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

FY 2012–2013 Site Review Report

for

Colorado Choice Health Plan

March 2013

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

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Overview of FY 2012–2013 Compliance Monitoring Activities

Public Law 111-3, The Children's Health Insurance Program Reauthorization Act of 2009, requires that each state's Children's Health Insurance Program (CHIP) applies several provisions of Section 1932 of the Social Security Act in the same manner as the provisions apply under Title XIX of the Act. This requires managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to comply with specified provisions of the Balanced Budget Act of 1997, Public Law 105-33 (BBA). The BBA requires that states conduct a periodic evaluation of their MCOs and PIHPs to determine compliance with regulations and contractual 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).

This is the second annual external quality review of compliance with federal managed care regulations performed for the CHP+ program by HSAG. For the fiscal year (FY) 2012–2013 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the four performance areas chosen. The standards chosen were Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement.

The health plan's administrative records were also reviewed to evaluate implementation of National Committee for Quality Assurance (NCQA) Standards and Guidelines related to credentialing and recredentialing. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of 5 records. Using a random sampling technique, HSAG selected the samples from all applicable practitioners who had been credentialed or recredentialed in the previous 36 months. For the record review, the health plan received a score of *Yes* (compliant), *No* (not compliant), or *Not Applicable* for each of the elements evaluated. Compliance with federal managed care regulations was evaluated through review of the four standards. HSAG calculated a percentage of compliance score for each standard and an overall percentage of compliance score for all standards reviewed. HSAG also separately calculated an overall record review score.

This report documents results of the FY 2012–2013 site review activities for the review period—July 1, 2012, through December 31, 2012. Section 2 contains summaries of the findings, strengths, opportunities for improvement, and required actions for each standard area. Appendix A contains details of the findings for the review of the standards. Appendix B contains details of the findings for the credentialing and recredentialing record reviews. Appendix C lists HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process the health plan will be required to complete for FY 2012–2013 and the required template for doing so.

Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the health plan's contract requirements, NCQA Credentialing and Recredentialing Standards and Guidelines, and regulations specified by the BBA, with revisions issued June 14, 2002, and effective August 13, 2002. HSAG conducted a desk review of materials submitted prior to the on-site review activities, a review of documents and materials provided on-site, and on-site interviews of key health plan personnel to determine readiness to comply with federal managed care regulations. Documents submitted for the desk review and during the on-site document review consisted of policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials.

The four standards chosen for the FY 2012–2013 site reviews represent a portion of the Medicaid managed care requirements. Standards that will be reviewed in subsequent years are: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

The site review processes were consistent with the February 11, 2003, Centers for Medicare & Medicaid Services (CMS) final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs).* Appendix D contains a detailed description of HSAG's site review activities as outlined in the CMS final protocol.

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

Summary of Results

Based on the results from the compliance monitoring tool and conclusions drawn from the review activities, HSAG assigned each requirement within the standards in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. HSAG assigned required actions to any individual requirement within the compliance monitoring tool receiving a score of *Partially Met* or *Not Met*. HSAG also identified opportunities for improvement with associated recommendations for enhancement for some elements, regardless of the score. Recommendations for enhancement for requirements scored as *Met* did not represent noncompliance with contract requirements or BBA regulations.

Table 1-1 presents the score for **Colorado Choice Health Plan** (**Colorado Choice**) for each of the standards. Details of the findings for each standard follow in Appendix A—Compliance Monitoring Tool.

Table 1-1—Summary of Scores for the Standards

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
III Coordination and Continuity of Care	9	9	3	4	2	0	33%
IV Member Rights and Protections	5	5	1	3	1	0	20%
VIII Credentialing and Recredentialing	50	49	19	17	13	1	39%
X Quality Assessment and Performance Improvement	11	11	2	4	5	0	18%
Totals	**75**	**74**	**25**	**28**	**21**	**1**	**34%**

Table 1-2 presents the scores for **Colorado Choice** for the record reviews. Details of the findings for the record reviews are in Appendix B—Record Review Tools.

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

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Credentialing Record Review	80	77	75	2	0	97%
Recredentialing Record Review	80	80	73	7	0	91%
Totals	**160**	**157**	**148**	**9**	**0**	**94%**

2. Summary of Performance Strengths and Required Actions

for **Colorado Choice Health Plan**

Overall Summary of Performance

In one area of performance, Credentialing and Recredentialing, although **Colorado Choice** lacked complete policies and procedures, it demonstrated strong performance. On-site review of independent practitioner credentialing and recredentialing records demonstrated that **Colorado Choice** effectively ensured that network practitioners possessed the required qualifications and eligibility to participate in federal health care programs.

Overall performance, however, for **Colorado Choice** demonstrated a lack of understanding of federal health care regulations and the CHP+ managed care contract. While **Colorado Choice** had basic processes and program descriptions and a powerful health information system capable of providing data essential for program design and improvement initiatives, underutilization or ineffective application of these processes resulted in poor overall performance.

Standard III—Coordination and Continuity of Care

Summary of Findings and Opportunities for Improvement

Colorado Choice's Case Management (CM) Program policy outlined assessment, planning, facilitation, and advocacy for needed services for members with complex conditions and addressed many of the requirements in the standard.

Staff stated that the Selection of PCP form is distributed in the member's enrollment packet and directs the member to choose an in-network PCP by contacting the Customer Services Department or by returning the completed form; however, the form did not describe how to obtain a list of network providers. HSAG recommended that **Colorado Choice** revise the Selection of PCP form to include directions about how to select a PCP online and include the Web site address.

The handbook informed members that the PCP list was available by contacting the Customer Services Department or by accessing the **Colorado Choice** Web site. **Colorado Choice** might want to consider removing the member login requirements to access the online provider directory to increase the ease of selecting a provider online.

The Colorado Choice Health Plan Provider Handbook (applicable to all lines of business) defined coordination of care as the transmitting of information between referring providers, and did not describe the provider's responsibilities regarding care coordination for members and what case management activities can be provided by **Colorado Choice** staff members. HSAG recommended that the provider handbook include a full description of care coordination as outlined in the CM Program policy, descriptions of case management and care coordination responsibilities assigned to both the provider and to **Colorado Choice**, and under what circumstances members should receive care coordination or case management from either party.

The Health Assessment Survey, distributed to members at the time of enrollment and annually thereafter, solicited information regarding multiple medical providers, current or anticipated medical procedures or therapies (including mental health therapies), and the presence of specific acute or chronic health conditions. Staff stated that any assessments returned are reviewed by the nurse manager to determine the need for a more in-depth assessment of special health care needs, but that only a small percentage of the Health Assessment Surveys are returned to **Colorado Choice**. Staff also reported that **Colorado Choice** does not conduct outreach activities to contact non-responding members. HSAG recommended that **Colorado Choice** consider implementing a mechanism for follow-up contact with non-responding members to screen for special health care needs.

During the on-site interview, **Colorado Choice** staff was unprepared to discuss care coordination cases per pre-audit instructions. Once requested on-site, however, staff members did identify and describe ongoing case management activities for three individuals with complex medical needs, one of which was a CHP+ member. Case discussions demonstrated that **Colorado Choice** provided personalized contact with members; coordinated care with multiple providers, ancillary services, and transportation services; and provided assistance with benefit and coverage determinations.

Summary of Strengths

Colorado Choice had care coordination policies that described a basic framework for care coordination processes, although these policies were not completely implemented. **Colorado Choice** had a health information system capable of identifying appropriate candidates for the case management program. While underutilized at the time of the site review, **Colorado Choice** had other basic processes described in policy that, if properly used, could enhance the provision of case management services (e.g., risk stratification, member self-assessment). Rigorous implementation of specific processes already available to **Colorado Choice** will further **Colorado Choice**'s efforts to comply with federal health care regulations and the Colorado CHP+ managed care contract.

Summary of Required Actions

During the on-site interview, staff stated that **Colorado Choice** assumes that the PCP coordinates covered services for members who are not referred to CM, and **Colorado Choice** does not formally designate a person responsible for coordination of services. **Colorado Choice** must develop policies, procedures, and processes to designate the party responsible for the member's care coordination. **Colorado Choice** may want to build on the risk stratification concept discussed in policy and assign the party responsible based on the risk category (for example, lower risk member care coordinated by the PCP, with higher risk care or inpatient care coordinated by **Colorado Choice** case management staff).

The General Initial Assessment template was designed for post-hospitalization assessment and did not include assessment of social or community support needs, mental health needs, cultural needs, functional problems, comprehension problems, or other special health care needs. **Colorado Choice** must define a comprehensive assessment tool that includes all of the elements referenced in the requirement and document the assessment in the case management record.

In one of the three care coordination cases discussed during the on-site interview, **Colorado Choice** identified the member's post-discharge needs through communication with the hospital case manager. In another case, staff reported that the member's needs were anticipated based on monitoring the progress of the member. In the third case, staff reported that assessment and care plan development were incomplete due to the ongoing intensity of acute treatment. **Colorado Choice** did not provide evidence on-site of having completed and documented comprehensive assessments of special health care needs. **Colorado Choice** must assess its members' health care needs on enrollment and at any other necessary time (e.g., on referral to case management).

The Case Management Program policy stated that the assessment and care plan, developed for moderate- and high-risk CM members, will be shared with the PCP and any specialty care physicians. The policy did not address sharing the assessment with other organizations involved in these members' care. **Colorado Choice** did not provide documentation of having shared assessment of member needs with other health care organizations involved in serving those needs. **Colorado Choice** must define a process for sharing the assessment of special health care needs with other health care or community organizations serving the member, as appropriate, to prevent duplication of services. **Colorado Choice** must develop a mechanism to document release of this information.

On-site, **Colorado Choice** staff described case management activities for three individuals with complex medical needs who were being monitored or assisted through case management; however, staff did not provide examples of completed treatment plans, as required. **Colorado Choice** must implement procedures to ensure that an individual care coordination plan is developed and documented in the case management file.

While **Colorado Choice** staff described processes that allow direct access to specialists for members with special health care needs, the provider manual was ambiguous and indicated that an additional benefit must have been purchased by the member to allow direct access. **Colorado Choice** must clarify when statements in the provider manual do and do not apply to CHP+ members and clearly state that CHP+ members with special health care needs have direct access to specialists.

Colorado Choice did not provide evidence of written care plans or documentation of member involvement in the care plan. **Colorado Choice** must provide documentation demonstrating member involvement and agreement with the care coordination plan.

Standard IV—Member Rights and Protections

Summary of Findings and Opportunities for Improvement

Colorado Choice had no policies and procedures regarding member rights. There were operational documents such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy statement for members and member rights statements in the provider service agreement and the member handbook. These member rights statements did not include all of the member rights afforded CHP+ members.

Colorado Choice used one provider manual for all lines of business. HSAG recommended that **Colorado Choice** include member rights statements and processes (particularly as they relate to grievance and appeal processes) in provider communication materials such as the provider manual or provider newsletters, if appropriate. HSAG also recommended that **Colorado Choice** develop sections in the provider manual for CHP+ and commercial lines of business, or develop exception statements to clarify when information applies to commercial lines of business, but not CHP+.

On-site, **Colorado Choice** discussed the development of annual CHP+ member communications and member newsletters, expected to be implemented in 2013.

Summary of Strengths

There was evidence that **Colorado Choice** notified both providers and members of member rights information. Member rights were found in the member handbook. Providers were notified via the provider contract. In addition, there were clear statements of nondiscrimination in both member and provider materials.

Summary of Required Actions

Colorado Choice must develop written CHP+ policies and procedures related to member rights and responsibilities. The policies and procedures should address all of the components of rights as stated at 42CFR438.100 and in the Colorado CHP+ managed care contract. The policies and procedures should also address how members and providers are informed of member rights, how **Colorado Choice** monitors providers to ensure member rights are taken into account when furnishing services, and how **Colorado Choice** monitors its processes to ensure that members feel free to access rights processes without fear of retaliation.

Colorado Choice must ensure that each of its applicable documents (policies, member materials, and provider materials) address each of the rights at 42CFR438.100 and in the Colorado CHP+ managed care contract and inform members of their right to exercise their rights (for example, grievance and appeal rights) without adverse effect on the member's treatment or fear of retaliation. **Colorado Choice** must also develop a method to inform providers of the expectation to take member rights into consideration when furnishing services.

Colorado Choice must revise the member handbook to remove the statement that members may be terminated from the CHP+ program. If the member handbook is used for multiple lines of business and the statement in question applies to other lines of business, then separating sections or informing members regarding what does and does not apply to CHP+ members would be acceptable.

Standard VIII—Credentialing and Recredentialing

Summary of Findings and Opportunities for Improvement

HSAG found evidence that **Colorado Choice** had a well-defined credentialing program with policies and procedures that met many of the NCQA requirements. It was evident through on-site review of credentialing records that **Colorado Choice** followed NCQA processes for provider application processing, credentialing committee review, and monitoring of delegates that performed credentialing on behalf of **Colorado Choice**. There was also evidence of initial and ongoing monitoring of federal and State sanction activity, as required.

Summary of Strengths

Colorado Choice's credentialing records were well organized and demonstrated clear compliance with the requirements regarding provider application, primary source verification, and rigorous provider evaluation prior to acceptance into the provider network.

Summary of Required Actions

While **Colorado Choice** had an excellent beginning structure for credentialing and recredentialing policies and procedures, **Colorado Choice** must revise its policies and procedures related to the credentialing and recredentialing of practitioners with whom **Colorado Choice** has an independent relationship to address the following elements:

- The credentialing and recredentialing of non-physician practitioners such as nurse practitioners, physician assistants, and behavioral health practitioners (e.g., licensed counselors, social workers, and psychologists).
- The specific verification sources used for primary verification during credentialing and recredentialing.
- The criteria for credentialing and recredentialing that addresses each type of practitioner credentialed (e.g., non-physician practitioners).
- Processes used for prevention (proactive steps to prevent discrimination) and monitoring (tracking and identification) of potential discriminatory practices.
- The processes used to ensure the confidentiality of credentialing and recredentialing records and materials.
- How **Colorado Choice** ensures that listings in provider directories and other materials for members are consistent with credentialing data.
- The applicant's right to receive the status of his or her application, unrelated to correcting erroneous information.
- How applicants are informed of their rights under the credentialing program.
- Ongoing monitoring for sanction activity and the relationship of collecting and reviewing complaints and adverse events to practitioners' continued participation in the network.
- The range of actions available against practitioners for quality reasons.
- The process to report actions taken against practitioners for quality reasons to appropriate authorities. All practitioners must be included and the policy must describe all applicable agencies (such as the Department of Regulatory Agencies [DORA], other non-physician licensing agencies, and the Department, if applicable.
- The appeal process for instances in which **Colorado Choice** chooses to alter the conditions of a practitioner's participation based on quality of care or service issues. The policy must adequately describe all of the required components of an appeal process.
- How providers are informed of practitioner appeal processes in cases in which **Colorado Choice** has chosen to alter the conditions of a practitioner's participation based on quality of care or service issues.

While it was clear that **Colorado Choice** required applicants to complete an application for network participation that included the required elements, there was one instance in which the practitioner was approved by the credentialing committee prior to the date of the application and attestation. **Colorado Choice** must ensure that each applicant has signed an application and attestation at the time of credentialing.

Colorado Choice did not have a process for ensuring that the offices of all practitioners meet its office-site standards. **Colorado Choice** must set quality standards and thresholds for office site quality and perform office site visits for offices about which **Colorado Choice** has received complaints, meeting the criteria and threshold for receiving a site visit. Policies and procedures must include follow-up action when office sites do not meet **Colorado Choice**'s standards.

While **Colorado Choice**'s policy addressed recredentialing practitioners every 36 months and the verification time frames for recredentialing, on-site review of 10 recredentialing records demonstrated that in 6 of 10 records, the recredentialing was not completed within the 36-month time frame. **Colorado Choice** must ensure that practitioners are recredentialed with 36 months of the initial credentialing or the previous recredentialing date.

Colorado Choice did not have policies and procedures that addressed assessment of organization providers. **Colorado Choice** must develop policies, procedures, and processes for the assessment and reassessment of organizational providers that include the following elements:

- Application and assessment with reassessment of the provider every 36 months.
- Verification of whether the organizational provider has been reviewed and approved by an accrediting body.
- Processes to conduct on-site quality assessments for nonaccredited organizational providers.
- Listing the accrediting bodies the Contractor accepts for each type of organizational provider.
- Selection process and assessment criteria for each type of nonaccredited provider with which it contracts.
- How **Colorado Choice** will ensure that each organizational provider credentials its practitioners.
- Whether **Colorado Choice** will accept substitution of a CMS or State review in lieu of the required site visit, and if so, the process for doing so.
- The types of medical and behavioral health facilities with which **Colorado Choice** contracts.

Colorado Choice must maintain a file for each organizational provider with which it contracts that contains each of the required elements (documentation of good standing with federal and State regulatory bodies, accreditation status, site visits completed, and monitoring performed).

Colorado Choice must amend the delegation agreements to include each of the required provisions, and specify, as required:

- Reporting requirements.
- How **Colorado Choice** will evaluate the delegate.
- Remedies available for insufficient performance of delegated activities.

Colorado Choice must also develop a process to ensure follow-up on delegates' opportunities for improvement, based on monitoring activities.

Standard X—Quality Assessment and Performance Improvement

Summary of Findings and Opportunities for Improvement

The QM Program applied to all **Colorado Choice** lines of business (Medicare, CHP+, and commercial). The QM Program Descriptions delineated three primary components of the program: utilization management (UM), peer review activities, and QM projects. The QM Program description outlined processes for review and corrective action for each component.

