverse to the member. • The availability of assistance in the filing process. • The fact that, when requested by the member: – Benefits that the Contractor seeks to reduce or terminate will continue if the member files an appeal or if a request for State fair hearing is filed within the time frames specified for filing. – If benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal or State fair hearing is pending if the final decision is adverse to the member. *42 CFR 438.10(g)(2)(xi)* Contract: Exhibit B—1.1.16.6, 1.1.16.6.1, 1.1.16.6.3	**HMO** • Evidence of Coverage Page 94-100, Grievances and Appeals **SMCN** • Evidence of Coverage Page 99, Complaints, Appeals and Grievances	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
19. The member handbook provided to members following enrollment includes the extent to which and how after-hours and emergency coverage are provided, including: • What constitutes an emergency medical condition and emergency services. • The fact that prior authorization is not required for emergency services. • The fact that the member has the right to use any hospital or other setting for emergency care. *42 CFR 438.10(g)(2)(v)* Contract: Exhibit K—1.1.10.1, 1.1.10.1.1–2, and 5	**HMO** • Evidence of Coverage Page 43, Member Benefits - Urgent After-Hours Care Page 44, Emergency Care Page 46, Travel Outside of the Country **SMCN** • Evidence of Coverage Page 48, Urgent After-Hours Care Page 49, Emergency Care Page 51, Travel Outside of the Country	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
20. The member handbook provided to members following enrollment includes: • That cost-sharing, if any, is imposed under the State plan. • How and where to access any benefits that are available under the State plan but not covered under the CHP+ managed care contract. • How transportation is provided. *42 CFR 438.10(g)(2)(ii, viii)* Contract: Exhibit K—1.1.3	**HMO** • Evidence of Coverage Page 24, Cost Sharing Page 21, Paragraph 3 – lack of in-network specialist Page 47, Member Benefits – Ambulance Transportation **SMCN** • Evidence of Coverage Page 30-32, Copayments Page 9, paragraph 4- lack of in-network provider Page 52, Member Benefits – Ambulance Transportation	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
21. The member handbook provided to members following enrollment includes: • **The toll-free telephone number for member services, medical management, and any other unit providing services directly to members.** • **Information on how to report suspected fraud or abuse.** • **How to access auxiliary aids and services, including information in alternative formats or languages.** *42 CFR 438.10(g)(2)(xiii, xiv, xv)*	**HMO** • Evidence of Coverage Page 3, last paragraph Page 4, first 2 paragraphs Page 29-30 Fraud Page 88, UM phone numbers (same as CS) Footer of every page: *Have questions? Need help?* *We are here to help you in the language you speak! Free interpretation services are available* Call us at 303-751-9021 or 888-214-1101 (toll free) TTY users should call 720-744-5126 or 888-803-4494 (toll free) **SMCN** • Evidence of Coverage Page 6, last paragraph Page 7, SMCN Customer Service; TTY for the Deaf or Hard of Hearing Page 27, UM phone numbers (same as CS) Page 93, Fraudulent Insurance Acts Footer of every page: "Have questions? Need help? We are here to help you in the language you speak! Call us at 303-751-9051 or 800-414-6198 (toll free) TTY users should call 720-744-5126 or 888-803-4494 (toll free)"	**CHP+** ☒ Met ☐ Not Scored **SMCN** ☒ Met ☐ Not Scored

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
22. The member handbook provided to members following enrollment includes **how to exercise** an advance directive as required in 438.3 (j): • The member's right under the State law to make decisions regarding medical care and to formulate advance directives, including the right to accept or refuse medical or surgical treatment. • The Contractor's policies and procedures respecting implementation of advance directives, with a clear statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience. • Instructions that complaints concerning noncompliance with advance directives requirements may be filed with the Colorado Department of Public Health and Environment. *42 CFR 438.10(g)(2)(xii)* Exhibit B—14.1.1.2.7, 14.1.1.2.7.1, 14.1.9	**HMO & SMCN** • CCS303 – Advance Directives **HMO** • http://www.coaccess.com/advance-directives • Evidence of Coverage Page 89-90, Advance Medical Directives **SMCN** • https://www.chpplusproviders.com/members.asp Advance Directives • Evidence of Coverage Page 16-17, Advance Medical Directives	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
23. **The Contractor provides member information by any of:** • **Mailing a printed copy of the information to the member's mailing address.** • **Providing the information by email after obtaining the member's agreement to receive the information by email.** • **Posting the information on the Web site of the MCO and advising the member in paper or electronic form that the information is available on the Internet and including the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost.** • **Providing the information by any other method that can reasonably be expected to result in the member receiving that information.** *42 CFR 438.10(g)(3)*	**HMO & SMCN** • ADM207 Effective Communication with Limited English Proficient Persons and SI/SI Persons • CHP+ Communications Plan	**CHP+** ☒ Met ☐ Not Scored **SMCN** ☒ Met ☐ Not Scored

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
24. The Contractor must make available to members, upon request, any physician incentive plans in place. *42 CFR 438.10(f)(3)*	**HMO & SMCN** • CS DP24 Physician Incentive Plans **HMO** • Evidence of Coverage Page 17, Member Rights, 2nd to last bullet **SMCN** • Evidence of Coverage Page 14, Member Rights, 3rd to last bullet	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Note: While scoring of evidence related to individual, new federal requirements in the tool may indicate *Met* or *Not Scored*, all new requirements were scored *Not Applicable* in the total results; new federal requirements do not apply to CHP+ until July 1, 2018.

