Fiscal Year 2019–2020 Site Review Report

for

Colorado Access CHP+ MCO and State Managed Care Network

April 2020

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

Table of Contents

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 federal managed care regulations and State contract requirements, the Department determined that the review period for fiscal year (FY) 2019–2020 was January 1, 2019, through December 31, 2019. This report documents results of the FY 2019–2020 site review activities for **Colorado Access** (**COA**) in its role as a contracted MCO and as the State Managed Care Network (SMCN) administrative service organization (ASO) for the State's CHP+ program. 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 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 2019–2020 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the 2018–2019 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 denials of authorization of services (denials) record reviews. Appendix C lists HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process the health plan will be required to complete for FY 2019–2020 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)
I. Coverage and Authorization of Services	36	32	25	7	0	4	78%
II. Access and Availability	16	16	16	0	0	0	100%
Totals	**52**	**48**	**41**	**7**	**0**	**4**	**85%**

*The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements from the standards in the compliance monitoring tool.

Table 1-2 presents the scores for **COA** CHP+ for the denial 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)
Denials	90	58	38	20	32	66%
Totals	**90**	**58**	**38**	**20**	**32**	**66%**

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

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 denial 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)
I. Coverage and Authorization of Services	36	32	28	4	0	4	88%
II. Access and Availability	16	16	16	0	0	0	100%
Totals	**52**	**48**	**44**	**4**	**0**	**4**	**92%**

*The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements from the standards in the compliance monitoring tool.

Standard I—Coverage and Authorization of Services

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

Summary of Strengths and Findings as Evidence of Compliance

Findings regarding **COA**'s written policies, procedures, and processes were applicable to both CHP+ and SMCN. HSAG conducted no denial record reviews for SMCN; therefore, findings related to record reviews apply to CHP+ only.

COA's *Utilization Management (UM) Program Description* and *Utilization Review (UR) Determinations* policy outlined a thorough and comprehensive approach for review and authorization of covered services using medical necessity, and Interqual criteria and operational processes in compliance with regulatory guidelines. **COA** conducted annual inter-rater reliability testing to ensure that UM staff members applied criteria consistently. **COA** had established a panel of regularly scheduled pediatrics and family practice medical reviewers for making CHP+ authorization determinations and had further access to a specialist panel of reviewers through a contract with National Medical Review. Medical reviewers routinely offered a peer review consultation to the requesting provider prior to making a final adverse benefit determination. Denial record reviews demonstrated 100 percent compliance with requirements for application of criteria, decisions made by a qualified reviewer, and outreach to the requesting provider to obtain additional information when necessary. Policies and procedures addressed the required content of the notice of adverse benefit determination (NABD) and timelines for making

authorization decisions. **COA** time- and date-stamped all authorization requests and notice of authorization decisions, ensuring that the required 72-hour time frame for expedited decisions and 24-hour time frame for covered outpatient drug decisions were met. While UM policies and procedures accurately addressed all requirements related to the termination of previously authorized services, including information related to requests for continuation of benefits during an appeal. However, staff members stated that **COA** does not ever reduce or terminate previously authorized services. The CHP+ and SMCN NABDs to members and providers included all required content and were written in a format and language easy for the member to understand. The NABD informed members of availability of the letter in numerous languages and in alternative formats. Whereas on-site record reviews of claims revealed that **COA** overlooked sending a written NABD to members for claims denials, record reviews conversely demonstrated that all UM denials of new requests were fully compliant with sending notice to the member within required timeframes, required content of the letter, and written in easy to understand language. **COA** properly extended the authorization decision as necessary to obtain additional information and extension letters sent to members included all required content. Although anticipated mental health parity requirements were for information only and were not reviewed or scored in this standard, HSAG observed that **COA** has already incorporated applicable mental health parity requirements into its policies.

COA's policies and procedures accurately defined "emergency condition," "emergency services," and "post-stabilization services" consistent with regulatory definitions. **COA** did not require authorization for emergency services in or out of network. During on-site interviews, staff members stated that all emergency services claims are auto-paid by the claims system, and that emergency services claims are never reviewed for medical necessity or denied for any reason (except inaccurate billing processes). **COA**'s *Emergency and Post-Stabilization Care* policy addressed verbatim the requirements pertaining to determining financial responsibility for post-stabilization care. **COA**'s *Post Stabilization Care Services* desktop procedure outlined some of the procedures for implementing the review of post-stabilization services and communicating the results of UM determinations through the claims management system. For post-stabilization services a member receives out of network, staff members stated that **COA** bills CHP+ members only for applicable co-pays, consistent with what the member would have been charged for services delivered in network.

Summary of Findings Resulting in Opportunities for Improvement

While on-site interviews with staff members verified that the information specified in **COA**'s *Medication Utilization Review* desktop procedure met the requirement for notification of an authorization decision for covered outpatient drugs within 24 hours of request, HSAG found that some of the language in the written desktop procedure was confusing or may be misleading. For example, the procedure stated that injectables and medications administered through intravenous infusion are authorized within the usual 10-day standard and 72-hour expedited time frames without clarifying that these are CHP+ "medical benefits" rather than "pharmacy benefits" (subject to 24-hour authorization). In addition, the procedure describes that "notification" will be made but did not specify that the notification is the authorization decision. HSAG recommends that **COA** modify language in its desktop

procedure to clearly state that, for CHP+ covered outpatient drugs, **COA** will notify the requestor of an "authorization" decision within 24 hours.

While **COA**'s *UR Determinations* policy included all required information related to the member's right to request continued benefits during an appeal of a reduction or termination of previously authorized services, the policy also stated and staff members confirmed that **COA** does not reduce or terminate any previously authorized services. In addition, the CHP+ and SMCN NABDs included extensive information regarding the member's right to continue benefits during an appeal and how to request continued benefits. Whereas continued benefit requirements are generally confusing to members and staff members and if, in fact, **COA** never reduces or terminates previously authorized services, HSAG recommends that **COA** consider whether or not continued benefit information should be retained in its policies and procedures or template NABDs. However, HSAG cautions that, if **COA** considers eliminating or clarifying continued benefit information, its policies should clearly state it is **COA**'s policy to never reduce or terminate previously authorized services and, therefore, requests for continued benefits during an appeal or State fair hearing do not apply.

If **COA** retains continued benefit information in the CHP+ and SMCN NABDs, **COA** should clarify in the appeal information attachment the time frame for requesting continued benefits from "when you request an appeal" to "within 10 days of receiving the NABD."

While **COA**'s *Emergency and Post-Stabilization Care* policy addressed all requirements related to the review of or payment for emergency services in or out of network, staff members stated that **COA** never reviews or denies emergency services claims and that the claims system auto-pays every emergency service claim. Whereas auto-pay of all emergency service claims accounts for and supersedes specific regulatory requirements (#28 through #31 in the compliance monitoring tool) related to payment for emergency services, HSAG recommends that **COA**'s policies and related procedures clearly state that no emergency service claim is reviewed for authorization or denied for payment. **COA** might also consider whether or not to retain in its policy the specific criteria for review and payment of emergency services, which may conflictingly imply that emergency service claims are subject to retrospective review. HSAG also recommends **COA** specify that the *Emergency and Post-Stabilization Care* policy, as well as the *Post Stabilization Care Services* desktop procedure, apply to both the UM Department and the Claims Management Department. Furthermore, if **COA** determines that it will retain all criteria for payment of emergency services in its policy, **COA** did not include the criterion "a representative of the organization instructed the member to seek emergency services" and should do so.

As stated in the findings and required actions, **COA**'s policies and procedures did not clearly address how the financial responsibility for post-stabilization services take into consideration the regulatory criteria for determining payment for post-stabilization services. HSAG recommends **COA** consider incorporating one or more of the following processes into its post-stabilization review procedures:

- Extend 24/7 UM coverage (currently offered for Regional Accountable Entity [RAE] behavioral health services) to the CHP+ line of business to enable an inpatient authorization decision to be made within 24 hours.

- Implement a policy to pay for all CHP+ post-stabilization care delivered within the first 24 hours of hospitalization and/or within 24 hours of request for authorization.
- Clearly state that authorization determinations apply only to services following the initial 24 hours of care or following a request for authorization.

While **COA** clearly documented that **COA** does not bill members for out-of-network post-stabilization services, the intent of the federal requirement extends to the Contractor also making best efforts to ensure that an out-of-network provider does not balance bill members for denied out-of-network post-stabilization services. HSAG recommends **COA** consider communicating to the out-of-network providers that they may not bill CHP+ members for unauthorized services and communicating to the members through the NABDs that providers cannot charge members for services not paid by **COA**.

Summary of Required Actions

While **COA**'s *UR Determinations* policy specified that written notice would be sent to the member and provider and denial record reviews demonstrated that members and providers were notified in writing of adverse benefit determinations made by UM, NABDs for claims denials were sent only to the provider. Therefore, five of 10 CHP+ denial record reviews (related to claims) were scored *Not Met* for "notice sent to provider and member." HSAG did not conduct SMCN denial record reviews. **COA** must ensure that CHP+ members receive written notification of any decision to deny a service, including denial or partial denial of a claim.

COA demonstrated that the CHP+ and SMCN NABDs used for UM denials were written in language easy to understand and informed the member of the availability of the letter in other languages and alternative formats. However, **COA** sent no notice to members regarding denial of a claim; therefore, five of 10 CHP+ denial record reviews (related to claims) were scored *Not Met* for "correspondence with the member was easy to understand." HSAG did not conduct SMCN denial record reviews. **COA** must ensure that CHP+ members receive written notification of any decision to deny a service, including denial or partial denial of a claim. **COA** must ensure that the NABD regarding a claim is written in language that is easy for the member to understand.

