CHP+

Child Health Plan *Plus*

Fiscal Year 2018–2019 Site Review Report

for

Colorado Access CHP+ MCO and State Managed Care Network

March 2019

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

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 provisions of the Code of Federal Regulations (CFR), Title 42—federal Medicaid managed care regulations published May 6, 2016. Revisions to federal Medicaid managed care regulations published May 6, 2016, became applicable to CHIP effective July 1, 2018. The CFR 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 CHP+ health plans' compliance with new federal managed care regulations published May 2016, the Department determined that the review period for fiscal year (FY) 2018–2019 was July 1, 2018, through December 31, 2018. This report documents results of the FY 2018–2019 site review activities for **Colorado Access** (**COA**) in its role as a contracted CHP+ MCO and as the administrative service organization (ASO) for the State Managed Care Network (SMCN). Although HSAG reviewed the two lines of business concurrently, the results for the CHP+ 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 2018–2019 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the 2017–2018 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 credentialing and recredentialing record reviews. Appendix C lists HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process the health plan will be required to complete for FY 2018–2019 and the required template for doing so. Appendix E contains a detailed description of HSAG's site review activities consistent with the Centers for Medicare & Medicaid Services (CMS) final protocol.

Summary of Results

Based on conclusions drawn from the review activities, HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. HSAG assigned required actions to any requirement receiving a score of *Partially Met* or *Not Met*. HSAG also identified opportunities for improvement with associated recommendations for some elements, regardless of the score.

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

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

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
III. Coordination and Continuity of Care	10	10	10	0	0	0	100%
IV. Member Rights and Protections	8	8	7	1	0	0	88%
VIII. Credentialing and Recredentialing	32	32	32	0	0	0	100%
X. Quality Assessment and Performance Improvement	18	18	16	2	0	0	89%
Totals	**68**	**68**	**65**	**3**	**0**	**0**	**96%**

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

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

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Credentialing	100	86	86	0	14	100%
Recredentialing	90	82	82	0	8	100%
Totals	**190**	**168**	**168**	**0**	**22**	**100%**

*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 **COA**'s SMCN line of business for each of the standards. Findings for all requirements are summarized in this section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* follow in Appendix A—Compliance Monitoring Tool. The Department required no credentialing or recredentialing 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)
III. Coordination and Continuity of Care	10	10	10	0	0	0	100%
IV. Member Rights and Protections	8	8	7	1	0	0	88%
VIII. Credentialing and Recredentialing	32	32	32	0	0	0	100%
X. Quality Assessment and Performance Improvement	18	15	14	1	0	3	93%
Totals	**68**	**65**	**63**	**2**	**0**	**3**	**97%**

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

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

Standard III—Coordination and Continuity of Care

Summary of Strengths and Findings as Evidence of Compliance

COA's policies and procedures included a comprehensive description of **COA**'s care coordination program which applied to all lines of business. The care coordination program and associated procedures addressed provision of care coordination for all members through either the primary care provider (PCP) or **COA** care coordination staff. Processes included:

- Criteria for making referrals to and ensuring coordination of services among appropriate primary care, specialty, and community providers.
- Providing for continuity of care for members transitioning into the health plan, between providers, and transitioning from institutional to other settings of care.
- Coordinating with multiple providers, agencies, and community organizations for members with complex care coordination needs.

Staff members stated that due to the short-term transitional length of enrollment (approximately 45 days) of children in SMCN, coordination of care processes were primarily applicable to pregnant women enrolled in SMCN and were administered through the Healthy Mom, Healthy Baby program.

COA demonstrated that it had processes for ensuring that each member is assigned a PCP on enrollment and notifying the member of PCP contact information through the member identification card. PCPs were responsible for coordinating care unless the member was identified to **COA** case management through a health risk assessment (HRA) or referral for assistance with coordinating complex physical, behavioral, and/or or social support needs. Members were informed of their assigned case manager through personal outreach contacts between the member and **COA** care coordinator. **COA** administered an interactive voice recognition call to perform an HRA shortly after enrollment for all CHP+ members and SMCN pregnant women enrolled in the Healthy Mom, Healthy Baby program. **COA** used results of the initial HRA to generate care alerts to care management staff and to stratify levels of need for care management. **COA** care managers administered a comprehensive assessment of needs and developed a service or treatment plan for members with complex problems, serious health conditions, or special health care needs (SHCN). **COA** shared results of the assessment and intervention plans with other entities involved in the member's care. Case managers coordinated treatment plans with involvement of the member's providers and family members, and plans were updated regularly when needs or the member's circumstances changed during the course of active care coordination. Staff members stated that all CHP+ members were allowed open access to specialists within **COA**'s provider network and that an ongoing course of treatment for members with SHCN requiring access to out-of-network specialists was arranged through single case agreements. Members' privacy in the process of

coordinating care was protected through extensive processes outlined in confidentiality policies and procedures and through secure information exchanges.

Summary of Findings Resulting in Opportunities for Improvement

The **COA** provider manual described the PCP's responsibility for coordinating the member's care with medical and nonmedical providers, maintaining documentation of care coordination information, and sharing care coordination information. However, HSAG noted that this information was included in the section of the manual describing the responsibilities of Regional Accountable Entity (RAE) providers rather than CHP+ providers. HSAG also noted that the SMCN provider manual described the provider's responsibility for coordinating *benefits* only. HSAG recommends that **COA** clarify that the CHP+ and SMCN network PCPs are responsible for coordinating *care* for members.

During on-site interviews, staff members stated that results of member needs assessments were communicated to providers and other entities primarily through verbal contacts between case managers and other entities involved in the member's care. HSAG recommends that **COA** consider enhancing this process to include written communication of the full member assessment and identified needs in order to prevent duplication of these efforts.

Summary of Required Actions

HSAG identified no required actions for this standard.

Standard IV—Member Rights and Protections

Summary of Strengths and Findings as Evidence of Compliance

COA maintained written policies on member rights applicable to both its CHP+ MCO and SMCN lines of business. Within its policies, **COA** delineated the rights and responsibilities allotted to members and included methods for the distribution of these rights to members, employees, and providers. Avenues for distribution included the Evidence of Coverage booklet, Member Benefits Handbook Summary, provider manual, new provider orientation, newsletters, and the **COA** website. HSAG identified the full list of member rights within the Evidence of Coverage booklet, Member Benefits Handbook Summary, and on the **COA** CHP+/SMCN website. **COA** required that providers adhere to these member rights through a stipulation within its provider contracts.

COA ensured that employees and providers afford members their rights through the **COA** Code of Ethics. Internally, staff members had a robust process for monitoring calls received via the customer service phone line. Calls that described any issue of dissatisfaction were reviewed and assessed on various levels, including as a potential member rights violation.

COA delineated advance directive information within its policies and provider manual. Additional information was available for members and providers on the website. **COA**'s website also directed members and providers to the Colorado Advance Directives Consortium, a Colorado organization that has developed tools and resources for healthcare decision making.

COA complied with federal and State laws that pertain to member rights, as evidenced through numerous policies that addressed nondiscrimination, communication with limited English speakers, cultural awareness strategies, member publication ease-of-understanding guidelines, and disability rights. **COA** evidenced compliance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E—Health Insurance Portability and Accountability Act of 1996 (HIPAA) through its policies, staff procedures, and mandatory in-service trainings. During on-site interviews, staff members were able to describe the methods used to safeguard protected health information (PHI) including secured printers, efax, shredder boxes, and secured emails.

Summary of Findings Resulting in Opportunities for Improvement

During the review of **COA**'s policies, HSAG noted that the requirement stating that the member is "free to exercise his or her rights without adversely affecting how the Contractor, its network providers, or the State Medicaid agency treat(s) the member" was not addressed within the member rights policy. While it is not a requirement that **COA** include this in written policy, HSAG suggests that **COA** consider adding this stipulation to its Member Rights and Responsibilities policy to place additional emphasis on member protections.

Summary of Required Actions

COA's Member Rights and Responsibilities policy directed the reader to the State's rights and responsibilities listed in the Medicaid Managed Care Program section of the Colorado Code of Regulations (CCR) 2505-20 Section 8.205.2-3. The CCR listed all bulleted requirements, except:

- Receive information in accordance with information requirements (42 CFR §438.10).
- Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFRs §438.206 through §438.210).