Results for Standard V—Member Information for CHP+							
Total	Met	=	12	X	1.00	=	12
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	12	X	NA	=	0
Total Applicable		=	12	**Total Score**		=	12
				Total Score ÷ Total Applicable		=	100%

Results for Standard V—Member Information for SMCN							
Total	Met	=	12	X	1.00	=	12
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	12	X	NA	=	0
Total Applicable		=	12	**Total Score**		=	12
				Total Score ÷ Total Applicable		=	100%

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. **The Contractor has established internal grievance procedures under which members, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance. The Contractor must have a grievance and appeal system in place to handle appeals of an adverse benefit determination and grievances, as well as processes to collect and track information about them.** • **The Contractor may have only one level of appeal for members (or providers acting on their behalf).** • **A member may request a State fair hearing after receiving an appeal resolution notice from the Contractor that the adverse benefit determination has been upheld.** • **If the Contractor fails to adhere to required timeframes for processing appeals, the member is deemed to have exhausted the Contractor's appeal process and the member may initiate a State fair hearing.** *42 CFR 438.400(a)(3)* *42 CFR 438.402(a-c)* *42 CFR 438.400(b)* 10 CCR 2505-10—8.209.3.A, 8.209.4.A.2.c, 8.208.4.N, and 8.209.4.O	**HMO & SMCN** • ADM203-Member Grievance Process • ADM219- Member Appeal Process • QM201- Quality of Care Concern Investigations	**CHP+** ☒ Met ☐ Not Scored **SMCN** ☒ Met ☐ Not Scored

Findings:
Colorado Access stated that it would implement its grievance and appeal policies—revised for compliance with new federal and State requirements—for CHP+ members effective November 13, 2017. All updated policies describe procedures in compliance with new regulations (with few exceptions noted following). Prior to implementation of updated policies and procedures, CHP+ members remained subject to the grievance and appeal procedures outlined in Colorado Access' contract with the State.

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Recommendations: Colorado Access should ensure that member handbooks for CHP+ and SMCN as well as provider manuals for CHP+ and SMCN are updated to coincide with implementation of revised grievance and appeal policies and procedures, and should alert members and providers of these changes.		
2. The Contractor defines **adverse benefit determination** as: • The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. • The reduction, suspension, or termination of a previously authorized service. • The denial, in whole, or in part, of payment for a service. • The failure to provide services in a timely manner, as defined by the State. • The failure to act within the time frames defined by the State for standard resolution of grievances and appeals. • For a resident of a rural area with only one managed care plan, the denial of a CHP+ member's request to exercise his or her rights to obtain services outside of the network under the following circumstances: – The service or type of provider (in terms of training, expertise, and specialization) is not available within the network. – The provider is not part of the network, but is the main source of a service to the member—provided that:	**HMO and SMCN** • CCS307- Utilization Review Determinations • ADM219 Member Appeal Process	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
○ The provider is given the opportunity to become a participating provider. ○ If the provider does not choose to join the network or does not meet the Contractor's qualification requirements, the member will be given the opportunity to choose a participating provider and then will be transitioned to a participating provider within 60 days. *42 CFR 438.400(b)* *42 CFR 438.52(b)(2)(ii)* Contract: Exhibit B—1.1.1		
3. The Contractor also defines **adverse benefit determination** as: • **The denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other).** *42 CFR 438.400(b)* *42 CFR 438.52(b)(2)(ii)* 10 CCR 2505-10—8.209.2.A.7	**HMO and SMCN** • CCS307- Utilization Review Determinations • ADM219 Member Appeal Process	**CHP+** ☒ Met ☐ Not Scored **SMCN** ☒ Met ☐ Not Scored

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor defines "Appeal" as "a review by the Contractor of an **adverse benefit determination**." *42 CFR 438.400(b)* Contract: Exhibit B—1.1.4	**HMO and SMCN** • ADM219 Member Appeal Process	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. The Contractor defines "grievance" as "an expression of dissatisfaction about any matter other than an **adverse benefit determination**." Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights **regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision.** *42 CFR 438.400(b)* 10 CCR 2505-10—8.209.2.D, 8.209.4.A.3.c.i	**HMO and SMCN** • ADM203 Member Grievance Process	**CHP+** ☒ Met ☐ Not Scored **SMCN** ☒ Met ☐ Not Scored