COA demonstrated that the CHP+ and SMCN NABDs used for UM denials included all required content. However, **COA** sent no notice to members regarding denial of a claim; therefore, five of 10 CHP+ denial record reviews (related to claims) were scored *Not Met* for "notice includes required content." HSAG did not conduct SMCN denial record reviews. **COA** must ensure that CHP+ members receive written notification of any decision to deny a service, including denial or partial denial of a claim. **COA** must ensure that the NABD regarding a claim includes all required content.

While **COA**'s *UR Determinations* policy addressed all required time frames for mailing the NABD to the member, the format of information in the policy resulted in inaccurate information regarding required time frames. Specifically, several of the time frames applicable to all NABDs were listed as *exceptions* to the time frame for notice of reduction or termination of previously authorized services. In addition, **COA** sent no notice to members regarding denial of a claim; therefore, five of 10 CHP+ denial

record reviews (related to claims) were scored *Not Met* for "notice sent within required time frame." **COA** must:

- Correct the formatting in its *UR Determinations* policy to accurately address all required time frames for mailing the NABD to the member.
- Ensure that CHP+ members receive written notification of any decision to deny a service, including denial or partial denial of a claim, and that the NABD regarding denial of payment is sent at the time of any denial affecting the claim.

While **COA**'s *UR Determinations* policy addressed all required time frames for mailing the NABD to the member, the format of information in the policy resulted in inaccurate information regarding required time frames. Specifically, the circumstances related to exceptions to the 10-day time frame for notifying the member regarding the reduced or terminated previously authorized services were not listed in the policy as only associated with the reduction, suspension, or termination of previously authorized services. **COA** must correct information in its *UR Determinations* policy to accurately address the exceptions to the time frames for mailing the NABD related to reduction or termination of previously authorized services, as stated in 42 CFR 431.211, 431.213, and 431.214.

COA's *Emergency and Post-Stabilization Care* policy stated verbatim the requirements related to financial responsibility for post-stabilization care that was not pre-approved by **COA**; however, the policy included no procedures for implementation. **COA**'s *Post Stabilization Care Services* desktop procedure outlined procedures related to UM processes applied to CHP+ post-stabilization care, specifying that the UM authorization process applied traditional medical necessity criteria to the hospitalization. In addition, the desktop procedures stated that UM coverage 24/7 is not available for the CHP+ line of business. The desktop procedure failed to clearly address how the criteria specified in 42 CFR 422.113(c)(iii)—i.e., **COA** does not respond to a request for approval within one hour or cannot be contacted; **COA** and the treating physician do not agree and a plan physician is not available for consultation with the treating provider—are applied when necessary to determine financial responsibility for post-stabilization care. **COA** must develop or enhance its UM and claims payment procedures applicable to post-stabilization care to ensure its UM processes account for review of the circumstances outlined in 42 CFR 422.113(c)(iii) when determining financial responsibility for payment of post-stabilization services that were not pre-approved.

COA's *Emergency and Post-Stabilization Care* policy stated verbatim the requirements related to when financial responsibility ends for post-stabilization care that was not pre-approved by **COA**; however, the policy included no procedures for implementation. **COA**'s *Post Stabilization Care Services* desktop procedure outlined procedures related to UM processes applied to CHP+ post-stabilization care but did not clearly address how the application of the criteria specified in 42 CFR 422.113(c)(3)—i.e., a plan physician assumes responsibility for the member's care; **COA** and the treating provider reach an agreement; the member is discharged—are applied in determining when financial responsibility (i.e., payment of a claim) ends for post-stabilization services that were not pre-approved. **COA** must develop or enhance its UM and claims payment procedures applicable to post-stabilization care to clarify processes for applying the criteria outlined in 42 CFR 422.113(c)(3) to determine when financial responsibility ends for payment of post-stabilization services that were not pre-approved.

Standard II—Access and Availability

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

Summary of Strengths and Findings as Evidence of Compliance

COA effectively demonstrated that it monitors and maintains its network of providers to ensure the timely provision of covered services. Monitoring methods included use of GeoAccess reports that use time and driving distance calculations, and calculation of caseload ratios. **COA** provided descriptions of creative programs such as telehealth programs and contracts with providers who provide physical health and behavioral health services at the same site. The provider manual, provider newsletters, and periodic ad hoc provider communications informed providers of the timely appointment standards. **COA**'s quarterly quality reporting included results of secret shopper calls designed to assess compliance with timely appointment standards.

COA's policies, procedures, and processes adequately addressed second opinions and entering into single case agreements (SCAs) with out-of-network providers when needed to ensure timely provision of services. Through on-site review of documents and administrative records, HSAG found evidence that SCAs are employed when needed. On site, **COA** staff members described analysis of gaps in provider availability identified through the GeoAccess reports and subsequent recruitment efforts within rural and frontier counties. **COA** staff members described the provider network as stable given **COA**'s 25 years in business. **COA** staff members also described processes in place to report provider availability gaps; Healthcare Effectiveness Data and Information Set (HEDIS®)[1-1] and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-2] scores; and network recruiting activities to committees, such as the behavioral health network management committee or the quality improvement committee, to determine if additional initiatives may be needed. **COA** staff members described a new initiative planned for calendar year (CY) 2020: A two question survey asked of members during an incoming phone contact to the customer service line. The purpose of the project will be to assess members' perception of having received access to care needed.

COA had policies, procedures, and processes to address cultural competency. **COA** used in-person and language line translation and offered written materials in alternative languages. **COA**'s website had a button to allow the member to choose the website to be presented in nearly 100 languages. Grievance and appeal member-specific communications included the required tag lines in the required alternate languages. Cultural competency training was required for **COA** staff members and available on the website for providers. **COA** staff members reported that, in CY 2020, **COA** will develop the capability to track providers' access to online training.

[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 (AHRQ).

Summary of Findings Resulting in Opportunities for Improvement

Although requests for second opinions are rare, **COA**'s communication with providers regarding second opinions could be improved. The provider manual informed providers that they may not charge members for helping to arrange for a second opinion. HSAG recommends this language be revised to let providers know that members also may not be charged for provision of second opinions. This may be an important distinction given potential co-pays allowed for select CHP+ services. **COA** may also want to consider adding "at no cost" to the right to a second opinion on the rights list on the **COA** CHP+ tab of its website (https://www.coaccess.com/members/services/rights/), or to the discussions regarding second opinions in the CHP+ and SMCN member handbooks.

Summary of Required Actions

HSAG identified no required corrective actions related to the Access and Availability standard.

2. Overview and Background

Overview of FY 2019–2020 Compliance Monitoring Activities

For the FY 2019–2020 site review process, the Department requested a review of two areas of performance. HSAG developed a review strategy and monitoring tools consisting of two standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of the two standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the two standards, HSAG used the health plan's contract requirements and regulations specified by the 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+ denial of authorization.

HSAG also reviewed a sample of the health plan's administrative records related to CHP+ denials to evaluate implementation of federal healthcare regulations. 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 sample from all CHP+ denial records that occurred between January 1, 2019, and December 31, 2019. 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 I—Coverage and Authorization of Services. HSAG separately calculated a record review score for each record 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 two standards chosen for the FY 2019–2020 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VI—Grievances and Appeals, Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, and Standard X—Quality Assessment and Performance Improvement.

Objective of the Site Review

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

- The health plan's compliance with federal healthcare regulations and managed care contract requirements in the two areas selected for review.
- Strengths, opportunities for improvement, and actions required to bring the health plan into compliance with federal 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: Aug 5, 2019.

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

FY 2018–2019 Corrective Action Methodology

As a follow-up to the FY 2018–2019 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 2018–2019 compliance monitoring site review.

Summary of FY 2018–2019 Required Actions

For FY 2018–2019, HSAG reviewed 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.

Related to member rights and protections, **COA** CHP+ and SMCN were required to ensure that all federally-required member rights were accounted for within its *Member Rights and Responsibilities* policy.

Related to quality assessment and performance improvement, **COA** was required to complete two corrective actions, including:

- Implementing mechanisms to assess the quality and appropriateness of care furnished to CHP+ and SMCN members with special health care needs (SHCN).
- Implementing an annual process for evaluating the impact and effectiveness of the CHP+ Quality Assurance and Performance Improvement (QAPI) Program.

Summary of Corrective Action/Document Review

COA submitted a proposed CAP in April 2019. HSAG and the Department reviewed and approved the proposed plan and responded to **COA**. **COA** submitted initial documents as evidence of completion in August 2019. HSAG and the Department reviewed and approved **COA**'s documents submitted as evidence of completion and responded to **COA** in August 2019.