COA must ensure that all required member rights are accounted for within its policy. HSAG recommends that **COA** consider doing so by listing all required member rights directly within its policy.

Standard VIII—Credentialing and Recredentialing

Summary of Strengths and Findings as Evidence of Compliance

HSAG reviewed **COA**'s credentialing policies and procedures related to the credentialing of providers and organizations, applicable to both CHP+ MCO and SMCN. The policies were well-written, comprehensive, and compliant with National Committee for Quality Assurance (NCQA) credentialing and recredentialing standards and guidelines. During on-site interviews, credentialing staff members displayed extensive knowledge of NCQA requirements and **COA** policies.

During the interview and record review, **COA** demonstrated that staff were credentialing and recredentialing providers and organizations in a manner consistent with written procedures. Credentialing and recredentialing files included an application with required attestations, documentation that staff verified licensure, Drug Enforcement Administration (DEA) certification (as applicable), board certification status (as indicated in policy), education and training, work history, and current malpractice insurance. Files also included documentation that **COA** queried the National Practitioner Data Bank (NPDB) for a history of professional liability claims and to ensure that the provider had not been excluded from federal participation. **COA** staff members described the process for ongoing review of Office of Inspector General (OIG) and System for Award Management (SAM) queries and how the queries were used to resolve issues prior to the provider being brought forth for credentialing committee review.

COA delegated credentialing and recredentialing to several contracted organizations. HSAG reviewed delegation agreements which described the activities, responsibilities, and reporting requirements. **COA** retained the right to approve, suspend, or terminate providers approved by any of its delegated entities. Within the contracts, **COA** delineated available remedies should the delegate fall short of its obligations. During the on-site review, staff members discussed the process for **COA**'s annual audit of credentialing delegates and the methods used for corrective actions during the period under review. The audit process was comprehensive and aligned with what was delineated in the contract and in the requirements.

HSAG reviewed credentialing committee meeting minutes from the most recent committee meeting. The minutes evidenced a review of specific providers and the votes related to provider participation within the network. Minutes reflected a quorum of clinically qualified participants representing various specialties.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Required Actions

HSAG identified no required actions for this standard.

Standard X—Quality Assessment and Performance Improvement

Summary of Strengths and Findings as Evidence of Compliance

COA's Quality Assessment and Performance Improvement (QAPI) Program description defined the corporate-wide QAPI Program, including organizational structure, goals and objectives, committee composition and roles, and program components. Program components include:

- Access and availability (i.e., surveys, appointment availability, Healthcare Effectiveness Data and Information Set [HEDIS®][1-1]).
- Utilization management (UM).
- Member satisfaction.
- Clinical outcomes (i.e., key performance indicators, HEDIS, performance measures).
- Quality, safety, and appropriateness of clinical care (i.e., quality of care concerns, pharmacy utilization, medical records).
- Performance improvement projects (PIPs).
- Service monitoring (i.e., turnaround times).
- Clinical practice guidelines.
- Care management.

The program description stated that **COA** uses a Plan-Do-Study-Act (PDSA) model for quality improvement. The quality management (QM) department collaborates with all areas of **COA** to drive improvement activities and collects and distributes data to providers. Staff members stated that QAPI-related policies and procedures apply to all lines of business. While the SMCN contract requires limited QAPI Program activities, staff members stated that the SMCN population is integrated into all quality program activities, whenever applicable.

At the time of the on-site review, **COA** was reorganizing staff and resources to support a functional rather than line-of-business-oriented approach to QAPI component activities. Staff members stated that the next update of the QAPI Program description would reflect revision in structure, committees, reporting processes, and responsibilities related to QAPI Program activities. **COA** demonstrated through the 2017–2018 CHP+ HMO Annual Quality Report the results, analysis, interventions for improvement, and reporting of CHP+ PIPs, HEDIS measures, CAHPS®[1-2] measures, utilization measures, quality of care concerns (QOCCs), grievances, network adequacy, and other quality improvement activities to the Department. **COA** presents quarterly and annual CHP+ quality performance reports to its Quality Improvement Committee. The CHP+ PIP met the required design parameters (previously evaluated by HSAG). Staff members stated that the SMCN population was not involved in this PIP but would be

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

involved in the new PIP being initiated in FY 2018–2019. While the CHP+ annual report documented only limited high-level utilization trends, **COA** demonstrated on-site a dashboard of numerous data elements used to monitor costs, members served, pharmacy use, and provider and diagnosis group utilization patterns that may detect over- or underutilization of services. Staff members stated that the Resource Management Committee reviews any deviations in utilization trends that may require further evaluation or follow-up.

During on-site interviews, staff members described a process intended to be implemented in 2019 to target members with SHCN in medical record audits to determine the quality of care provided to these members and provided a draft of comprehensive criteria for evaluating documentation in the assessment and treatment plan related to the quality of care furnished to such members. In addition, staff members described that **COA**'s health strategy group was determining a better method for evaluating the effectiveness of the overall QAPI Program at least annually.

COA adopted clinical practice guidelines (CPGs) in compliance with requirements and had practice guidelines in place for all specific health conditions required by the Department. Staff members stated that **COA** defers to nationally recognized sources of expertise for defining clinical guidelines, which are then approved by **COA** medical directors. Staff members described that the Quality Improvement Committee (QIC), which includes program managers and medical directors, approves the guidelines and thus ensures that decisions in other program areas are consistent with clinical guidelines. **COA**'s Clinical Practice Guidelines policy stated that CPGs are available to providers and members through the **COA** website (availability confirmed by HSAG) and to members upon request at no cost. The **COA** provider manual directed providers to the website, and staff stated that monthly provider bulletins alert providers to any updated guidelines. The CHP+ member handbook informed members that printable guidelines are available through the website.

COA documented that it has a fully integrated health information system configured through its enterprise data warehouse (EDW) and major component systems, including:

- Altruista Guiding Care—utilization management, grievances and appeals, care management, and customer service system.
- QNXT—claims/encounter transaction system.
- Navitus—pharmacy system.
- Apogee—credentialing and provider information system.

Data from the enterprise-wide system were aggregated, analyzed, and reported through the EDW and provided information about utilization, claims, grievances and appeals, enrollment and disenrollment, and numerous other data to support corporate operations and the QAPI Program. Staff members stated that the Business Analyst team responds to requests to build routine, ongoing reports and develops dashboards through which staff members may access reports, and that staff members may run custom reports directly through software applications. The QNXT claims processing and retrieval system enabled electronic submission of encounter data to the State in the American National Standards Institute (ANSI) X 12N 837 format. **COA** submitted batch encounter data—including paid, adjusted, or

denied claims—monthly to the Department. **COA** demonstrated that the encounter data system collects and submits member and provider demographic characteristics and services furnished to members by the rendering provider. **COA**'s claim and transaction systems applied automated edits at several points in the claims submission process, as well as manual auditing, to ensure accuracy, timeliness, completeness, logic, and consistency of data received from providers prior to submission of data to the Department.

Summary of Findings Resulting in Opportunities for Improvement

COA demonstrated on-site a dashboard of numerous data elements used to monitor patterns of utilization that may detect over- or underutilization of services. HSAG encourages **COA** to continue active use of the extensive claims database of services and member and provider demographics to track selected service utilization trends as a mechanism to detect over- or underutilization.

During on-site interviews, staff members described that program managers and medical directors on the QIC—which approves clinical guidelines—ensure that decisions in other program areas are consistent with clinical guidelines and provided an example of how the prenatal program incorporated information specified in the guidelines. However, neither the Clinical Practice Guidelines policy nor other procedures assigned accountability for ensuring that decisions in areas to which the guidelines apply are consistent with the guidelines. HSAG recommends that **COA** enhance its policy or other procedures to more specifically define expectations for ensuring that member information, UM criteria, and other clinical materials and guidelines are consistent with practice guidelines.

Summary of Required Actions

Although staff members described that **COA** is developing a medical record review of the provider assessment and treatment plan targeted toward members with SHCN, **COA** did not demonstrate that its QAPI Program included evaluation of the quality of care provided to members with SHCN during the review period. **COA** must implement mechanisms to assess the quality and appropriateness of care furnished to CHP+ and SMCN members with SHCN as a component of its QAPI Program.