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor has provisions for who may file: • A member may file a grievance or a Contractor-level appeal and may request a State fair hearing. • With the member's written consent, a provider or authorized representative may file a grievance or a Contractor-level appeal and may request a State fair hearing on behalf of a member. *42 CFR 438.402(c)* Contract: Exhibit B—14.1.4.5, 14.1.5.1	**HMO and SMCN** • ADM203- Member Grievance Process • ADM219- Member Appeal Process	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
7. The Contractor accepts grievances orally or in writing. *42 CFR 438.402(c)(3)(i)* Contract: Exhibit B—14.1.5.6	**HMO and SMCN** • ADM203- Member Grievance Process	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. Members may file a grievance **at any time.** *42 CFR 438.402(c)(2)(i)* 10 CCR 2505-10—8.209.5.A	**HMO and SMCN** • ADM203- Member Grievance Process	**CHP+** ☐ Met ☒ Not Scored **SMCN** ☐ Met ☒ Not Scored
Findings: While policy ADM203—Member Grievance Process correctly stated that a member may file a grievance at any time, the related policy QM201- Quality of Care Concern (QOCC) Investigations stated that a member may file a quality of care grievance within 30 days of the incident. The CHP+ HMO and SMCN member handbooks also state that the member must file a grievance within 30 days of the incident.		
Recommendations: Colorado Access intends to convert CHP+ members to the updated corporate procedures applying to grievances and appeals effective November 13, 2017; therefore, Colorado Access should ensure that the QOCC policy is corrected to state that members may file QOCCs at any time. In addition, the CHP+ HMO and SMCN member handbooks should be updated to state that members may file grievances at any time.		
9. The Contractor sends the member written acknowledgement of each grievance within two (2) working days of receipt. *42 CFR 438.406(b)(1)* Contract: Exhibit B—14.1.5.5	**HMO and SMCN** • ADM203 Member Grievance Process	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor must resolve each grievance and provide notice as expeditiously as the member's health condition requires, and **within 15 working days of when the member files the grievance.** • **Notice to the member must be in a format and language that may be easily understood by the member.** *42 CFR 438.408(a) and (b)(1) and (d)(1)* Contract: Exhibit B—14.1.5.7, 14.1.5.9	**HMO and SMCN** • ADM203 Member Grievances Process • ADM208 Member Materials	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11. The written notice of grievance resolution includes: • Results of the disposition/resolution process and the date it was completed. Contract: Exhibit B—14.1.5.1.1	**HMO and SMCN** • ADM203 Member Grievance Process	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, **auxiliary aids and services upon request**, as well as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. *42 CFR 438.406(a)(1)* 10 CCR 2505-10—8.209.4.C	**HMO and SMCN** • ADM203- Member Grievance Process • ADM219- Member Appeal Process • ADM207- Effective Communication with limited English proficient persons and SI/SI Persons	**CHP+** ☒ Met ☐ Not Scored **SMCN** ☒ Met ☐ Not Scored
13. The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who: • Were not involved in any previous level of review or decision-making nor a subordinate of any such individual. • Have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding any of the following: – An appeal of a denial that is based on lack of medical necessity. – A grievance regarding the denial of expedited resolution of an appeal. – A grievance or appeal that involves clinical issues. *42 CFR 438.406(b)(2)* Contract: Exhibit B—14.1.5.8	**HMO and SMCN** • ADM219- Member Appeal Process • ADM203- Member Grievance Process	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. Contractor ensures that the individuals who make decisions on grievances and appeals: • **Take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.** *42 CFR 438.406(b)(2)* 10 CCR 2505-10—8.209.5.C, 8.209.4.E	**HMO and SMCN** • ADM219- Member Appeal Process • ADM203- Member Grievance Process	**CHP+** ☒ Met ☐ Not Scored **SMCN** ☒ Met ☐ Not Scored
15. A member may file an appeal with the Contractor **within 60 calendar days** from the date on the adverse benefit determination notice. *42 CFR 438.402 (c)(2)(ii)* 10 CCR 2505-10—8.209.4.B	**HMO and SMCN** • ADM219- Member Appeal Process	**CHP+** ☐ Met ☒ Not Scored **SMCN** ☐ Met ☒ Not Scored
Findings: Staff members stated that Colorado Access intends to implement the corporate policy ADM219 for CHP+ members effective November 13, 2017. The policy ADM219—Member Appeal Process states that members may file an appeal within 60 days of receiving the notice of adverse benefit determination. However, the CHP+ and SMCN handbooks and CHP+ provider manual state the 30-day time, as outlined in the CHP+ contract requirements.		
Recommendations: Colorado Access intends to apply updated corporate appeal procedures to CHP+ members effective November 13, 2017; therefore, Colorado Access should ensure that the CHP+ HMO and SMCN member handbooks and provider manual are updated to state that a member may file an appeal within 60 days of receiving an adverse benefit determination.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The member may file an appeal either orally or in writing, and must follow the oral request with a written, signed appeal (unless the request is for expedited resolution). *42 CFR 438.402(c)(3)(ii)* *42 CFR 438.406 (b)(3)* Contract: Exhibit B—14.1.4.6, 14.1.4.16.1	**HMO and SMCN** • ADM219- Member Appeal Process	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
17. The Contractor sends written acknowledgement of each appeal within two (2) working days of receipt, unless the member or designated client representative requests an expedited resolution. *42 CFR 438.406(b)(1)* Contract: Exhibit B—14.1.4.7	**HMO and SMCN** • ADM219- Member Appeal Process	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. The Contractor's appeal process must provide: • That oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date), and must be confirmed in writing unless the member or provider requests expedited resolution. • That if the member orally requests an expedited appeal, the Contractor shall not require a written, signed appeal following the oral request. • That included, as parties to the appeal, are: – The member and his or her representative, or – The legal representative of a deceased member's estate. *42 CFR 438.406(b)(3) and (6)* Contract: Exhibit B—14.1.4.9.3	**HMO and SMCN** • ADM219- Member Appeal Process	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
19. The Contractor's appeal process must provide: • The member a reasonable opportunity, in person and in writing, to present evidence **and testimony** and make legal and factual arguments. (**The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution time frame in the case of expedited resolution.**) • The member and his or her representative the member's case file, including medical records, other documents and records, and **any new or additional documents considered, relied upon, or generated by the**	**HMO and SMCN** • ADM219- Member Appeal Process	**CHP+** ☒ Met ☐ Not Scored **SMCN** ☒ Met ☐ Not Scored