Colorado Choice used the Health Trio information system (IS) to collect, maintain, and report data. During the on-site interview, staff provided an online demonstration of the Health Trio IS that demonstrated integration of data from enrollment files, the claims database, authorization and referral information, and the case management system. Staff also provided sample reports of data from the claims database used in QI monitoring processes and stated that the ad-hoc queries reporting system is user-friendly. Staff also demonstrated that the Connect system application allows provider access to claims history and diagnostic information or any member-specific information maintained in the system through the online provider portal.

Summary of Strengths

Because **Colorado Choice**'s CHP+ population was small, it integrated data and monitoring of CHP+ members into the greater **Colorado Choice** population and the overall QI program activities. **Colorado Choice** had an integrated health information system that has the capability to provide many routine and ad-hoc reports for QI monitoring and analysis activities.

Summary of Required Actions

Although **Colorado Choice** had a written Quality Management Program Description, there was no evidence that it implemented the essential components of an ongoing quality assessment and improvement program. **Colorado Choice** must designate a QI oversight committee within a defined accountability structure and ensure that the committee reviews the results of ongoing quality performance measures, survey results, outcomes of focus studies, and other quality data. The committee meeting minutes should include conclusions and recommendations for improvement to impact indicators of the quality of care for members. The QI oversight committee should review and endorse overall program direction.

HSAG found no evidence of ongoing review or reporting of utilization data or analysis of utilization patterns or trends. **Colorado Choice** must develop a mechanism for systematic monitoring of over- and underutilization and report the results to the QI oversight committee(s).

While it was premature to have an annual CHP+-specific report due to the CHP+ contract effective date of July 2012, **Colorado Choice**'s existing evaluation and impact analysis format and report structure did not meet the standards for quality program impact analysis. **Colorado Choice** must develop an annual report format and reporting structure that includes all of the elements of the

requirement, including documented conclusions and recommendations related to the impact of QI activities.

Colorado Choice must develop a process/procedure for the adoption of clinical practice guidelines (beyond the application of Milliman guidelines for UM decisions) that are evidence-based, consider the needs of **Colorado Choice** members, address the topics required in the CHP+ managed care contract, consider the input of **Colorado Choice** health care professionals, and are reviewed and updated annually. **Colorado Choice** must define and implement a process for the dissemination of clinical care guidelines, once developed, to providers, members, and the public. **Colorado Choice** must also define a mechanism for ensuring that any adopted clinical practice guidelines are considered in utilization management decisions, member education materials, or other operating processes to which the guidelines apply.

Colorado Choice staff members stated that, although **Colorado Choice** receives data on member perceptions as outlined in the requirement, it does not review or act on the results. **Colorado Choice** must submit evidence that member perceptions of access and availability, as measured by member surveys, grievance data, and enrollment/disenrollment information, are monitored and reviewed, and that results and recommendations are documented in QI oversight committee meeting minutes.

Colorado Choice did not provide evidence of a grievance summary report or analysis. Committee of the Whole meeting minutes did not include review of member survey data, patterns of grievances, or document analysis for the presence of potential quality of care concerns identified through grievances. **Colorado Choice** did not submit a written procedure related to review of member grievance data for CHP+ members. **Colorado Choice** must define a process for the review of serious member complaints, patterns of complaints, and member survey data, and the process to develop corrective action when indicated. **Colorado Choice** must also submit evidence of committee review, recommendations, and conclusions related to member complaints, including any applicable actions taken.

The completed compliance monitoring tool follows this cover page.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has written policies and procedures to ensure timely coordination with any of a member's other providers of the provision of Covered Services to its members and to ensure: ◆ Service accessibility. ◆ Attention to individual needs. ◆ Continuity of care to promote maintenance of health and maximize independent living. Contract: Exhibit A—2.7.4.1	**Documents:** 1.) Precertification Procedures for Authorizations and Referrals, Policy and Procedure No. 3504, page 2 paragraph 3. (Standard III_Q1_1_Precert Proc for Auth and Ref, 3504.pdf) 2.) Case Management Program, Policy and Procedure No. 3000, page 2, paragraph B (Standard III_Q1_2_Case Management Program, 3000.pdf) 3.) Health Assessment Survey (Standard III_Q1_3_Health Assessment Survey.pdf) **Narrative:** The policy states that Colorado Choice will process and return clean requests for services within three working days whenever possible. Requests requiring more information are held until all appropriate material is received, and are then processed within three working days. Requests must be completed or extended within fourteen days, regardless of whether all information has been received. Urgent care requests will be processed as quickly as possible and always within 72 hours of receipt. A health assessment survey is sent to members to determine the need for a case manager. Upon return of the assessment the contractor will determine the level of individual attention in order to ensure no lapse with continuity of care.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:
The Case Management Program policy defined case management (CM) as assessment, planning, facilitation, and advocacy for services needed by members with complex, serious or high-cost conditions. It outlined the procedures for identifying members in need of CM and stated that potential CM candidates may be identified through referrals from the member, the provider, or internal Colorado Choice departments; or they may also be identified through data sources, such as claims or pharmacy data. The policy stated that the case manager conducts an assessment of the health status and coordination needs for each member referred to CM. The Health Assessment Survey, distributed to all members at the time of enrollment, solicited information from members regarding service needs, providers involved with the member, and presence of specific acute and chronic diseases. The

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Precertification Procedures for Authorization and Referral policy stated that most prior authorization requests will be processed within three days to ensure timely access to needed services.		
Required Actions: None.		
2. The Contractor's procedures are designed to address those members who may require services from multiple providers, facilities, and agencies; and require complex coordination of benefits and services and those members who require ancillary, social, or other community services. The Contractor coordinates with the member's mental health providers to facilitate the delivery of mental health services, as appropriate. *42CFR438.208(b)(2)* Contract: Exhibit A—2.7.4.2, 2.7.4..3..2, 2.7.4.3.3	**Documents:** 1.) Health Assessment Survey (Standard III_Q1_3_Health Assessment Survey.pdf) 2.) Case Management Program, Policy and Procedure No. 3000, Page 4, IV Procedures and Page 6, last bullet in Paragraph F. (Standard III_Q1_2_Case Management Program, 3000.pdf) **Narrative:** A Health Survey is sent to member and upon return reviewed by the nurse manager for needs. Case management is utilized for those patients that need coordination of care for more complex issues. This is done through the referral process and case management when necessary.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Case Management Program policy described methods of identifying candidates for case management services and stated that, once identified, the case manager telephones the member to conduct an in-depth assessment of needs. The policy outlined the criteria for assigning a risk level regarding the need for CM services (based on the assessment) and stated that an individualized care plan would be developed for high- and moderate-risk members. Although Colorado Choice staff members were unprepared to present cases on-site that demonstrated that these policies were followed, staff did describe the case management activities for three individuals with complex medical needs who were being monitored or assisted through CM. One of the three cases was an 18-year-old CHP+ member at the time of identification for case management services who suffered multiple injuries related to a traffic accident. This member was hospitalized out of state and required interstate transfer arrangements post-hospitalization, multiple post-hospitalization therapies, and home-based assistive equipment. This individual turned 19 years old while in recovery and was no longer eligible for CHP+ medical insurance coverage. The Colorado Choice case manager assisted with transitioning this member to alternative health plan coverage. The other two cases discussed included one individual with metastatic cancer who required surgery with follow-up radiation and chemotherapy and one child engaged in ongoing cancer treatment who required multiple hospitalizations, chemotherapy appointments, home medical supplies, and family support. These three cases demonstrated care coordination with hospital case managers, multiple providers, ancillary services, transportation services, and		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
assistance with benefit and coverage determinations. Staff described the possible need for mental health services in each of the three cases, which had not been determined at the time of the site review.		
Required Actions: None.		
3. The Contractor has a mechanism to ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating covered services furnished to the member. If a member does not select a primary care physician (PCP), the Contractor assigns the member to a PCP or a primary care facility and notifies the member, by telephone or in writing, of his/her facility's or PCP's name, location, and office telephone number. *42CFR438.208(b)(1)* Contract: Exhibit A—2.5.8.2	**Documents:** 1.) New Member Routing Sheet (Standard III_Q3_1_new member routing sheet.pdf) 2.) Selection of PCP (Standard III_Q3_2_Selection of PCP form.pdf) 3.) Notification of PCP Assignment letter (Standard III_Q3_3_Notification of PCP Assignment letter.pdf) **Narrative:** Upon notification of enrollment, Colorado Choice will attempt to contact by phone, the member/guardian within 10 days to discuss PCP selection. Colorado Choice will also send a "Selection of PCP" form to all members in their enrollment packet. If Colorado Choice fails to receive any feedback from member/guardian regarding the PCP selection, Colorado Choice will automatically assign PCPs based on several factors including: provider relationships, known language needs, prior visits, and zip codes. The member/guardian will then be notified in writing of the PCP assignment including name, location and telephone number.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Staff stated that the Selection of PCP form is distributed in the member's enrollment packet and directs the member to choose an in-network PCP by contacting the Customer Services department or by returning the completed form; however, the form did not describe how to obtain a list of network providers. HSAG recommended that Colorado Choice revise the Selection of PCP form to include directions about how to select a PCP online and include the Web site address. On-site, Colorado Choice staff members stated that customer services staff members attempt to contact the member by telephone within 10 days of enrollment to discuss PCP selection. The CHP+ Member Handbook informed members that they may select a PCP within 10 days of enrollment or Colorado Choice will assign them to one. The handbook informed members that the PCP list was available by contacting the Customer Services department or by accessing the Colorado Choice Web site. Colorado Choice might want to consider removing the member login		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
requirements to access the online provider directory to increase the ease of selecting a provider online. The Notification of PCP Assignment letter, sent following the 10-day period if the member has not chosen a PCP, informed the member that a PCP had been assigned to the member by Colorado Choice and included the provider's name, address, and telephone number. Staff members stated that PCP assignment considers previous provider relationships, location, and language needs of the member, derived from the Xpress claims and enrollment system. During the on-site interview, staff stated that Colorado Choice assumes that the PCP coordinates covered services for members who are not referred to CM, and Colorado Choice does not formally designate a person responsible for coordination of services. The Colorado Choice Health Plan Provider Handbook (applicable to all lines of business) defined coordination of care as the transmitting of information between referring providers, but it did not describe the provider's responsibilities regarding care coordination for members and what case management activities can be provided by Colorado Choice staff members. HSAG recommended that the provider handbook include a full description of care coordination as outlined in the CM Program policy, descriptions of case management and care coordination responsibilities assigned to both the provider and to Colorado Choice, and under what circumstances members should receive care coordination or case management from either party.		
Required Actions: Colorado Choice must develop policies, procedures, and processes to designate the party responsible for the member's care coordination. Colorado Choice may want to build on the risk stratification concept discussed in policy and assign the party responsible based on the risk category (for example, lower risk member care coordinated by the PCP, with higher risk care or inpatient care coordinated by Colorado Choice case management staff).		
4. The Contractor implements procedures to provide an individual needs assessment after enrollment and at any other necessary time, including the screening for special health care needs (e.g., mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems). The assessment mechanisms must use appropriate health care professionals. *42CFR438.208(c)(2)* Contract: Exhibit A—2.7.4.3.1.1	**Documents:** 1.) Health Assessment Survey (Standard III_Q1_3_Health Assessment Survey.pdf) **Narrative:** A Health Assessment survey is sent to the member with the initial enrollment packets. We also send the health assessment survey with the annual letter that is provided to members. The questionnaire is then assessed by the nurse manager for complex issue identification or needs assessment.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The CM Program policy stated that case managers would conduct an assessment of needs for all members referred to CM using pre-defined templates for one of five designated medical conditions (clinical assessments) or the General Initial Assessment. The General Initial Assessment template was designed for post-hospitalization assessment and did not include assessment of social or community support needs, mental health needs, cultural needs, functional problems, comprehension problems, or other special health care needs.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
The Health Assessment Survey, distributed to members at the time of enrollment and annually thereafter, solicited information regarding multiple medical providers, current or anticipated medical procedures or therapies (including mental health therapies), and the presence of specific acute or chronic health conditions. Staff stated that any assessments returned are reviewed by the nurse manager to determine the need for a more in-depth assessment of special health care needs, but that only a small percentage of the Health Assessment Surveys are returned to Colorado Choice, and that staff does not perform follow-up outreach to contact non-responding members. HSAG recommended that Colorado Choice consider implementing a mechanism for follow-up contact with non-responding members to screen for special health care needs. In one of the three care coordination cases discussed during the on-site interview, Colorado Choice identified the member's post-discharge needs through communication with the hospital case manager. In another case, staff reported that the member's needs were anticipated based on monitoring the progress of the member. In the third case, staff reported that assessment and care plan development were incomplete due to the ongoing intensity of acute treatment. Colorado Choice did not provide evidence on-site of having completed and documented comprehensive assessments of special health care needs.		
Required Actions: Colorado Choice must define a comprehensive assessment tool that includes all of the elements referenced in the requirement and document the assessment in the case management record. Colorado Choice must assess its members' health care needs upon enrollment and at any other necessary time (e.g., upon referral to case management).		
5. The Contractor shares with other health care organizations serving the member with special health care needs, the results of its identification and assessment of that member's needs, to prevent duplication of those activities. *42CFR438.208(b)(3)* Contract: Exhibit A—2.7.5.2	**Documents:** 1.) Case Management Program, Policy and Procedure No. 3000 (Standard III_Q1_2_Case Management Program, 3000.pdf) **Narrative:** This is accomplished during the referral process to determine use and overuse through prior authorization. Case Management system also identifies areas for communication between providers.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Case Management Program policy stated that the assessment and care plan, developed for moderate- and high-risk CM members, will be shared with the PCP and any specialty care physicians. The policy did not address sharing the assessment with other organizations involved in these members' care. Colorado Choice did not provide documentation of having shared assessment of member needs with other health care organizations involved in serving those needs.		
Required Actions: Colorado Choice must define a process for sharing the assessment of special health care needs with other health care or community organizations serving the member, as appropriate, to prevent duplication of services. Colorado Choice must develop a mechanism to document release of this information.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor implements procedures to develop an individual treatment plan as necessary. *42CFR438.208(c)(3)* Contract: Exhibit A—2.7.4.3.1.2	**Documents:** 1.) Case Management Program, Policy and Procedure No. 3000, page 5, Letter E. (Standard III_Q1_2_Case Management Program, 3000.pdf) **Narrative:** Colorado Choice develops relationships with the providers to obtain treatment plans. The plans are reviewed as needed to assure care is appropriate and not duplicated.	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: The CM Program policy stated that a care plan is developed for moderate- and high-risk CM members and will include planned communications, referrals, and interventions to address individual needs. The CM Program policy stated that case managers would conduct an assessment of needs for all members referred to CM using pre-defined templates for one of five designated medical conditions (clinical assessment) or the General Initial Assessment. The template included a section for documenting follow-up monitoring notes. On-site, Colorado Choice staff described case management activities for three individuals with complex medical needs who were being monitored or assisted through case management; however, staff did not provide examples of completed treatment plans, as required.		
Required Actions: Colorado Choice must implement procedures to ensure that an individual care coordination plan is developed and documented in the case management file.		
7. The Contractor's procedures for individual needs assessment and treatment planning are designed to: ◆ Accommodate the specific cultural and linguistic needs of the members. ◆ Allow members with special health care needs direct access to a specialist as appropriate to the member's conditions and needs. *42CFR438.208(c)(3)(iii)* Contract: Exhibit A—2.7.4.3.1.4	**Documents:** 1.) Health Assessment Survey (Standard III_Q1_3_Health Assessment Survey.pdf) 2.) Case Management Program, Policy and Procedure No. 3000, Page 2, Paragraph B and Page 5, Paragraph E. (Standard III_Q1_2_Case Management Program, 3000.pdf) **Narrative:** The Health Assessment Survey is provided in both English and Spanish. Consultations with specialist do not require prior authorization, so the member can have direct access to appropriate	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	specialists. A list of approved specialists is available to members in the online provider directory or through the Choice Connect portal, or by request for hard copy.	

Findings:
Colorado Choice provided evidence that the Health Assessment Survey was available in Spanish and English. The CM Program policy described the use of needs assessments that documented the member's language. Cultural needs, other than language, were not included on assessment templates. The policy stated that the member care plan would address "ethnic, religious, or spiritual concerns."

Staff stated that referrals to specialists do not require prior authorization, and that the member may obtain information regarding approved Colorado Choice specialists through the online provider directory. The CHP+ Member Handbook stated that members may access in-network specialists for consultation without PCP referral and that a list of participating specialists was included in the provider directory. The member handbook also stated that if a member has needs that cannot be addressed by a participating provider, Colorado Choice would arrange for services with a provider who has the necessary expertise. The provider manual instructed providers that members who have purchased the Open Access Rider Benefit may have direct access to a specialist. During the on-site interview, staff clarified that the Open Access Rider Benefit does not apply to CHP+ members.

On-site, Colorado Choice did not provide evidence or examples of completed assessments or care plans that address cultural or linguistic needs, or the need for access to specialists. Colorado Choice may want to consider either developing separate sections in the provider manual for different lines of business or using qualifying statements to clearly indicate want does and does not apply to CHP+ members.