While the FY 2017–2018 CHP+ HMO Annual Quality Report documented summary results of all quality initiatives undertaken in the fiscal year, neither the report nor the quality improvement committee minutes documented statements or conclusions regarding the overall effectiveness of the QAPI Program or any of its component activities. **COA** must implement an annual process for evaluating the impact and effectiveness of the CHP+ QAPI Program (not applicable to SMCN).

2. Overview and Background

Overview of FY 2018–2019 Compliance Monitoring Activities

For the FY 2018–2019 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement. Compliance with applicable federal managed care regulations and related 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. 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+ credentialing and recredentialing.

HSAG also reviewed a sample of the health plan's administrative records related to CHP+ credentialing and recredentialing to evaluate implementation of federal healthcare regulations and compliance with National Committee for Quality Assurance (NCQA) requirements effective July 2018. 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 CHP+ credentialing and recredentialing records that occurred between July 1, 2018, and December 31, 2018. 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 VIII—Credentialing and Recredentialing. HSAG also separately calculated a credentialing record review score, a recredentialing 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.[2-3] 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 2018–2019 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 V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

Objective of the Site Review

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

- The health plan's compliance with federal healthcare 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 healthcare 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.

[2-3] 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: Jan 25, 2019.

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

FY 2017–2018 Corrective Action Methodology

As a follow-up to the FY 2017–2018 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 **COA** until it completed each of the required actions from the FY 2017–2018 compliance monitoring site review.

Summary of FY 2017–2018 Required Actions

For FY 2017–2018, HSAG reviewed Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

For the Grievance and Appeal Standard for CHP+, **COA** was required to ensure that appeal resolution letters to CHP+ members are written using language that may be easily understood by members.

For the Member Information Standard, **COA** had no CHP+ or SMCN required actions.

For the Provider Participation and Program Integrity standard, **COA** had no CHP+ or SMCN required actions.

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

Summary of Corrective Action/Document Review

COA submitted a proposed CAP in February 2018. HSAG and the Department reviewed and approved the proposed plan and responded to **COA**. **COA** submitted documents as evidence of completion of its proposed interventions in October 2018. HSAG and the Department reviewed and approved **COA**'s documents submitted as evidence of completion and responded to **COA** in December 2018.

Summary of Continued Required Actions

COA successfully completed the FY 2017–2018 CAP, resulting in no continued corrective actions.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements procedures to deliver care to and coordinate services for all members. These procedures meet State requirements, including: • Ensuring timely coordination with any of a member's providers, including mental health providers, for the provision of covered services. • Addressing those members who may require services from multiple providers, facilities, and agencies; and who require complex coordination of benefits and services. • Ensuring that all members and authorized family members or guardians are involved in treatment planning and consent to any medical treatment. • Criteria for making referrals and coordinating care with specialists, subspecialists, and community-based organizations. • Providing continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services. *42 CFR 438.208(b)* Contract: Exhibit B—10.5.1, 10.5.2, 10.5.3.3, 10.5.3.5, 10.5.3.6	**Both**: • CCS305 Colorado Access Care Coordination • CCS306 Delivering Continuity and Transition of Care for Members • CCS310 Access to Primary and Secondary Care • CM DP10 – CHP+ Health Risk Assessment Follow-up Program	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor ensures that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member. • The member must be provided information on how to contact the designated person or entity. *42 CFR 438.208(b)(1)* Contract: Exhibit B—1.1.79, 7.11.1.2	**Both**: • CCS305 Colorado Access Care Coordination • CCS310 Access to Primary and Secondary Care • EE DP30 – Trouble Shooter Report No PCP • EE DP29 – Running Auto-PCP Assignments	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor implements procedures to coordinate services the Contractor furnishes the member: • Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. • With the services the member receives from any other managed care plan. • With the services the member receives in fee-for-service (FFS) plans. • With the services the member receives from community and social support providers. *42 CFR 438.208(b)(2)* Contract—Exhibit B—10.5.3.3.1	**Both:** • CCS305 Care Coordination	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor provides best efforts to conduct an initial screening of each new member's needs within 90 days of enrollment, including subsequent attempts if the initial attempt to contact the member is unsuccessful. • Assessment includes screening for special health care needs including mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems. *42 CFR 438.208(b)(3)* Contract: Exhibit B—10.5.3.1.1	**Both:** • CCS305 Colorado Access Care Coordination • CM DP10 CHP+ Health Risk Assessment Follow-up Program • CM DP09 CHP+ Healthy Mom-Healthy Baby Program	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Contractor shares with other entities serving the member the results of identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR 438.208(b)(4)* Contract: Exhibit B—10.6.1	**Both:** • CCS305 Care Coordination	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor ensures that each provider furnishing services to members maintains and shares, as appropriate, a member health record, in accordance with professional standards. *42 CFR 438.208(b)(5)* Contract: Exhibit B—14.1.6.6–7	**Both:** • QM302 Quality Review of Provider Medical Records **SMCN:** • Provider Manual – Section 3 **HMO:** • Provider Manual – Section 3	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The Contractor ensures that, in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent applicable. *42 CFR 438.208(b)(6)* Contract: Exhibit B—10.5.1.1	**Both:** • PRI 100 Protecting Member PHI • PRI 101 Clinical Staff Use and Disclosure of Member PHI • PRI 103 Authorizations to Disclose Member PHI • PRI 104 Member Rights and Requests Regarding PHI • PRI 105 Personal Representatives and Member PHI • PRI 200 Sanctions Policy • HIP 204 Security of EPHI	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor implements mechanisms to comprehensively assess each CHP+ member identified by the State as having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. *42 CFR 438.208(c)(2)* Contract: Exhibit B—10.6.2	**Both:** • CCS305 Care Coordination • CM DP10 CHP+ Health Risk Assessment Follow-up Program • CM DP09 CHP+ Healthy Mom-Healthy Baby Program	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor produces a treatment or service plan for members with special health care needs who are determined, through assessment, to need a course of treatment or regular care monitoring. The treatment plan must be: • Developed by the member's primary care provider with member participation, and in consultation with any specialists caring for the enrollee. • Approved by the Contractor in a timely manner (if such approval is required by the Contractor). • In accordance with any applicable State quality assurance and utilization review standards. • Reviewed and revised upon reassessment of functional need, at least every 12 months, when the member's circumstances or needs change significantly, or at the request of the member. *42 CFR 438.208(c)(3)* Contract: Exhibit B—10.5.3.2.1–4	**Both:** • CCS305 Care Coordination • QM302 Quality Review of Provider Medical Records **SMCN:** SMCN Provider Manual – Section 3 **HMO:** COA Provider Manual – Section 3	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. For members with special health care needs determined to need a course of treatment or regular care monitoring, the Contractor must have a mechanism in place to allow members direct access to a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. *42 CFR 438.208(c)(4)* Contract: Exhibit B—10.5.3.5; 10.6.3	**Both:** • CCS305 Care Coordination • CCS310 Access to Primary and Secondary Care	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard III—Coordination and Continuity of Care for CHP+							
Total	Met	=	10	X	1.00	=	10
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	10	**Total Score**		=	10
			Total Score ÷ Total Applicable			=	100%

Results for Standard III—Coordination and Continuity of Care for SMCN							
Total	Met	=	10	X	1.00	=	10
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	10	**Total Score**		=	10
			Total Score ÷ Total Applicable			=	100%