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contractor in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame. *42 CFR 438.406(b)(4-5)* 10 CCR 2505-10—8.209.4.F, 8.209.4.G, 8.209.4.H, 8.209.4.I		
20. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. *Note: If the written appeal is not signed by the member or designated client representative (DCR), the appeal resolution will remain pending until the appeal is signed. All attempts to gain a signature shall be included in the record of the appeal.* • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)* *42 CFR 438.408(d)(2)* *42 CFR 438.10* Contract: Exhibit B—14.1.4.8, 14.1.3.1	**HMO and SMCN** • ADM219- Member Appeal Process	**CHP+** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Policy ADM 219—Member Appeal Process accurately stated that standard appeals will be resolved in 10 days, and all CHP+ record reviews indicated resolution within the required time frame. Policy ADM 208—Member Materials stated that NOAs, grievance, appeal, and SFH		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
information must use easily understood language and format. However, in three of eight CHP+ record reviews, the appeal resolution letter was written in language not easy to understand and another three records were determined to be borderline regarding ease of understanding. In all cases, the explanation of the appeal decision included clinical jargon. Staff members stated that the appeal manager attempts to make phone contact with each member to verbally explain the outcome of the appeal and ensure member understanding. HSAG did not conduct appeal record reviews for SMCN.		
Required Actions: Colorado Access must ensure that appeal resolution letters to CHP+ members are written in language that may be easily understood by the members.		
21. For expedited appeal, the Contractor must resolve the appeal and provide written notice of disposition to affected parties **within 72 hours** after the Contractor receives the appeal. • For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. *42 CFR 438.408(b)(3) and (d)(2)(ii)* 10 CCR 2505-10—8.209.4.J.2, 8.209.4.L	**HMO and SMCN** • ADM219- Member Appeal Process	**CHP+** ☒ Met ☐ Not Scored **SMCN** ☒ Met ☐ Not Scored
22. The Contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: • The member requests the extension; or • The Contractor shows (to the satisfaction of the Department, upon request) that there is need for additional information and how the delay is in the member's interest. *42 CFR 438.408(c)(1)* Contract: Exhibit B—14.1.5.10	**HMO and SMCN** • ADM203- Member Grievance Process • ADM219- Member Appeal Process	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
23. If the Contractor extends the time frames, it must—for any extension not requested by the member: • Make reasonable efforts to give the member prompt oral notice of the delay. • **Within two (2) calendar days**, give the member written notice of the reason for the delay **and inform the member of the right to file a grievance if he or she disagrees with that decision.** • Resolve the appeal as expeditiously as the enrollees health condition requires and no later than the date that the extension expires. *42 CFR 438.408(c)(2)*	**HMO and SMCN** • ADM203- Member Grievance Process • ADM219- Member Appeal Process	**CHP+** ☒ Met ☐ Not Scored **SMCN** ☒ Met ☐ Not Scored
24. The written notice of appeal resolution must include: • The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. – The right to request that benefits/services continue* while the hearing is pending, and how to make the request. o That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's adverse benefit determination.	**HMO and SMCN** • ADM219- Member Appeal Process	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
**Continuation of benefits applies only to previously authorized services for which the Contractor provides 10-day advance notice to terminate, suspend, or reduce.* *42 CFR 438.408(e)* Contract: Exhibit B—14.1.4.10		
25. **The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of resolution.** • If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. *42 CFR 438.408(f)(1–2)* 10 CCR 2505-10—8.209.4.N, 8.209.4.O	**HMO and SMCN** • ADM219- Member Appeal Process	**CHP+** ☐ Met ☒ Not Scored **SMCN** ☐ Met ☒ Not Scored
Findings: Staff members stated that Colorado Access intends to implement the corporate policy ADM219 for CHP+ members effective November 13, 2017. The policy ADM219—Member Appeal Process states that members may request a State fair hearing within 120 days following completion of the contractor appeal process. In addition, the appeal resolution letters include information informing members of the new time frames for requesting a State fair hearing. However, the CHP+ HMO and SMCN member handbooks as well as the provider manuals do not include the updated regulatory information.		
Recommendations: Colorado Access intends to apply updated corporate appeal procedures to CHP+ members effective November 13, 2017; therefore, Colorado Access should ensure that the CHP+ HMO and SMCN member handbooks and provider manuals are similarly updated to state that the member may request a State fair hearing within 120 calendar days from the date of the notice of appeal resolution upholding the adverse benefit determination.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
26. The parties to the State fair hearing include the Contractor as well as the member and his or her representative or the representative of a deceased member's estate. *42 CFR 438.408(f)(3)* Contract: Exhibit B—14.1.4.17.5	**HMO and SMCN** • ADM219- Member Appeal Process	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
27. The Contractor maintains an expedited review process for appeals when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life; physical or mental health; or ability to attain, maintain, or regain maximum function. The Contractor's expedited review process includes that: • The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. *42 CFR 438.410(a-b)* Contract: Exhibit B—14.1.4.16, 14.1.4.16.4	**HMO and SMCN** • ADM219- Member Appeal Process	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
28. If the Contractor denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the time frame for standard resolution. • **Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and within two (2) calendar days provide the member written notice of the reason for the decision and inform the member of the right to file a grievance if he or she disagrees with that decision.** *42 CFR 438.410(c)* Contract: Exhibit B—15.1.4.16.5	**HMO and SMCN** • ADM219- Member Appeal Process	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
29. The Contractor provides for continuation of benefits/services while the Contractor-level appeal and the State fair hearing are pending if: • The member files timely* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the Contractor mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired.	**HMO and SMCN** • ADM219- Member Appeal Process	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The member requests an appeal in accordance with required timeframes. ** This definition of "timely filing" only applies for this scenario–i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced. Note: The provider may not request continuation of benefits on behalf of the member.)* *42 CFR 438.420(a) and (b)* Contract: Exhibit B—14.1.4.11		
30. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of the following occurs: • The member withdraws the appeal or request for a State fair hearing. • The member fails to request a State fair hearing and continuation of benefits within 10 calendar days after the Contractor sends the notice of an adverse resolution to the member's appeal. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR 438.420(c)* Contract: Exhibit B—14.1.4.12	**HMO and SMCN** • ADM219- Member Appeal Process	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
31. Member responsibility for continued services: • If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's adverse benefit determination, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. *42 CFR 438.420(d)* Contract: Exhibit B—14.1.4.13	**HMO and SMCN** • ADM219- Member Appeal Process	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
32. If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services as promptly and as expeditiously as the member's health condition requires but no later than **72 hours** from the date it receives notice reversing the determination. *42 CFR 438.424(a)* 10 CCR 2505-10—8.209.W	**HMO and SMCN** • ADM219- Member Appeal Process	**CHP+** ☒ Met ☐ Not Scored **SMCN** ☒ Met ☐ Not Scored

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
33. If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCO or the State must pay for those services, in accordance with State policy and regulations. *42 CFR 438.424(b)* Contract: Exhibit B—14.1.4.15	**HMO and SMCN** • ADM219- Member Appeal Process	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
34. The Contractor maintains records of all grievances and appeals. **The records must be accurately maintained in a manner accessible to the State and available on request to CMS. The record of each grievance and appeal must contain, at a minimum, all of the following information:** • **A general description of the reason for the grievance or appeal.** • **The date received.** • **The date of each review or, if applicable, review meeting.** • **Resolution at each level of the appeal or grievance.** • **Date of resolution at each level, if applicable.** • **Name of the person for whom the appeal or grievance was filed.** *42 CFR 438.416* 10 CCR 2505-10—8.209.3.C	**HMO and SMCN** • ADM219- Member Appeal Process • ADM203- Member Grievance Process	**CHP+** ☒ Met ☐ Not Scored **SMCN** ☒ Met ☐ Not Scored