Required Actions:
Colorado Choice must revise the provider manual to clearly state that CHP+ members with special health care needs have direct access to specialists.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that they are applicable. In all other operations as well the Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42CFR438.208(b)(4)* *42CFR438.224* Contract: Exhibit A—2.7.4.1, 3.1.4.3 (RMHP—3.1.3.3)	**Documents:** 1.) Privacy Notice (Standard III_Q8_1_Privacy Notice.pdf) 2.) Authorization for Release of Protected Health Information (Standard III_Q8_2_Authorization for Release of PHI.pdf) 3.) Privacy/HIPAA Certification of employee training (Standard III_Q8_3_Privacy-HIPAA Certification of employee training.pdf) **Narrative:** HIPAA is followed for all written and oral communications. Oral authorization is valid for 14 days. Written authorization is valid for the time periods specified by member/guardian. Employees are HIPPA trained upon hire. Release of information forms are required in appropriate circumstances. The Privacy Notice is sent to the member with the initial enrollment packet.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:
Colorado Choice submitted several organizational policies related to HIPAA privacy requirements. These policies addressed confidentiality, use and disclosure of protected health information (PHI), "minimum necessary" requirements, and verification of identification. The Colorado Choice Privacy Notice, distributed to members on enrollment, informed the member about the use of PHI for internal health operations and for external communications, as outlined in HIPAA specifications. The privacy notice informed members of the type of information that may be shared, with what entities, and for what purposes, without permission from the member. The notice stated that Colorado Choice may share PHI with doctors, hospitals, or others to help manage the member's health care. The notice also stated that written permission from the member will be obtained for releasing information in any other circumstance. The Authorization for Release of PHI form provided evidence of obtaining member permission for release of PHI to specific providers or other entities. The Colorado Choice Health Plan Confidentiality Agreement, signed by all employees, stated that Medical Management Department personnel have greater access to medical information and would not discuss or disclose information except as necessary for business purposes. The provider manual stated that providers are bound to compliance with HIPAA laws. HSAG recommended that Colorado Choice provide references to providers, perhaps through the Web site provider portal, regarding HIPAA laws, or provide Colorado Choice Health Plan HIPAA-related policies.

Required Actions:
None.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor's procedures include a strategy to ensure that all members and/or authorized family members are involved in treatment planning and consent to medical treatment. Contract: Exhibit A—2.7.4.3.4	**Documents:** 1.) Case Management Program, Policy and Procedure No. 3000, Page 5, Letter E, paragraph 1. (Standard III_Q1_2_Case Management Program, 3000.pdf) **Narrative:** We do not employee the providers and so do not do consent for medical treatment nor involve the family to a great extent in treatment planning. However, for those enrolled in case management, there may be family involvement where appropriate and consented.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The CM Program policy stated that the case manager would complete a telephonic needs assessment with the member, develop a care plan, discuss the care plan with the member, and document the member's agreement to participate in the care plan. The policy also described the option for the member to opt-out of case management services during the initial contact by the case manager. The CHP+ Member Handbook informed members about CM services and about their right to participate in decisions regarding treatment or services, including the right to refuse treatment. Colorado Choice did not provide evidence of written care plans or documentation of member involvement in the care plan.		
Required Actions: Colorado Choice must provide documentation demonstrating member involvement and agreement with the care coordination plan.		

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	3	X	1.00	=	3
	Partially Met	=	4	X	.00	=	0
	Not Met	=	2	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	9	**Total Score**		=	3

Total Score ÷ Total Applicable	=	33%

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has written policies and procedures regarding member rights. *42CFR438.100(a)(1)* Contract: Exhibit A—3.1.1.1	Due to plan size, Colorado Choice does not have any written formal policies regarding member rights. Colorado Choice does follow the procedures outlined in the following documents: **Documents:** 1.) CHP+ Member Handbook, Pages 13 and 14 (Standard IV_Q1_1_CHP+ Member Handbook.pdf) 2.) Privacy Notice (Standard III_Q8_1_Privacy Notice.pdf) **Narrative:** Contractor has a Member Handbook that helps members understand their rights. This handbook is sent to all members upon enrollment with the plan. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services to them. The Privacy Notice also informs the member of their rights.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The CHP+ Member Handbook included a section regarding member rights and responsibilities. Staff stated that the member handbook is distributed to members upon enrollment and is used as a reference for staff when communicating with members. The Colorado Choice Health Plan Privacy Notice informed members of their rights regarding confidentiality of member information, including the confidentiality and privacy rights required by HIPAA. Staff stated that, due to the small size of the CHP+ population, Colorado Choice has not developed written policies and procedures regarding member rights and responsibilities.		
Required Actions: Colorado Choice must develop written CHP+ policies and procedures related to member rights and responsibilities. The policies and procedures should address all of the components of rights as stated at 42CFR438.100 and in the Colorado CHP+ managed care contract. The policies and procedures should also address how members and providers are informed of member rights, how Colorado Choice monitors providers to ensure member rights are taken into account when furnishing services, and how Colorado Choice monitors its processes to ensure that members feel free to access rights processes without fear of retaliation.		

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor ensures that its staff and affiliated network providers take member rights into account when furnishing services to members. *42CFR 438.100(a)(2)* Contract: Exhibit A—3.1.1.1.1	**Documents:** 1.) CHP+ Member Handbook, Pages 13 and 14 (Standard IV_Q1_1_CHP+ Member Handbook.pdf) 2.) Professional Services Agreement, Page 4, Article II, Sections 2.5 and 3.2 and Page 9, Article VI, Sections 6.2 and 6.5. (Standard IV_Q2_2_Professional services agreement.pdf) **Narrative:** Handbook is provided to all members upon enrollment with the plan so that they are informed of their rights. This Handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services to them. Professional Services Agreement contains protectionary language to ensure members rights. Colorado Choice has a method of tracking member grievances, so that if an issue arises regarding member rights an investigation can be done	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Colorado Choice Health Plan Professional Services Agreement included statements regarding the ability of the provider to freely communicate with the member about treatment options regardless of benefit coverage, the responsibility of the provider to treat each member in a non-discriminatory manner, and the responsibility of the provider to comply with HIPAA provisions. On-site, Colorado Choice staff stated that the member handbook, which included the listing of member rights and responsibilities, was used by staff as a guide when communicating with members. Member rights statements were not included in any provider documents or communication reviewed. Staff members stated that the provider manual is used for all of Colorado Choice's lines of business. HSAG recommended developing separate sections for each line of business, with each section containing specific requirements or information that is unique to that line of business.		
Required Actions: Colorado Choice must develop a method to inform providers of each of the member rights guaranteed under the CHP+ program, and of the expectation that providers take those rights into consideration when furnishing services.		

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's policies and procedures ensure that each member is treated by staff and affiliated network providers in a manner consistent with the following specified rights: ◆ Receive information in accordance with information requirements (42CFR438.10). ◆ Be treated with respect and with due consideration for his or her dignity and privacy. ◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. ◆ Participate in decisions regarding his or her health care, including the right to refuse treatment. ◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. ◆ Request and receive a copy of his or her medical records and request that they be amended or corrected. ◆ Be furnished health care services in accordance with requirements for access and quality of services (42CFR438.206 and 42CFR438.210). *42CFR438.100(b)(2) and (3)* Contract: Exhibit A—3.1.1.1	**Documents:** 1.) Professional Services Agreement, Page 4, Article II, Sections 2.5 and 3.2 and Page 9, Article VI, Sections 6.2 and 6.5. (Standard IV_Q2_2_Professional services agreement.pdf) **Narrative:** Due to plan size, Colorado Choice does not have any written formal policies regarding member rights. Colorado Choice does follow what is outlined in the Professional Services Agreement. Professional services agreement contains protectionary language to ensure member rights. Contractor has a Member Handbook that helps members understand their rights. This handbook is sent to all members upon enrollment with the plan. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services to them. The plan also provides members with an annual letter informing them of their rights. The Privacy Notice also informs the member of their privacy and confidentiality rights.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The member handbook outlined the member rights in easy-to-understand language, including the information specified in the requirement, with the exception of the right to be free of restraint or seclusion. The Colorado Choice Health Plan Privacy policy included detailed language concerning confidentiality of member records and the member's right to receive and request amendment to records. The Professional Services Agreement addressed the ability of the provider to freely communicate with the member regarding treatment options, regardless of benefit coverage; the responsibility of the provider to treat each member in a non-discriminatory manner; and the responsibility of the provider to comply with HIPAA provisions. The Professional Services Agreement addressed only some of the member rights required by the CHP+ managed care contract. The right to be free from restraint and		

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
seclusion as a means of coercion was not addressed in any documents. While the member rights and responsibilities in the member handbook included the right to participate in treatment decisions and refuse treatment, the handbook also included a lengthy discussion that refusal of treatment that is recommended by the provider may result in the member's termination from the CHP+ program. This statement is in conflict with the rights guaranteed by federal health care regulations. During the on-site interview, Colorado Choice staff members stated that the annual letter informing member of their rights was being drafted and had not yet been implemented.		
Required Actions: Colorado Choice must ensure that each of its applicable documents (policies, member materials, and provider materials) address each of the rights at 42CFR438.100 and in the Colorado CHP+ managed care contract. Colorado Choice must also revise the member handbook to remove the statement that members may be terminated from the CHP+ program. If the member handbook is used for multiple lines of business and the statement in question applies to other lines of business, then separating sections or informing members regarding what does and does not apply to CHP+ members would be acceptable.		
4. The Contractor ensures that each member is free to exercise his or her rights and that exercising those rights does not adversely affect the way the Contractor or its providers treat the member. *42CFR438.100(c)* Contract: Exhibit A—3.1.1.1.7	**Documents:** 1.) CHP+ Member Handbook, Pages 13 and 14 (Standard IV_Q1_1_CHP+ Member Handbook.pdf) 2.) Professional Services Agreement (Standard IV_Q2_3_Professional Services Agreement.pdf) **Narrative:** Colorado Choice has a Member Handbook that includes the members' rights. This Handbook is provided to all members upon enrollment with the plan so that they are informed of their rights. This Handbook is also a reference guide that is followed by Colorado Choice when dealing with members. Colorado Choice does have in place a Grievance system that allows Colorado Choice to monitor any and all member grievances, in order to ensure member rights are not violated. Colorado Choice's Professional Services Agreement does have protectionary language regarding treatment options.	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: HSAG found no evidence of member or provider communications or policies that addressed the member's right to exercise his or her rights without adverse effect on the member's treatment. During the on-site interview, Colorado Choice staff members reported that they are planning to develop a member newsletter that would be distributed three times per year and would include a variety of member communications including information about member rights.		

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: Colorado Choice must develop member, staff, and provider materials that inform members of their right to exercise their rights (for example, grievance and appeal rights) without adverse effect on the member's treatment.		
5. Contractor complies with any other federal and State laws that pertain to member rights including Title VI of the Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act, and titles II and III of the Americans with Disabilities Act. *42CFR438.100(d)* Contract: 21.A	**Documents:** 1.) CHP+ Member Handbook, Pages 13 and 14 (Standard IV_Q1_1_CHP+ Member Handbook.pdf) **Narrative:** Contractor has a Member handbook that includes the member's rights. This handbook is provided to all members upon enrollment with the plan so that they are informed of their rights. This Handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services. Colorado Choice does comply with federal and state laws. Colorado Choice goes through state (Division of Insurance) and federal (CMS) audits upon state/federal request.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Professional Services Agreement stated that the provider shall not discriminate against the member for any reason, including all of the circumstances outlined in the laws specified in this requirement. The member rights section of the CHP+ Member Handbook included an easy-to-understand description of the member's right to receive treatment without discrimination for any of the reasons addressed in the requirement. Although the aforementioned documents clearly articulated Colorado Choice's commitment to provide services without discrimination, HSAG recommends that Colorado Choice also address nondiscrimination related to race, ethnicity, gender, sexual orientation, or disability in policy while developing policies and procedures that address member rights.		
Required Actions: None.		

Results for Standard IV—Member Rights and Protections							
Total	Met	=	1	X	1.00	=	1
	Partially Met	=	3	X	.00	=	0
	Not Met	=	1	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	5	**Total Score**		=	1