Summary of Continued Required Actions

COA successfully completed the FY 2018–2019 CAP, resulting in no continued corrective actions.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor ensures that the services are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished. *42 CFR 438.210(a)(3)(i)* CHP+ Contract: Exhibit B-1—8.3 SMCN Contract: Exhibit C—None	**Both CHP+ and SMCN** • Utilization Management Program Description o Philosophy Section o Program Framework Section	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42 CFR 438.210(a)(3)(ii)* CHP+ Contract: Exhibit B-1—8.11 SMCN Contract: Exhibit C—None	**Both CHP+ and SMCN** • CCS307 Utilization Review Determinations o Policy Statement Bullet 7	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor may place appropriate limits on services— • On the basis of criteria applied under the State plan (such as medical necessity). • For the purpose of utilization control, provided that: – The services furnished can reasonably achieve their purpose. – Family planning services are provided in a manner that enables the member to be free from coercion and choose the method of family planning to be used. – Long-term services and supports (LTSS) supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the member's ongoing need for such services. *42 CFR 438.210(a)(4)* CHP+ Contract: Exhibit B-1—8.15.8.1 SMCN Contract: Exhibit C—None	**Both CHP+ and SMCN** • CCS307 Utilization Review Determinations o Definitions Section • Utilization Management Program Description o Program Framework o Goals and Objectives o Program Components	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. The Contractor may place appropriate limits on services for utilization control, provided that any financial requirement or treatment limitation applied to mental health or SUD benefits in any classification is no more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to members (whether or not the benefits are furnished by the same Contractor). *HB19-1269: Section 3—10-16-104(3)(B)* CHP+ Contract: Exhibit B-1—8.15.4.1		*For Information Only*

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: Although HB19-1269 requirements were *for information only* and not scored, COA's *Criteria for Utilization Review* policy addressed the requirements specified in elements #4, #5, and #6 of this tool as follows: "COA ensures that any UM criteria or service limitations for mental health disorders and substance use disorders are no more restrictive than the predominant UM criteria or service limitations under the medical/surgical benefits for the same treatment classification. The presence of a non-covered diagnosis does not preclude a member from receiving covered services for a co-occurring covered diagnosis; all medically necessary covered services for covered diagnoses are covered, regardless of any co-occurring condition."		
5. The Contractor must ensure that the diagnosis of an intellectual or developmental disability, a neurological or neurocognitive disorder, or a traumatic brain injury does not preclude an individual from receiving a covered behavioral health (BH) service. *HB19-1269: Section 12—25.5-5-402(3)(h)*		*For Information Only*
6. The Contractor covers all medically necessary covered treatments for covered BH diagnoses, regardless of any co-occurring conditions. *HB19-1269: Section 12—25.5-5-402(3)(i)*		*For Information Only*
7. The Contractor specifies what constitutes "medically necessary" in a manner that is: • Consistent with the symptom, diagnosis, and treatment of a member's medical condition. • Widely accepted by the practitioner's peer group as effective and reasonably safe based on scientific evidence. • Not experimental, investigational, unproven, unusual, or not customary. • Not solely for cosmetic purposes.	**Both CHP+ and SMCN** • CCS302 Criteria for Utilization Review o Definitions Section **CHP+ Specific** • COA Provider Manual o Section 9 Utilization Management Program ▪ Medical Necessity	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Not solely for the convenience of the member, subscriber, physician, or other provider. • The most appropriate level of care that can be safely provided to the member, and failure to provide the service would adversely affect the member's health. • When applied to inpatient care—medically necessary services cannot be safely provided in an ambulatory setting. CHP+ Contract: Exhibit B-1—1.1.62.1–8 SMCN Contract: Exhibit C—I.60	**SMCN Specific** • SMCN Provider Manual-1219 o Section VIII Authorizations & Referrals ▪ Medical Necessity	
8. The Contractor and its subcontractors have in place and follow written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42 CFR 438.210(b)(1)* Contract: Exhibit B-1—11.1.5 SMCN Contract: Exhibit C—21.2.1, 22.2.1, 24.1, 24.3	**Both CHP+ and SMCN** • CCS307 Utilization Review Determinations **CHP+ Specific** • COA Provider Manual o Section 9 Utilization Management Program ▪ Prior Authorization Request Process **SMCN Specific** • SMCN Provider Manual-1219 o Section VIII Authorizations & Referrals ▪ Submitting an Authorization Request	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor and its subcontractors have in place mechanisms to ensure consistent application of review criteria for authorization decisions. *42 CFR 438.210(b)(2)(i)* CHP+ Contract: Exhibit B-1—11.1.6 SMCN Contract: Exhibit C—None	**Both CHP+ and SMCN** • CCS302 Criteria for Utilization Review • 2018 Inter-Rater Reliability Report	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. The Contractor and its subcontractors have in place mechanisms to consult with the requesting provider for medical services when appropriate. *42 CFR 438.210(b)(2)(ii)* CHP+ Contract: Exhibit B-1—11.1.6 SMCN Contract: Exhibit C—None	**Both CHP+ and SMCN** • CCS307 Utilization Review Determinations o Section 2 D • CCS316 Peer Review Process **CHP+ Specific** • COA Provider Manual o Section 9 Utilization Management Program ▪ Peer Review **SMCN Specific** • SMCN Provider Manual-1219 o Section VIII Authorizations & Referrals	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	▪ Submitting an Authorization Request	
11. The Contractor ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by an individual who has appropriate expertise in treating the member's medical or BH needs. *42 CFR 438.210(b)(3)* CHP+ Contract: Exhibit B-1—11.1.3 SMCN Contract: Exhibit C—22.2.1, 22.2.2	**Both CHP+ and SMCN** • CCS301 Qualifications for Staff Engaged in Utilization Management Activities	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor notifies the requesting provider and gives the member written notice of any decision by the Contractor to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. *Note: Notice to the provider may be oral or in writing.* *42 CFR 438.210(c)* CHP+ Contract: Exhibit B-1—11.1.8 SMCN Contract: Exhibit C—19.1.13.1	**Both CHP+ and SMCN** • CCS307 Utilization Review Determinations o Section 7 **CHP+ Specific** • CHP_HMO Denial Letter **SMCN Specific** • CHP_SMCN Denial Letter	**CHP+** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: COA's *UR Determinations* policy specified that written notice would be sent to the member and provider. COA demonstrated having template NABDs for both CHP+ and SMCN, and denial record reviews demonstrated that members and providers were notified in writing of adverse benefit determinations made by UM. However, NABDs for claims denials were sent only to the provider. No NABD was sent to the member regarding a claims denial; therefore, five of 10 CHP+ denial record reviews (related to claims) were scored *Not Met* for "notice sent to provider and member." HSAG did not conduct SMCN record reviews.		
Required Actions: COA must ensure that CHP+ members receive written notification of any decision to deny a service, including denial or partial denial of a claim.		
13. The Contractor adheres to the following time frames for making standard and expedited authorization decisions: • For standard authorization decisions—as expeditiously as the member's condition requires and not to exceed 10 calendar days following the receipt of the request for service. • If the provider indicates, or the Contractor determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service. *42 CFR 438.210(d)(1–2)* CHP+ Contract: Exhibit B-1—11.1.10–11.1.12 SMCN Contract: Exhibit C—19.1.13.2.5, 19.1.13.2.7	**Both CHP+ and SMCN** • CCS307 Utilization Review Determinations o Section 3.B o Section 4.A	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor may extend the time frame for making standard or expedited authorization decisions by up to 14 additional calendar days if: • The member or the provider requests an extension, or • The Contractor justifies a need for additional information and how the extension is in the member's interest. *42 CFR 438.210(d)(1)(i–ii) and (d)(2)(ii)* CHP+ Contract: Exhibit B-1—11.1.10.1–2; 11.1.12.1–2 SMCN Contract: Exhibit C—19.1.13.2.5.1, 19.1.13.2.7.1	**Both CHP+ and SMCN** • CCS307 Utilization Review Determinations o Section 3.F.a	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
15. The Contractor provides telephonic or telecommunications notice within twenty-four (24) hours of a request for prior authorization of covered outpatient drugs. *42 CFR 438.210(c)(3)* *42 US Code 1396r-8(d)(5)(a)* CHP+ Contract: Exhibit B-1—8.18.3.1 SMCN Contract: Exhibit C—None	**Both CHP+ and SMCN** • Rx DP 28 Medication Utilization Review o Section 2	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The notice of adverse benefit determination must be written in language easy to understand, available in prevalent non-English languages in the region, and available in alternative formats for persons with special needs. *42 CFR 438.404(a)* *42 CFR 438.10(c)* CHP+ Contract: Exhibit B-1—14.1.3.15.1.1–4 SMCN Contract: Exhibit C—19.1.13.1.1–4	**Both CHP+ and SMCN** • ADM206 Culturally Sensitive Services for Diverse Populations • ADM207 Effective Communication with LEP and SI-SI Persons • ADM208 Member Materials • CCS307 Utilization Review Determinations o Section 7.C	**CHP+** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: COA demonstrated that the CHP+ and SMCN NABDs used for UM denials were written in language easy to understand and informed the member of the availability of the letter in other languages and alternative formats. However, COA sent no notice to members regarding denial of a claim; therefore, five of 10 CHP+ denial record reviews (related to claims) were scored *Not Met* for "correspondence with the member was easy to understand." HSAG did not conduct SMCN record reviews.		
Required Actions: COA must ensure that CHP+ members receive written notification of any decision to deny a service, including denial or partial denial of a claim. COA must ensure that the NABD regarding a claim is written in language that is easy for the member to understand.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to and copies of all documents and records relevant to the adverse benefit determination (includes medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits). • The member's (or member's designated representative's) right to request one level of appeal with the Contractor and the procedures for doing so. • The member's right to request a State review after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State review. • The circumstances under which an appeal process can be expedited and how to make this request. • The member's rights to have benefits/services continue (if applicable) pending the resolution of the appeal, how to request that benefits continue, and the circumstances under which the member may be required to pay the cost of these services. • The member's right to appeal under the Child Mental Health Treatment Act (CMHTA), when applicable. *42 CFR 438.404(b)* CHP+ Contract: Exhibit B-1—14.1.3.15.1.5–12 SMCN Contract: Exhibit B—19.1.13.1.5–12	**Both CHP+ and SMCN** • CCS307 Utilization Review Determinations o Section 7.B a-o **CHP+ Specific** • CHP_HMO Denial Letter **SMCN Specific** • CHP_SMCN Denial Letter	**CHP+** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: COA demonstrated that the CHP+ and SMCN NABDs used for UM denials included all required content. However, COA sent no notice to members regarding denial of a claim; therefore, five of 10 CHP+ denial record reviews (related to claims) were scored *Not Met* for "notice includes required content." HSAG did not conduct SMCN record reviews. In addition, the letter included conflicting information regarding how the member may request continued benefits during an appeal. In one location, the member was erroneously instructed to request continued benefits at the time of filing the appeal—which could be up to 60 days following the NABD—and in another location, accurately instructed the member to request continued benefits within 10 days of the NABD. HSAG recommends that COA resolve the conflicting information in the NABDs regarding when to request continued benefits.		
Required Actions: COA must ensure that CHP+ members receive written notification of any decision to deny a service, including denial or partial denial of a claim. COA must ensure that the NABD regarding a claim includes all required content.		
18. Notice of adverse benefit determination for denial of behavioral, mental health, or SUD benefits includes, in plain language: • A statement explaining that members are protected under the federal Mental Health Parity and Addiction Equity Act (MHPAEA), which provides that limitations placed on access to mental health and SUD benefits may be no greater than any limitations placed on access to medical and surgical benefits. • A statement providing information about contacting the office of the ombudsman for BH care if the member believes his or her rights under the MHPAEA have been violated. • A statement specifying that members are entitled, upon request to the Contractor and free of charge, to a copy of the medical necessity criteria for any behavioral, mental, and SUD benefit. *HB19-1269: Section 6—10-16-113 (I), and (II), and (III)*	**Both CHP+ and SMCN** • CCS307 Utilization Review Determinations o Section 7.B.f-h	*For Information Only*