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
35. The Contractor provides the information about the grievance, appeal, and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. – The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member. *42 CFR 438.414* *42 CFR 438.10(g)(xi)* Contract: Exhibit B—11.1.12	**HMO and SMCN** • PNS201- Manual Directory and Communication Updates **HMO** • Provider Manual Page 115, Member Rights – last bullet Page 118-124 – Clinical Appeals and Grievances **SMCN** • Provider Manual Page 12, 3rd to last bullet Page 33-38, Member Grievances and Clinical Appeals	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Note: While scoring of evidence related to individual, new federal requirements in the tool may indicate *Met* or *Not Scored*, all new requirements were scored *Not Applicable* in the total results; new federal requirements do not apply to CHP+ until July 1, 2018.

Results for Standard VI—Grievance System for CHP+							
Total	Met	=	21	X	1.00	=	21
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	13	X	NA	=	NA
Total Applicable		=	22	**Total Score**		=	21
				Total Score ÷ Total Applicable		=	95%

Results for Standard VI—Grievance System for SMCN							
Total	Met	=	22	X	1.00	=	22
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	13	X	NA	=	NA
Total Applicable		=	22	**Total Score**		=	22
				Total Score ÷ Total Applicable		=	100%

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements written policies and procedures for selection and retention of providers. *42 CFR 438.214(a)* Contract: Exhibit B—14.2.1.1	**HMO and SMCN** • PNS202 Selection and Retention of Providers	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor follows a documented process for credentialing and recredentialing that complies with the State's policies for credentialing. *State policies require compliance with National Committee for Quality Assurance (NCQA) standards.* *42 CFR 438.214(b)* Contract: Exhibit B—14.2.1.3	**HMO and SMCN** • PNS202 Selection and Retention of Providers • CR301 Provider Credentialing and Recredentialing • CR305 Assessment of Organizational Providers	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's provider selection policies and procedures include provisions that the Contractor does not: • Discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. • Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42 CFR 438.12(a)(1) and (2)* *42 CFR 438.214(c)* Contract: Exhibit B—14.4.1 and 14.2.1.6	**HMO and SMCN** • PNS202- Selection and Retention of Providers • CR301 –Provider Credentialing and Recredentialing Procedure 3 Non-Discrimination • CR305 Assessment of Organizational Providers	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This is not construed to: • Require the Contractor to contract with providers beyond the number necessary to meet the needs of its members. • Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. • Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members. *42 CFR 438.12(a–b)* Contract: Exhibit B—14.4.1 and 14.4.1.1–3	**HMO and SMCN** • CR305 Assessment of Organizational Providers • PNS202- Selection and Retention of Providers	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor has a signed contract or participation agreement with each provider. *42 CFR 438.206(b)(1)* Contract: Exhibit B—10.1	**HMO and SMCN** • CR301 –Provider Credentialing and Recredentialing Procedure 3 Non-Discrimination • CR305 Assessment of Organizational Providers • PNS217-Single Case Agreement	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
6. The Contractor does not employ or contract with providers or other individuals or entities excluded for participation in federal healthcare programs under either Section 1128 or 1128 A of the Social Security Act. *42 CFR 438.214(d)* *42 CFR 438.610* Contract: Exhibit B—19.1.1.1	**HMO and SMCN** • CMP206- Sanction and Exclusion Screening • CR301- Provider Credentialing & Recredentialing • CR305 Assessment of Organizational Providers • PNS202- Selection and Retention of Providers	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549. *42 CFR 438.610* Contract: Exhibit B—19.1.1 and 19.1.2	**HMO and SMCN** • CMP 206 Sanction and Exclusion Screening • CR301 Provider Credentialing & Recredentialing • CR305 Assessment of Organizational Providers	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: • The member's health status, medical care, or treatment options—including any alternative treatments that may be self-administered. • Any information the member needs in order to decide among all relevant treatment options. • The risks, benefits, and consequences of treatment or non-treatment. • The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. *42 CFR 438.102(a)(1)* Contract: Exhibit B—10.4.3	**HMO and SMCN** • CS212 Member Rights & Responsibilities **HMO** • Provider Manual Page 16 **SMCN** • Provider Manual Page 18	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: • To the State upon contracting or when adopting the policy during the term of the contract. • To members before and during enrollment. • To members within 90 days after adopting the policy with respect to any particular service. *42 CFR 438.102(b)* Contract: Exhibit B—14.1.3.14 and Exhibit K—1.1.7	**HMO** • Provider Manual Page 16, Moral or Religious Objections **SMCN** • Provider Manual Page 42, Types of Utilization Review Determination	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. The Contractor has administrative and management arrangements or procedures, including a compliance program to detect and prevent fraud, waste, and abuse, and which includes: • Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal, State, and contract requirements. • The designation of a compliance officer who is responsible for developing and implementing policies, procedures and practices to ensure compliance with requirements of the contract and who reports directly to the CEO and Board of Directors. • The establishment of a compliance committee of the Board of Directors and at the senior management level	**HMO and SMCN** • Compliance Plan • Code of Conduct • CMP DP08 Compliance Operations Manual • CMP206 Sanctions Screening • CMP211 Fraud, Waste and Abuse • CMP212 False Claims Act • CMP213 Internal Compliance Reviews • Board of Directors Finance Audit and Compliance Committee Charter (available to review onsite) • CMP204- Compliance Training and Education • CMP DP08 Compliance Operations Manual, specifically following sections: o Responding to Issues o Complaint and Hotline Reports	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
charged with overseeing the organization's compliance program. • Training and education of the compliance officer, management, and organization's staff members for the federal and State standards and requirements under the contract. • Effective lines of communication between the compliance officer and the Contractor's employees. • Enforcement of standards through well-publicized disciplinary guidelines. • Implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks. • Procedures for prompt response to compliance issues as they are raised, investigation of potential compliance problems identified in the course of self-evaluation and audits, correction of such problems quickly and thoroughly to reduce the potential for reoccurrence, and ongoing compliance with the requirements under the contract. *42 CFR 438.608(a)(1)* Contract: Exhibit B—14.2.5.2–4, 14.2.7.3—14.2.7.9	o Reporting Suspected Provider or Member Fraud • QM302- Review of Provider Medical Records	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor's administrative and management procedures to detect and prevent fraud, waste, and abuse include: • Written policies for all employees, contractors or agents that provide detailed information about the False Claims Act, including the right of employees to be protected as whistleblowers. • Provisions for prompt referral of any potential fraud, waste, or abuse to the State Medicaid program integrity unit and any potential fraud to the State Medicaid Fraud Control Unit. • Provisions for suspension of payments to a network provider for which the State determines there is credible allegation of fraud (in accordance with 455.12). *42 CFR 438.608(a)(6–8)* Contract: Exhibit B—14.2.6.1, 14.2.7.1, 14.2.7.7	**HMO and SMCN** • CMP 212 False Claims Act • CMP DP08 Compliance Operations Manual, Sections: o Reporting Suspected Provider or Member Fraud o HCPF Payment Suspension Requests	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor's compliance program includes: • Provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying which overpayments are due to potential fraud. • Provision for prompt notification to the State about member circumstances that may affect the member's eligibility, including change in residence or member death. • Provision for notification to the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care	**HMO and SMCN** • CS DP25 Notification Process for Changes that May Impact Member Eligibility • CMP DP08 Compliance Operations Manual, Overpayment Section • ADM300 Provider Terminations • CHP DP02 Member Service Verification	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
program, including termination of the provider agreement with the Contractor. • Provision for a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. *42 CFR 438.608(a)(2–5)* Contract: Exhibit B—14.2.5.4.3–7		
13. **The Contractor ensures that all network providers are enrolled with the State as CHP+ providers consistent with the provider disclosure, screening, and enrollment requirements of the State.** *42 CFR 438.608(b)*	**HMO and SMCN** • CR301 Provider Credentialing and Recredentialing • CR305 Organizational Providers Credentialing *With the exception of services related to urgent or emergent care, Colorado Access does not pay claims to providers that have not enrolled with the State of Colorado	**CHP+** ☒ Met ☐ Not Scored **SMCN** ☒ Met ☐ Not Scored
14. The Contractor has procedures to provide to the State: • Written disclosure of any prohibited affiliation (as defined in 438.610). • Written disclosure of ownership and control (as defined in 455.104). • Identification within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract.	**HMO and SMCN** • CMP DP08 Compliance Operations Manual, Written Disclosure of Prohibited Affiliation • LGL DP02 Disclosure or Change in Ownership and Control **Procedures to identify to the Department within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract:** The Department	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.608(c) Contract: 21.B, Exhibit B—19.4.1, 19.1.1.1	provides a list/files to Colorado Access of the members and the applicable capitation rate and payment. The Department also identifies errors and automatically adjusts error payments in following months.	
15. The Contractor has mechanisms for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days of identifying the overpayment, and to notify the Contractor in writing of the reason for the overpayment. • The Contractor reports annually to the State on recoveries of overpayments. *42 CFR 438.608(d)(2) and (3)*	**HMO and SMCN** • CLM DP10 Claims Overpayments • CMP DP08 Compliance Operations Manual, Overpayment Section	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
16. The Contractor provides that CHP+ members are not held liable for: • The Contractor's debts in the event of the Contractor's insolvency. • Covered services provided to the member for which the State does not pay the Contractor. • Covered services provided to the member for which the State or the Contractor does not pay the health care provider that furnishes the services under a contractual, referral, or other arrangement. • Payments for covered services furnished under a contract, referral, or other arrangement to the extent that	**HMO and SMCN** • Contract Professional Provider Page 10, C.6 **HMO** • Provider Manual Page 52, Hold Harmless Clause **SMCN** • SMCN Provider Manual Page 33, Hold Harmless Clause	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. *42 CFR 438.106* Contract: Exhibit B—16.4.1–4		