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has written policies regarding the member rights specified in this standard. *42 CFR 438.100(a)(1)* Contract: Exhibit B—14.1.1.2	**Both:** CS212- Member Rights and Responsibilities	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor complies with any applicable federal and State laws that pertain to member rights and ensures that its employees and contracted providers observe and protect those rights. *42 CFR 438.100(a)(2)* Contract: Exhibit B—14.1.1.1	**Both:** • CS212- Member Rights and Responsibilities • Std.IV_Req2_Member Rights **SMCN:** • CHP SMCN Evidence of Coverage Booklet Member Rights • SMCN Provider Manual Member Rights and Responsibilities **HMO:** • CHP HMO Evidence of Coverage Booklet Member Rights • Provider Manual Section 2 • Members Benefits Handbook Summary	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's policies and procedures ensure that each member is guaranteed 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. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding his or her health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. • Request and receive a copy of his or her medical records and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210). *42 CFR 438.100(b)(2) and (3)* Contract: Exhibit B—14.1.1.2.1–5; 14.1.1.3	**Both:** CS212 – Member Rights and Responsibilities ADM208 – Member Materials **SMCN:** • Provider Manual – Section 2 • Evidence of Coverage Member Rights & Responsibilities **HMO:** • Provider Manual – Section 2 • Evidence of Coverage Member Rights & Responsibilities	**CHP+** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: COA's Member Rights and Responsibilities policy directed the reader to the State's rights and responsibilities listed in the Colorado Medicaid Managed Care Program Code of Regulations (CCR) 2505-20 Section 8.205.2-3. The CCR listed all of the bulleted requirements except: • Receive information in accordance with information requirements (42 CFR 438.10). • Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210).		
Required Actions: COA must ensure that all required member rights are accounted for within its policy.		
4. The Contractor ensures that each member is free to exercise his or her rights and that the exercise of those rights does not adversely affect how the Contractor, its network providers, or the State Medicaid agency treat(s) the member. *42 CFR 438.100(c)* Contract: Exhibit B—14.1.1.2.6	**Both:** ADM203 Member Grievance Process All **SMCN:** • Member Benefit Handbook Member Rights and Responsibilities • Provider Manual – Section 2 **HMO:** • Evidence of Coverage Member Rights and Responsibilities, and Grievances • Provider Manual – Section 2	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. Member's rights and responsibilities are included in the member handbook and provided to all enrolled members. *42 CFR 438.10(2)(ix)* Contract: Exhibit B—14.1.3.10	**SMCN:** • Evidence of Coverage Member Rights and Responsibilities • CHP SMCN Member Benefits Handbook Summary **HMO:** • CHP HMO Members Benefits Handbook Summary • Evidence of Coverage Member Rights and Responsibilities	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The Contractor complies with any other federal and State laws that pertain to member rights, including Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975, as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and Section 1557 of the Patient Protection and Affordable Care Act. *42 CFR 438.100(d)* Contract: 21.A	**Both**: ADM205 – Nondiscrimination ADM 206 – Culturally Sensitive Services for Diverse Populations ADM 207 – Effective Communication with LEP/SI-SI Person ADM 208 – Member Materials MKT 001 – Printed Marketing Informational and Corporate Branding Materials ADM230 – Member Disability Rights Request and Complaint Resolution **SMCN:** • Provider Manual Section 2 • Member Benefit Handbook Summary **HMO:** • Provider Manual Section 2 • Members Benefits Handbook Summary	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. For medical records and any other health and enrollment information which identify a particular member, the Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42 CFR 438.224* Contract: Exhibit B—14.1.6.7	**Both** • PRI 100 Protecting Member PHI • PRI 101 Clinical Staff Use and Disclosure of Member PHI • PRI 103 Authorizations to Disclose Member PHI • PRI 104 Member Rights and Requests Regarding PHI • PRI 105 Personal Representatives and Member PHI • PRI 200 Sanctions Policy • HIP 204 Security of EPHI	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

8. The Contractor maintains written policies and procedures and provides written information to individuals concerning advance directives with respect to adult members receiving care by or through the Contractor. Advance directives policies and procedures include:
• A clear statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience.
• The difference between institution-wide conscientious objections and those raised by individual physicians.
• Identification of the State legal authority permitting such objection.
• Description of the range of medical conditions or procedures affected by the conscientious objection.
	Both:
	CCS303 – Advance Directives
	
	SMCN:
	• Provider Manual Section 2
	• New Member Packet Member Benefits Booklet Summary
	• Website: https://www.chpplusproviders.com/members.asp
	
	HMO:
	• CHP+ HMO Packets – All materials
	• Members Benefits Handbook Summary
	• Web Site:
	  ○ https://www.coaccess.com/providers/resources/
	  ○ https://www.coaccess.com/members/services/
		CHP+
		☒ Met
		☐ Partially Met
		☐ Not Met
		☐ Not Applicable
		
		SMCN
		☒ Met
		☐ Partially Met
		☐ Not Met
		☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and unable to receive information. • Provisions for providing advance directive information to the incapacitated member once he or she is no longer incapacitated. • Provisions for documenting in a prominent part of the member's medical record whether the member has executed an advance directive. • Provisions that the decision to provide care to a member is not conditioned on whether the member has executed an advance directive and that members are not discriminated against based on whether they have executed an advance directive. • Provisions for ensuring compliance with State laws regarding advance directives. • Provisions for informing members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. • Provisions for educating staff concerning policies and procedures about advance directives.		

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Provisions for community education regarding advance directives, to include: – What constitutes an advance directive. – Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. – Description of applicable State law concerning advance directives. *42 CFR 438.3(j)* *42 CFR 422.128* Contract: Exhibit B—14.1.9.1		

Results for Standard IV—Member Rights and Protections CHP+							
Total	Met	=	7	X	1.00	=	7
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	8	**Total Score**		=	7
			Total Score ÷ Total Applicable			=	88%