Total Score ÷ Total Applicable	=	20%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. NCQA CR1	**Documents:** 1.) Credentialing and Recredentialing, Policy and Procedure No. 3300 (Standard VIII_Q1_1_Credentialing and Recredentialing, 3300.pdf) **Narrative:** Colorado Choice follows the credentialing and recredentialing policy above.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing policy described Colorado Choice's credentialing program and processes for evaluating potential participating practitioners.		
Required Actions: None.		
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners to credential and recredential. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. (Examples include doctors of medicine [MDs], doctors of osteopathy [DOs], podiatrists, and each type of behavioral health provider). *42CFR438.214(a)* NCQA CR1—Element A1	**Documents:** 1.) Credentialing and Recredentialing, Policy and Procedure No. 3300- Page 1, Paragraph 2 (Standard VIII_Q1_1_Credentialing and Recredentialing, 3300.pdf) **Narrative:** Colorado Choice does not discriminate in its willingness to credential providers. Colorado Choice is dedicated to expanding our provider network and maintains provider relationships.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: While Colorado Choice's policy and procedure named several types of practitioners that Colorado Choice credentials, the policy should be expanded to include and describe each type of practitioner Colorado Choice credentials and recredentials. For example non-physician practitioners such as nurse practitioners, physician assistants, and behavioral health practitioners e.g., licensed counselors, social workers, and psychologists) must be addressed.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: Colorado Choice must revise its policy to address the credentialing and recredentialing of non-physician practitioners such as nurse practitioners, physician assistants, and behavioral health practitioners (e.g., licensed counselors, social workers, and psychologists).		
2.B. The verification sources used. NCQA CR1—Element A2	**Documents/Sources:** National Practitioner Data Bank – http://www.npdb-hipdb.hrsa.gov/ CMS Sanctions – http://exclusions.oig.hhs.gov/search.aspx ABMS – http://www.certifacts.org/ DO Certification – https://www.doprofiles.org/ P.A. Certification – https://www.nccpa.net/pa/CredentialPublicSend.aspx Colorado License & Discipline Action – https://www.colorado.gov/dora/licensing/ **Narrative:** The above sources are used to verify credentialing and recredentialing information.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Although record review demonstrated that NCQA-compliant verification sources were being used, Colorado Choice's policy did not depict all sources used and what information is obtained from each.		
Required Actions: Colorado Choice must revise its policy to specify the verification sources used for primary source verification during credentialing and recredentialing.		
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	**Documents:** 1.) Credentialing and Recredentialing Policy and Procedure No. 3300, Page 4, Criteria for Participating Provider with SLVHMO (Standard VIII_Q1_1_Credentialing and Recredentialing, 3300.pdf) **Narrative:** Colorado Choice follows criteria found in its Credentialing and Recredentialing Policy and Procedure No. 3300.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The general criteria statement in the policy is very good; however, it limits the criteria for credentialing to having a medical license.		
Required Actions: Colorado Choice must expand the policy to clearly describe the criteria for credentialing and recredentialing that addresses each type of practitioner credentialed (e.g., non-physician practitioners).		
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	**Documents:** 1.) Credentialing and Recredentialing Policy and Procedure No. 3300, Page 3, Completion, Verification, and Decision (Standard VIII_Q1_1_Credentialing and Recredentialing, 3300.pdf) **Narrative:** Colorado Choice follows criteria found in its Credentialing and Recredentialing Policy and Procedure No. 3300. Upon completion of credentialing application, it is reviewed by the "Committee of the Whole" for acceptance or denial.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing policy described the processes for making credentialing and recredentialing decisions.		
Required Actions: None.		
2.E. The process for managing credentialing/ recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	**Documents:** 1.) Credentialing and Recredentialing, Policy and Procedure No. 3300, Page 3 Completion, Verification and Decision. (Standard VIII_Q1_1_Credentialing and Recredentialing, 3300.pdf) 2.) Provider Credentialing Application Log (Standard VIII_Q2E_2_Provider Credentialing Application Log.pdf) 3.) Provider Credentialing Checklist (Standard VIII_Q2E_3_Provider Credentialing Checklist.pdf)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	4.) Provider Recredentialing Application Log (Standard VIII_Q2E_4_Provider Recredentialing Application Log.pdf) 5.) Provider Recredentialing Checklist (Standard VIII_Q2E_5_Provider Recredentialing Checklist.pdf) **Narrative:** Once an application is received, a confidential file is made or updated for each provider including a Provider Credentialing/Recredentialing Application Log and Provider Credentialing/Recredentialing Checklist. The checklists are then used to ensure established criteria are met.	
Findings: The Credentialing and Recredentialing policy described the processes for managing credentialing and recredentialing files and included templates and tools used to manage files. On-site review of 10 credentialing and 10 recredentialing records demonstrated that credentialing records were managed and documentation maintained as indicated in Colorado Choice's policy.		
Required Actions: None.		
2.F. The process for delegating credentialing or recredentialing (if applicable). NCQA CR1—Element A6	**Documents:** 1.) Delegation of Provider Credentialing, Policy and Procedure No. 3301 (Standard VIII_Q2F_1_Delegation of Provider Credentialing, 3301.pdf) 2.) Credentialing Delegation Addendum to Provider Contract (Standard VIII_Q2F_2_Credentialing Delegation Addendum.pdf) **Narrative:** Colorado Choice follows policy No. 3301, Delegation of Provider Credentialing, for its credentialing delegation agreements. The Credentialing Delegation Addendum is added to the Provider Contract and made part of the Professional Services Agreement between Colorado Choice Health Plans and that specific Provider.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The Delegation of Provider Credentialing policy described processes for delegating credentialing. Processes described included a delegate application process, review of policies and procedures, predelegation audit of credentialing files or verification of NCQA certification, execution of a delegation agreement, and monitoring of performance.		
Required Actions: None.		
2.G. The process for ensuring that credentialing and recredentialing are conducted in a non-discriminatory manner, (i.e., must describe the steps the Contractor takes to ensure that it does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes). NCQA CR1—Element A7	**Documents:** 1.) Credentialing and Recredentialing, Policy and Procedure No. 3300, Page 4-5, Criteria for Participating Provider with SLVHMO (Standard VIII_Q1_1_Credentialing and Recredentialing, 3300.pdf.) **Narrative:** Colorado Choice's "Committee of the Whole" makes its decision based on the skill, competence and necessary requirements of the applicant, not on the race, ethnic/national identity, gender, age or sexual orientation of the applicant.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing policy described the criteria for credentialing and recredentialing and stated that decisions are based on the criteria. The policy also made an affirmative statement of nondiscrimination.		
Required Actions: A statement that the organization does not discriminate is not sufficient to meet NCQA standards. Colorado Choice must revise its policy to describe prevention (proactive steps to prevent discrimination) and monitoring (tracking and identification of potential discriminatory practices).		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.H. The process for notifying practitioners if information obtained during the Contractor's credentialing/recredentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A8	**Documents:** 1.) Credentialing and Recredentialing, Policy and Procedure No. 3300, Page 5-Notification of Discrepancies (Standard VIII_Q1_1_Credentialing and Recredentialing, 3300.pdf) **Narrative:** Providers are notified by Colorado Choice in writing of any issues found during credentialing or recredentialing.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The policy adequately described how applicants are notified of discrepancies between information obtained by Colorado Choice and information submitted by the provider in support of the application.		
Required Actions: None.		
2.I. The process for ensuring that practitioners are notified of credentialing and recredentialing decisions within 60 calendar days of the committee's decision. NCQA CR1—Element A9	**Documents:** 1.) Initial Credentialing letter example (Standard VIII_Q2I_1_Initial Credentialing letter.pdf) 2.) Recredentialing letter example (Standard VIII_Q2I_2_Recredentialing letter.pdf) **Narrative:** Colorado Choice's standard practice is to mail the decision letters the day following the "Committee of the Whole" Meeting.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Colorado Choice's policy stated that providers are notified in writing of the credentialing committee's decision within 60 days of the decision. Colorado Choice provided a template letter used.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.J. The medical director's or other designated physician's direct responsibility and participation in the credentialing/ recredentialing program. NCQA CR1—Element A10	**Documents:** 1.) Provider Credentialing Checklist (Standard VIII_Q2E_3_Provider Credentialing Checklist.pdf) 2.) Provider Recredentialing Checklist (Standard VIII_Q2E_5_Provider Recredentialing Checklist.pdf) 3.) Quality Management Program 2013, Page 5, See Committee Composition (Standard X_Q1_1_Quality Management Program 2013.pdf) **Narrative:** Colorado Choice's Medical Director reviews the credentialing or recredentialing application and signs the internal checklist. The Medical Director is also the chair of the Committee of the Whole, and as such conducts the meetings, signs and reviews the letters sent to providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing policy stated that the medical director determines whether files are designated as "clean files." On-site, Colorado Choice staff members stated that all credentialing and recredentialing files are sent through the credentialing committee and presented as either clean files, or as files in need of further discussion.		
Required Actions: None.		
2.K. The process for ensuring the confidentiality of all information obtained in the credentialing/ recredentialing process, except as otherwise provided by law. NCQA CR1—Element A11	**Documents:** 1.) Credentialing files, available upon site review **Narrative** All credentialing files are kept by the Credentialing Coordinator who prepares a confidential file for each provider. Provider credentialing and recredentialing files are kept in a locked cabinet and available for the "Committee of the Whole" and Medical Director to review.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The policy stated that credentialing files are confidential; however, it did not describe the process used to maintain confidentiality of credentialing and recredentialing records. During the on-site interview, Colorado Choice staff members described both physical and electronic safeguards that were NCQA-compliant.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: Colorado Choice must revise the credentialing and recredentialing policy to describe the processes used to ensure the confidentiality of credentialing and recredentialing records.		
2.L. The process for ensuring that listings in provider directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty. NCQA CR1—Element A12	**Documents:** N/A **Narrative:** Current policy does not require this, Colorado Choice will update in the future to comply with regulation.	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: The policy did not address this requirement. On-site, Colorado Choice staff members stated that the provider directory is developed from the database that houses provider credentialing information.		
Required Actions: Colorado Choice must revise the policy to describe how Colorado Choice ensures that listings in provider directories and other materials for members are consistent with credentialing data.		
2.M. The right of practitioners to review information submitted to support their credentialing or recredentialing application, upon request. NCQA CR1—Element B1	**Documents:** 1.) Credentialing and Recredentialing, Policy and Procedure No. 3300, Page 6, Right to Review or Correct Credentials Information (Standard VIII_Q1_1_Credentialing and Recredentialing, 3300.pdf) 2.) Colorado Health Care Professional Credentials Application, Page 23, #12 (Standard VIII_Q2M_2_Colorado Health Care Professional Credentials Application.pdf) **Narrative:** Provider is informed of this right in the Colorado Health Care Professional Credentials Application.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing policy included the process to allow practitioners to review their application. Practitioners were informed of this right via the Colorado Health Care Professional Credentials Application.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.N. The right of practitioners to correct erroneous information. NCQA CR1—Element B2	**Documents:** 2.) Credentialing and Recredentialing, Policy and Procedure No. 3300, Page 6, Right to Review or Correct Credentials Information (Standard VIII_Q1_1_Credentialing and Recredentialing, 3300.pdf) 2.) Colorado Health Care Professional Credentials Application, Page 23, #12 (Standard VIII_Q2M_2_Colorado Health Care Professional Credentials Application.pdf) **Narrative:** Provider is informed of this right in the Colorado Health Care Professional Credentials Application.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing policy included the process to allow practitioners to correct erroneous information related to the credentialing and recredentialing process. Practitioners were informed of this right via the Colorado Health Care Professional Credentials Application.		
Required Actions: None.		
2.O. The right of practitioners, upon request, to receive the status of their application. NCQA CR1—Element B3	**Documents:** 2.) Credentialing and Recredentialing, Policy and Procedure No. 3300, Page 6, Right to Review or Correct Credentials Information (Standard VIII_Q1_1_Credentialing and Recredentialing, 3300.pdf) 2.) Colorado Health Care Professional Credentials Application, Page 23, #12 (Standard VIII_Q2M_2_Colorado Health Care Professional Credentials Application.pdf) **Narrative:** Provider is informed of this right in the Colorado Health Care Professional Credentials Application.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: While the policy addressed the applicant's right to review and correct the credentialing or recredentialing information, it did not address requests to receive the status of applications unrelated to correcting information.		
Required Actions: Colorado Choice must revise the policy to specifically address the applicant's right to receive the status of his or her application, unrelated to correcting erroneous information.		
2.P. The right of the applicant to receive notification of their rights under the credentialing program. NCQA CR1—Element B4	**Documents:** 1.) Colorado Health Care Professional Credentials Application, Page 23, #12 (Standard VIII_Q2M_2_Colorado Health Care Professional Credentials Application.pdf) **Narrative:** Provider rights are discussed in the Colorado Health Care Professional Credentials Application.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Colorado Health Care Professional Credentials Application informed practitioners of their rights under the credentialing program; however, the policy did not indicate this.		
Required Actions: Colorado Choice must revise the policy to state how applicants are informed of their rights under the credentialing program.		
2.Q. How the Contractor accomplishes ongoing monitoring of practitioner sanctions, complaints, and adverse events between recredentialing cycles including: ◆ Collecting and reviewing Medicare and Medicaid sanctions. ◆ Collecting and reviewing sanctions or limitations on licensure. ◆ Collecting and reviewing complaints. ◆ Collecting and reviewing information from identified adverse events.	**Documents:** 1.) Ongoing Monitoring of Participating Providers, Policy and Procedure No. 3302 (Standard VIII_Q2Q_1_Ongoing Monitoring of Participating Providers, 3302.pdf) **Narrative:** A notebook of sanctions is kept in the Medical Department showing all sanctions and actions found by Colorado Choice.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
◆ Implementing appropriate interventions when it identified instances of poor quality related to the above. NCQA CR9—Element A		
Findings: On-site, Colorado Choice staff provided evidence of ongoing review for sanctions and stated that the federal database queries for sanctions are performed monthly, although the policy indicated quarterly queries in one section and monthly queries in another. While the Quality Improvement Program Description addressed review of grievances and appeals, the discussion did not adequately describe the use of the information related to continuing or changing the terms of a practitioner's participation in the network. In addition, the policy did not address the collection and review of complaints and adverse events during recredentialing.		
Required Actions: Colorado Choice must revise or develop policies to accurately describe ongoing monitoring for sanction activity and the relationship of collecting and reviewing complaints and adverse events to practitioners' continued participation in the network.		
2.R. The range of actions available to the Contractor against the practitioner (for quality reasons). NCQA CR10—Element A1	**Documents:** 1.) Ongoing Monitoring of Participating Providers, Policy and Procedure No. 3302, Pages 17-20 (Standard VIII_Q2Q_1_Ongoing Monitoring of Participating Providers, 3302.pdf) **Narrative:** Colorado Choice uses Ongoing Monitoring of Participating Providers, Policy and Procedure No. 3302. Colorado Choice also maintains a notebook of monthly sanctions that is kept in the Medical Department showing all sanctions and actions.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Although Colorado Choice's policy did address ongoing monitoring for sanction activity, it did not address the range of actions available against the practitioner for quality reasons, or for inadequate performance. The Quality Management Program Description did address a range of actions that included monitoring, education, inquiry, warning, and termination. On-site, Colorado Choice staff members described the use of provisional credentialing to monitor practitioners and take action, when necessary.		
Required Actions: While Colorado Choice briefly addressed in a program description the range of actions available against practitioners for quality reasons, it must also describe this information in a policy and procedure.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.S. If the Contractor has taken action against a practitioner for quality reasons, the Contractor reports the action to the appropriate authorities (including State licensing agencies for each practitioner type and the National Practitioner Data Bank [NPDB]). NCQA CR10—Element A2 and B	**Documents:** 2.) Ongoing Monitoring of Participating Providers, Policy and Procedure No. 3302 (Standard VIII_Q2Q_1_Ongoing Monitoring of Participating Providers, 3302.pdf) 2.) Provider Handbook, Page 18, Reporting Requirement (Standard VIII_Q2S_2_Provider Handbook.pdf) **Narrative:** As per policy, State licensing and NPDB would be notified following instruction from legal counsel. If any action is taken against a practitioner for quality issues, issue will go to the" Committee of the Whole" for decision. Upon "Committee of the Whole's" decision the medical director will notify administration and await instruction by legal counsel before reporting to the state licensing agencies and NPDB.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Although the provider manual alerted providers that Colorado Choice may report sanctions to the appropriate authorities, this topic was addressed only as it relates to physicians and the Board of Medical Examiners. The policy did not address non-physician practitioners or the process.		
Required Actions: Colorado Choice must address, in a policy and procedure, the process to report actions taken against practitioners for quality reasons to appropriate authorities. All practitioners must be included and the policy must describe all applicable agencies (such as the Department of Regulatory Agencies [DORA], other non-physician licensing agencies, and the Department of Health Care Policy and Financing, if applicable.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.T. A well-defined appeal process for instances in which the Contractor chooses to alter the conditions of a practitioner's participation based on issues of quality of care or service which includes: ◆ Providing written notification indicating that a professional review action has been brought against the practitioner, reasons for the action, and a summary of the appeal rights and process. ◆ Allowing the practitioner to request a hearing and the specific time period for submitting the request. ◆ Allowing at least 30 days after the notification for the practitioner to request a hearing. ◆ Allowing the practitioner to be represented by an attorney or another person of the practitioner's choice. ◆ Appointing a hearing officer or panel of the individuals to review the appeal. ◆ Providing written notification of the appeal decision that contains the specific reasons for the decision. NCQA CR10—Element A3and C	**Documents:** 1.) Provider Handbook, Page 19, Quality of Care Concerns (Standard VIII_Q2S_2_Provider Handbook.pdf) 2.) Professional Services Agreement, Page 10, Article 8 (Standard IV_Q2_3_Professional Services Agreement.pdf) **Narrative:** For issues of Quality of Care or services, the issues would be taken to the "Committee of the Whole" by the Medical Director for review. The "Committee of the Whole" would then decide on what actions need to be taken.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The provider manual described Colorado Choice's appeal process for instances in which it chooses to alter the conditions of a practitioner's participation based on quality of care or service issues; however, the description did not include all of the required components, and it was not described in a policy/procedure.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: Colorado Choice must develop a policy/procedure to define and describe its appeal process for instances when it chooses to alter the conditions of a practitioner's participation based on quality of care or service issues. The policy must adequately describe all of the required components of an appeal process.		
2.U. Making the appeal process known to practitioners. NCQA CR10—Element A4	**Documents:** 2.) Professional Services Agreement, Page 10, Article 8 (Standard IV_Q2_3_Professional Services Agreement.pdf) 2.) Provider Handbook, Page 19 (Standard VIII_Q2S_2_Provider Handbook.pdf) **Narrative:** Practitioners are informed of appeal rights from the Provider Handbook and Professional Services Agreement.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Although Colorado Choice described the appeal process in its provider manual, its policies did not indicate how providers are informed of the appeal process.		
Required Actions: Colorado Choice's credentialing policies and procedures must address how providers are informed of the practitioner appeal processes.		
3. The Contractor designates a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions. The committee includes representation from a range of participating practitioners. NCQA CR2—Element A	**Documents:** 1.) Quality Management Program 2013, Page 5, Paragraph C, Committee Composition (Standard X_Q1_1_Quality Management Program 2013.pdf) **Narrative:** Colorado Choice's Quality Management Program outlines the committee composition.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: On-site review of credentialing committee meeting minutes demonstrated the use of the committee and peer review process to make credentialing and recredentialing recommendations. The committee participation included a range of provider types.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor provides evidence of the following: ◆ Credentialing committee review of credentials for practitioners who do not meet established thresholds. ◆ Medical director or equally qualified individual review and approval of clean files. NCQA CR2—Element B	**Documents:** 1.) Credentialing and Recredentialing, Policy and Procedure No. 3300, Page 5 (Standard VIII_Q1_1_Credentialing and Recredentialing, 3300.pdf) 2.) Provider Credentialing Checklist (Standard VIII_Q2E_2_Provider Credentialing Application Log.pdf) 3.) Provider Recredentialing Checklist (Standard VIII_Q2E_5_Provider Recredentialing Checklist.pdf) 4.) Letter for approval of credentialing application (Standard VIII_Q2I_1_Initial Credentialing Letter.pdf) 5.) Recredentialing Letter (Standard VIII_Q2I_2_Recredentialing Letter.pdf) 6.) Additional info needed letter (Standard VIII_Q4_6_Additional information needed letter.pdf) **Narrative:** Providers are listed on the "Committee of the Whole" Meeting Agenda and are reviewed by the Committee. Approved files are signed off by the Medical Director (Committee Chair). Files that are in need of further information will be sent a letter by the Medical director to obtain further information.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: On-site review of credentialing committee meeting minutes demonstrated the use of the committee and peer review process to discuss applicants that did not initially meet Colorado Choice's standards for a "clean file."		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor conducts timely verification (at credentialing) of information, using primary sources, to ensure that practitioners have the legal authority and relevant training and experience to provide quality care. Verification is within the prescribed time limits and includes: ◆ A current, valid license to practice (verification time limit = 180 calendar days). ◆ A valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (effective at the time of the credentialing decision). ◆ Education and training, including board certification, if applicable (verification of the highest of graduation from medical/ professional school, residency, or board certification [board certification time limit = 180 calendar days]). ◆ Work history (verification time limit = 365 calendar days) (non-primary verification—most recent 5 years). ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (verification time limit = 180 calendar days). NCQA CR3—Elements A and B	**Documents:** 1.) Colorado Health Care Professional Credentials Application and attached internal checklist (Standard VIII_Q2M_2_Colorado Health Care Professional Credentials Application.pdf) 2.) Provider Credentialing Checklist (Standard VIII_Q2E_3_Provider Credentialing Checklist.pdf) 3.) Provider Recredentialing Checklist (Standard VIII_Q2E_5_Provider Recredentialing Checklist.pdf) Checklist to Provider (Checklist for Credentialing) **Narrative:** The Colorado Health Care Professional Credentials Application is used, which includes on Page 3, the list of documents that should be included with the application. We also provide a checklist to providers which lists the documents that must be included: valid license, DEA certificate, education and training certificates, work history, professional claims history. Our verification time limit is 180 days which is also listed on the letter we send with application materials. A checklist is provided to the provider to ensure that all necessary and required items are provided to Colorado Choice for the credentialing / recredentialing process. An internal checklist is prepared and reviewed to ensure the criteria were met for credentialing / recredentialing.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The policy included the NCQA-compliant time limits for primary source verification of each element. On-site review of 10 credentialing records demonstrated that 9 of 9 applicable records reviewed were compliant with this element. In one file, the application and attestation was dated 10 days after the credentialing date; therefore, verification time limits could not be measured. HSAG recommends that Colorado Choice ensure presence of application and attestation in the applicant's file prior to credentialing committee review and approval.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: None.		
6. Practitioners complete an application for network participation (at initial credentialing and recredentialing) that includes a current and signed attestation and addresses the following: ◆ Reasons for inability to perform the essential functions of the position, with or without accommodation. ◆ Lack of present illegal drug use. ◆ History of loss of license and felony convictions. ◆ History of loss or limitation of privileges or disciplinary actions. ◆ Current malpractice/professional liability insurance coverage (minimums = physician—.5mil/1.5mil; facility—.5mil/3mil), ◆ The correctness and completeness of the application. NCQA CR4—Element A NCQA CR7—Element C C.R.S.—13-64-301-302	**Documents:** 1.) Colorado Health Care Professional Credentials Application, Pages 26, 25, 20 Section F, 20, 17, 21, respectively (Standard VIII_Q2M_2_Colorado Health Care Professional Credentials Application.pdf) **Narrative:** These attestations are included in the Colorado Health Care Professionals credentials application prepared by the Colorado Division of Insurance.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Colorado Health Care Professionals credentials application contained all of the required components. Review of 10 credentialing records and 10 recredentialing records demonstrated that 19 of 20 records were compliant with this requirement. In one credentialing file, the application and attestation was dated 10 days after the credentialing date.		
Required Actions: Colorado Choice must ensure that each applicant has signed an application and attestation at the time of credentialing.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor verifies the following sanction activities for initial credentialing and recredentialing: ◆ State sanctions, restrictions on licensure or limitations on scope of practice. ◆ Medicare and Medicaid sanctions. *42CFR438.610(b)(3)* NCQA CR5—Element A NCQA CR7—Element D	**Documents:** 1.) Credentialing and Recredentialing, Policy and Procedure No. 3300 (Standard VIII_Q1_1_Credentialing and Recredentialing, 3300.pdf) 2.) Ongoing Monitoring of Participating Providers, Policy and Procedure No. 3302 (Standard VIII_Q2Q_1_Ongoing Monitoring of Participating Providers, 3302.pdf) **Narrative:** DORA and CMS sanctions are checked in the credentialing / recredentialing process. A notebook of sanctions is kept in the Medical Department showing all sanctions and actions.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing policy included the process for verification of sanction activities at credentialing and recredentialing. On-site review of 10 credentialing records and 10 recredentialing records demonstrated that each file contained evidence of verification of Medicare, Medicaid, and State sanction activity.		
Required Actions: None.		
8. The Contractor has a process to ensure that the offices of all practitioners meet its office-site standards. The organization sets standards and performance thresholds for: ◆ Physical accessibility. ◆ Physical appearance. ◆ Adequacy of waiting and examining room space. ◆ Adequacy of treatment record-keeping. NCQA CR6—Element A	**Documents:** N/A **Narrative:** Current policy does not require this, will update in the future to comply with current regulations.	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: There was no policy that addressed office quality site visits. Colorado Choice staff members confirmed that there was no process in place to perform site visits based on office site quality thresholds.		
Required Actions: Colorado Choice must develop a process to ensure offices of all practitioners meet its office-site standards. Colorado Choice must set its own standards and thresholds for performance.		
9. The Contractor implements appropriate interventions by: ◆ Conducting site visits of offices about which it has received member complaints. ◆ Instituting actions to improve offices that do not meet thresholds. ◆ Evaluating effectiveness of the actions at least every six months, until deficient offices meet the thresholds. ◆ Continually monitoring member complaints for all practitioner sites and performing a site visit within 60 days of determining a complaint threshold was met. ◆ Documenting follow-up visits for offices that had subsequent deficiencies. NCQA CR6—Element B	**Documents:** 1.) Reason Tool (Standard VIII_Q9_1_Reason Tool.pdf) **Narrative:** Colorado Choice records all complaints (grievances) in the customer service module in our Xpress operating system. There is an individual grievance reason code for "grievances on physical address" (G90) that would be assigned in such a circumstance. The calls are monitored monthly, in order to ensure proper assignment of codes. Current policy only requires an investigation into grievances. We will update in the future to comply with current regulations.	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: Colorado Choice's processes do not address office site quality.		
Required Actions: Colorado Choice must develop a process to ensure offices of all practitioners meet its office-site standards. The policy must address when site visits are indicated and actions are to be taken when offices do not meet Colorado Choice's standards.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor formally recredentials its practitioners (at least every 36 months) through information verified from primary sources. The information is within the prescribed time limits and includes: ◆ A current, valid license to practice (verification time limit = 180 calendar days). ◆ A valid DEA or CDS certificate (effective at the time of recredentialing). ◆ Board certification (verification time limit = 180 calendar days). ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (verification time limit = 180 calendar days). NCQA CR7—Elements A and B NCQA CR8— Element A	**Documents:** 1.) Credentialing and Recredentialing, Policy and Procedure No. 3300 (Standard VIII_Q1_1_Credentialing and Recredentialing, 3300.pdf) 2.) Colorado Health Care Professional Credentials Application, Page 3 (Standard VIII_Q2M_2_Colorado Health Care Professional Credentials Application.pdf) 3.) Provider Recredentialing Checklist (Standard VIII_Q2E_5_Provider Recredentialing Checklist.pdf) 4.) Provider Recredentialing Application Log (Standard VIII_Q2E_4_Provider Recredentialing Application Log.pdf) **Narrative:** Colorado Choice uses same format for recredentialing as credentialing and primary sources are validated.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Colorado Choice's policy addressed recredentialing practitioners every 36 months and the verification time frames for recredentialing. On-site review of 10 recredentialing records demonstrated that verification time limits were met for 10 of 10 records, but that in 6 of 10 records, the recredentialing was not completed within the 36-month time frame.		
Required Actions: Colorado Choice must ensure that practitioners are recredentialed with 36 months of the initial credentialing or the previous recredentialing date.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of (organizational) providers with which it contracts, which include: 11.A. The Contractor confirms that the provider is in good standing with State and federal regulatory bodies. NCQA CR11—Element A1	**Documents:** N/A **Narrative:** Current policy does not require this, will update in the future to comply with current regulations.	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: Colorado Choice did not have policies that addressed assessment of organizational providers. On-site, Colorado Choice staff confirmed that there were few processes in place to assess organizational providers.		
Required Actions: Colorado Choice must develop policies, procedures, and processes for adequately assessing organizational providers with which it contracts.		
11.B. The Contractor confirms that the provider has been reviewed and approved by an accrediting body. NCQA CR11—Element A2	**Documents:** N/A **Narrative:** Current policy does not require this, will update in the future to comply with current regulations.	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: Colorado Choice did not have policies that addressed assessment of organization providers. On-site, Colorado Choice staff provided evidence that it had begun requesting accreditation certificates from some organizational providers.		
Required Actions: Colorado Choice must develop policies, procedures, and processes that address verification of whether the organizational provider has been reviewed and approved by an accrediting body.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11.C. The Contractor conducts an on-site quality assessment if there is no accreditation status. NCQA CR11—Element A3	**Documents:** N/A **Narrative:** Current policy does not require this, will update in the future to comply with current regulations.	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: Although Colorado Choice had a policy that addressed assessment of credentialing delegates, the policy did not address organizational provider assessment.		
Required Actions: Colorado Choice must develop policies, procedures, and processes to conduct on-site quality assessments for nonaccredited organizational providers.		
11.D. The Contractor confirms at least every three years that the organizational provider continues to be in good standing with State and federal regulatory bodies, and if applicable, is reviewed and approved by an accrediting body. The Contractor conducts a site visit every three years if the organizational provider has no accreditation status. NCQA CR11—Element A	**Documents:** N/A **Narrative:** Current policy does not require this, will update in the future to comply with current regulations.	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: Colorado Choice did not have policies that addressed assessment of organization providers.		
Required Actions: Colorado Choice must develop policies and procedures for the assessment of organizational providers that include the process for assessing providers at least every three years.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11.E. The Contractor's policies list the accrediting bodies the Contractor accepts for each type of organizational provider. (If the Contractor only contracts with organizational providers that are accredited, the Contractor must have a written policy that states it does not contract with nonaccredited facilities.) NCQA CR11—Element A	**Documents:** N/A **Narrative:** Current policy does not require this, will update in the future to comply with current regulations.	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: Colorado Choice did not have policies that addressed assessment of organization providers.		
Required Actions: Colorado Choice must develop policies and procedures for the assessment of organizational providers that list the accrediting bodies the Contractor accepts for each type of organizational provider.		
12. The Contractor has a selection process and assessment criteria for each type of nonaccredited organizational provider with which the Contractor contracts. NCQA CR11—Element A	**Documents:** N/A **Narrative:** Current policy does not require this, will update in the future to comply with current regulations.	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: Colorado Choice did not have policies that addressed assessment of organization providers.		
Required Actions: Colorado Choice must develop a selection process and assessment criteria for each type of nonaccredited provider with which it contracts.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. Site visits for nonaccredited facilities include a process for ensuring that the provider credentials its practitioners. NCQA CR11—Element A	**Documents:** N/A **Narrative:** Colorado Choice does credential our participating providers. Colorado Choice also does credentialing audits on organizational providers that credential their own providers of which a delegation agreement is in place for credentialing. Current policy does not require site visits for non-accredited facilities. Colorado Choice will update in the future to comply with current regulations.	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: Colorado Choice did not have policies that addressed assessment of organization providers.		
Required Actions: Colorado Choice must develop policies and procedures for the assessment of organizational providers that describe how Colorado Choice will ensure that each organizational provider credentials its practitioners.		
14. If the Contractor chooses to substitute a CMS or State review in lieu of the required site visit, the Contractor must obtain the report from the organizational provider to verify that the review has been performed and that the report meets its standards. (CMS or State review or certification does not serve as accreditation of an institution.) A letter from CMS or the applicable State agency which shows that the facility was reviewed and indicates that it passed inspection is acceptable in lieu of the survey report if the organization reviewed and approved the CMS or State criteria as meeting the organization's standard. NCQA CR11—Element A	**Documents:** N/A **Narrative:** Current policy does not require this, will update in the future to comply with current regulations.	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: Colorado Choice did not have policies that addressed assessment of organization providers.		
Required Actions: Colorado Choice must develop policies and procedures for the assessment of organizational providers that state whether Colorado Choice will accept substitution of a CMS or State review in lieu of the required site visit, and if so, the process for doing so.		
15. The Contractor's organizational provider assessment policies and process include assessment of at least the following medical providers: ◆ Hospitals. ◆ Home health agencies. ◆ Skilled nursing facilities. ◆ Free-standing surgical centers. NCQA CR11—Element B	**Documents:** N/A **Narrative:** Current policy does not require this, will update in the future to comply with current regulations.	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: Colorado Choice did not have policies that addressed assessment of organization providers.		
Required Actions: Colorado Choice must develop policies and procedures for the assessment of organizational providers that address each type of medical facility with which Colorado Choice contracts.		
16. The Contractor's organizational provider assessment policies and process include assessment of at least the following behavioral health and substance abuse settings: ◆ Inpatient. ◆ Residential. ◆ Ambulatory. NCQA CR11—Element C	**Documents:** N/A **Narrative:** Current policy does not require this, will update in the future to comply with current regulations.	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: Colorado Choice did not have policies that addressed assessment of organization providers.		
Required Actions: Colorado Choice must develop policies and procedures for the assessment of organizational providers that address each type of behavioral health facility with which Colorado Choice contracts.		
17. The Contractor has documentation that it has assessed contracted medical health care (organizational) providers. NCQA CR11—Element D	**Documents:** N/A **Narrative:** Colorado Choice does maintain documentation on the credentialing assessment of organizational providers. Files available for review upon request.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Colorado Choice had begun maintaining a file that included accreditation certificates for some of the organizational providers with which Colorado Choice contracts.		
Required Actions: Colorado Choice must maintain a file for each organizational provider with which it contracts that contains each of the required elements (documentation of good standing with federal and State regulatory bodies, accreditation status, site visits completed, and monitoring performed).		
18. If the Contractor delegates any NCQA-required credentialing activities, there is evidence of oversight of the delegated activities. NCQA CR12	**Documents:** 2.) Credentialing Delegation Agreement – Valley Wide (Standard VIII_Q18_1_Credentialing Delegation Agreement – Valley Wide.pdf) 3.) Credentialing Delegation Agreement – UPI (Standard VIII_Q18_2 Credentialing Delegation Agreement – UPI.pdf) 4.) Delegation of Provider Credentialing, Policy and Procedure No. 3301 (Standard VIII_Q2F_1_Delegation of Provider Credentialing, 3301.pdf).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Narrative: Colorado Choice has two active delegation agreements in place (Valley Wide and UPI). Colorado Choice follows the delegation of provider credentialing policy No. 3301 to ensure oversight. Completed audit logs of organizational provider credentialing assessments are kept and available for review.	
Findings: Colorado Choice maintained documentation of monitoring (receipt of periodic reports and annual audits) of activities perform by the two credentialing delegates (Valley Wide and University Physicians Incorporated [UPI]).		
Required Actions: None.		
19. The Contractor has a written delegation document with the delegate that: ◆ Is mutually agreed upon. ◆ Describes the responsibilities of the Contractor and the delegated entity. ◆ Describes the delegated activities. ◆ Requires at least semiannual reporting by the delegated entity to the Contractor. ◆ Describes the process by which the Contractor evaluates the delegated entity's performance. ◆ Describes the remedies available to the Contractor (including revocation of the contract) if the delegate does not fulfill its obligations. NCQA CR12—Element A	**Documents:** 1.) Credentialing Delegation Agreement – Valley Wide (Standard VIII_Q18_1_Credentialing Delegation Agreement – Valley Wide.pdf) 2.) Credentialing Delegation Agreement – UPI (Standard VIII_Q18_2 Credentialing Delegation Agreement – UPI.pdf) **Narrative:** Colorado Choice has executed credentialing delegation agreements in place with Valley Wide and University Physicians.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: On-site, Colorado Choice provided copies of signed agreements for both credentialing delegates. The agreements described the activities delegated and responsibilities of Colorado Choice and the delegate. The agreements did not specify reporting requirements, how Colorado Choice will evaluate the delegate, or remedies available for insufficient performance of delegated activities.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: Colorado Choice must amend the delegation agreements to include each of the required provisions.		
20. If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes: ◆ A list of allowed use of PHI. ◆ A description of delegate safeguards to protect the information from inappropriate use or further disclosure. ◆ A stipulation that the delegate will ensure that subdelegates have similar safeguards. ◆ A stipulation that the delegate will provide members with access to their PHI. ◆ A stipulation that the delegate will inform the Contractor if inappropriate uses of the information occur. ◆ A stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends. NCQA CR12—Element B	**Documents:** N/A **Narrative:** Colorado Choice's delegation agreement does not use PHI.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: During the on-site interview, Colorado Choice staff clarified that the delegates made credentialing decisions and therefore used member level complaint information. Staff also reported that Colorado Choice had a HIPAA-compliant Business Associate agreement with each delegate.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
21. The Contractor retains the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision making. This right is reflected in the delegation agreement. NCQA CR12—Element C	**Documents:** 1.) Credentialing Delegation Agreement – Valley Wide, Page 1 (Standard VIII_Q18_1_Credentialing Delegation Agreement – Valley Wide.pdf) 2.) Credentialing Delegation Agreement – UPI, Page 1 (Standard VIII_Q18_2 Credentialing Delegation Agreement – UPI.pdf) **Narrative:** The delegation agreement with the individual provider organization gives the right to Colorado Choice to approve, suspend or terminated individual practitioners and providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The delegation agreement with each delegate included the provision that Colorado Choice retains the right to approve, suspend, and terminate individual practitioners and providers		
Required Actions: None.		
22. For delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity before the delegation document was signed. NCQA CR12—Element D	**Documents:** N/A **Narrative:** Colorado Choice has no new delegation agreements that have been entered into in the last 12 months.	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Findings: Not Applicable.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
23. For delegation agreements in effect 12 months or longer, the Contractor audits credentialing files against NCQA standards for each year that the delegation has been in effect. NCQA CR12—Element E	**Documents:** 1.) Delegation of Provider Credentialing, Policy and Procedure N. 3301 (Standard VIII_Q2F_1_Delegation of Provider Credentialing, 3301.pdf) **Narrative:** Colorado Choice follows Policy 3301, delegation of Provider Credentialing.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: On-site, HSAG reviewed the completed 2012 credentialing file audits for Valley Wide and UPI.		
Required Actions: None.		
24. For delegation arrangements in effect 12 months or longer, the Contractor performs an annual substantive evaluation of delegated activities against NCQA standards and organization expectations. NCQA CR12—Element F	**Documents:** N/A **Narrative:** Current policy does not require this, will update in the future to comply with current regulations.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: On site, HSAG reviewed annual audits for both delegates. The annual audits included a review of the delegate's credentialing policies and procedures.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
25. For delegation arrangements in effect 12 months or longer, the Contractor evaluates regular reports (at least semiannually). NCQA CR12—Element G	**Documents:** N/A **Narrative:** Current policy does not require this, will update in the future to comply with current regulations.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: On-site, Colorado Choice provided evidence of having received regular reports from credentialing delegates.		
Required Actions: None.		
26. The Contractor identifies and follows up on opportunities for improvement, if applicable. NCQA CR12—Element H	**Documents:** N/A **Narrative:** Colorado Choice will use this opportunity to improve.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: On-site review of delegate audits revealed that, in one case (Valley Wide), Colorado Choice followed up on adverse audit findings and requested corrective action. In another case (UPI) there was no evidence of follow-up or corrective action following an adverse audit finding.		
Required Actions: Colorado Choice must develop a process to ensure follow-up on delegates' opportunities for improvement, based on monitoring activities.		