Note: While scoring of evidence related to individual, new federal requirements in the tool may indicate *Met* or *Not Scored*, all new requirements were scored *Not Applicable* in the total results; new federal requirements do not apply to CHP+ until July 1, 2018.

Results for Standard VII—Provider Participation and Program Integrity for CHP+							
Total	Met	=	15	X	1.00	=	15
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	0
Total Applicable		=	15	**Total Score**		=	15
				Total Score ÷ Total Applicable		=	100%

Results for Standard VII—Provider Participation and Program Integrity for SMCN							
Total	Met	=	15	X	1.00	=	15
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	0
Total Applicable		=	15	**Total Score**		=	15
				Total Score ÷ Total Applicable		=	100%

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. **Notwithstanding any relationship(s) with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State.** *42 CFR 438.230(b)(1)* Contract: Exhibit B—5.5.3.3	**HMO & SMCN** • ADM223 Delegation • Delegation agreement template, Article B.1. (pg 5) (available for review on site)	**CHP+** ☒ Met ☐ Not Scored **SMCN** ☒ Met ☐ Not Scored
Findings: Although the CHP+ program does not have subcontractors or delegates specific to the CHP+ program, some CHP+ processes are subcontracted as a component of the Colorado Access corporate agreements. HSAG found that Colorado Access' *subcontractor written agreements and processes met the requirements outlined in this standard. However, all requirements were scored as not applicable* for CHP+ due to an effectiveness date of July 1, 2018, for new federal requirements.		
2. All contracts or written arrangements between the Contractor and any subcontractor specify: • The delegated activities **or obligations** and related reporting responsibilities. • **That the subcontractor agrees to perform the delegated activities and reporting responsibilities** • Provision for revocation of the delegation of activities or obligation, or **specify other remedies in instances where the State or Contractor determines** that the subcontractor has not performed satisfactorily. *42 CFR 438.230(b)(2) and (c)(1)*	**HMO & SMCN** • ADM223 Delegation • Delegation agreement template, Article B.1. (pg 5) (available for review on site)	**CHP+** ☒ Met ☐ Not Scored **SMCN** ☒ Met ☐ Not Scored