Results for Standard IV—Member Rights and Protections SMCN							
Total	Met	=	7	X	1.00	=	7
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	8	**Total Score**		=	7
			Total Score ÷ Total Applicable			=	88%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. • The Contractor's credentialing program complies with the standards of the National Committee on Quality Assurance (NCQA) for initial credentialing and re-credentialing of participating providers. *42 CFR 438.214(a)* Contract: Exhibit B—14.2.1.3	**Both**: • CMP206 – Sanction and Exclusion Screening (Procedure 4) • CR301 – Provider Credentialing and Recredentialing (All) • CR305 – Organizational Provider Credentialing and Recredentialing (All)	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: • The types of practitioners it credentials and recredentials. This includes all physicians and non-physician practitioners who have an independent relationship with the Contractor. (Examples include MDs, DOs, podiatrists, nurse practitioners, and each type of behavioral health provider.) NCQA CR1—Element A1	**Both**: • CR301 – Provider Credentialing and Recredentialing (p. 1-2, Procedure 1A & 1B, Procedure 2) • CR305 – Organizational Provider Credentialing and Recredentialing (p.1, Procedure 1)	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's written policies and procedures for the selection and retention of providers specify: • The verification sources it uses. NCQA CR1—Element A2	**Both:** • CR301 - Provider Credentialing and Recredentialing (p. 3, Procedure 5; p. 5, Procedure 7; p. 7-10 Procedure 13) • CR305 - Organizational Provider Credentialing and Recredentialing (p. 1, Procedure 2; p. 5 Procedure 5)	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor's written policies and procedures for the selection and retention of providers specify: • The criteria for credentialing and recredentialing. NCQA CR1—Element A3	**Both:** • CR301 - Provider Credentialing and Recredentialing (p. 6, Procedure 9; p. 7 Procedure 13; p.10, Procedure 14) • CR305 - Organizational Provider Credentialing and Recredentialing (p. 1, Procedure 2; p. 3, Procedure 3, p. 5, procedure 5) • CR DP04 – Ongoing Monitoring of Providers (All)	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	**Both:** • CR301 - Provider Credentialing and Recredentialing (p.6-11, Procedures 8, 9, 10, 11, 12, 13, and 14) • CR305 - Organizational Provider Credentialing and Recredentialing (p.5-8, Procedures 4,5,6,7) • CR DP04 – Ongoing Monitoring of Providers (All)	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for managing credentialing and recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	**Both:** • CR301 - Provider Credentialing and Recredentialing (p. 4-11, Procedures 6,7, 8,9,10,11,12, 13,14) • CR305 – Organizational Provider Credentialing and Recredentialing (p. 2-8, Procedures 2,3,4,5, and 6). • CR DP04 – Ongoing Monitoring of Providers (All) • CR DP02 – Organizational Assessment File Audit (All)	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for delegating credentialing or recredentialing (if applicable). NCQA CR1—Element A6	**Both:** • CR301 - Provider Credentialing and Recredentialing (p.3, Procedure 5) • ADM223 – Delegation (All) • CR DP06 – Updating Delegated Providers in Apogee (All)	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for ensuring that credentialing and recredentialing are conducted in a non-discriminatory manner, (i.e., must describe the steps the Contractor takes to ensure that it does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnic or national identity, gender, age, sexual orientation, or patient type in which the practitioner specializes). NCQA CR1—Element A7	**Both:** • CR301 - Provider Credentialing and Recredentialing (p. 3, Procedure 2)	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for notifying practitioners if information obtained during the Contractor's credentialing/recredentialing process varies substantially from the information provided to the Contractor. NCQA CR1—Element A8	**Both:** • CR301 - Provider Credentialing and Recredentialing (p.3, Procedure 4) • CR DP01 – Provider Rights (All)	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for ensuring that practitioners are notified of credentialing and recredentialing decisions within 60 calendar days of the committee's decision. NCQA CR1—Element A9	**Both:** • CR301 - Provider Credentialing and Recredentialing (p.11, Procedure 15) • CR305 – Organizational Provider Credentialing and Recredentialing (p. 8, Procedure 7)	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor's written policies and procedures for the selection and retention of providers specify: • The medical director's or other designated physician's direct responsibility and participation in the credentialing/recredentialing program. NCQA CR1—Element A10	**Both:** • CR301 - Provider Credentialing and Recredentialing (p. 3, Procedure 3; p. 6 Procedure 8) • CR305 Organizational Provider Credentialing and Recredentialing (p.8, Procedure 6A)	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for ensuring the confidentiality of all information obtained in the credentialing/recredentialing process. NCQA CR1—Element A11	**Both:** • CR301 - Provider Credentialing and Recredentialing (p. 4, Procedure 6)	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for ensuring that listings in provider directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty. NCQA CR1—Element A12	**Both:** • CR301 - Provider Credentialing and Recredentialing (p. 12, Procedure 16)	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contactor notifies practitioners about their rights: • To review information submitted to support their credentialing or recredentialing application. • To correct erroneous information. • To receive the status of their credentialing or recredentialing application, upon request. NCQA CR1—Element B	**Both:** • CR301 - Provider Credentialing and Recredentialing (p. 3, Procedure 4) • CR DP01 - Provider Rights (All)	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing and recredentialing decisions. The committee uses participating practitioners to provide advice and expertise for credentialing decisions. NCQA CR2—Element A1	**Both:** • CR301 - Provider Credentialing and Recredentialing (p. 3, Procedure 2; p. 6 Procedure 8) • CR305 – Organizational Provider Credentialing and Recredentialing (p.8, Procedure 6) • CR DP04 – On-going Monitoring of Providers (p.3, Procedure 3)	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. The Credentialing Committee: • Reviews credentials for practitioners who do not meet established thresholds. • Ensures that files which meet established criteria are reviewed and approved by a medical director or designated physician. NCQA CR2—Element A2 and A3	**Both** • CR301 - Provider Credentialing and Recredentialing (p. 6, Procedure 8) • CR305 – Organizational Provider Credentialing and Recredentialing (p.8, Procedure 6) • CR DP04 – On-going Monitoring of Providers (p.3, Procedure 3)	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The Contractor verifies credentialing and recredentialing information through primary sources to ensure that practitioners have the legal authority and relevant training and experience to provide quality care. Verification is within the prescribed time limits and includes: • A current, valid license to practice (verification time limit=180 calendar days). • A current, valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (verification time limit=prior to the credentialing decision). • Education and training—highest level obtained—e.g., medical/ professional school graduate; residency (verification time limit=prior to the credentialing decision). Required at initial credentialing only. • Board certification—if the practitioner states on the application that he or she is board certified (board certification time limit=180 calendar days). • Work history—most recent five years—if less, from time of initial licensure—from practitioner's application or curriculum vitae (CV) (verification time limit=365 calendar days). Required at initial credentialing only. • History of malpractice settlements—most recent five years (verification time limit=180 calendar days). NCQA CR3—Element A	**Both:** • CR301 - Provider Credentialing and Recredentialing (p. 5, Procedure 7; p. 7 Procedure 13)	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. The Contractor verifies the following sanction information for credentialing and recredentialing (verification time limit=180 days): • State sanctions, restrictions on licensure, or limitations on scope of practice. • Medicare and Medicaid sanctions. NCQA CR3—Element B	**Both:** • CR301 - Provider Credentialing and Recredentialing (p.9, Procedure 13J) • CMP206 – Sanction and Exclusion Screening (All) • CR DP04 – On-going Monitoring of Providers (p.2, Procedure 2)	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
19. Practitioners complete an application for network participation (at initial credentialing and recredentialing) that includes a signed attestation (attestation verification time limit=365 days). The application addresses the following: • Reasons for inability to perform the essential functions of the position. • Lack of present illegal drug use. • History of loss of license and felony convictions. • History of loss or limitation of privileges or disciplinary actions. • Current malpractice or professional liability insurance coverage (minimums=physician—0.5mil/1.5mil; facility—0.5mil/3mil). • Attestation confirming the correctness and completeness of the application. NCQA CR3—Element C	**Both:** • CR301 - Provider Credentialing and Recredentialing (p. 6, Procedure 9B)	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
