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

FY 2013–2014 Site Review Report

for

Colorado Choice Health Plan

February 2014

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

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for **Colorado Choice Health Plan**

Introduction

Public Law 111-3, The Children's Health Insurance Program Reauthorization Act (CHIPRA) 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 federal health care regulations and managed care contract requirements. The Department of Health Care Policy and Financing (the Department) has elected to complete this requirement for Colorado's Child Health Plan *Plus* (CHP+) managed care health plans by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This report documents results of the FY 2013–2014 site review activities for the review period of January 1, 2013, through December 31, 2013. This section contains summaries of the findings as evidence of compliance, strengths, findings resulting in opportunities for improvement, and required actions for each of the two standard areas reviewed this year. Section 2 contains graphical representation of results for all standards reviewed over the past two years and trending of required actions. Section 3 describes the background and methodology used for the 2013–2014 compliance monitoring site review. Section 4 describes follow-up on the corrective actions required as a result of the 2012–2013 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the denials 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 2013–2014 and the required template for doing so.

Summary of Results

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

Table 1-1 presents the scores for **Colorado Choice Health Plan** (**Colorado Choice**) for each of the standards. Findings for requirements receiving a score of *Met* are summarized in this section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* follow in Appendix A—Compliance Monitoring Tool.

Table 1-1—Summary of Scores for the Standards

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
I Coverage and Authorization of Services	34	34	24	9	1	0	71%
II Access and Availability	22	22	16	6	0	0	73%
Totals	**56**	**56**	**40**	**15**	**1**	**0**	**71%**

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

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)
Denials	150	75	42	33	75	56%
Totals	**150**	**75**	**42**	**33**	**75**	**56%**

Standard I—Coverage and Authorization of Services

Summary of Findings as Evidence of Compliance

Colorado Choice had a Utilization Management (UM) program in place to monitor services and ensure that services provided were sufficient in amount, scope, and duration to achieve the purpose of the provided services. **Colorado Choice**'s electronic authorization system had fields to track the service request and decision date as well as the reviewer and other pertinent steps in processing requests for services.

On-site review of committee meeting minutes demonstrated that **Colorado Choice** reviewed grievances and appeals as well as utilization patterns to determine over- and underutilization. On-site, **Colorado Choice** staff provided a template attestation document used to ensure that staff and committee members are aware that no compensation or incentive would be paid for the denial or limited authorization of services.

On-site, **Colorado Choice** provided committee meeting minutes as evidence that it reviewed and responded to HEDIS results. The CAHPS corrective action plan (submitted on-site) was responsive to the CAHPS results.

Summary of Strengths

On-site review of denials records demonstrated that the individuals making denial decisions had the appropriate clinical expertise to do so. The on-site demonstration of the electronic authorization system and the record review also demonstrated that decisions were made and notification was provided to members within the required time frames.

Summary of Findings Resulting in Opportunities for Improvement

Colorado Choice's staff reported using Milliman guidelines for authorization determinations and documented the processing of requests for services in an electronic authorization management system. The system contained a notes section that staff could use to add communication and documentation regarding justification of the determination and guidelines used for the decision; however, the decisions for several cases reviewed on-site were not clearly based on the contract benefit package or the guidelines **Colorado Choice** reported using, and the notes section was not used to provide clarification about the determination. **Colorado Choice** should consider developing procedures or protocols (and the associated staff training) regarding documentation and communication among staff related to authorization determinations.

Colorado Choice had a UM Program Description that generally described the philosophy of the program and activities; however, some key components did not have specific policy statements or procedural descriptions. Since some components require policies and procedures according to federal regulations, **Colorado Choice** may want to consider developing policies and procedures for each UM Program component, incorporating the policies and procedures into the UM Program Description by reference, to create a more comprehensive UM Program Description and provide direction to staff to standardize authorization system processes and use.

The Precertification Procedures for Authorization and Referrals policy stated that when requests for services are received with insufficient information to make an authorization decision, the request is held until all appropriate material is received and then processed with three working days. **Colorado Choice** may want to consider stating specifically that the three working days are counted from the date the additional materials are received. The policy also stated that requests must be completed or extended within 14 days, regardless of whether all information has been received. Since the three-working-day time frame referenced above is counted from the date the material is received, **Colorado Choice** should clarify that the time frame for completing or extending begins when the initial request is made.

While there were documents that indicated that prior authorization is not required for urgent care services, the prior authorization policy had processes for urgent requests for care. **Colorado Choice** may want to consider clarifying the policy to delineate the difference between urgent requests for services that require prior authorization, and urgent care provided to prevent the onset of the need for emergency care.