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	19	X	1.00	=	19
	Partially Met	=	17	X	.00	=	0
	Not Met	=	13	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	49	**Total Score**		=	19

Total Score ÷ Total Applicable	=	39%

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an ongoing Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. 42CFR438.*240*(a) Contract: Exhibit A—2.9	**Documents:** 1.) Quality Management Program 2013. (Standard X_Q1_1_Quality Management Program 2013.pdf) **Narrative:** Colorado Choice's Quality Management Program is reviewed and updated annually. The Medical Department analyzes the quality progress and amends as needed. It is then reviewed by the "Committee of the Whole", where a recommendation is made to the Colorado Choice Board of Directors, who ultimately approves, denies or amends the Quality Management Program.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Findings:
The Quality Management (QM) Program Description stated that the Colorado Choice Board of Directors designated oversight of the QM program to the Committee of the Whole, which consisted of a cross-section of participating providers and meets no less than eight times per year. The QM Program Description stated that the Board of Directors reviews and approves the QM Program, annual evaluation report, and proposed plans for the coming year annually. The QM Program applies to all Colorado Choice lines of business (Medicare, CHP+, and commercial). The QM Program Description delineated three primary components of the program: utilization management (UM), peer review activities, and QM projects. The QM Program description outlined processes for review and corrective action for each component. The program description also included review of grievances and appeals, provider credentialing, and member survey results. The program description stated that QM projects are primarily defined through national priorities, systematic review of records, or mandatory review of specific adverse events that indicate opportunities for improvement and are financially feasible to pursue. Selection of performance monitoring indicators that track progress toward specific QM project goals was also described. Staff stated that the small size of the CHP+ population and the wide distribution of members within the rural and geographically large Colorado Choice service area required that much of the quality improvement (QI) monitoring be conducted on an individual case basis and/or that CHP+ member data be combined with the QI monitoring data from other lines of business. The Committee of the Whole (QI oversight) meeting minutes did not include any detailed descriptions of the committee's periodic review and analysis of the QI outcomes, or QI annual evaluation or work plan. Meeting minutes indicated that the committee primarily conducted peer review of individual cases and credentialing committee activities.