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's written agreement with any subcontractor includes: • **The subcontractor's agreement to comply with all applicable Medicaid laws and regulations, including applicable sub-regulatory guidance and contract provisions.** *42 CFR 438.230(c)(2)*	**HMO & SMCN** • ADM223 Delegation • Delegation agreement template, Article B.1. (pg 5) (available for review on site)	**CHP+** ☒ Met ☐ Not Scored **SMCN** ☒ Met ☐ Not Scored
4. The written agreement with the subcontractor includes: • **The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State.** – **The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, and computer or other electronic systems related to CHP+ members.** – **The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.** – **If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS**	**HMO & SMCN** • ADM223 Delegation • Delegation agreement template, Article B.1. (pg 5) (available for review on site)	**CHP+** ☒ Met ☐ Not Scored **SMCN** ☒ Met ☐ Not Scored

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Inspector General may inspect, evaluate, and audit the subcontractor at any time. *42 CFR 438.230(c)(3)*		

Note: While scoring of evidence related to individual, new federal requirements in the tool may indicate *Met* or *Not Scored*, all new requirements were scored *Not Applicable* in the total results; new federal requirements do not apply to CHP+ until July 1, 2018.

Results for Standard IX—Subcontracts and Delegation for CHP+							
Total	Met	=	0	X	1.00	=	0
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	4	X	NA	=	0
Total Applicable		=	0	**Total Score**		=	0
				Total Score ÷ Total Applicable		=	NA

Results for Standard IX—Subcontracts and Delegation for SMCN							
Total	Met	=	0	X	1.00	=	0
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	4	X	NA	=	0
Total Applicable		=	0	**Total Score**		=	0
				Total Score ÷ Total Applicable		=	NA

Appendix B. Record Review Tools

The completed record review tools follow this cover page.

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Appeals Record Review Tool
for Colorado Access

Review Period:	July1, 2017–December 31, 2017
Date of Review:	November 7, 2017
Reviewer:	Kathy Bartilotta
Participating Health Plan Staff Member:	Christine Gillespie

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
1	***	07/07/17	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	07/08/17	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: Expedited request; pharmacy request; appeal overturned denial; called member; borderline for easy to understand.											
2	***	07/10/17	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	07/10/17	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: Expedited appeal; pharmacy request; appeal overturned denial; called member to ensure understanding; borderline for easy to understand.											
3	***	07/11/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	07/15/17	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: Pharmacy request; appeal overturned denial; letter not easy to understand (explanation of decision includes clinical jargon).											
4	***	07/13/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	07/17/17	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: Children's Hospital; pharmacy request; appeal overturned denial; letter not easy to understand (explanation of decision includes clinical jargon).											
5	***	07/12/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	07/26/17	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: Referred to external specialist vendor for review; appeal upheld denial; called member; notice sent within time frame (weekend included).											
6	***	08/25/17	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	08/25/17	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: Expedited request; neonatologist reviewed; oral notice to member.											
7	***	08/21/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	09/01/17	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: Pharmacy request; appeal overturned denial; borderline for easy to understand.											
8	***	09/19/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	09/21/17	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: Pharmacy request; provider was designated representative; appeal overturned denial; letter not easy to understand (explanation of decision includes clinical jargon).											
9			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
10			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Appeals Record Review Tool
for Colorado Access

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
OS1			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS2			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS3			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS4			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS5			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
Do not score shaded columns below.											
Column Subtotal of Applicable Elements			**5**	**8**	**8**				**8**	**8**	**8**
Column Subtotal of Compliant (M) Elements			**5**	**8**	**8**				**8**	**8**	**5**
Percent Compliant (Divide Compliant by Applicable)			**100%**	**100%**	**100%**				**100%**	**100%**	**63%**

Key: M = Met; N = Not Met
N/A = Not Applicable

Total Applicable Elements	**45**
Total Compliant (M) Elements	**42**
Total Percent Compliant	**93%**

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Grievance Record Review Tool
for Colorado Access

Review Period:	July 1, 2017–December 31, 2017
Date of Review:	November 7, 2017
Reviewer:	Gina Stepuncik
Participating Health Plan Staff Member:	Veronica Rodriguez

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame	Decision Maker Not Previous Level (If Clinical)	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
1	***	07/18/17	Y ☒ N ☐ N/A ☐	08/07/17	19	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
2	***	07/24/17	Y ☒ N ☐ N/A ☐	08/11/17	18	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
3	***	08/09/17	Y ☒ N ☐ N/A ☐	08/25/17	16	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
4	***	08/16/17	Y ☒ N ☐ N/A ☐	09/05/17	20	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
5	***	08/16/17	Y ☒ N ☐ N/A ☐	08/18/17	2	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
6	***	09/08/17	Y ☒ N ☐ N/A ☐	09/22/17	14	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
7	****	09/12/17	Y ☒ N ☐ N/A ☐	09/22/17	10	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
8	***	09/15/17	Y ☒ N ☐ N/A ☐	09/22/17	7	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
9	***	09/26/17	Y ☒ N ☐ N/A ☐	10/12/17	16	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
10	***	10/05/17	Y ☒ N ☐ N/A ☐	10/09/17	4	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Grievance Record Review Tool
for Colorado Access

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame	Decision Maker Not Previous Level (If Clinical)	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
OS 1			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 2			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 3			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 4			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 5			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
Do not score shaded columns below.										
Column Subtotal of Applicable Elements			**10**			**10**	**0**	**0**	**10**	**10**
Column Subtotal of Compliant (Yes) Elements			**10**			**10**	**0**	**0**	**10**	**10**
Percent Compliant (Divide Compliant by Applicable)			**100%**			**100%**	**NA**	**NA**	**100%**	**100%**

Key: Y = Yes; N = No
N/A = Not Applicable

Total Applicable Elements	**40**
Total Compliant (Yes) Elements	**40**
Total Percent Compliant	**100%**

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2017–2018 site review of **Colorado Access**.