The on-site demonstration of the electronic authorization system demonstrated that review of new service request occurred immediately and that **Colorado Choice** processes ensured that extensions would rarely be needed. Staff reported regular and frequent contact with providers to ensure that all

information necessary to make a determination is obtained. To avoid an unnecessary denial if a situation involving an extension were to arise, **Colorado Choice** may want to consider developing an extension policy and letter template.

Staff members reported that **Colorado Choice** uses the prudent layperson standard for payment of emergency claims. Member information defined emergency and poststabilization services and informed members that emergency services may be obtained in- or out-of-network and without prior authorization. **Colorado Choice** may want to consider developing policies and procedures that specifically address the payment of emergency and poststabilization services.

Summary of Required Actions

The **Colorado Choice** UM Program Description did not address concurrent reviews for the request for continuing services, or on-site reviews related to concurrent review and continuing authorizations, to the extent that **Colorado Choice** uses on-site reviews for concurrent review processes. **Colorado Choice** must ensure that its UM Program Description clearly describes processes for discharge planning, on-site utilization review, and concurrent review to the extent that they are used.

The precertification policy included inaccurate time frames for making authorization decisions and was unclear regarding the fact that prior authorization is not required for emergency or urgent care services. In addition, several elements that are required to be included in policies and procedures were not included in the policy. **Colorado Choice** must revise or develop policies as follows:

- Language referencing authorization of emergency services must be removed.
- Continuing authorization of services and **Colorado Choice**'s procedures for on-site review must be addressed in either the precertification policy or other policies or procedures.
- **Colorado Choice** must develop and implement policies and procedures designed to ensure consistent application of review criteria to authorization decisions.
- **Colorado Choice** must have and follow written policies and procedures that include a mechanism to consult with the requesting provider when appropriate.
- **Colorado Choice** must revise the stated 14-day time frame in the pre-authorization policy to comply with the 8.209 requirement to make standard preservice authorization decisions within 10 calendar days of receiving the request.
- **Colorado Choice** must clarify any applicable policies to state that precertification requests or prior authorization is not required for emergency or urgent care services. **Colorado Choice** must also revise member materials, removing any qualification to providing urgent care services.

Notice of action (NOA) templates and notices found in the records reviewed on-site contained inaccurate time frames for filing appeals (stated as 180 days rather than the CHP+ 30-calendar-day requirement), and for processing appeals (stated as 30 days rather than the CHP+ 10-calendar-day requirement). NOA templates also did not contain information regarding the State fair hearing or continuation of benefits. **Colorado Choice** must review NOA templates and revise to ensure that correct information is provided in an easy-to-understand format, and to include State fair hearing and continuation of benefits information. **Colorado Choice** must ensure that all NOAs—whether

using a letter format for UM denials or an explanation of benefits (EOB) format for claims denials—include the required and accurate information. **Colorado Choice** must also develop a mechanism to ensure that notices of action are available to members in the prevalent non-English language for its service area.

Colorado Choice must review its coding and claims systems and processes, making revisions as required, to ensure that services are not denied arbitrarily, and that documentation exists to indicate that authorizations and denial decisions are based on established criteria. To the extent that the initial presentation for emergency care meets the definition of emergency medical condition (using the prudent layperson standard), **Colorado Choice** must pay for the emergency treatment obtained and may not deny payment for emergency services for members who leave against medical advice (AMA).

Standard II—Access and Availability

Summary of Findings as Evidence of Compliance

The Network Access Plan—an overview of the network for all populations, not just CHP+—described contracting with a comprehensive array of providers; that PCPs include general and family medicine, internal medicine, pediatrics, nurse practitioners and physician's assistants; and that females may obtain care from obstetricians/gynecologists (OB/GYNs) or midwives. The plan specified the PCP-to-member ratio is 1:2000 but that the specialist-to-member ratio is much higher. The plan described the strategy for contracting with all PCPs, specialists, acute care, and ancillary providers in the service area to provide reasonable access to services for all covered benefits. Given the rural nature of the area, some specialist services were contracted in nearby urban centers. The plan outlined geographic access standards for both urban and rural areas.

The Provider Network Adequacy Report showed a county-specific breakdown of the available PCPs and specialists in the county that are contracted with **Colorado Choice**. During the on-site interview, **Colorado Choice** staff members reported that **Colorado Choice** has a contract with all available PCPs in the service area and the majority of specialists in each county. On-site review of committee minutes demonstrated that provider network issues were evaluated by the executive team. During the on-site interview, **Colorado Choice** staff members described the specialist provider network and explained that **Colorado Choice** must look to larger metropolitan areas such as Pueblo, Colorado Springs, and Denver to provide some specialty care. Staff members described their philosophy of provider network management as the "pathway of care" model. For example, **Colorado Choice** evaluates the typical referral patterns of the contracted PCPs and makes efforts to contract with those specialty providers.