20. The Contractor formally recredentials practitioners at least every 36 months. NCQA CR4	**Both:** • CR301 - Provider Credentialing and Recredentialing (p. 7, Procedure 11B) • CR305 - Organizational Provider Credentialing and Recredentialing (p.1, policy section; p.7, Procedure 5I)	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
21. The Contractor has and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints, and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identifies issues related to poor quality. Monitoring includes: • Collecting and reviewing Medicare and Medicaid sanctions. • Collecting and reviewing sanctions or limitations on licensure. • Collecting and reviewing complaints. • Collecting and reviewing information from identified adverse events. • Implementing appropriate interventions when it identifies instances of poor quality related to the above. NCQA CR5—Element A	**Both:** • CR301 - Provider Credentialing and Recredentialing (p.7, Procedure 10) • QM201 - Quality of Care Concern Investigation (All) • CMP206 – Sanction and Exclusion Screening (All) • CR DP04 – On-going Monitoring of Providers (All)	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
22. The Contractor has policies and procedures for taking action against a practitioner for quality reasons, reporting the action to the appropriate authorities, and offering the practitioner a formal appeal process. Policies and procedures address: • The range of actions available to the Contractor to improve practitioner performance before termination. • Procedures for reporting to National Practitioner Data Bank (NPDB), State agency, or other regulatory body, as appropriate. NCQA CR6—Element A1 and A2	**Both:** • ADM301 - Adverse Actions Hearing and Appeal Process for Providers (All) • QM201 - Quality of Care Concern Investigation (All) • CR301 - Provider Credentialing and Recredentialing (p.7, Procedures 10 and 11) • CR305 – Organizational Provider Credentialing and Recredentialing (p.8, Procedure 6) • CR DP04 – On-going Monitoring of Providers (p.3, Procedure 3)	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
23. When taking action against a practitioner for quality reasons, the Contractor offers the practitioner a formal appeal process. Policies and procedures address: • A well-defined practitioner appeal process, including: – Written notification when a professional review action has been brought against a practitioner, reasons for the action, and a summary of the appeal rights and process. – Allowing practitioners to request a hearing and the specific time period for submitting the request. – Allowing at least 30 calendar days, after notification for practitioners, to request a hearing. – Allowing practitioners to be represented by an attorney or another person of their choice.	**Both:** • ADM301 - Adverse Actions Hearing and Appeal Process for Providers (All) • CR301 - Provider Credentialing and Recredentialing (p. 7, Procedure 12)	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Appointing a hearing officer or a panel of individuals to review the appeal. – Notifying practitioners of the appeal decision in writing, including specific reasons for the decision. • Making the appeal process known to practitioners. NCQA CR6—Element A3 and A4		
24. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of *organizational* providers with which it contracts, which include: • The Contractor confirms—initially and at least every three years—that the provider is in good standing with State and federal regulatory bodies. – Policies specify the sources used to confirm—which may only include applicable State or federal agency, agent of the applicable State or federal agency, or copies of credentials (e.g., state licensure) from the provider. NCQA CR7—Element A1	**Both** • CR305 - Organizational Provider Credentialing and Recredentialing (p.1, Procedure 2; p. 3, Procedure 3; p. 5, Procedure 5; p. 8 Procedure 6) • CR DP04 – On-going Monitoring of Providers (All)	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
25. The Contractor confirms, initially and at least every three years, provider review and approval by an accrediting body. • Policies specify the sources used to confirm—which may only include applicable State or federal agency or applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, or copies of credentials—e.g., licensure, accreditation report or letter—from the provider.	**Both** • CR305 - Organizational Provider Credentialing and Recredentialing (p. 1, Procedure 2; p.3, Procedure 3; p. 5, Procedure 5) • CR DP04 – On-going Monitoring of Providers (All)	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
NCQA CR7—Element A2		**SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
26. The Contractor conducts, initially and at least every three years, an on-site quality assessment if the provider is not accredited. • Polices include: on-site quality assessment criteria for each type of unaccredited organizational provider; a process for ensuring that that the provider credentials its practitioners. • The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: – The CMS or state review is no more than three years old. – The organization obtains a survey report or letter from CMS or the State, from either the provider or from the agency, stating that the facility was reviewed and passed inspection. – The report meets the organization's quality assessment criteria or standards. NCQA CR7—Element A3	**Both:** • CR305 - Organizational Provider Credentialing and Recredentialing (p. 7, Procedure 5H)	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
27. The Contractor's organizational provider assessment policies and processes include assessment of at least the following medical providers: • Hospitals • Home health agencies • Skilled nursing facilities • Freestanding surgical centers NCQA CR7—Element B	**Both:** • CR305 - Organizational Provider Credentialing and Recredentialing (p.1, Procedure 1)	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
28. The Contractor has documentation that it has assessed contracted medical health care (organizational) providers. NCQA CR7—Element D	**Both:** • CR305 - Organizational Provider Credentialing and Recredentialing (All) • CR DP02 – Organizational Assessment and File Audit	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
29. If the Contractor delegates any NCQA-required credentialing or recredentialing activities, the Contractor has a written delegation document with the delegate that: • Is mutually agreed upon. • Describes the delegated activities and responsibilities of the Contractor and the delegated entity. • Requires at least semiannual reporting by the delegated entity to the Contractor. • Describes the process by which the Contractor evaluates the delegated entity's performance. • Specifies that the organization retains the right to approve, suspend, or terminate individual practitioners, providers, and sites—even if the organization delegates decision making. • Describes the remedies available to the Contractor (including revocation of the contract) if the delegate does not fulfill obligations. NCQA CR8—Element A	**Both** • ADM223 – Delegation (All) • CR301 - Provider Credentialing and Recredentialing (p.3, Procedure 5)	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
30. If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes the following provisions: • The allowed uses of PHI. • A description of delegate safeguards to protect the information from inappropriate use or further disclosure. • A stipulation that the delegate will ensure that subdelegates have similar safeguards. • A stipulation that the delegate will provide members with access to their PHI. • A stipulation that the delegate will inform the Contractor if inappropriate use of information occurs. • A stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends. NCQA CR8—Element B	**Both:** • ADM223 – Delegation (p. 3, Procedure 2C)	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
31. For new delegation agreements in effect fewer than 12 months, the Contractor evaluated delegate capacity to meet NCQA requirements before delegation began. NCQA CR8—Element C	**Both:** • ADM223 – Delegation (p. 2, Procedure 1.B.a) • CR301 - Provider Credentialing and Recredentialing (p. 3, Procedure 5A)	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
32. For delegation agreements in effect 12 months or longer, the Contractor: • Annually reviews its delegates' credentialing policies and procedures. • Annually audits credentialing and recredentialing files against NCQA standards for each year that delegation has been in effect. • Annually evaluates delegate performance against NCQA standards for delegated activities. • Semiannually evaluates delegate reports specified in the written delegation agreement. • At least once in each of the past two years, identified and followed up on opportunities for improvement, if applicable. NCQA CR8—Elements D and E	**Both:** • CR301 - Provider Credentialing and Recredentialing (p. 4, Procedure 5) • ADM223 – Delegation (p. 3, Procedure 3)	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard VIII—Credentialing and Recredentialing CHP+							
Total	Met	=	32	X	1.00	=	32
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	32	**Total Score**		=	32
				Total Score ÷ Total Applicable		=	100%