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: Although requirements of HB19-1269 were *for information only* and not scored, COA's *UR Determinations* policy stated: "For mental health, behavioral health, or substance use disorder benefits, the Notice of Adverse Benefit Determination will also include a statement explaining that members are protected under the federal Mental Health Parity and Addiction Equity Act (MHPAEA), which provides that limitations placed on access to mental health and substance use disorder benefits may be no greater than any limitations placed on access to medical and surgical benefits. The statement also includes information about contacting the office of the ombudsman for behavioral healthcare if the member believes his or her rights under MHPAEA have been violated." Staff members stated that COA is currently revising its NABD template to include this information. HSAG recommended COA consider waiting for forthcoming instructions from the Department and/or ensure that information in the NABD is written in language easy for the member to understand.		
19. The Contractor mails the notice of adverse benefit determination within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, as defined in 42 CFR 431.211, 431.213 and 431.214 (see below). • For denial of payment, at the time of any denial affecting the claim. • For standard service authorization decisions that deny or limit services, no later than 10 calendar days after receipt of request for service. • For expedited service authorization decisions, no later than 72 hours after receipt of request for service. • For extended service authorization decisions, no later than the date the extension expires. • For service authorization decisions not reached within the required time frames, on the date the time frames expire. *42 CFR 438.404(c)* CHP+ Contract: Exhibit B-1—14.1.3.15.2.1–7 SMCN Contract: Exhibit C—19.1.13.2	**Both CHP+ and SMCN** • CCS307 Utilization Review Determination o Section 7.A.a,b 1-4	**CHP+** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **SMCN** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: COA's *UR Determinations* policy addressed all required time frames for mailing the NABD to the member. However, the format of information in the policy (section 7.A) resulted in inaccurate information regarding required time frames. Specifically, several of the above time frames (bullets 2 through 5 of the requirement) were listed as *exceptions* to the time frame for notice of reduction or termination of previously authorized services. These required time frames are independent requirements applicable to all NABDs, not related to previously authorized services. In addition, COA sent no notice to members regarding denial of a claim; therefore, five of 10 CHP+ denial record reviews (related to claims) were scored *Not Met* for "notice sent within required time frame."		
Required Actions: COA must correct information in its *UR Determinations* policy and any related documents to accurately address all required time frames for mailing the NABD to the member. COA must also ensure that CHP+ members receive written notification of any decision to deny a service, including denial or partial denial of a claim, and that the NABD regarding denial of payment is sent at the time of any denial affecting the claim.		
20. For reduction, suspension, or termination of a previously authorized Medicaid-covered service, the Contractor gives notice at least ten (10) days before the intended effective date of the proposed adverse benefit determination except: • The Contractor gives notice on or before the intended effective date of the proposed adverse benefit determination if: – The Agency has factual information confirming the death of a member. – The Agency receives a clear written statement signed by the member that he/she no longer wishes services, or gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information. – The member has been admitted to an institution where he/she is ineligible under the plan for further services.	**Both CHP+ and SMCN** • CCS307 Utilization Review Determination o Section 7.A.c 1-8	**CHP+** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **SMCN** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– The member's whereabouts are unknown, and the post office returns Agency mail directed to him/her indicating no forwarding address. – The Agency establishes that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth. – A change in the level of medical care is prescribed by the member's physician. – The notice involves an adverse benefit determination made with regard to the preadmission screening requirements. • If probable member fraud has been verified, the Contractor gives notice five (5) calendar days before the intended effective date of the proposed adverse benefit determination. *42 CFR 438.404(c)* *42 CFR 431.211* *42 CFR 431.213* *42 CFR 431.214* CHP+ Contract: Exhibit B-1—14.1.3.15.2.1–3 SMCN Contract: Exhibit C—19.1.13.2.1–3		
Findings: COA's *UR Determinations* policy addressed all required time frames for mailing the NABD to the member. However, the format of information in the policy (section 7.A) resulted in inaccurate information regarding required time frames. Specifically, the circumstances related to the above exceptions to the 10-day time frame for notifying the member regarding the reduced or terminated previously authorized services were not listed in the policy as only associated with the reduction, suspension, or termination of previously authorized services.		
Required Actions: COA must correct information in its *UR Determinations* policy to accurately address the exceptions to the time frames for mailing the NABD related to reduction or termination of previously authorized services, as stated in 42 CFR 431.211, 431.213, and 431.214.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
21. If the Contractor extends the time frame for standard authorization decisions, it must give the member written notice of the reason for the extension and inform the member of the right to file a grievance if he or she disagrees with that decision. *42 CFR 438.404(c)(4)* CHP+ Contract: Exhibit B-1—14.1.3.15.2.5.2 SMCN Contract: Exhibit C—19.1.13.2.5.2	**Both CHP+ and SMCN** • CCS307 Utilization Review Determinations o Section 3.F.b-c	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
22. The Contractor provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42 CFR 438.210(e)* CHP+ Contract: Exhibit B-1—11.1.1 SMCN Contract: Exhibit C—None	**Both CHP+ and SMCN** • CCS301 Qualifications for Staff Engaged in Utilization Management Activities o Section 1.A	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
23. The Contractor defines emergency medical condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part. *42 CFR 438.114(a)* CHP+ Contract: Exhibit B-1—1.1.31 SMCN Contract: Exhibit C—I.33	**Both CHP+ and SMCN** • CCS307 Utilization Review Determinations o Definitions • CCS309 Emergency and Post-Stabilization Care o Definitions Section **CHP+ Specific** • COA Provider Manual o Section 9 Utilization Management Program ▪ Emergency and Urgent Care **SMCN Specific** • SMCN Provider Manual-1219 o Section VIII Authorizations & Referrals ▪ Emergency and Urgent Care	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
24. The Contractor defines emergency services as covered inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title and are needed to evaluate or stabilize an emergency medical condition. *42 CFR 438.114(a)* CHP+ Contract: Exhibit B-1—1.1.32 SMCN Contract: Exhibit C—I.35	**Both CHP+ and SMCN** • CCS307 Utilization Review Determinations o Definitions Section • CCS309 Emergency and Post-Stabilization Care o Definitions Section	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
25. The Contractor defines poststabilization care services as covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or provided to improve or resolve the member's condition. *42 CFR 438.114(a)* CHP+ Contract: Exhibit B-1—1.1.75 SMCN Contract: Exhibit C—I.73	**Both CHP+ and SMCN** • CCS309 Emergency and Post- Stabilization Care o Definitions Section	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
26. The Contractor does not require prior authorization for emergency services or urgently needed services. CHP+ Contract: Exhibit B-1—8.17.1.3 SMCN Contract: Exhibit C—None	**Both CHP+ and SMCN** • CCS309 Emergency and Post-Stabilization Care o Section 1.A	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
27. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. *42 CFR 438.114(c)(1)(i)* CHP+ Contract: Exhibit B-1—8.17.1.4 SMCN Contract: Exhibit C—None	**Both CHP+ and SMCN** • CCS309 Emergency and Post-Stabilization Care o Section 1.C.	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
28. The Contractor may not deny payment for treatment obtained under either of the following circumstances: • A member had an emergency medical condition, including cases in which the absence of immediate medical attention would *not* have had the following outcomes: – Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; – Serious impairment to bodily functions; or – Serious dysfunction of any bodily organ or part. *(Note: The Contractor bases its coverage decisions for emergency services on the severity of the symptoms at the time of presentation and covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. 42 CFR 438.114—Preamble)* • A representative of the Contractor's organization instructed the member to seek emergency services. *42 CFR 438.114(c)(1)(ii)* CHP+ Contract: Exhibit B-1—8.17.1.4, 8.17.1.6 SMCN Contract: Exhibit C—None	**Both CHP+ and SMCN** • CCS309 Emergency and Post-Stabilization Care o Definitions Section o Section 1.D.	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
29. The Contractor does not: • Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms. • Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent failing to notify the member's primary care provider or the Contractor of the member's screening and treatment within 10 calendar days of presentation for emergency services. *42 CFR 438.114(d)(1)* CHP+ Contract: Exhibit B-1—8.17.3.3, 8.20.1, 8.17.1.7 SMCN Contract: Exhibit C—None	**Both CHP+ and SMCN** • CCS309 Emergency and Post-Stabilization Care o Section 1.E	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
30. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42 CFR 438.114(d)(2)* CHP+ Contract: Exhibit B-1—8.17.1.8 SMCN Contract: Exhibit C—None	**Both CHP+ and SMCN** • CCS309 Emergency and Post-Stabilization Care o Section 1.G	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
31. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment. *42 CFR 438.114(d)(3)* CHP+ Contract: Exhibit B-1—8.17.1.5 SMCN Contract: Exhibit C—None	**Both CHP+ and SMCN** • CCS309 Emergency and Post-Stabilization Care o Section 1.F	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
32. The Contractor is financially responsible for poststabilization services that are prior authorized by an in-network provider or Contractor representative, regardless of whether they are provided within or outside the Contractor's network of providers. *42 CFR 438.114(e)* *42 CFR 422.113(c)(i)* CHP+ Contract: Exhibit B-1—8.17.4.1, 8.17.4.3, 8.17.4.5 SMCN Contract: Exhibit C—None	**Both CHP+ and SMCN** • CCS309 Emergency and Post-Stabilization Care o Section 2.A.1	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
33. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative but are administered to maintain the member's stabilized condition within one (1) hour of a request to the organization for pre-approval of further poststabilization care services. *42 CFR 438.114(e)* *42 CFR 422.113(c)(ii)* CHP+ Contract: Exhibit B-1—8.17.4.6 SMCN Contract: Exhibit C—None	**Both CHP+ and SMCN** • CCS309 Emergency and Post-Stabilization Care o Section 2.A.2	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
34. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the member's stabilized condition if: • The organization does not respond to a request for pre-approval within 1 hour. • The organization cannot be contacted. • The organization's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the organization must give the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with care of the patient until a plan provider is reached or one of the criteria in 422.113(c)(3) is met. *42 CFR 438.114(e)* *42 CFR 422.113(c)(iii)*	**Both CHP+ and SMCN** • CCS309 Emergency and Post-Stabilization Care o Section 2.A.3.a-c	**CHP+** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **SMCN** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
CHP+ Contract: Exhibit B-1—8.17.4.7 SMCN Contract: Exhibit C—None		
Findings: COA's *Emergency and Post-Stabilization Care* policy stated verbatim the requirements related to financial responsibilities for post-stabilization care that was not pre-approved by COA; however, the policy included no procedures for implementation. COA's *Post Stabilization Care Services* desktop procedure outlined procedures related to UM processes applied to CHP+ post-stabilization care requests for authorization and how results of UM determinations are communicated to the claims management department for determining payment of a post-stabilization claim. The desktop procedure specified that notification by a provider of inpatient post-stabilization care triggered the UM authorization process, which applied traditional medical necessity criteria to the hospitalization. In addition, the procedures stated that UM coverage 24/7 is not available for the CHP+ line of business. The desktop procedure failed to clearly address how the criteria specified in 42 CFR 422.113(c)(iii) are applied when necessary to determine financial responsibility for post-stabilization care.		
Required Actions: COA must develop or enhance its UM and claims payment procedures applicable to post-stabilization care to clarify processes that account for review of the circumstances outlined in 42 CFR 422.113(c)(iii) when determining financial responsibility for payment of post-stabilization services that were not pre-approved.		
35. The Contractor's financial responsibility for poststabilization care services it has not pre-approved ends when: • A plan physician with privileges at the treating hospital assumes responsibility for the member's care, • A plan physician assumes responsibility for the member's care through transfer, • A plan representative and the treating physician reach an agreement concerning the member's care, or • The member is discharged. *42 CFR 438.114(e)* *42 CFR 422.113(c)(3)* CHP+ Contract: Exhibit B-1—8.17.4.9 SMCN Contract: Exhibit C—None	**Both CHP+ and SMCN** • CCS309 Emergency and Post-Stabilization Care o Section 2.B	**CHP+** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **SMCN** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: COA's *Emergency and Post-Stabilization Care* policy stated verbatim the requirements related to when financial responsibility ends for post-stabilization care that was not pre-approved by COA; however, the policy included no procedures for implementation. COA's *Post Stabilization Care Services* desktop procedure outlined procedures related to UM processes applied to CHP+ post-stabilization care requests for authorization but did not clearly address how the application of the criteria specified in 42 CFR 422.113(c)(3) are applied in determining when financial responsibility (i.e., payment of a claim) ends for post-stabilization services not pre-approved.		
Required Actions: COA must develop or enhance its UM and claims payment procedures applicable to post-stabilization care to clarify processes for applying the criteria outlined in 42 CFR 422.113(c)(3) to determine when financial responsibility ends for payment of post-stabilization services that were not pre-approved.		
36. If the member receives poststabilization services from a provider outside the Contractor's network, the Contractor does not charge the member more than he or she would be charged if he or she had obtained the services through an in-network provider. *42 CFR 438.114(e)* *42 CFR 422.113(c)(iv)* CHP+ Contract: Exhibit B-1—8.17.4.8 SMCN Contract: Exhibit C—None	**Both CHP+ and SMCN** • CCS309 Emergency and Post-Stabilization Care o Section 2.C	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard I—Coverage and Authorization of Services CHP+							
Total	Met	=	25	X	1.00	=	25
	Partially Met	=	7	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	4	X	NA	=	NA
Total Applicable		=	32	**Total Score**		=	25
				Total Score ÷ Total Applicable		=	78%