Colorado Choice staff members reported contracting with all of the federally qualified health centers (FQHCs) and rural health centers (RHCs) in the service area. In addition, staff members reported that, although **Colorado Choice** uses a memorandum of understanding for single cases when necessary for continuity of care, when possible, it works with the providers to add them to the network.

Summary of Strengths

The Provider Office Site Evaluation check list included numerous criteria related to physical accessibility of provider offices for persons with disabilities. During the on-site interview, **Colorado Choice** staff members reported that site visits are conducted at the time of contracting and at recredentialing, although NCQA guidelines no longer require on-site visits to practitioner offices unless complaint thresholds are met.

The sample provider contract (applicable to CHP+) required that providers offer **Colorado Choice** CHP+ members and commercial members the same standard of care and access to services. The Network Access Plan outlined appointment scheduling standards and stated that providers are expected to meet all standards.

Summary of Findings Resulting in Opportunities for Improvement

Colorado Choice staff members stated that several of the counties in the service area are designated as medically underserved areas (MUAs) or health provider shortage areas (HPSAs). As such, staff members reported that **Colorado Choice** has not prioritized investing in software to calculate access distance (e.g., GeoAccess mapping), to confirm the shortage. **Colorado Choice** should continue to work with the Department to evaluate shortage areas and develop strategies for provider network development.

Summary of Required Actions

The member handbook stated that members may receive emergency services from any provider in any location, inside or outside the network. Federal regulations require policies and procedures that address the availability of emergency services 24 hours per day, seven days per week and that address out-of-area emergency and urgently needed services. **Colorado Choice** must develop policies and procedures that address the availability of emergency services 24 hours per day, seven days per week and that state emergency services and urgently needed services are covered when members are temporarily out of the service area.

The provider handbook communicated appointment availability standards to providers for emergent, urgent, non-urgent symptomatic, and preventive care. The provider handbook did not address mental health and substance abuse standards, and the member handbook did not include any scheduling guidelines. **Colorado Choice** must develop a mechanism to communicate mental health and substance abuse scheduling guidelines to providers and all scheduling guidelines to members.

Colorado Choice was unable to demonstrate development of preventive service guidelines for members with disabilities, monitoring/evaluation of the use of preventive services, methods to identify priorities for and development of preventive service guidelines, provider education about preventive services, or provider evaluation of the provision of such services. **Colorado Choice** must develop policies and procedures that address the required elements of a preventive medicine program.

Policies and procedures did not address assessment of the cultural norms or practices with respect to their effect on the member's health care needs. The provider handbook did not address cultural responsiveness or describe how providers may access interpreter services for patients. **Colorado Choice** documents also did not address cultural competency training for providers or staff, policies and procedures related to access to interpreter services by providers, or arranging for covered services with non-participating providers when necessary to accommodate independent living of members with disabilities. **Colorado Choice** must ensure that the required elements are present in its policies and/or practices to promote the State's efforts for delivery of services in a culturally competent manner.

Colorado Choice's method to monitor provider scheduling wait times was by self-report from the provider at the time of credentialing and recredentialing (every three years). **Colorado Choice** must develop a mechanism to monitor actual scheduling wait times. Sampling providers for this monitoring would be acceptable.

Comparison of Results

Review of Compliance Scores for All Standards

Figure 2-1 shows the scores for all standards reviewed over the past two years of compliance monitoring. (The Department chose not to assign scores for the FY 2011–2012 site reviews.)