Results for Standard VIII—Credentialing and Recredentialing SMCN							
Total	Met	=	32	X	1.00	=	32
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	32	**Total Score**		=	32
				Total Score ÷ Total Applicable		=	100%

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. *42 CFR 438.330(a)* Contract: Exhibit B—12.1	**Both:** • Quality Assessment and Performance Improvement Program Description	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor's QAPI Program includes conducting and submitting (to the State) annually and when requested by the Department performance improvement projects (PIPs) that focus on both clinical and nonclinical areas. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. Each PIP includes the following: • Measurement of performance using objective quality indicators. • Implementation of interventions to achieve improvement in the access to and quality of care. • Evaluation of the effectiveness of the interventions based on the objective quality indicators.	**Both:** • Quality Assessment and Performance Improvement Program Description.	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Planning and initiation of activities for increasing or sustaining improvement. *42 CFR 438.330(b)(1) and (d)(2) and (3)* Contract: Exhibit B—12.3.1, 12 3.2, 12.3.4		
Findings: The State does not require and COA did not conduct Performance Improvement Projects for the SMCN population during the compliance review period; therefore, HSAG scored this requirement *Not Applicable.* However, during on-site interviews, staff members stated that COA intends to include the SMCN members in the CHP+ PIP—improving well-child visits ages 3 to 9 years-- to be implemented in 2018-2019.		
3. The Contractor's QAPI Program includes collecting and submitting (to the State) annually: • Performance measure data using standard measures identified by the State. • Data, specified by the State, which enable the State to calculate the Contractor's performance using the standard measures identified by the State. • A combination of the above activities. *42 CFR 438.330(b)(2) and (c)* Contract: Exhibit B—12.4.1, 12.4.2	**HMO**: • FY17 COA CHP+HMO Annual Quality Report **SMCN:** N/A	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Findings: The State does not require reporting of standard performance measure data for the SMCN population; therefore, HSAG scored this requirement *Not Applicable.*		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42 CFR 438.330(b)(3)* Contract: Exhibit B—12.4.4	**Both**: • CM DP06 - ED Diversion Program • CHP+ Asthma Management Program	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Contractor's QAPI program includes investigation of any alleged quality of care concerns. Contract: Exhibit B—12.4.5.1	**Both:** • QM 201 – Quality of Care Concern Investigation	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. *Note: Persons with special health care needs means persons with ongoing heath conditions that: have lasted or are expected to last for at least one year; produce significant limitations in physical, cognitive, emotions, or—in the case of children—social growth or developmental function; or produce dependency on medical or assistive devices; or—in the case of children—unusual need for psychological, educational, or medical services or ongoing special treatments (e.g. medications, special diets, accommodations at home or at school).* *42 CFR 438.330(b)(4)* Contract: Exhibit B—None	**Both:** • Quality Assessment and Performance Improvement Program Description. • QM302 - Quality Review of Provider Medical Records • QM DP13 – Conducting Record Reviews	**CHP+** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Quality Assessment and Performance Improvement Program Description policy described overall mechanisms for monitoring the quality and appropriateness of care for all members but did not address evaluation of quality of care specific to members with SHCN. During on-site interviews, staff members described that COA is developing a medical record review of the provider assessment and treatment plan targeted toward members with SHCN. COA submitted on-site a draft of the proposed medical record review tool which will collect data to enable an assessment of the quality and appropriateness of care for members with SHCN. However, this process was in development and was not in place during the compliance review period. HSAG encourages COA to continue its development and implementation of this process.		
Required Actions: COA must implement mechanisms to assess the quality and appropriateness of care furnished to CHP+ and SMCN members with SHCN as a component of its QAPI Program.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program at least annually. *42 CFR 438.330(e)(2)* Contract: Exhibit B—12.4.7.1	**HMO**: • FY18 COA CHP+ HMO Annual Quality Report **SMCN:** N/A	**CHP+** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Findings: The FY 2017–2018 CHP+ HMO Annual Quality Report documented summary results of all quality initiatives undertaken in the fiscal year, including analysis of statistical findings, as well as strategies and goals for the upcoming year. However, neither the report nor the quality improvement committee minutes documented statements or conclusions regarding the overall effectiveness of the QAPI Program or any of its component activities. Staff members stated that COA's health strategy committee was considering ideas on how to best evaluate the effectiveness of the program and may seek external consultation to do so. Nevertheless, COA did not have a process or evaluation mechanism in place during the compliance review period. The SMCN contract requires a QAPI Program for the prenatal population only. The CHP+ annual quality report describes the high-risk obstetrics care management program, which staff members stated is also applied to SMCN members. However, due to the short-term time of enrollment of members in SMCN, COA does not perform an annual assessment of the effectiveness of the QAPI Program specific to SMCN. HSAG scored this requirement *Not Applicable* for SMCN.		
Required Actions: COA must implement an annual process for evaluating the impact and effectiveness of the CHP+ QAPI Program.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor adopts practice guidelines that meet the following requirements: • Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. • Consider the needs of the Contractor's members. • Are adopted in consultation with participating providers. • Are reviewed and updated at least every two years. *42 CFR 438.236(b)* Contract: Exhibit B—12.2.1.2	**Both**: • QM311 – Clinical Practice Guidelines	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor develops practice guidelines for the following: • Perinatal, prenatal, and postpartum care. • Conditions related to persons with a disability or special health care needs. • Well-child care. Contract: Exhibit B—12.2.1.1	**Both:** • QM311 – Clinical Practice Guidelines **HMO:** • Provider Manual – Section 3 • Website: https://www.coaccess.com/providers/resources/ **SMCN:** • Provider Manual – Section 3 • Website – https://www.chpplusproviders.com/materials.asp	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor disseminates the guidelines to all affected providers and, upon request, members, non-members, and the public—at no cost. *42 CFR 438.236(c)* Contract: Exhibit B—12.2.1.3	**Both:** • QM311 - Clinical Practice Guidelines **HMO:** • Provider Manual – Section 3 • Website - https://www.coaccess.com/providers/resources/ **SMCN:** • Provider Manual – Section 3 • Website - https://www.chpplusproviders.com/materials.asp	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42 CFR 438.236(d)* Contract: Exhibit B—12.2.1.4	**Both**: • QM 311 - Clinical practice guidelines • CCS302- Medical Criteria for Utilization Review	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42 CFR 438.242(a)* Contract: Exhibit B—12.4.10.1	**Both*:*** • StandardX_Req12 and 13_SystemstoManageHealthInformationData • COA Architecture Diagram V1.3	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
13. The Contractor's health information system provides information about areas including but not limited to utilization, claims, grievances and appeals, and disenrollment for other than loss of CHP+ eligibility. *42 CFR 438.242(a)* Contract: Exhibit B—12.4.10.1	**Both*:*** • StandardX_Req12 and 13_SystemstoManageHealthInformationData • COA Architect Diagram V1.3	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor's claims processing and retrieval systems collect data elements necessary to enable the mechanized claims processing and information retrieval systems operated by the State. • Contractor electronically submits encounter claims data in the interChange ANSI X12N 837 format directly to the Department's fiscal agent using the Department's data transfer protocol. The 837-format encounter claims (reflecting claims paid, adjusted, and/or denied by the Contractor) shall be submitted via a regular batch process. *42 CFR 438.242(b)(1)* Contract: Exhibit B—18.2.1	**Both**: • 837 Workflow	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. The Contractor collects data on member and provider characteristics and on services furnished to members through an encounter data system (or other methods specified by the State). *42 CFR 438.242(b)(2)* Contract: Exhibit B—12.4.10.2	**Both:** • COA Architect Diagram V1.3	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The Contractor ensures that data received from providers are accurate and complete by: • Verifying the accuracy and timeliness of reported data, including data from network providers compensated through capitation payments. • Screening the data for completeness, logic, and consistency. • Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies used for CHP+ quality improvement and care coordination efforts. *42 CFR 438.242(b)(3) and (4)* Contract: Exhibit B—12.4.10.3.1	***Documents Submitted:*** • StandardX_Req16_MechanismsEnsureDataAccuracy Complete	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
17. The Contractor: • Collects and maintains sufficient member encounter data to identify the provider who delivers any items or services to members. • Submits member encounter data to the State in standardized ASC X12N 837, NCPDP, and ASC X12N 835 formats as appropriate. • Submits member encounter data to the State at the level of detail and frequency specified by the State. *42 CFR 438.242(c)* Contract: Exhibit B—18.2.6; 18.2.7, 18.2.8	**Both:** • 837 Workflow • Optumas Workflow	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. The Contractor monitors members' perceptions of accessibility and adequacy of services provided, including: • Member surveys. • Anecdotal information. • Grievance and appeals data. • Enrollment and disenrollment information. Contract: Exhibit B—12.4.3.2	**Both**: • FY18 COA CHP+ HMO QAPI Work Plan • FY17 COA CHP+ HMO Annual Quality Report	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard X—Quality Assessment and Performance Improvement for CHP+							
Total	Met	=	16	X	1.00	=	16
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	18	**Total Score**		=	16
				Total Score ÷ Total Applicable		=	89%

Results for Standard X—Quality Assessment and Performance Improvement for SMCN							
Total	Met	=	14	X	1.00	=	14
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	3	X	NA	=	NA
Total Applicable		=	15	**Total Score**		=	14
				Total Score ÷ Total Applicable		=	93%

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2018–2019 Credentialing Record Review Tool
for Colorado Access

Review Period:	July 1, 2018–December 31, 2018
Date of Review:	January 9, 2019
Reviewer:	Katherine Bartilotta
Health Plan Participant:	Travis Roth

Sample #	1	2	3	4	5
Provider ID	***	***	***	***	***
Credentialing Date	07/10/18	07/24/18	08/05/18	09/09/18	09/15/18
The Contractor, using primary sources, verifies that the following are present:					
1. A current, valid license to practice with verification that no State sanctions exist	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
2. A valid DEA or CDS certificate (if applicable)	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒
3. Education and training	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
4. Board certification (if the practitioner states on the application that he or she is board certified)	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒
5. Work history (most recent 5 years or from time of initial licensure)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
6. History of malpractice settlements (most recent 5 years)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
7. Current malpractice insurance in required amount (physicians: 0.5mil/1.5mil)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
8. Verification that the provider has not been excluded from participation in federal programs	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
9. Signed application and attestation	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
10. Verification was within the allowed time limits (verification time limits are included below).	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Number of applicable elements	**9**	**8**	**9**	**8**	**8**
Number of compliant elements	**9**	**8**	**9**	**8**	**8**
Percentage compliant	**100%**	**100%**	**100%**	**100%**	**100%**

Verification time limits:

Prior to Credentialing Decision	180 Calendar Days	365 Calendar Days
• DEA or CDS certificate • Education and training	• Current, valid license • Board certification status • Malpractice history • Exclusion from federal programs	• Signed application/attestation • Work history

Comments:

Sample #	6	7	8	9	10
Provider ID	***	***	***	***	***
Credentialing Date	10/11/18	10/23/18	11/06/18	11/20/18	11/29/18
The Contractor, using primary sources, verifies that the following are present:					
1. A current, valid license to practice with verification that no State sanctions exist	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
2. A valid DEA or CDS certificate (if applicable)	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐
3. Education and training	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
4. Board certification (if the practitioner states on the application that he or she is board certified)	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒
5. Work history (most recent 5 years or from time of initial licensure)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
6. History of malpractice settlements (most recent 5 years)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
7. Current malpractice insurance in required amount (physicians: 0.5mil/1.5mil)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
8. Verification that the provider has not been excluded from participation in federal programs	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
9. Signed application and attestation	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
10. Verification was within the allowed time limits (verification time limits are included below).	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Number of applicable elements	**9**	**9**	**9**	**8**	**9**
Number of compliant elements	**9**	**9**	**9**	**8**	**9**
Percentage compliant	**100%**	**100%**	**100%**	**100%**	**100%**

Verification time limits:

Prior to Credentialing Decision	180 Calendar Days	365 Calendar Days
• DEA or CDS certificate • Education and training	• Current, valid license • Board certification status • Malpractice history • Exclusion from federal programs	• Signed application/attestation • Work history

Comments:

Total number of applicable elements	**86**
Total number of compliant elements	**86**
Overall percentage compliant	**100%**

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2018–2019 Recredentialing Record Review Tool
for Colorado Access