Results for Standard I—Coverage and Authorization of Services SMCN							
Total	Met	=	28	X	1.00	=	28
	Partially Met	=	4	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	4	X	NA	=	NA
Total Applicable		=	32	**Total Score**		=	28
				Total Score ÷ Total Applicable		=	88%

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor maintains and monitors a network of providers sufficient to provide access to all covered services to all members, including those with limited English proficiency or physical or mental disabilities. The provider network includes the following provider types: • Physicians • Specialists • Hospitals • Pharmacies • BH providers • LTSS providers, as appropriate *42 CFR 438.206(b)(1)* CHP+ Contract: Exhibit B-1—7.13.1, 14.1.3.6 SMCN Contract: Exhibit C—7.1, 21.1, 22.1	**Both CHP+ and SMCN** • PNS202 Selection and Retention of Providers • PNS217 Single Case Agreement Policy • Provider Contract Appendix 1 **CHP+ Specific** • Network Adequacy Report CHP HMO Q4 **SMCN Specific** • Network Adequacy Report CHP SMCN Q4	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. In establishing and maintaining the network adequacy standards, the Contractor considers: • The anticipated CHP+ enrollment. • The expected utilization of services, taking into consideration the characteristics and health care needs of specific CHP+ populations represented in the Contractor's service area. • The numbers, types, and specialties of network providers required to furnish the contracted CHP+ services.	**Both CHP+ and SMCN** • PNS202 Selection and Retention of Providers **CHP+ Specific** • Network Adequacy Report CHP HMO Q4 **SMCN Specific** • Network Adequacy Report CHP SMCN Q4	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The number of network providers accepting/not accepting new CHP+ members. • The geographic location of providers in relationship to where CHP+ members live, considering distance, travel time, and means of transportation used by members. • The ability of providers to communicate with limited-English-proficient members in their preferred language. • The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for members with physical or mental disabilities. • The availability of triage lines or screening systems, as well as use of telemedicine, e-visits, and/or other technology solutions. *42 CFR 438.206(a); 438.68(c)(i)–(ix)* CHP+ Contract: Exhibit B-1—7.13.2.2.1 SMCN Contract: Exhibit C—22.3		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor ensures that its primary care and specialty care provider network complies with time and distance standards as follows: • Pediatric primary care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Pediatric specialty care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—100 miles or 100 minutes • Obstetrics or gynecology: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Physical therapy/occupational therapy/speech therapy: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—100 miles or 100 minutes • Pharmacy: – Urban counties—10 miles or 10 minutes – Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes	**Both CHP+ and SMCN** • PNS202 Selection and Retention of Providers **CHP+ Specific** • Network Adequacy Report CHP HMO Q4 **SMCN Specific** • Network Adequacy Report CHP SMCN Q4	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Acute care hospitals: – Urban counties—20 miles or 20 minutes – Rural counties—30 miles or 30 minutes – frontier counties—60 miles or 60 minutes *42 CFR 438.206(a); 438.68(b)* CHP+ Contract: Exhibit B-1—10.2.1.10 SMCN Contract: Exhibit C—22.3		
4. The Contractor ensures that its BH provider network complies with time and distance standards as follows: • Acute care hospitals: – Urban counties—20 miles or 20 minutes – Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes • Psychiatrists and psychiatric prescribers for children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes • Mental health providers for children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes • SUD providers for children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes	**Both CHP+ and SMCN** • PNS202 Selection and Retention of Providers **CHP+ Specific** • Network Adequacy Report CHP HMO Q4 **SMCN Specific** • Network Adequacy Report CHP SMCN Q4	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Frontier counties—90 miles or 90 minutes *Note: If there are no BH providers that meet the BH provider standards within the defined area for a specific member, then the Contractor shall not be bound by the time and distance requirements. (Exhibit B1—10.2.1.11.1)* *42 CFR 438.206(a); 438.68(b)* CHP+ Contract: Exhibit B-1—10.2.1.12, 10.2.1.13.1 SMCN Contract: Exhibit C—22.3		
5. The Contractor provides female members with direct access to a women's health care specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health care specialist. *42 CFR 438.206(b)(2)* CHP+ Contract: Exhibit B-1—10.2.1.15 SMCN Contract: Exhibit C—None	**Both CHP+ and SMCN** • NA **CHP+ Specific** • CHP_HMO Member Handbook o Member Benefits-Covered Services-Family Planning/Reproductive Health **SMCN Specific** • CHP_SMCN Member Handbook o Section 6 Member Benefits-Covered Services-Family Planning/Reproductive Health	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor provides for a second opinion from a network provider or arranges for the member to obtain one outside the network (if there is no qualified provider within the network), at no cost to the member. *42 CFR 438.206(b)(3)* CHP+ Contract: Exhibit B-1—10.2.1.16 SMCN Contract: Exhibit C—None	**Both CHP+ and SMCN** • CCS310 Access to Primary and Secondary Care **CHP+ Specific** • COA Provider Manual o Section 4 Provider Responsibilities ▪ Second Opinion • CHP Member Handbook o Member Benefits-Covered Services-Provider Office Services **SMCN Specific** • CHP SMCN Provider Manual o II Primary Care Providers & Specialists ▪ Second Opinion • SMCN Member Handbook o Member Benefits-Covered Services-Provider Office Services	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
7. If the provider network is unable to provide necessary covered services to a particular member in network, the Contractor must adequately and in a timely manner cover the services out of network for as long as the Contractor is unable to provide them. *42 CFR 438.206(b)(4)* CHP+ Contract: Exhibit B-1—10.2.2.1 SMCN Contract: Exhibit C—None	**Both CHP+ and SMCN** • PNS217 Single Case Agreement Policy • CCS310 Access to Primary and Secondary Care	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor requires out-of-network providers to coordinate with the Contractor for payment and ensures that the cost to the member is no greater that it would be if the services were furnished within the network. *42 CFR 438.206(b)(5)* CHP+ Contract: Exhibit B-1—10.2.2.2 SMCN Contract: Exhibit C—None	**Both CHP+ and SMCN** • CCS310 Access to Primary and Secondary Care • PNS217 Single Case Agreement Policy	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services. *42 CFR 438.206(b)(7)* CHP+ Contract: Exhibit B-1—None SMCN Contract: Exhibit C—None	**Both CHP+ and SMCN** • NA **CHP+ Specific** • Network Adequacy Report CHP HMO Q4 **SMCN Specific** • Network Adequacy Report CHP SMCN Q4 • SMCN Annual Report SFY18-19	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor must meet, and require its providers to meet, the State standards for timely access to care and services, taking into account the urgency of the need for services. The Contractor ensures that services are available as follows: • Emergency BH care: – By phone within 15 minutes of the initial contact. – In-person within 1 hour of contact in urban and suburban areas. – In-person