Figure 2-1—Colorado Choice's Compliance Scores for All Standards

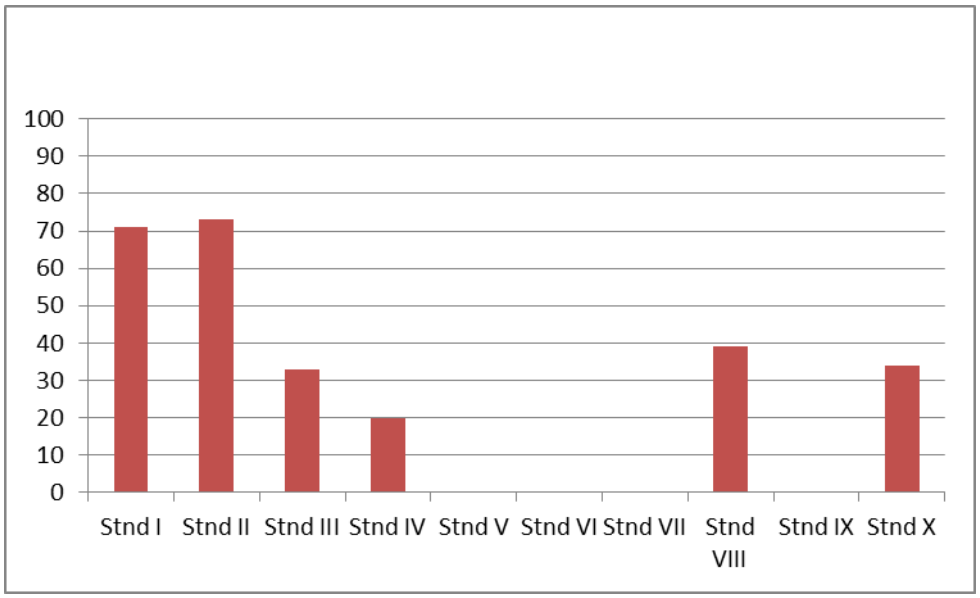


Table 2-1 presents the list of standards by review year.

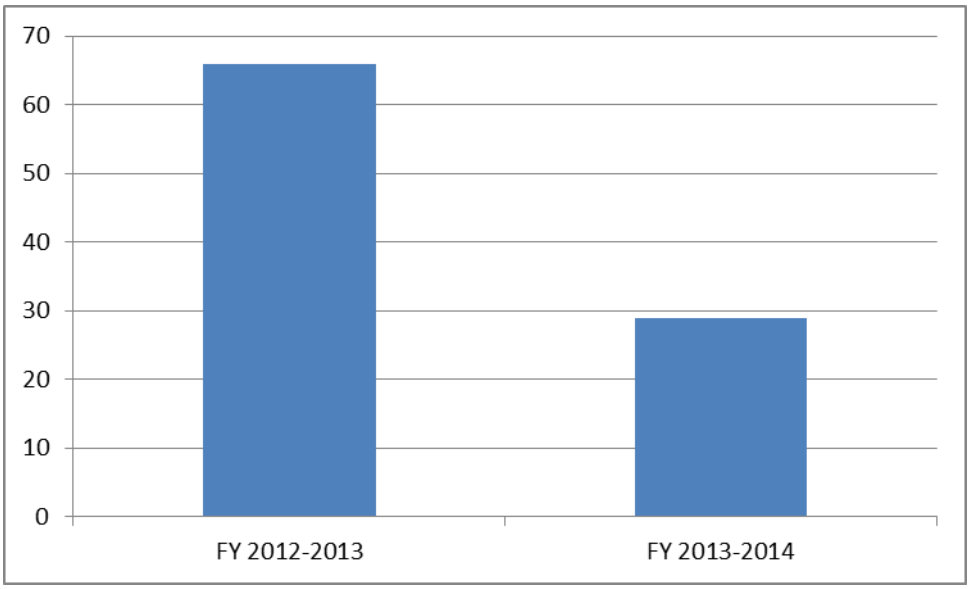
Table 2-1—List of Standards by Review Year			
Standard	**2011–12**	**2012–13**	**2013–14**
I—Coverage and Authorization of Services			X
II—Access and Availability			X
III—Coordination and Continuity of Care		X	
IV—Member Rights and Protections		X	
V—Member Information	X*		
VI—Grievance System	X*		
VII—Provider Participation and Program Integrity	X*		
VIII—Credentialing and Recredentialing		X	
IX—Subcontracts and Delegation	X*		
X—Quality Assessment and Performance Improvement		X	

*These standards were reviewed but were not scored.

Trending the Percentage of Required Actions

Figure 2-2 shows the percentage of requirements that resulted in required actions over the past two years of compliance monitoring. (The Department chose not to assign scores to the CHP+ plans during the FY 2011–2012 site reviews.) Each year represents the results for review of different standards.

Figure 2-2—Percentage of Required Actions—All Standards Reviewed



Overview of FY 2013–2014 Compliance Monitoring Activities

For the fiscal year (FY) 2013–2014 site review process, the Department requested a review of two areas of performance. HSAG developed a review strategy and monitoring tools consisting of two standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. Compliance with federal managed care regulations and managed care contract requirements was evaluated through review of the two standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the two standards, HSAG used the health plan's contract requirements and regulations specified by the 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 records, documents, and materials provided on-site; and on-site interviews of key health plan personnel to determine compliance with federal managed care regulations and contract requirements. Documents submitted for the desk review and on-site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to CHP+ service and claims denials. In addition, HSAG conducted a high-level review of the health plan's authorization processes through a demonstration of the health plan's electronic system used to document and process requests for CHP+ services.