During the on-site interview, staff stated that the medical director and QI director review all quality data including results of the asthma and teenage depression screening performance improvement projects (PIPS), quarterly review of claims-based readmission data, and compliance with flu immunizations. Staff stated that Colorado Choice was pursuing an outside vendor to assist with Healthcare Effectiveness Data and Information Set (HEDIS®) measurement. Colorado Choice staff members described recent medical and QI staff turnover and acknowledged the need to revise QI operations and processes.

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: Although Colorado Choice had a written Quality Management Program Description, there was no evidence that it implemented the essential components of an ongoing quality assessment and improvement program. Colorado Choice must designate a QI oversight committee with a defined accountability structure and ensure that the committee reviews the results of ongoing quality performance measures, survey results, outcomes of focus studies, and other quality data. The committee meeting minutes should include conclusions and recommendations for improvement to impact indicators of the quality of care for members. The QI oversight committee should review and endorse overall program direction.		
2. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42CFR438.240(b)(3)* Contract: Exhibit A—2.9.4.4	**Documents:** 1.) Quality Management Program 2013, Page 7, Letter V, A. (Standard X_Q1_1_Quality Management Program 2013.pdf) **Narrative:** Overutilization is detected through the review process (outpatient and ER), referral process, and authorization process. Underutilization is detected through the Quality Improvement Projects and the case management program. Data can be pulled by the IT department upon staff request.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The QM Program Description stated that patterns of overutilization and underutilization are identified through the routine UM review of referrals, authorizations, and hospital admissions and emergency department (ED) visits. Summaries of the review results are presented to the board of directors monthly. The UM Program Description addressed the various methods of monitoring and intervening to control overutilization or inefficiencies in care. Committee of the Whole meeting minutes included a report of the number of authorization requests that were approved or denied, but no detailed results. During the on-site interview, staff described the review of a 90-day compliance report regarding member use of continuous positive airway pressure (CPAP) equipment as an example of monitoring for underutilization of services. Staff stated that underutilization may also be identified through the case management of individual members. Staff provided sample reports of claims data related to inpatient days and ED visits, which are monitored by QI staff and the medical director. There was no evidence of ongoing review or reporting of utilization data or analysis of utilization patterns or trends.		
Required Actions: Colorado Choice must develop a mechanism for systematic monitoring of utilization patterns with reporting of results to the QI oversight committee(s).		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis. The annual QAPI report describes: ◆ The specific preventive care priorities, and services covered in and goals of the program over the prior 12-month period. ◆ The status and results of each PIP started, continuing, or completed during the prior 12-month period. ◆ The results of member satisfaction surveys completed during the prior 12-month period. ◆ A detailed description of the findings of the program impact analysis. ◆ Techniques used by the Contractor to improve performance. ◆ The overall impact and effectiveness of the QAPI Program during the prior 12-month period. *42CFR438.240(e)(2)* Contract: Exhibit A—2.9.4.7, 4.7.2.1 (RMHP—4.6.2.1)	**Documents:** 1.) Quality Management Program – Attachment J (Standard X_Q1_1_Quality Management Program 2013.pdf) **Narrative:** An annual evaluation of the quality management program is conducted by the medical department. The CHP+ PIP / Healthy Living Initiative are evaluated quarterly by the medical department and provided to CHP+ upon contracting deliverables. Satisfaction survey results will be presented to the "Committee of the Whole" on an annual basis as well.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Findings:
The QM Program Description included, as an attachment, the annual evaluation of quality and utilization management projects for 2012, which described the various areas of focus, objectives, and activities or interventions implemented for all lines of business. CHP+ members were included in the general population of Colorado Choice members for QM activities. The report stated that more effective disease management of chronic conditions "was encouraged," and Colorado Choice participated in the Healthy Livings Initiative PIPs for depression screening and Asthma for CHP+ members. The report did not describe or contain data or findings and analysis related to many of the QM activities and did not include assessment of the overall impact and effectiveness of the QI program. Many projects were ongoing or evolving and did not include definitive quality improvement goals or measures. The report also did not include assessment of member survey results.

While it was premature to have an annual CHP+-specific report due to the CHP+ contract effective date of July 2012, Colorado Choice's current evaluation and impact analysis format and report structure does not meet the standards for quality program impact analysis.

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: Colorado Choice must develop an annual report format and reporting structure that includes all of the elements of the requirement, including documented conclusions and recommendations related to the impact of QI activities.		
4. The Contractor shall adopt practice guidelines for the following: ◆ Perinatal, prenatal, and postpartum care for women. ◆ Conditions related to persons with a disability or special health care needs. ◆ Well child care. Contract: Exhibit A—2.9.2.1	**Documents:** 1.) Milliman guidelines, www.careguidelines.com **Narrative:** Interactions with providers and the administration/authorization of members' care are guided by Milliman Guidelines criteria.	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: The UM Program Description stated that Colorado Choice uses Milliman Care Guidelines and clinical practice guidelines as accessed through the Milliman Web site to guide utilization review decision-making. Colorado Choice did not provide evidence of the adoption or use of clinical practice guidelines related to pregnancy, well-child care, or conditions related to persons with special health care needs.		
Required Actions: Colorado Choice must provide evidence that clinical practice guidelines have been adopted for the conditions outlined in the requirement.		
5. The Contractor ensures that practice guidelines comply with the following requirements: ◆ Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. ◆ Consider the needs of the Contractor's members. ◆ Are adopted in consultation with contracting health care professionals. ◆ Are reviewed and updated annually. *42CFR438.236(b)* Contract: Exhibit A—2.9.2.1.2	**Documents:** 1.) Milliman guidelines, www.careguidlines.com **Narrative:** Milliman Guidelines are established with the most current evidence based information. References are readily available on all guidelines for accuracy and further research.	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: Staff stated, and the Milliman Web site confirmed, that Milliman practice guidelines are developed with national-level professional expertise and input and are evidence-based. HSAG noted that Milliman guidelines provide guidance for UM decision-making and are not used to provide clinical practice guidance to health care professionals for the clinical care of members.		
Required Actions: Colorado Choice must develop a process/procedure for the adoption of clinical practice guidelines (beyond the application of Milliman guidelines for UM decisions) that are evidence-based, consider the needs of the Colorado Choice members, consider the input of Colorado Choice health care professionals, and are reviewed and updated annually.		
6. The Contractor disseminates the guidelines to all affected providers, and upon request, to members, potential members, and the public, at no cost. *42CFR438.236(c)* Contract: Exhibit A—2.9.2.1.3	**Documents:** N/A **Narrative:** The guidelines used to make decisions are available upon request to anyone. When denials are processed, the guidelines are provided to the member to demonstrate where the decision has been generated.	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: Staff stated that guidelines used in UM decision-making are distributed to the member when an authorization for services is denied, and that anyone may request a copy of UM guidelines. Colorado Choice did not have the required clinical practice guidelines.		
Required Actions: Colorado Choice must define and implement a process for the dissemination of clinical care guidelines, once developed, to providers, members, and the public.		
7. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42CFR438.236(d)* Contract: Exhibit A—2.9.2.1.4	**Documents:** 1.) Milliman guidelines, www.careguidelines.com **Narrative:** Milliman Guidelines are utilized for all referrals and authorizations prior to approval or denial. The Medical Director and UR Nurse verify and research on case by case basis.	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: The UM Program Description stated that Colorado Choice uses Milliman Care Guidelines to guide utilization review decision-making and coverage of services. Colorado Choice did not have the required clinical practice guidelines.		
Required Actions: Colorado Choice must define a mechanism for ensuring that any adopted clinical practice guidelines are considered in any utilization management decisions, member education materials, or other operating process to which the guidelines apply.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42CFR438.242(a)* Contract: Exhibit A—2.9.4.10	**Documents:** N/A **Narrative:** Information Technologies personnel are available for consultation as needed to retrieve necessary data for analysis and integration into care. Colorado Choice uses the Xpress Operating System through Health Trio to collect, report, and maintain data. Upon request, data can be pulled from the system for analysis.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Staff stated that Colorado Choice uses the Health Trio information system (IS) to collect, maintain, and report data. The Quality and Utilization Management Program Projects 2012 report (the annual evaluation report) stated that Colorado Choice has been working toward defining a more robust set of routine and query reporting from the claims database and CM system and working with the IS vendor to improve access to reports. During the on-site interview, staff provided an online demonstration of the Health Trio IS that demonstrated integration of data from enrollment files, the claims database, authorization and referral information, and the case management system. Staff also provided sample reports of data from the claims database used in QI monitoring processes and stated that the ad-hoc queries reporting system is user-friendly. Staff stated that member grievance and appeal information was tracked in a separate database. Staff also demonstrated that the Connect system application allows provider access to claims history and diagnostic information or any member-specific information maintained in the system through the online provider portal.		
Required Actions: None.		
9. The Contractor collects data on member and provider characteristics and on services furnished to members. *42CFR438.242(b)(1)* Contract: Exhibit A—2.9.4.10.2	**Documents:** N/A **Narrative:** Colorado Choice uses Xpress Operating System through Health Trio to collect and maintain data on members, providers, and services provided.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: During the on-site interview, staff stated that the Health Trio IS collects information on member and provider characteristics and services provided to members. Colorado Choice collects member demographic information through the enrollment files, provider characteristics through the provider contracting and credentialing files, and a multitude of service data through the claims database.		
Required Actions: None.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor monitors member perceptions of accessibility and adequacy of services provided. Tools shall include: ◆ Member surveys (Consumer Assessment of Healthcare Providers and Systems [CAHPS]). ◆ Anecdotal information. ◆ Grievance and appeals data. ◆ Enrollment and disenrollment information. Contract: Exhibit A—2.9.4.3.2, 2.9.4.3.1	**Documents:** N/A **Narrative:** Colorado Choice's calls are monitored on a monthly basis by the compliance department to ensure that calls are accurately being coded into the customer service module. Appeals and Grievance data is reported on a quarterly basis to CHP+ per contract deliverables. Appeals and grievances are maintained in the operating system (Xpress) in the customer service module which logs all member and provider calls. Enrollment and disenrollment is also tracked in Xpress. Upon notice from CHP+ Colorado Choice will add or term members. CAHPS are conducted on an annual basis. The last CHP+ CAHPS was completed in 2011 and conducted by CHP+ with the results being reported to Colorado Choice upon completion.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Staff stated that member grievances are recorded and maintained in the customer service module of the Xpress operating system. Staff reported that Colorado Choice receives results from the CHP+ CAHPS satisfaction survey. During the on-site interview, staff confirmed that Colorado Choice receives data on member perceptions as outlined in the requirement, but it does not review or act on the results. Staff stated that the small size of the CAHPS survey sample inhibits the analysis of results for CHP+ members.		
Required Actions: Colorado Choice must submit evidence that member perceptions of access and availability, as measured by member surveys, grievance data, and enrollment/disenrollment information, are monitored and reviewed, and that results and recommendations are documented in QI oversight committee meeting minutes. Colorado Choice does not need to analyze results specifically for the CHP+ population if the small CHP+ population is included in the overall data and there is valid analysis and corrective action, if indicated.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor develops a corrective action plan when members report statistically significant levels of dissatisfaction, when a pattern of complaint is detected, or when a serious complaint is reported. Contract: Exhibit A—2.9.4.3.5	**Documents:** N/A **Narrative:** Compliance reviews the appeals and grievances data for patterns and to ensure issues were resolved. Most grievance issues revolve around enrollment / disenrollment issues.	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: Staff stated that the Compliance Department reviews grievance and appeals data to identify any patterns or significant complaints, and that most member grievances were related to the enrollment and disenrollment process. Colorado Choice did not provide evidence of a grievance summary report or analysis. Committee of the Whole meeting minutes did not include review of member survey data, patterns of grievances, or document analysis for the presence of potential quality of care concerns identified through grievances. Colorado Choice did not submit a written procedure related to review of member grievance data for CHP+ members.		
Required Actions: Colorado Choice must define a process for the review of serious member complaints, patterns of complaints, and member survey data, and the process to develop corrective action when indicated. Colorado Choice must also submit evidence of committee review, recommendations, and conclusions related to member complaints, including any applicable actions taken.		

Results for Standard X—Quality Assessment and Performance Improvement							
Total	Met	=	2	X	1.00	=	2
	Partially Met	=	4	X	.00	=	0
	Not Met	=	5	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	11	**Total Score**		=	4

Total Score ÷ Total Applicable	=	18%

The completed record review tools follow this cover page.

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix B. Colorado Department of Health Care Policy and Financing
Credentialing Record Review Tool
for Colorado Choice Health Plan

Reviewer:	Rachel Henrichs	**Review Period:**	January 1, 2009, through December 31, 2012
Participating Plan Staff Member:	Cindy Palmer	**Date of Review:**	January 11, 2013

SAMPLE	**1**		**2**		**3**		**4**		**5**		**6**		**7**		**8**		**9**		**10**	
Provider ID#	S0438501		S0569101		S0709101		S0708701		S0005601		E0127101		S0006402		E0129501		S0684601		S0732501	
Provider Type (MD, PhD, NP, PA, MSW, etc.)	MD		MD		MD		MD		MD		PA-C		DO		PA-C		MD		MD	
Application Date	1/6/10		2/3/10		2/24/12		3/12/12		9/8/09		9/28/10		11/20/10		10/28/10		5/16/12		4/5/12	
Specialty	IM/Neph		Gen Surgery		Gastro		Gen Surgery		IM/Cardio		Fam Medicine		Cardiology		Orthopedic		Gen Surgery		Internal Med	
Credentialing Date (Committee/Medical Director Approval Date)	2/16/10		4/13/10		5/15/12		8/21/12		1/12/10		11/9/10		4/13/10 11/9/10		1/11/11		8/21/12		5/15/12	
Item	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Initial Credentialing Verification: The contractor, using primary sources, verifies that the following are present:																				
♦ A current, valid license to practice (with verification that no State sanctions exist)	X		X		X		X		X		X		X		X		X		X	
♦ A valid DEA or CDS certificate (if applicable)	X		X		X		X		X		NA		X		NA		X		X	
♦ Credentials (i.e., education and training, including board certification if the practitioner states on the application that he or she is board certified)	X		X		X		X		X		X		X		X		X		X	
♦ Work history	X		X		X		X		X		X		X		X		X		X	
♦ Current malpractice insurance in the required amount (with history of professional liability claims)	X		X		X		X		X		X		X			X	X		X	
♦ Verification that the provider has not been excluded from federal participation	X		X		X		X		X		X		X		X		X		X	
♦ Signed application and attestation	X		X		X		X		X		X			X	X		X		X	
♦ The provider's credentialing was completed within verification time limits (see specific verification element—180/365 days)	X		X		X		X		X		X		NA		X		X		X	
Applicable Elements	**8**		**8**		**8**		**8**		**8**		**7**		**7**		**7**		**8**		**8**	
Point Score	**8**		**8**		**8**		**8**		**8**		**7**		**6**		**6**		**8**		**8**	
Percentage Score	**100**		**100%**		**100%**		**100%**		**100%**		**100%**		**88%**		**88%**		**100%**		**100%**	

Total Record Review Score					**Total Applicable: 77**		**Total Point Score: 75**		**Total Percentage: 97%**	

Notes: The provider for Sample 7 was approved on a provisional basis on 4/13/10. The provider was reviewed again on November 9 and accepted into the network without limitation; however, the only application included in the credentialing file was dated 11/20/10. Since, technically, there was no application on file when the application was approved on November 9, HSAG could not determine if the provider's application was processed within the verification time limits. For Sample 8, the provider's insurance certificate expired 10 days before committee approval.