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

HSAG Review Team	Title
Kathy Bartilotta	Associate Director
Gina Stepuncik	Project Manager
Colorado Access Participants	**Title**
Bethany Hines	Vice President, Program Services
Christine E. Gillespie	Manager, Clinical Appeals
Claudine McDonald	Director, Member Engagement and Inclusion
Crystal Garrett	Compliance Specialist
David Rastatter	Director, Colorado Medicaid
Denise Brelsford	Configuration
Elizabeth Strammiello	Chief Compliance Officer
Heidi Warner	Marketing
Janet Milliman	Director CHP+, Pharmacy
Jason Smith	Provider Contracting
Jenny Nate	Department Director of Behavioral Health
Kristin Brown	Operations Manager, Behavioral Health
Marty Janssen	Deputy Director, Medicaid
Michelle Tomsche	Operations Director, Behavioral Health
Rebecca Lynn	Provider Contracting
Reyna Garcia	Sr. Director, Customer Service and Claim Appeals
Robert Bremer	Vice President, Integrated Care
Tanya Lilly	Grievance Manager
Travis Roth	Credentialing Manager
Veronica Rodriguez	Grievance
Department Observers	**Title**
Russ Kennedy	Quality/Compliance Specialist
Teresa Craig	Program and Contract Manager, CHP+

Appendix D. Corrective Action Plan Template for FY 2017–2018

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**
	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. For each element receiving a score of *Partially Met* or *Not Met*, the CAP must describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training and follow-up activities, and documents to be sent following the completion of the planned interventions.
Step 2	**Prior approval for timelines exceeding 30 days**
	If the health plan is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.
Step 3	**Department approval**
	Following review of the CAP, the Department and HSAG will: • Approve the planned interventions and instruct the health plan to proceed with implementation, or • Instruct the health plan to revise specific planned interventions and/or documents to be submitted as evidence of completion and also to proceed with implementation.
Step 4	**Documentation substantiating implementation**
	Once the health plan has received Department approval of the CAP, the health plan will have a time frame of six months to complete proposed actions and submit documents. The health plan will submit documents as evidence of completion one time only on or before the six-month deadline for all required actions in the CAP. (If necessary, the health plan will describe in the CAP document any revisions to the planned interventions that were required in the initial CAP approval document or determined by the health plan within the intervening time frame.)

Step	Action
Step 5	**Technical Assistance**
	HSAG will schedule with the health plan a one-time, interactive, verbal consultation and technical assistance session during the six-month time frame. The session may be scheduled at the health plan's discretion at any time the health plan determines would be most beneficial. HSAG will not document results of the verbal consultation in the CAP document.
Step 6	**Review and completion**
	Following a review of the CAP and all supporting documentation, the Department or HSAG will inform the health plan as to whether or not the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements. Any documentation that is considered unsatisfactory to complete the CAP requirements at the six-month deadline will result in assignment as a delinquent corrective action that will be continued into the following compliance review year. (HSAG will list delinquent actions in the annual technical report and the health plan's subsequent year's compliance site review report.)

The CAP template follows.

Table D-2—FY 2017–2018 Corrective Action Plan for Colorado Access

Standard VI—Grievance System—CHP+ Only		
Requirement	**Findings**	**Required Action**
20. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. *Note: If the written appeal is not signed by the member or designated client representative (DCR), the appeal resolution will remain pending until the appeal is signed. All attempts to gain a signature shall be included in the record of the appeal.* • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)* *42 CFR 438.408(d)(2)* *42 CFR 438.10* Contract: Exhibit B—14.1.4.8, 14.1.3.1	Policy ADM 219—Member Appeal Process accurately stated that standard appeals will be resolved in 10 days, and all CHP+ record reviews indicated resolution within the required time frame. Policy ADM 208—Member Materials stated that NOAs, grievance, appeal, and SFH information must use easily understood language and format. However, in three of eight CHP+ record reviews, the appeal resolution letter was written in language not easy to understand and another three records were determined to be borderline regarding ease of understanding. In all cases, the explanation of the appeal decision included clinical jargon. Staff members stated that the appeal manager attempts to make phone contact with each member to verbally explain the outcome of the appeal and ensure member understanding. HSAG did not conduct appeal record reviews for SMCN.	Colorado Access must ensure that appeal resolution letters to CHP+ members are written in language that may be easily understood by the members.

Standard VI—Grievance System—CHP+ Only		
Requirement	**Findings**	**Required Action**
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

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**
	Before the site review to assess compliance with federal CHP+ managed care regulations and contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, on-site agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all site reviewers to ensure consistency in scoring across plans.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Medical Quality Improvement Committee (MQuIC) meetings and provided group technical assistance and training, as needed. • Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the health plan in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the two standards and on-site activities. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. • Documents submitted for the desk review and on-site review consisted of the completed desk review form, the compliance monitoring tool with the health plan's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The health plans also submitted a list of all CHP+ appeals and grievances that occurred between July 1, 2017, and December 31, 2017 (to the extent possible). HSAG used a random sampling technique to select records for review during the site visit. • The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct Site Visit**
	• During the on-site portion of the review, HSAG met with the health plan's key staff members to obtain a complete picture of the health plan's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan's performance. • HSAG reviewed a sample of administrative records to evaluate implementation of managed care regulations related to CHP+ appeals and grievances. • Also while on-site, HSAG collected and reviewed additional documents as needed. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were confidential or proprietary, or were requested as a result of the pre-on-site document review.) • At the close of the on-site portion of the site review, HSAG met with health plan staff and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2017–2018 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. • HSAG analyzed the findings. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the State**
	• HSAG populated the report template. • HSAG submitted the 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.