within 2 hours of contact in rural and frontier areas. • Urgent care within 24 hours from the initial identification of need. • Non-urgent symptomatic care visit within 7 calendar days after member request. • Non-urgent medical or non-symptomatic well care within 30 calendar days after member request. • Outpatient follow-up appointments within 7 days after discharge from hospitalization. • Members may not be placed on waiting lists for initial routine BH services. *42 CFR 438.206(c)(1)(i)* CHP+ Contract: Exhibit B-1—10.2.1.23.1–7, 10.2.1.23.7.2 SMCN Contract: Exhibit C—22.3	**Both CHP+ and SMCN** • Provider Communication - December 2019 Access to Care Standards **CHP+ Specific** • COA Website o Member Services Quality https://www.coaccess.com/members/services/quality • Navigator - Provider Newsletter from Colorado Access • COA Provider Manual o Section 3 Quality Management ▪ Accessibility and Availability of Services • COA CHP HMO_Quality Report_SFY18-19 FINAL **SMCN Specific** • CHP SMCN Provider Manual o Section II Primary Care Providers & Specialists ▪ Appointments and Service Standards	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor and its providers offer hours of operation that are no less than the hours of operation offered to commercial members or Medicaid members. The Contractors network provides: • Minimum hours of provider operation from 8 a.m. to 5 p.m. Monday through Friday. • Extended hours on evenings and weekends. • Alternatives for emergency department visits for after-hours urgent care. *42 CFR 438.206(c)(1)(ii)* CHP+ Contract: Exhibit B-1—10.2.1.5–7 SMCN Contract: Exhibit C—22.3	**Both CHP+ and SMCN** • Provider Contract Appendix 1 • PNS306 Provider Availability • COA Website (can search provider directory for urgent care providers) o Find A Provider: https://coadirectory.info/search-member Provider Contract **CHP+ Specific** • COA Provider Manual o Section 4 Provider Responsibilities ▪ Primary Care Providers ▪ Specialist Care Providers **SMCN Specific** • CHP SMCN Provider Manual o Section II Provider Responsibilities ▪ Primary Care Provider Responsibilities ▪ Specialist Responsibilities	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor makes services included in the contract available 24 hours a day, 7 days a week, when medically necessary. *42 CFR 438.206(c)(1)(iii)* CHP+ Contract: Exhibit B-1—10.2.4.1 SMCN Contract: Exhibit C—22.3	**Both CHP+ and SMCN** • PNS 306 Provider Availability **CHP+ Specific** • COA Provider Manual o Section 4 Provider Responsibilities	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	▪ Primary Care Providers ▪ Specialist Care Providers **SMCN Specific** • CHP SMCN Provider Manual o Section II Provider Responsibilities ▪ Primary Care Provider Responsibilities ▪ Specialist Responsibilities	**SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. The Contractor ensures timely access by: • Establishing mechanisms to ensure compliance with access (e.g., appointment) standards by network providers. • Monitoring network providers regularly to determine compliance. • Taking corrective action if there is failure to comply. *42 CFR 438.206(c)(1)(iv)–(vi)* CHP+ Contract: Exhibit B-1—10.2.1.25.2 SMCN Contract: Exhibit C—22.3	**Both CHP+ and SMCN** • PR DP01Complaints Regarding Access to Care • PNS306 Provider Availability • Navigator - Provider Newsletter 2019 **CHP+ Specific** • COA Quality Assessment and Performance Improvement Program Description o Accessibility and Availability of Services • COA CHP HMO_Quality Report SFY 18-19 o Access to Care **SMCN Specific** • NA	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. This includes: • Maintaining policies to provide prevention, health education, and treatment for diseases prevalent in specific cultural or ethnic groups. • Maintaining policies to provide health care services to members that respect individual health care attitudes, beliefs, customs, and practices related to cultural affiliation. • Maintaining written policies and procedures to ensure compliance with requirements of the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973. • Making written materials that are critical to obtaining services available in prevalent non-English languages and alternative formats for the visually and reading-impaired. • Providing cultural competency training programs, as needed, to network providers and health plan staff regarding: – Health care attitudes, values, customs, and beliefs that affect access to and benefit from health care services.	**Both CHP+ and SMCN** • ADM206 Culturally Sensitive Services for Diverse Populations • ADM207 Communications for LEP and SI-SI Persons • ADM208 Member Materials • Cultural Competency for Providers • COA Cultural Competency for Staff **CHP+ Specific** • COA Provider Manual o Section 2 Colorado Access Policies ▪ Diversity and Cultural Competency Training Program ▪ Effective Communication and Language Assistance **SMCN Specific** • CHP SMCN Provider Manual o Section II Primary Care Provider and Specialist ▪ Primary Care Provider Responsibilities ▪ Effective Communication with Limited English Proficient (LEP) Persons & Sensory-Impaired Speech-Impaired Persons	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Medical risks associated with the member population's racial, ethnic, and socioeconomic conditions. • Identifying members whose cultural norms and practices may affect their access to health care. These efforts shall include, but are not limited to, inquiries conducted by the Contractor of the language proficiency of individual members. • Providing language assistance services for all Contractor interactions with members, including interpreter services and TDD. *42 CFR 438.206(c)(2)* CHP+ Contract: Exhibit B-1—10.8.2.1-4, 10.8.2.9-10, 10.8.2.12-13 SMCN Contract: Exhibit C—I.27		
15. The Contractor must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities. *42 CFR 438.206(c)(3)* CHP+ Contract: Exhibit B-1—10.8.2.10 SMCN Contract: Exhibit C—None	**Both CHP+ and SMCN** • Provider Contract Appendix 1 • COA Provider Agreement o Section B2 o Section H6 • COA Website o Find A Provider: https://coadirectory.info/search-member Provider Contract **CHP+ Specific** • COA Provider Manual o Section 2 Colorado Access Policies	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	▪ Effective Communication and Language Assistance ▪ Non-Discrimination **SMCN Specific** • Professional Provider Contract_SMCN o B2 o G6 • SMCN Provider Manual o Primary Care Providers & Specialist ▪ Non-Discrimination Policy ▪ Effective Communication with Limited English Proficient (LEP) Persons & Sensory-Impaired Speech-Impaired Persons	
16. The Contractor submits to the State (in a format specified by the State) documentation to demonstrate that the Contractor offers an appropriate range of preventive, primary care, and specialty services that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. • A Provider Network Strategic Plan is submitted to the State annually. • A Provider Network Capacity and Services Report is submitted to the State quarterly. *42 CFR 438.207(b)* CHP+ Contract: Exhibit B-1—15.3.1, 15.3.2 SMCN Contract: Exhibit C—22.3	**Both CHP+ and SMCN** • NA **CHP+ Specific** • COA CHP HMO Annual Provider Network Strategic Plan SFY18-19 • Network Adequacy Report CHP HMO Q4 **SMCN Specific** • Network Adequacy Report CHP SMCN Q4 • SMCN Annual Rpt. SFY18-19	**CHP+** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **SMCN** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard II—Access and Availability CHP+							
Total	Met	=	16	X	1.00	=	16
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	16	**Total Score**		=	16
				Total Score ÷ Total Applicable		=	100%