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix B. Colorado Department of Health Care Policy and Financing
Recredentialing Record Review Tool
for Colorado Choice Health Plan

Reviewer:	Rachel Henrichs	**Review Period:**	January 1, 2009, through December 31, 2012
Participating Plan Staff Member:	Cindy Palmer	**Date of Review:**	January 11, 2013

SAMPLE	1		2		3		4		5		6		7		8		9		10	
Provider ID#	S0033602		S0516601		E0090601		S0030702		S0244602		S0532801		S0593401		S0299201		E0084901		S0404302	
Provider Type (MD, PhD, NP, PA, MSW, etc.)	MD		MD		CNM				MD		MD		MD		MD		CNM		MD	
Application/Attestation Date	3/22/10		7/9/12		7/20/12				5/5/10		6/29/12		5/19/11		4/9/10		9/10/12		4/12/10	
Specialty	Oncology		Ortho Surgery		Midwife				Urology		Ortho Surgery		Pediatrics		Fam Medicine		Midwife		Internal Med	
Last Credentialing/Recredentialing Date	3/13/09		11/10/09		11/10/09				3/17/07		10/13/09		6/8/10		3/13/07		11/10/09		3/13/07	
Recredentialing Date (Committee/Medical Director Approval Date)	4/13/10		11/20/12		1/20/12				5/11/10		11/20/12		8/9/11		5/11/10		11/20/12		5/11/10	
Item	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Recredentialing Verification: The contractor, using primary sources, verifies that the following are present:																				
♦ A current, valid license to practice (with verification that no State sanctions exist)	X		X		X				X		X		X		X		X		X	
♦ A valid DEA or CDS certificate (if applicable)	X		X		X				X		X		X		X		X		X	
♦ Credentials (i.e., verified board certification only if the practitioner states on the recredentialing application that there is new board certification since last credentialing/recredentialing date)	X		X		X				X		X		X		X		X		X	
♦ Current malpractice insurance in the required amount (with history of professional liability claims)	X		X		X				X		X		X		X		X			X
♦ Verification that the provider has not been excluded from federal participation	X		X		X				X		X		X		X		X		X	
♦ Signed application and attestation	X		X		X				X		X		X		X		X		X	
♦ The provider's recredentialing was completed within verification time limits (see specific verification element—180/365 days)	X		X		X				X		X		X		X		X		X	
♦ Recredentialing was completed within 36 months of last credentialing/recredentialing date		X	X		X					X		X	X			X	X			X
Applicable Elements	**8**		**8**		**8**				**8**		**8**		**8**		**8**		**8**		**8**	
Point Score	**7**		**8**		**8**				**7**		**7**		**8**		**7**		**8**		**6**	
Percentage Score	**88%**		**100%**		**100%**				**88%**		**88%**		**100%**		**88%**		**100%**		**75%**	

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix B. Colorado Department of Health Care Policy and Financing
Recredentialing Record Review Tool
for Colorado Choice Health Plan

OVERSAMPLE	1		2		3		4		5											
Provider ID#	E0058402																			
Provider Type (MD, PhD, NP, PA, MSW, etc.)	FNP																			
Application/Attestation Date	9/15/10																			
Specialty	Fam Medicine																			
Last Credentialing/Recredentialing Date	8/14/07																			
Recredentialing Date (Committee/Medical Director Approval Date)	1/11/11																			
Item	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**										
Recredentialing Verification The contractor, using primary sources, verifies that the following are present:																				
♦ A current, valid license to practice (with verification that no State sanctions exist)	X																			
♦ A valid DEA or CDS certificate (if applicable)	X																			
♦ Credentials (i.e., verified board certification only if the practitioner states on the recredentialing application that there is new board certification since last credentialing/recredentialing date)	X																			
♦ Current malpractice insurance in the required amount (with history of professional liability claims)	X																			
♦ Verification that the provider has not been excluded from federal participation	X																			
♦ Signed application and attestation	X																			
♦ The provider's recredentialing was completed within verification time limits (see specific verification element—180/365 days)	X																			
♦ Recredentialing was completed within 36 months of last credentialing/recredentialing date		X																		
Applicable Elements	**8**																			
Point Score	**7**																			
Percentage Score	**88%**																			
Total Record Review Score									**Total Applicable: 80**				**Total Point Score: 73**				**Total Percentage: 91%**			

Notes: Record 4 was for a terminated provider. The record had been archived and was not available for review.
The insurance certificate for Record 9 had expired 10 days before the approval date.

Appendix C. Site Review Participants for Colorado Choice Health Plan

Table C-1 lists the participants in the FY 2012–2013 site review of **Colorado Choice**.

Table C-1—HSAG Reviewers and Health Plan Participants	
HSAG Review Team	**Title**
Barbara McConnell, MBA, OTR	Director, State & Corporate Services
Katherine Bartilotta, BSN	Project Manager
Rachel Henrichs	Project Coordinator
Colorado Choice Participants	**Title**
April Gonzales	Compliance Analyst
Manuela Heredia	Compliance Analyst
Chris Kingston (telephonically)	Utilization Review Lead
Lynne Nash	Nurse Manager
Ashley Palmer (telephonically)	Special Projects
Cindy Palmer	Chief Executive Officer
Lisa Sandival	Chief Financial Officer
Department Observers	**Title**
Teresa Craig (telephonically)	Contract Manager
Russ Kennedy	Quality Compliance Specialist

Appendix D. Corrective Action Plan Process for FY 2012–2013 for Colorado Choice Health Plan

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 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 external quality review site review report via e-mail or through the file transfer protocol (FTP) site, with an e-mail notification regarding the FTP posting to HSAG and the Department. The health plan will submit the CAP using the template provided. For each of the elements 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 or HSAG will notify the health plan via e-mail whether: ◆ The plan has been approved and the health plan should proceed with the interventions as outlined in the plan. ◆ Some or all of the elements of the plan must be revised and resubmitted.
Step 4	**Documentation substantiating implementation**
	Once the health plan has received Department approval of the CAP, the health plan should implement all the planned interventions and submit evidence of such implementation to HSAG via e-mail or the FTP site, with an e-mail notification regarding the posting. The Department should be copied on any communication regarding CAPs.
Step 5	**Progress reports may be required**
	For any planned interventions requiring an extended implementation date, the Department may, based on the nature and seriousness of the noncompliance, require the health plan to submit regular reports to the Department detailing progress made on one or more open elements of the CAP.

Table D-1—Corrective Action Plan Process	
Step 6	**Documentation substantiating implementation of the plans is reviewed and approved**
	Following a review of the CAP and all supporting documentation, the Department or HSAG will inform the health plan as to whether: (1) the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements or (2) the health plan must submit additional documentation. The Department or HSAG will inform each health plan in writing when the documentation substantiating implementation of all Department-approved corrective actions is deemed sufficient to bring the health plan into full compliance with all the applicable federal Medicaid managed care regulations and contract requirements.

The template for the CAP follows.

Table D-2—FY 2012–2013 Corrective Action Plan *for* Colorado Choice					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
Standard III—Coordination and Continuity of Care					
3. The Contractor has a mechanism to ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating covered services furnished to the member. If a member does not select a primary care physician (PCP), the Contractor assigns the member to a PCP or a primary care facility and notifies the member, by telephone or in writing, of his/her facility's or PCP's name, location, and office telephone number.	Colorado Choice does not formally designate a person responsible for coordination of services. Colorado Choice must develop policies, procedures, and processes to designate the party responsible for the member's care coordination. Colorado Choice may want to build on the risk stratification concept discussed in policy and assign the party responsible based on the risk category (for example, lower risk member care coordinated by the PCP, with higher risk care or inpatient care coordinated by Colorado Choice case management staff).				

Table D-2—FY 2012–2013 Corrective Action Plan *for* Colorado Choice					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
4. The Contractor implements procedures to provide an individual needs assessment after enrollment and at any other necessary time, including the screening for special health care needs (e.g., mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems). The assessment mechanisms must use appropriate health care professionals.	The General Initial Assessment template was designed for post-hospitalization assessment and did not include assessment of social or community support needs, mental health needs, cultural needs, functional problems, comprehension problems, or other special health care needs. Colorado Choice did not provide evidence on-site of having completed and documented comprehensive assessments of special health care needs. Colorado Choice must define a comprehensive assessment tool that includes all of the elements referenced in the requirement and document the assessment in the case management record. Colorado Choice must assess its members' health care needs upon enrollment and at any other necessary time (e.g., upon referral to case management).				

Table D-2—FY 2012–2013 Corrective Action Plan *for* Colorado Choice					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
5. The Contractor shares with other health care organizations serving the member with special health care needs, the results of its identification and assessment of that member's needs, to prevent duplication of those activities.	The Case Management Program policy did not address sharing the assessment with other organizations involved in these members' care. Colorado Choice did not provide documentation of having shared assessment of member needs with other health care organizations involved in serving those needs. Colorado Choice must define a process for sharing the assessment of special health care needs with other health care or community organizations serving the member, as appropriate, to prevent duplication of services. Colorado Choice must develop a mechanism to document release of this information.				
6. The Contractor implements procedures to develop an individual treatment plan as necessary.	On-site, Colorado Choice staff described case management activities for three individuals with complex medical needs who were being monitored or				

Table D-2—FY 2012–2013 Corrective Action Plan *for* Colorado Choice					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
	assisted through case management; however, staff did not provide examples of completed treatment plans, as required. Colorado Choice must implement procedures to ensure that an individual care coordination plan is developed and documented in the case management file.				
7. The Contractor's procedures for individual needs assessment and treatment planning are designed to: ◆ Accommodate the specific cultural and linguistic needs of the members. ◆ Allow members with special health care needs direct access to a specialist as appropriate to the member's conditions and needs.	The provider manual instructed providers that members who have purchased the Open Access Rider Benefit may have direct access to a specialist. During the on-site interview, staff clarified that the Open Access Rider Benefit does not apply to CHP+ members. Colorado Choice must revise the provider manual to clearly state that CHP+ members with special health care needs have direct access to specialists.				

Table D-2—FY 2012–2013 Corrective Action Plan *for* Colorado Choice					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
9. The Contractor's procedures include a strategy to ensure that all members and/or authorized family members are involved in treatment planning and consent to medical treatment.	Colorado Choice did not provide evidence of written care plans or documentation of member involvement in the care plan. Colorado Choice must provide documentation demonstrating member involvement and agreement with the care coordination plan.				
Standard IV—Member Rights and Protections					
1. The Contractor has written policies and procedures regarding member rights.	Staff stated that, due to the small size of the CHP+ population, Colorado Choice has not developed written policies and procedures regarding member rights and responsibilities. Colorado Choice must develop written CHP+ policies and procedures related to member rights and responsibilities. The policies and procedures should address all of the components of rights as stated at 42CFR438.100 and in the Colorado CHP+ managed care contract. The				

Table D-2—FY 2012–2013 Corrective Action Plan *for* Colorado Choice					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
	policies and procedures should also address how members and providers are informed of member rights, how Colorado Choice monitors providers to ensure member rights are taken into account when furnishing services, and how Colorado Choice monitors its processes to ensure that members feel free to access rights processes without fear of retaliation.				
2. The Contractor ensures that its staff and affiliated network providers take member rights into account when furnishing services to members.	Member rights statements were not included in any provider documents or communication reviewed. Colorado Choice must develop a method to inform providers of each of the member rights guaranteed under the CHP+ program, and of the expectation that providers take those rights into consideration when furnishing services.				

Table D-2—FY 2012–2013 Corrective Action Plan *for* Colorado Choice					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
3. The Contractor's policies and procedures ensure that each member is treated by staff and affiliated network providers in a manner consistent with the following specified rights: ◆ Receive information in accordance with information requirements (42CFR438.10). ◆ Be treated with respect and with due consideration for his or her dignity and privacy. ◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's	The member handbook outlined the member rights in easy-to-understand language, including the information specified in the requirement, with the exception of the right to be free of restraint or seclusion. The Professional Services Agreement addressed only some of the member rights required by the CHP+ managed care contract. The right to be free from restraint and seclusion as a means of coercion was not addressed in any documents. While the member rights and responsibilities in the member handbook included the right to participate in treatment decisions and refuse treatment, the handbook also included a lengthy discussion that refusal of treatment that is recommended by the provider may result in the member's termination from the CHP+ program. This statement is in conflict with				

Table D-2—FY 2012–2013 Corrective Action Plan *for* Colorado Choice					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
condition and ability to understand. ◆ Participate in decisions regarding his or her health care, including the right to refuse treatment. ◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. ◆ Request and receive a copy of his or her medical records and request that they be amended or corrected. ◆ Be furnished health care services in accordance with requirements for access and	the rights guaranteed by federal health care regulations. During the on-site interview, Colorado Choice staff members stated that the annual letter informing member of their rights was being drafted and had not yet been implemented. Colorado Choice must ensure that each of its applicable documents (policies, member materials, and provider materials) address each of the rights at 42CFR438.100 and in the Colorado CHP+ managed care contract. Colorado Choice must also revise the member handbook to remove the statement that members may be terminated from the CHP+ program. If the member handbook is used for multiple lines of business and the statement in question applies to other lines of business, then separating sections or informing members				

Table D-2—FY 2012–2013 Corrective Action Plan *for* Colorado Choice					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
quality of services (42CFR438.206 and 42CFR438.210).	regarding what does and does not apply to CHP+ members would be acceptable.				
4. The Contractor ensures that each member is free to exercise his or her rights and that exercising those rights does not adversely affect the way the Contractor or its providers treat the member.	HSAG found no evidence of member or provider communications or policies that addressed the member's right to exercise his or her rights without adverse effect on the member's treatment. Colorado Choice must develop member, staff, and provider materials that inform members of their right to exercise their rights (for example, grievance and appeal rights) without adverse effect on the member's treatment.				
Standard VIII—Credentialing and Recredentialing					
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and	While Colorado Choice's policy and procedure named several types of practitioners that Colorado Choice credentials, the policy should be expanded to include and describe each type of practitioner Colorado				

Table D-2—FY 2012–2013 Corrective Action Plan *for* Colorado Choice					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
retention of providers that specify: 2.A. The types of practitioners to credential and recredential. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. (Examples include doctors of medicine [MDs], doctors of osteopathy [DOs], podiatrists, and each type of behavioral health provider).	Choice credentials and recredentials. Colorado Choice must revise its policy to address the credentialing and recredentialing of non-physician practitioners such as nurse practitioners, physician assistants, and behavioral health practitioners (e.g., licensed counselors, social workers, and psychologists).				
2.B. The verification sources used.	Although record review demonstrated that NCQA-compliant verification sources were being used, Colorado Choice's policy did not depict all sources used and what information is obtained from each. Colorado Choice must revise its policy to specify the verification sources used for				

Table D-2—FY 2012–2013 Corrective Action Plan *for* Colorado Choice					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
	primary source verification during credentialing and recredentialing.				
2.C. The criteria for credentialing and recredentialing.	The general criteria statement in the policy is very good; however, it limits the criteria for credentialing to having a medical license. Colorado Choice must expand the policy to clearly describe the criteria for credentialing and recredentialing that addresses each type of practitioner credentialed (e.g., non-physician practitioners).				
2.G. The process for ensuring that credentialing and recredentialing are conducted in a non-discriminatory manner, (i.e., must describe the steps the Contractor takes to ensure that it does not make	A statement that the organization does not discriminate is not sufficient to meet NCQA standards. Colorado Choice must revise its policy to describe prevention (proactive steps to prevent discrimination) and monitoring (tracking and identification of potential discriminatory practices).				

Table D-2—FY 2012–2013 Corrective Action Plan *for* Colorado Choice					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
credentialing and recredentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes).					
2.K. The process for ensuring the confidentiality of all information obtained in the credentialing/ recredentialing process, except as otherwise provided by law.	The policy stated that credentialing files are confidential; however, it did not describe the process used to maintain confidentiality of credentialing and recredentialing records. Colorado Choice must revise the credentialing and recredentialing policy to describe the processes used to ensure the confidentiality of credentialing and recredentialing records.				

Table D-2—FY 2012–2013 Corrective Action Plan *for* Colorado Choice					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
2.L. The process for ensuring that listings in provider directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty.	The policy did not address this requirement. Colorado Choice must revise the policy to describe how Colorado Choice ensures that listings in provider directories and other materials for members are consistent with credentialing data.				
2.O. The right of practitioners, upon request, to receive the status of their application.	While the policy addressed the applicant's right to review and correct the credentialing or recredentialing information, it did not address requests to receive the status of applications unrelated to correcting information. Colorado Choice must revise the policy to specifically address the applicant's right to receive the status of his or her application, unrelated to correcting erroneous information.				

Table D-2—FY 2012–2013 Corrective Action Plan *for* Colorado Choice					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
2.P. The right of the applicant to receive notification of their rights under the credentialing program.	The Colorado Health Care Professional Credentials Application informed practitioners of their rights under the credentialing program; however, the policy did not indicate this. Colorado Choice must revise the policy to state how applicants are informed of their rights under the credentialing program.				
2.Q. How the Contractor accomplishes ongoing monitoring of practitioner sanctions, complaints, and adverse events between recredentialing cycles including: ◆ Collecting and reviewing Medicare and Medicaid sanctions.	While the Quality Improvement Program Description addressed review of grievances and appeals, the discussion did not adequately describe the use of the information related to continuing or changing the terms of a practitioner's participation in the network. In addition, the policy did not address the collection and review of complaints and adverse events during recredentialing. Colorado Choice must revise or				

Table D-2—FY 2012–2013 Corrective Action Plan *for* Colorado Choice					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
◆ Collecting and reviewing sanctions or limitations on licensure. ◆ Collecting and reviewing complaints. ◆ Collecting and reviewing information from identified adverse events. ◆ Implementing appropriate interventions when it identified instances of poor quality related to the above.	develop policies to accurately describe ongoing monitoring for sanction activity and the relationship of collecting and reviewing complaints and adverse events to practitioners' continued participation in the network.				
2.R. The range of actions available to the Contractor against the practitioner (for quality reasons).	Although Colorado Choice's policy did address ongoing monitoring for sanction activity, it did not address the range of actions available against the practitioner for quality reasons, or for inadequate performance. While				

Table D-2—FY 2012–2013 Corrective Action Plan *for* Colorado Choice					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
	Colorado Choice briefly addressed in a program description the range of actions available against practitioners for quality reasons, it must also describe this information in a policy and procedure.				
2.S. If the Contractor has taken action against a practitioner for quality reasons, the Contractor reports the action to the appropriate authorities (including State licensing agencies for each practitioner type and the National Practitioner Data Bank [NPDB]).	Although the provider manual alerted providers that Colorado Choice may report sanctions to the appropriate authorities, this topic was addressed only as it relates to physicians and the Board of Medical Examiners. The policy did not address non-physician practitioners or the process. Colorado Choice must address, in a policy and procedure, the process to report actions taken against practitioners for quality reasons to appropriate authorities. All practitioners must be included and the policy must describe all applicable agencies (such as the Department of Regulatory Agencies [DORA], other non-				

Table D-2—FY 2012–2013 Corrective Action Plan *for* Colorado Choice					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
	physician licensing agencies, and the Department of Health Care Policy and Financing, if applicable.				
2.T. A well-defined appeal process for instances in which the Contractor chooses to alter the conditions of a practitioner's participation based on issues of quality of care or service which includes: ◆ Providing written notification indicating that a professional review action has been brought against the practitioner, reasons for the action, and a summary of the appeal rights and process.	The provider manual described Colorado Choice's appeal process for instances in which it chooses to alter the conditions of a practitioner's participation based on quality of care or service issues; however, the description did not include all of the required components, and it was not described in a policy/procedure. Colorado Choice must develop a policy/procedure to define and describe its appeal process for instances when it chooses to alter the conditions of a practitioner's participation based on quality of care or service issues. The policy must adequately describe all of the required components of an appeal process.				