Review Period:	July 1, 2018–December 31, 2018
Date of Review:	January 9, 2019
Reviewer:	Gina Stepuncik
Health Plan Participant:	Travis Roth

Sample #	1	2	3	4	5
Provider ID	***	***	***	***	***
Prior Credentialing or Recredentialing Date	08/16/18	05/21/16	05/12/16	05/29/16	06/21/16
Current Recredentialing Date	07/23/18	07/30/18	08/08/18	08/31/18	09/09/18
The Contractor, using primary sources, verifies that the following are present:					
1. A current, valid license to practice with verification that no State sanctions exist	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
2. A valid DEA or CDS certificate (if applicable)	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐
3. Board certification (if the practitioner states on the application that he or she is board certified)	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐
4. History of malpractice settlements (most recent 5 years)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
5. Current malpractice insurance in required amount (physicians: 0.5mil/1.5mil)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
6. Verification that the provider has not been excluded from participation in federal programs	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
7. Signed application and attestation	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
8. Verification was within the allowed time limits (verification time limits are included below).	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
9. Provider was recredentialed within 36 months of previous approval date.	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Number of applicable elements	**9**	**9**	**7**	**9**	**9**
Number of compliant elements	**9**	**9**	**7**	**9**	**9**
Percentage compliant	**100%**	**100%**	**100%**	**100%**	**100%**

Verification time limits:

Prior to Credentialing Decision	180 Calendar Days	365 Calendar Days
• DEA or CDS certificate	• Current, valid license • Board certification status • Malpractice history • Exclusion from federal programs	• Signed application/attestation

Comments:

Sample #	6	7	8	9	10
Provider ID	***	***	***	***	***
Prior Credentialing or Recredentialing Date	05/08/16	05/29/16	10/16/15	06/21/16	08/16/16
Current Recredentialing Date	09/19/18	09/30/18	10/11/18	11/06/18	11/30/18
The Contractor, using primary sources, verifies that the following are present:					
1. A current, valid license to practice with verification that no State sanctions exist	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
2. A valid DEA or CDS certificate (if applicable)	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒
3. Board certification (if the practitioner states on the application that he or she is board certified)	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒
4. History of malpractice settlements (most recent 5 years)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
5. Current malpractice insurance in required amount (physicians: 0.5mil/1.5mil)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
6. Verification that the provider has not been excluded from participation in federal programs	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
7. Signed application and attestation	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
8. Verification was within the allowed time limits (verification time limits are included below).	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
9. Provider was recredentialed within 36 months of previous approval date.	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Number of applicable elements	**9**	**9**	**7**	**7**	**7**
Number of compliant elements	**9**	**9**	**7**	**7**	**7**
Percentage compliant	**100%**	**100%**	**100%**	**100%**	**100%**

Verification time limits:

Prior to Credentialing Decision	180 Calendar Days	365 Calendar Days
• DEA or CDS certificate	• Current, valid license • Board certification status • Malpractice history • Exclusion from federal programs	• Signed application/attestation

Comments:

Total number of applicable elements	**82**
Total number of compliant elements	**82**
Overall percentage compliant	**100%**

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2018–2019 site review of **COA**.

Table C-1—HSAG Reviewers and COA and Department Participants

HSAG Review Team	Title
Katherine Bartilotta	Associate Director
Gina Stepuncik	Senior Project Manager
COA Participants	**Title**
Andrea Rodriquez	Compliance Contractor
Bryce Andrew	Transition of Care, Physical Health Supervisor
Danielle Schroeder	Manager, Care Management
Elizabeth Strammiello	Chief Compliance Officer
Janet Milliman	Director of CHP+, SMCN, and Program Development and Operations
Janette Heung	Director, Care Management
Jeni Sargent	Director of Credentialing, Configuration, and Enrollment
Joseph Anderson	Director of Care Management
Josie Koth	Program Development and Operations
Krista Beckwith (telephonic)	Director of Population Health and Quality
Kristin Brown (telephonic)	Manager of Claims Monitoring and Research
Lindsey Lambert	Manager of Care Management
Lisa Hug	Manager of Program Development and Operations
Mika Gans	Manager of Quality
Sarah Lambie	Quality Improvement Program Manager
Travis Roth	Manager of Credentialing
Department Observers	**Title**
Jerry Smallwood (telephonic)	Contract Manager
Teresa Craig (telephonic)	SMCN Contract Manager
Russell Kennedy	Quality Compliance Specialist

Appendix D. Corrective Action Plan Template for FY 2018–2019

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 90 days (three 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 three-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.) If the health plan is unable to submit documents of completion for any required action on or before the three-month deadline, it must obtain approval in writing from the Department to extend the deadline.

Step	Action
Step 5	**Technical Assistance**
	At the health plan's request, HSAG will schedule an 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 three-month deadline will result in a continued corrective action with a new date for completion established by the Department. HSAG will continue to work with the health plan until all required actions are satisfactorily completed.

The CAP template follows.

Table D-2—FY 2018–2019 Corrective Action Plan for COA

Standard IV—Member Rights and Protections: CHP+ and SMCN		
Requirement	**Findings**	**Required Action**
3. The Contractor's policies and procedures ensure that each member is guaranteed 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. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding his or her health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. • Request and receive a copy of his or her medical records and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210).	COA's Member Rights and Responsibilities policy directed the reader to the State's rights and responsibilities listed in the Colorado Medicaid Managed Care Program Code of Regulations (CCR) 2505-20 Section 8.205.2-3. The CCR listed all of the bulleted requirements except: • Receive information in accordance with information requirements (42 CFR 438.10). • Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210).	COA must ensure that all required member rights are accounted for within its policy.

Standard IV—Member Rights and Protections: CHP+ and SMCN		
Requirement	**Findings**	**Required Action**
42 CFR 438.100(b)(2) and (3) Contract: Exhibit B—14.1.1.2.1–5; 14.1.1.3		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard X—Quality Assessment and Performance Improvement: CHP+ and SMCN		
Requirement	**Findings**	**Required Action**
6. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. *Note: Persons with special health care needs means persons with ongoing heath conditions that: have lasted or are expected to last for at least one year; produce significant limitations in physical, cognitive, emotions, or—in the case of children—social growth or developmental function; or produce dependency on medical or assistive devices; or—in the case of children—unusual need for psychological, educational, or medical services or ongoing special treatments (e.g. medications, special diets, accommodations at home or at school).* *42 CFR 438.330(b)(4)* Contract: Exhibit B—None	The Quality Assessment and Performance Improvement Program Description policy described overall mechanisms for monitoring the quality and appropriateness of care for all members but did not address evaluation of quality of care specific to members with SHCN. COA submitted on-site a draft of the proposed medical record review tool which will collect data to enable an assessment of the quality and appropriateness of care for members with SHCN. However, this process was in development and was not in place during the compliance review period.	COA must implement mechanisms to assess the quality and appropriateness of care furnished to CHP+ and SMCN members with SHCN as a component of its QAPI Program.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard X—Quality Assessment and Performance Improvement: CHP+ Only		
Requirement	**Findings**	**Required Action**
7. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program at least annually. *42 CFR 438.330(e)(2)* Contract: Exhibit B—12.4.7.1	The FY 2017–2018 CHP+ HMO Annual Quality Report documented summary results of all quality initiatives undertaken in the fiscal year, including analysis of statistical findings, as well as strategies and goals for the upcoming year. However, neither the report nor the quality improvement committee minutes documented statements or conclusions regarding the overall effectiveness of the QAPI Program or any of its component activities. Staff members stated that COA's health strategy committee was considering ideas on how to best evaluate the effectiveness of the program. Nevertheless, COA did not have a process or evaluation mechanism in place during the compliance review period.	COA must implement an annual process for evaluating the impact and effectiveness of the CHP+ QAPI Program.
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 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 Integrated Quality Improvement Committee (IQuIC) meetings and provided group technical assistance and training, as needed. • Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the health plan in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and on-site activities. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. • Documents submitted for the desk review and on-site review consisted of the completed desk review form, the compliance monitoring tool with the health plan's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The health plans also submitted a list of all credentialing and recredentialing records that occurred between July 1, 2018, and December 31, 2018 (to the extent available at the time of the site visit). 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 credentialing and recredentialing of providers. • While on-site, HSAG collected and reviewed additional documents as needed. • 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 2018–2019 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.