Results for Standard II—Access and Availability SMCN							
Total	Met	=	16	X	1.00	=	16
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	16	**Total Score**		=	16
				Total Score ÷ Total Applicable		=	100%

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Denials Record Review Tool
for Colorado Access CHP+

Review Period:	January 1, 2019–December 31, 2019
Date of Review:	February 4, 2020
Reviewer:	Kathy Bartilotta
Participating Plan Staff Member(s):	Thomas Freund, Lisa Steller, Kevin Lawrence, Lindsay Cowee

Requirements	File 1	File 2	File 3	File 4	File 5
Member ID	****	****	****	****	****
Date of initial request	11/15/19	1/10/19	2/28/19	3/8/19	4/16/19
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	CL	NR	CL	NR	NR
(Standard [S], Expedited [E], or Retrospective [R])	R	S	R	S	S
Date notice of adverse benefit determination (NABD) sent	11/20/19	1/11/19	3/5/19	3/12/19	5/10/19
Notice sent to provider and member? (M or NM)*	NM	M	NM	M	M
Number of days for decision/notice	5	1	5	4	24
Notice sent within required time frame? (M or NM) (S = 10 Cal days after; E = 72 hours after; T = 10 Cal days before)*	NM	M	NM	M	M
Was authorization decision timeline extended? (Y or N)	N	N	N	N	Y
If extended, extension notification sent to member? (M, NM, or NA)*	NA	NA	NA	NA	M
If extended, extension notification includes required content? (M, NM, or NA)*	NA	NA	NA	NA	M
NABD includes required content? (M or NM)*	NM	M	NM	M	M
Authorization decision made by qualified clinician? (M, NM, or NA)*	NA	M	NA	M	M
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (M, NM, or NA)*	NA	NA	NA	NA	M
Was the decision based on established authorization criteria (i.e., not arbitrary)? (M or NM)*	M	M	M	M	M
Was correspondence with the member easy to understand? (M or NM)*	NM	M	NM	M	M
Total Applicable Elements	**5**	**6**	**5**	**6**	**9**
Total Met Elements	**1**	**6**	**1**	**6**	**9**
Score (Number Met / Number Applicable) = %	**20%**	**100%**	**20%**	**100%**	**100%**

***** = Reference Denial Record Review Instructions for Corresponding Requirement in Compliance Monitoring Tool
M = Met, **NM** = Not Met, **NA** = Not Applicable, **Cal** = Calendar, **Y** = Yes, **N** = No (Yes and No = not scored—informational only)
**** = Redacted Member ID

Comments:

File 1: This was a claims denial. Per internal policy, all claims are processed within 30 days. For all claims denials, COA sent notice only to the provider in the weekly remittance report. No NABD was sent to the member; therefore, all requirements related to the member NABD—i.e., notice sent to member, sent in required time frame, included required content, and correspondence easy to understand—were scored *Not Met*.

File 3: This was a claims denial. Per internal policy, all claims are processed within 30 days. For all claims denials, COA sent notice only to the provider in the weekly remittance report. No NABD was sent to the member; therefore, all requirements related to the member NABD—i.e., notice sent to member, sent in required time frame, included required content, and correspondence easy to understand—were scored *Not Met*.

File 5: This new service request required additional information, which was requested from the provider. The decision was extended awaiting additional information from the provider. No additional information was received by the final date of extension and the service was denied. Notice sent in 10 days plus 14 extension days.

Appendix B. Colorado Department of Health Care Policy and Financing FY 2019–2020 Denials Record Review Tool for Colorado Access CHP+

Requirements	File 6	File 7	File 8	File 9	File 10
Member ID	****	****	****	****	****
Date of initial request	9/12/19	7/30/19	10/3/19	9/24/19	12/2/19
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	CL	NR	NR	CL	CL
(Standard [S], Expedited [E], or Retrospective [R])	R	S	S	R	R
Date notice of adverse benefit determination (NABD) sent	10/1/19	8/1/19	10/8/19	10/8/19	12/17/19
Notice sent to provider and member? (M or NM)*	NM	M	M	NM	NM
Number of days for decision/notice	19	2	5	14	15
Notice sent within required time frame? (M or NM) (S = 10 Cal days after; E = 72 hours after; T = 10 Cal days before)*	NM	M	M	NM	NM
Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
If extended, extension notification sent to member? (M, NM, or NA)*	NA	NA	NA	NA	NA
If extended, extension notification includes required content? (M, NM, or NA)*	NA	NA	NA	NA	NA
NABD includes required content? (M or NM)*	NM	M	M	NM	NM
Authorization decision made by qualified clinician? (M, NM, or NA)*	NA	M	M	NA	NA
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (M, NM, or NA)*	NA	NA	NA	NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (M or NM)*	M	M	M	M	M
Was correspondence with the member easy to understand? (M or NM)*	NM	M	M	NM	NM
Total Applicable Elements	**5**	**6**	**6**	**5**	**5**
Total Met Elements	**1**	**6**	**6**	**1**	**1**
Score (Number Met / Number Applicable) = %	**20%**	**100%**	**100%**	**20%**	**20%**

***** = Reference Denial Record Review Instructions for Corresponding Requirement in Compliance Monitoring Tool
M = Met, **NM** = Not Met, **NA** = Not Applicable, **Cal** = Calendar, **Y** = Yes, **N** = No (Yes and No = not scored—informational only)

**** = Redacted Member ID

Comments:

File 6: This was a claims denial. Per internal policy, all claims are processed within 30 days. For all claims denials, COA sent notice only to the provider in the weekly remittance report. No NABD was sent to the member; therefore, all requirements related to the member NABD—i.e., notice sent to member, sent in required time frame, included required content, and correspondence easy to understand—were scored *Not Met*.

File 7: This was a request for additional speech therapy services following several previous approvals. Request was denied because the maximum benefit for this service had been expended.

File 8: This request was denied due to out-of-network (OON) services that could be provided in network. Following initial denial, COA sent a single case agreement to the OON provider and, once processed, retrospectively approved this request.

File 9: This was a claims denial. Per internal policy, all claims are processed within 30 days. For all claims denials, COA sent notice only to the provider in the weekly remittance report. No NABD was sent to the member; therefore, all requirements related to the member NABD—i.e., notice sent to member, sent in required time frame, included required content, and correspondence easy to understand—were scored *Not Met*.

File 10: This was a claims denial. Per internal policy, all claims are processed within 30 days. For all claims denials, COA sent notice only to the provider in the weekly remittance report. No NABD was sent to the member; therefore, all requirements related to the member NABD—i.e., notice sent to member, sent in required time frame, included required content, and correspondence easy to understand—were scored *Not Met*.

Total Record Review Score*	Total Applicable Elements: 58	Total Met Elements: 38	Total Record Review Score: 66%

* Only requirements with an "*" in the tool were used to calculate the score. The total record review score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements.

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2019–2020 site review of **COA**.

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

HSAG Review Team	Title
Barbara McConnell	Executive Director
Katherine Bartilotta	Associate Director
COA Participants	**Title**
Aaron Brotherson	Director of Provider Relations
Amanda Fitzsimons	Senior Privacy Analyst
Christine E. Gillaspie	Manager of Physical Health Utilization Management
Elizabeth Strammiello	Chief Compliance Officer
Janet Milliman	Director of CHP+ Payment Reform
Jason Smith	Senior Provider Contract Manager
Josette Hizon	Behavioral Health Utilization Management Supervisor
Kevin Lawrence	Claims Operations Supervisor
Lindsay Cowee	Director of Utilization Management and Pharmacy
Lisa Steller	Behavioral Health Utilization Management Supervisor
Michelle Tomsche	Director of Claims Operations
Mika Gans	Senior Manager of Quality
Reyna Garcia	Senior Director of Customer Service
Sarrah Knause	Program Manager, CHP+
Thomas Freund	Supervisor of Utilization Management
Department Observers	**Title**
Elizabeth Mattes	Program Coordinator—HCPF
Jeff Appleman	Program Specialist—HCPF

Appendix D. Corrective Action Plan Template for FY 2019–2020

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 three-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 2019–2020 Corrective Action Plan for COA