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◆ Allowing the practitioner to request a hearing and the specific time period for submitting the request. ◆ Allowing at least 30 days after the notification for the practitioner to request a hearing. ◆ Allowing the practitioner to be represented by an attorney or another person of the practitioner's choice. ◆ Appointing a hearing officer or panel of the individuals to review the appeal. ◆ Providing written notification of the appeal decision that contains the specific reasons for the decision.					

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2.U. Making the appeal process known to practitioners.	Although Colorado Choice described the appeal process in its provider manual, its policies did not indicate how providers are informed of the appeal process. Colorado Choice's credentialing policies and procedures must address how providers are informed of the practitioner appeal processes.				
6. Practitioners complete an application for network participation (at initial credentialing and recredentialing) that includes a current and signed attestation and addresses the following: ◆ Reasons for inability to perform the essential functions of the position, with or without accommodation.	In one credentialing file, the application and attestation was dated 10 days after the credentialing date. Colorado Choice must ensure that each applicant has signed an application and attestation at the time of credentialing.				

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Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
◆ Lack of present illegal drug use. ◆ History of loss of license and felony convictions. ◆ History of loss or limitation of privileges or disciplinary actions. ◆ Current malpractice/professional liability insurance coverage (minimums = physician—.5mil/1.5mil; facility—.5mil/3mil), ◆ The correctness and completeness of the application.					

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8. The Contractor has a process to ensure that the offices of all practitioners meet its office-site standards. The organization sets standards and performance thresholds for: ◆ Physical accessibility. ◆ Physical appearance. ◆ Adequacy of waiting and examining room space. ◆ Adequacy of treatment record-keeping.	There was no policy that addressed office quality site visits. Colorado Choice staff members confirmed that there was no process in place to perform site visits based on office site quality thresholds. Colorado Choice must develop a process to ensure offices of all practitioners meet its office-site standards. Colorado Choice must set its own standards and thresholds for performance.				
9. The Contractor implements appropriate interventions by: ◆ Conducting site visits of offices about which it has received	Colorado Choice's processes do not address office site quality. Colorado Choice must develop a process to ensure offices of all practitioners meet its office-site standards. The policy must address when site visits are indicated and actions are				

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Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
member complaints. ◆ Instituting actions to improve offices that do not meet thresholds. ◆ Evaluating effectiveness of the actions at least every six months, until deficient offices meet the thresholds. ◆ Continually monitoring member complaints for all practitioner sites and performing a site visit within 60 days of determining a complaint threshold was met. ◆ Documenting follow-up visits for offices that had subsequent deficiencies.	to be taken when offices do not meet Colorado Choice's standards.				

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Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
10. The Contractor formally recredentials its practitioners (at least every 36 months) through information verified from primary sources. The information is within the prescribed time limits and includes: ◆ A current, valid license to practice (verification time limit = 180 calendar days). ◆ A valid DEA or CDS certificate (effective at the time of recredentialing). ◆ Board certification (verification time limit = 180 calendar days). ◆ A history of professional liability claims that resulted in	On-site review of 10 recredentialing records demonstrated that verification time limits were met for 10 of 10 records, but that in 6 of 10 records, the recredentialing was not completed within the 36-month time frame. Colorado Choice must ensure that practitioners are recredentialed with 36 months of the initial credentialing or the previous recredentialing date.				

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settlements or judgments paid on behalf of the practitioner (verification time limit = 180 calendar days).					
11. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of (organizational) providers with which it contracts, which include: 11.A. The Contractor confirms that the provider is in good standing with State and federal regulatory bodies.	Colorado Choice did not have policies that addressed assessment of organizational providers. On-site, Colorado Choice staff confirmed that there were few processes in place to assess organizational providers. Colorado Choice must develop policies, procedures, and processes for adequately assessing organizational providers with which it contracts.				
11.B. The Contractor confirms that the provider has been reviewed and approved by an accrediting body.	Colorado Choice did not have policies that addressed assessment of organization providers. On-site, Colorado Choice staff provided evidence that it had begun				

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Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
	requesting accreditation certificates from some organizational providers. Colorado Choice must develop policies, procedures, and processes that address verification of whether the organizational provider has been reviewed and approved by an accrediting body.				
11.C. The Contractor conducts an on-site quality assessment if there is no accreditation status.	Although Colorado Choice had a policy that addressed assessment of credentialing delegates, the policy did not address organizational provider assessment. Colorado Choice must develop policies, procedures, and processes to conduct on-site quality assessments for nonaccredited organizational providers.				
11.D. The Contractor confirms at least every three years that the organizational provider continues to be in good standing with State and federal	Colorado Choice did not have policies that addressed assessment of organization providers. Colorado Choice must develop policies and procedures for the assessment of organizational providers that include the process for assessing				

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Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
regulatory bodies, and if applicable, is reviewed and approved by an accrediting body. The Contractor conducts a site visit every three years if the organizational provider has no accreditation status.	providers at least every three years.				
11.E. The Contractor's policies list the accrediting bodies the Contractor accepts for each type of organizational provider. (If the Contractor only contracts with organizational providers that are accredited, the Contractor must have a written policy that states it does not contract with nonaccredited facilities.)	Colorado Choice did not have policies that addressed assessment of organization providers. Colorado Choice must develop policies and procedures for the assessment of organizational providers that list the accrediting bodies the Contractor accepts for each type of organizational provider.				

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Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
12. The Contractor has a selection process and assessment criteria for each type of nonaccredited organizational provider with which the Contractor contracts.	Colorado Choice did not have policies that addressed assessment of organization providers. Colorado Choice must develop a selection process and assessment criteria for each type of nonaccredited provider with which it contracts.				
13. Site visits for nonaccredited facilities include a process for ensuring that the provider credentials its practitioners.	Colorado Choice did not have policies that addressed assessment of organization providers. Colorado Choice must develop policies and procedures for the assessment of organizational providers that describe how Colorado Choice will ensure that each organizational provider credentials its practitioners.				
14. If the Contractor chooses to substitute a CMS or State review in lieu of the required site visit, the Contractor must obtain the report from the organizational provider to verify that	Colorado Choice did not have policies that addressed assessment of organization providers. Colorado Choice must develop policies and procedures for the assessment of organizational providers that state whether Colorado Choice will accept				

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Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
the review has been performed and that the report meets its standards. (CMS or State review or certification does not serve as accreditation of an institution.) A letter from CMS or the applicable State agency which shows that the facility was reviewed and indicates that it passed inspection is acceptable in lieu of the survey report if the organization reviewed and approved the CMS or State criteria as meeting the organization's standard.	substitution of a CMS or State review in lieu of the required site visit, and if so, the process for doing so.				

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Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
15. The Contractor's organizational provider assessment policies and process include assessment of at least the following medical providers: ◆ Hospitals. ◆ Home health agencies. ◆ Skilled nursing facilities. ◆ Free-standing surgical centers.	Colorado Choice did not have policies that addressed assessment of organization providers. Colorado Choice must develop policies and procedures for the assessment of organizational providers that address each type of medical facility with which Colorado Choice contracts.				
16. The Contractor's organizational provider assessment policies and process include assessment of at least the following behavioral health and substance abuse settings: ◆ Inpatient. ◆ Residential. ◆ Ambulatory.	Colorado Choice did not have policies that addressed assessment of organization providers. Colorado Choice must develop policies and procedures for the assessment of organizational providers that address each type of behavioral health facility with which Colorado Choice contracts.				

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17. The Contractor has documentation that it has assessed contracted medical health care (organizational) providers.	Colorado Choice had begun maintaining a file that included accreditation certificates for some of the organizational providers with which Colorado Choice contracts. Colorado Choice must maintain a file for each organizational provider with which it contracts that contains each of the required elements (documentation of good standing with federal and State regulatory bodies, accreditation status, site visits completed, and monitoring performed).				
19. The Contractor has a written delegation document with the delegate that: ◆ Is mutually agreed upon. ◆ Describes the responsibilities of the Contractor and the delegated entity. ◆ Describes the delegated	The delegation agreements did not specify reporting requirements, how Colorado Choice will evaluate the delegate, or remedies available for insufficient performance of delegated activities. Colorado Choice must amend the delegation agreements to include each of the required provisions.				

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Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
activities. ◆ Requires at least semiannual reporting by the delegated entity to the Contractor. ◆ Describes the process by which the Contractor evaluates the delegated entity's performance. ◆ Describes the remedies available to the Contractor (including revocation of the contract) if the delegate does not fulfill its obligations.					
26. The Contractor identifies and follows up on opportunities for improvement, if applicable.	On-site review of the UPI delegate audit revealed that there was no evidence of follow-up or corrective action following an adverse audit finding. Colorado Choice must develop a process to ensure follow-up				

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Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
	on delegates' opportunities for improvement, based on monitoring activities.				
Standard X—Quality Assessment and Performance Improvement					
1. The Contractor has an ongoing Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members.	Although Colorado Choice had a written Quality Management Program Description, there was no evidence that it implemented the essential components of an ongoing quality assessment and improvement program. Colorado Choice must designate a QI oversight committee with a defined accountability structure and ensure that the committee reviews the results of ongoing quality performance measures, survey results, outcomes of focus studies, and other quality data. The committee meeting minutes should include conclusions and recommendations for improvement to impact indicators of the quality of care for members. The QI oversight committee should				

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Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
	review and endorse overall program direction.				
2. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services.	There was no evidence of ongoing review or reporting of utilization data or analysis of utilization patterns or trends. Colorado Choice must develop a mechanism for systematic monitoring of utilization patterns with reporting of results to the QI oversight committee(s).				
3. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis. The annual QAPI report describes: ◆ The specific preventive care priorities, and services covered in and goals of the program over the prior 12-month period.	While it was premature to have an annual CHP+-specific report due to the CHP+ contract effective date of July 2012, Colorado Choice's current evaluation and impact analysis format and report structure does not meet the standards for quality program impact analysis. Colorado Choice must develop an annual report format and reporting structure that includes all of the elements of the requirement, including documented conclusions and				

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Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
◆ The status and results of each PIP started, continuing, or completed during the prior 12-month period. ◆ The results of member satisfaction surveys completed during the prior 12-month period. ◆ A detailed description of the findings of the program impact analysis. ◆ Techniques used by the Contractor to improve performance. ◆ The overall impact and effectiveness of the QAPI Program during the prior 12-month period.	recommendations related to the impact of QI activities.				

Table D-2—FY 2012–2013 Corrective Action Plan *for* Colorado Choice					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
4. The Contractor shall adopt practice guidelines for the following: ◆ Perinatal, prenatal, and postpartum care for women. ◆ Conditions related to persons with a disability or special health care needs. ◆ Well child care.	Colorado Choice did not provide evidence of the adoption or use of clinical practice guidelines related to pregnancy, well-child care, or conditions related to persons with special health care needs. Colorado Choice must provide evidence that clinical practice guidelines have been adopted for the conditions outlined in the requirement.				
5. The Contractor ensures that practice guidelines comply with the following requirements: ◆ Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. ◆ Consider the needs of the Contractor's members.	Staff stated, and the Milliman Web site confirmed, that Milliman practice guidelines are developed with national-level professional expertise and input and are evidence-based. HSAG noted that Milliman guidelines provide guidance for UM decision-making and are not used to provide clinical practice guidance to health care professionals for the clinical care of members. Colorado Choice must develop a process/procedure for the				

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Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
◆ Are adopted in consultation with contracting health care professionals. ◆ Are reviewed and updated annually.	adoption of clinical practice guidelines (beyond the application of Milliman guidelines for UM decisions) that are evidence-based, consider the needs of the Colorado Choice members, consider the input of Colorado Choice health care professionals, and are reviewed and updated annually.				
6. The Contractor disseminates the guidelines to all affected providers, and upon request, to members, potential members, and the public, at no cost.	Colorado Choice did not have the required clinical practice guidelines. Colorado Choice must define and implement a process for the dissemination of clinical care guidelines, once developed, to providers, members, and the public.				
7. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.	Colorado Choice did not have the required clinical practice guidelines. Colorado Choice must define a mechanism for ensuring that any adopted clinical practice guidelines are considered in any utilization management				

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Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
	decisions, member education materials, or other operating process to which the guidelines apply.				
10. The Contractor monitors member perceptions of accessibility and adequacy of services provided. Tools shall include: ◆ Member surveys (Consumer Assessment of Healthcare Providers and Systems [CAHPS]). ◆ Anecdotal information. ◆ Grievance and appeals data. ◆ Enrollment and disenrollment information.	During the on-site interview, staff confirmed that Colorado Choice receives data on member perceptions as outlined in the requirement, but it does not review or act on the results. Staff stated that the small size of the CAHPS survey sample inhibits the analysis of results for CHP+ members. Colorado Choice must submit evidence that member perceptions of access and availability, as measured by member surveys, grievance data, and enrollment/disenrollment information, are monitored and reviewed, and that results and recommendations are documented in QI oversight committee meeting minutes. Colorado Choice does not need to analyze results specifically for the CHP+ population if the				

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	small CHP+ population is included in the overall data and there is valid analysis and corrective action, if indicated.				
11. The Contractor develops a corrective action plan when members report statistically significant levels of dissatisfaction, when a pattern of complaint is detected, or when a serious complaint is reported.	Colorado Choice did not provide evidence of a grievance summary report or analysis. Committee of the Whole meeting minutes did not include review of member survey data, patterns of grievances, or document analysis for the presence of potential quality of care concerns identified through grievances. Colorado Choice did not submit a written procedure related to review of member grievance data for CHP+ members. Colorado Choice must define a process for the review of serious member complaints, patterns of complaints, and member survey data, and the process to develop corrective action when indicated. Colorado Choice must also submit evidence of committee				

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Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
	review, recommendations, and conclusions related to member complaints, including any applicable actions taken.				

Appendix E. Compliance Monitoring Review Activities for Colorado Choice Health Plan

The following table describes the activities performed throughout the compliance monitoring process. The activities listed below are consistent with CMS' final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)*, February 11, 2003.

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Planned for Monitoring Activities**
	Before the compliance monitoring review: ◆ HSAG and the Department held teleconferences to determine the content of the review. ◆ HSAG coordinated with the Department and the health plan to set the dates of the review. ◆ HSAG coordinated with the Department to determine timelines for the Department's review and approval of the tool and report template and other review activities. ◆ HSAG staff attended Medical Quality Improvement Committee (MQUIC) meetings to discuss the FY 2012–2013 compliance monitoring review process and answer questions as needed. ◆ HSAG assigned staff to the review team. ◆ Prior to the review, HSAG representatives also responded to questions via telephone contact or e-mails related to federal managed care regulations, contract requirements, the request for documentation, and the site review process to ensure that the health plans were prepared for the compliance monitoring review.
Activity 2:	**Obtained Background Information From the Department**
	◆ HSAG used the federal Medicaid managed care regulations, NCQA Credentialing and Recredentialing Standards and Guidelines, and the health plan's managed care contract with the Department, to develop HSAG's monitoring tool, on-site agenda, record review tools, and report template. ◆ HSAG submitted each of the above documents to the Department for its review and approval. ◆ HSAG submitted questions to the Department regarding State interpretation or implementation of specific Managed Care regulations or contract requirements. ◆ HSAG considered the Department responses when determining compliance and analyzing findings.
Activity 3:	**Reviewed Documents**
	◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the health plan in writing of the desk review request via e-mail delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. ◆ Documents submitted for the desk review and during the on-site document 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.

Table E-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG completed the following activities:**
	◆ The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.
Activity 4:	**Conducted Interviews**
	◆ 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.
Activity 5:	**Collected Accessory Information**
	◆ During the on-site portion of the review, HSAG collected and reviewed additional documents as needed. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were of a confidential or proprietary nature or were requested as a result of the pre-on-site document review.)
Activity 6:	**Analyzed and Compiled Findings**
	◆ Following the on-site portion of the review, HSAG met with health plan staff to provide an overview of preliminary findings. ◆ HSAG used the FY 2012–2013 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 and recommendations based on the review findings.
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 2012–2013 Site Review Report. ◆ HSAG submitted the site review report to the health plan and the Department for review and comment. ◆ HSAG incorporated the health plan's and Department's comments, as applicable and finalized the report. ◆ HSAG distributed the final report to the health plan and the Department.