Standard I—Coverage and Authorization of Services—CHP+ Only		
Requirement	**Findings**	**Required Action**
12. The Contractor notifies the requesting provider and gives the member written notice of any decision by the Contractor to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. *Note: Notice to the provider may be oral or in writing.* *42 CFR 438.210(c)* CHP+ Contract: Exhibit B-1—11.1.8 SMCN Contract: Exhibit C—19.1.13.1	COA's *UR Determinations* policy specified that written notice would be sent to the member and provider. COA demonstrated having template NABDs for both CHP+ and SMCN, and denial record reviews demonstrated that members and providers were notified in writing of adverse benefit determinations made by UM. However, NABDs for claims denials were sent only to the provider. No NABD was sent to the member regarding a claims denial; therefore, five of 10 CHP+ denial record reviews (related to claims) were scored *Not Met* for "notice sent to provider and member."	COA must ensure that CHP+ members receive written notification of any decision to deny a service, including denial or partial denial of a claim.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services—CHP+ Only		
Requirement	**Findings**	**Required Action**
16. The notice of adverse benefit determination must be written in language easy to understand, available in prevalent non-English languages in the region, and available in alternative formats for persons with special needs. *42 CFR 438.404(a)* *42 CFR 438.10(c)* CHP+ Contract: Exhibit B-1—14.1.3.15.1.1–4 SMCN Contract: Exhibit C—19.1.13.1.1–4	COA demonstrated that the CHP+ and SMCN NABDs used for UM denials were written in language easy to understand and informed the member of the availability of the letter in other languages and alternative formats. However, COA sent no notice to members regarding denial of a claim; therefore, five of 10 CHP+ denial record reviews (related to claims) were scored *Not Met* for "correspondence with the member was easy to understand."	COA must ensure that CHP+ members receive written notification of any decision to deny a service, including denial or partial denial of a claim. COA must ensure that the NABD regarding a claim is written in language that is easy for the member to understand.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services—CHP+ Only		
Requirement	**Findings**	**Required Action**
17. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to and copies of all documents and records relevant to the adverse benefit determination (includes medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits). • The member's (or member's designated representative's) right to request one level of appeal with the Contractor and the procedures for doing so. • The member's right to request a State review after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State review.	COA demonstrated that the CHP+ and SMCN NABDs used for UM denials included all required content. However, COA sent no notice to members regarding denial of a claim; therefore, five of 10 CHP+ denial record reviews (related to claims) were scored *Not Met* for "notice includes required content."	COA must ensure that CHP+ members receive written notification of any decision to deny a service, including denial or partial denial of a claim. COA must ensure that the NABD regarding a claim includes all required content.

Standard I—Coverage and Authorization of Services—CHP+ Only		
Requirement	**Findings**	**Required Action**
• The circumstances under which an appeal process can be expedited and how to make this request. • The member's rights to have benefits/services continue (if applicable) pending the resolution of the appeal, how to request that benefits continue, and the circumstances under which the member may be required to pay the cost of these services. • The member's right to appeal under the Child Mental Health Treatment Act (CMHTA), when applicable. *42 CFR 438.404(b)* CHP+ Contract: Exhibit B-1—14.1.3.15.1.5–12 SMCN Contract: Exhibit B—19.1.13.1.5–12		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services—CHP+ and SMCN		
Requirement	**Findings**	**Required Action**
19. The Contractor mails the notice of adverse benefit determination within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, as defined in 42 CFR 431.211, 431.213 and 431.214 (see below). • For denial of payment, at the time of any denial affecting the claim. • For standard service authorization decisions that deny or limit services, no later than 10 calendar days after receipt of request for service. • For expedited service authorization decisions, no later than 72 hours after receipt of request for service. • For extended service authorization decisions, no later than the date the extension expires. • For service authorization decisions not reached within the required time frames, on the date the time frames expire. *42 CFR 438.404(c)* CHP+ Contract: Exhibit B-1—14.1.3.15.2.1–7 SMCN Contract: Exhibit C—19.1.13.2	COA's *UR Determinations* policy addressed all required time frames for mailing the NABD to the member. However, the format of information in the policy (section 7.A) resulted in inaccurate information regarding required time frames. Specifically, several of the time frames (bullets 2 through 5 of the requirement) were listed as *exceptions* to the time frame for notice of reduction or termination of previously authorized services. These required time frames are independent requirements applicable to all NABDs; not related to previously authorized services. In addition, COA sent no notice to members regarding denial of a claim; therefore, five of 10 CHP+ denial record reviews (related to claims) were scored *Not Met* for "notice sent within required time frame."	COA must correct information in its UR Determinations policy and any related documents to accurately address all required time frames for mailing the NABD to the member. COA must also ensure that CHP+ members receive written notification of any decision to deny a service, including denial or partial denial of a claim, and that the NABD regarding denial of payment is sent at the time of any denial affecting the claim.

Standard I—Coverage and Authorization of Services—CHP+ and SMCN		
Requirement	**Findings**	**Required Action**
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services—CHP+ and SMCN		
Requirement	**Findings**	**Required Action**
20. For reduction, suspension, or termination of a previously authorized Medicaid-covered service, the Contractor gives notice at least ten (10) days before the intended effective date of the proposed adverse benefit determination except: • The Contractor gives notice on or before the intended effective date of the proposed adverse benefit determination if: – The Agency has factual information confirming the death of a member. – The Agency receives a clear written statement signed by the member that he/she no longer wishes services, or gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information. – The member has been admitted to an institution where he/she is ineligible under the plan for further services.	COA's *UR Determinations* policy addressed all required time frames for mailing the NABD to the member. However, the format of information in the policy (section 7.A) resulted in inaccurate information regarding required time frames. Specifically, the circumstances related to the exceptions to the 10-day time frame for notifying the member regarding the reduced or terminated previously authorized services were not listed in the policy as only associated with the reduction, suspension, or termination of previously authorized services.	COA must correct information in its *UR Determinations* policy to accurately address the exceptions to the time frames for mailing the NABD related to reduction or termination of previously authorized services, as stated in 42 CFR 431.211, 431.213, and 431.214.

Standard I—Coverage and Authorization of Services—CHP+ and SMCN		
Requirement	**Findings**	**Required Action**
– The member's whereabouts are unknown, and the post office returns Agency mail directed to him/her indicating no forwarding address. – The Agency establishes that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth. – A change in the level of medical care is prescribed by the member's physician. – The notice involves an adverse benefit determination made with regard to the preadmission screening requirements. • If probable member fraud has been verified, the Contractor gives notice five (5) calendar days before the intended effective date of the proposed adverse benefit determination. *42 CFR 438.404(c)* *42 CFR 431.211* *42 CFR 431.213* *42 CFR 431.214* CHP+ Contract: Exhibit B-1—14.1.3.15.2.1–3 SMCN Contract: Exhibit C—19.1.13.2.1–3		

Standard I—Coverage and Authorization of Services—CHP+ and SMCN		
Requirement	**Findings**	**Required Action**
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services—CHP+ and SMCN		
Requirement	**Findings**	**Required Action**
34. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the member's stabilized condition if: • The organization does not respond to a request for pre-approval within 1 hour. • The organization cannot be contacted. • The organization's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the organization must give the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with care of the patient until a plan provider is reached or one of the criteria in 422.113(c)(3) is met. *42 CFR 438.114(e)* *42 CFR 422.113(c)(iii)* CHP+ Contract: Exhibit B-1—8.17.4.7 SMCN Contract: Exhibit C—None	COA's *Emergency and Post-Stabilization Care* policy stated verbatim the requirements related to financial responsibilities for post-stabilization care that was not pre-approved by COA; however, the policy included no procedures for implementation. COA's *Post Stabilization Care Services* desktop procedure outlined procedures related to UM processes applied to CHP+ post-stabilization care requests for authorization and how results of UM determinations are communicated to the claims management department for determining payment of a post-stabilization claim. The desktop procedure specified that notification by a provider of inpatient post-stabilization care triggered the UM authorization process, which applied traditional medical necessity criteria to the hospitalization. In addition, the procedures stated that UM coverage 24/7 is not available for the CHP+ line of business. The desktop procedure failed to clearly address how the criteria specified in 42 CFR 422.113(c)(iii) are applied when necessary to determine financial responsibility for post-stabilization care.	COA must develop or enhance its UM and claims payment procedures applicable to post-stabilization care to clarify processes that account for review of the circumstances outlined in 42 CFR 422.113(c)(iii) when determining financial responsibility for payment of post-stabilization services that were not pre-approved.

Standard I—Coverage and Authorization of Services—CHP+ and SMCN		
Requirement	**Findings**	**Required Action**
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services—CHP+ and SMCN		
Requirement	**Findings**	**Required Action**
35. The Contractor's financial responsibility for poststabilization care services it has not pre-approved ends when: • A plan physician with privileges at the treating hospital assumes responsibility for the member's care, • A plan physician assumes responsibility for the member's care through transfer, • A plan representative and the treating physician reach an agreement concerning the member's care, or • The member is discharged. *42 CFR 438.114(e)* *42 CFR 422.113(c)(3)* CHP+ Contract: Exhibit B-1—8.17.4.9 SMCN Contract: Exhibit C—None	COA's *Emergency and Post-Stabilization Care* policy stated verbatim the requirements related to when financial responsibility ends for post-stabilization care that was not pre-approved by COA; however, the policy included no procedures for implementation. COA's *Post Stabilization Care Services* desktop procedure outlined procedures related to UM processes applied to CHP+ post-stabilization care requests for authorization but did not clearly address how the application of the criteria specified in 42 CFR 422.113(c)(3) are applied in determining when financial responsibility (i.e., payment of a claim) ends for post-stabilization services not pre-approved.	COA must develop or enhance its UM and claims payment procedures applicable to post-stabilization care to clarify processes for applying the criteria outlined in 42 CFR 422.113(c)(3) to determine when financial responsibility ends for payment of post-stabilization services that were not pre-approved.
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 two standards and on-site activities. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. • Documents submitted for the desk review and on-site review consisted of the completed desk review form, the compliance monitoring tool with the health plan's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The health plans also submitted a list of all denials of authorization of services (denials) records that occurred between January 1, 2019, and December 31, 2019 (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 denials. • 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 2019–2020 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 Department**
	• 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.