A sample of the health plan's administrative records were reviewed to evaluate implementation of managed care regulations related to CHP+ service and claims denials and notices of action. Reviewers used standardized monitoring tools to review records and document findings. HSAG reviewed a sample of 15 records with an oversample of 5 records. Using a random sampling technique, HSAG selected the samples from all applicable health plan CHP+ service and claims denials that occurred between January 1, 2013, and December 31, 2013 (to the extent possible). For the record review, the health plan received a score of *C* (compliant), *NC* (not compliant), or *NA* (not applicable) for each of the required elements. Results of record reviews were considered in the scoring of applicable requirements in Standard I—Coverage and Authorization of Services. HSAG also separately calculated an overall record review score.

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The two standards chosen for the FY 2013–2014 site reviews represent a portion of the Medicaid managed care requirements. These standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, Standard VIII—

Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, and Standard X—Quality Assessment and Performance Improvement.

Objective of the Site Review

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

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

4. Follow-up on Prior Year's Corrective Action Plan

for **Colorado Choice Health Plan**

FY 2012–2013 Corrective Action Methodology

As a follow-up to the FY 2012–2013 site review, each health plan that received one or more *Partially Met* or *Not Met* score was required to submit a corrective action plan (CAP) to the Department addressing those requirements found not to be fully compliant. If applicable, the health plan was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the health plan and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **Colorado Choice** until it completed each of the required actions from the FY 2012–2013 compliance monitoring site review.

Summary of 2012–2013 Required Actions

As a result of the 2012–2013 site review, **Colorado Choice** was required to create a corrective action plan to address 49 of the 74 reviewed elements. The following is an overview of the required actions.

Colorado Choice was required to develop policies, procedures, and processes to designate the party responsible for members' care coordination. It was required to define a comprehensive assessment tool that includes all of the required elements and assess its members' health care needs on enrollment and at any other necessary time (e.g., on referral to case management). **Colorado Choice** was required to implement procedures to ensure that an individual care coordination plan is developed and documented in the case management file and demonstrate member involvement and agreement with the plan.

Colorado Choice was required to 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.

Colorado Choice was required to revise its policies and procedures related to the credentialing and recredentialing of practitioners with whom **Colorado Choice** has an independent relationship to be consistent with NCQA requirements. **Colorado Choice** was also required to develop policies, procedures, and processes for the assessment and reassessment of organizational providers.

Colorado Choice was required to designate a quality improvement (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.

Colorado Choice was required to develop a process/procedure for the adoption and dissemination of clinical practice guidelines (beyond the application of Milliman guidelines for utilization management [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 was required to 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** was also required to submit evidence of committee review, recommendations, and conclusions related to member complaints, including any applicable actions taken.

Summary of Corrective Action/Document Review

Colorado Choice submitted a CAP to HSAG and the Department in April 2013. HSAG made suggestions and requested additional information before approving the plan in May 2013. **Colorado Choice** began to submit documents that demonstrated implementation of its plan to HSAG and the Department in August 2013. HSAG and the Department worked with **Colorado Choice** throughout the year, providing ongoing feedback as documents were submitted.

Summary of Continued Required Actions

During the 2013 on-site review, **Colorado Choice** submitted several documents, primarily related to training, as evidence of completion of corrective actions. **Colorado Choice** obtained permission from the Department to continue those required actions that necessitated revision of the member handbook and the provider handbook until after its upcoming URAC accreditation site visit. **Colorado Choice** will then make all revisions to those documents and submit for review. Additional required actions that remain outstanding are as follows:

- **Colorado Choice** must develop mechanisms for prevention of provider discrimination (proactive steps to prevent discrimination) and for monitoring (tracking and identifying potential discriminatory practices) and describe such mechanisms in a policy/procedure.
- **Colorado Choice** must develop a policy/procedure that describes the ongoing monitoring of sanction activity (Medicare and Medicaid as well as State sanction activity).
- **Colorado Choice** must develop policies and procedures that address site visits for organizational providers.
- **Colorado Choice** must provide evidence that the approved contract amendment with credentialing delegates has been executed.

Appendix A. Compliance Monitoring Tool *for* Colorado Choice Health Plan

The completed compliance monitoring tool follows this cover page.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor ensures that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. *42CFR438.210(a)(3)(i)* Contract: Amendment 02, Exhibit A-2, 2.6.3 Exhibit K, 1.1	**Documents:** 1. CHP+ Member Handbook – Section VII. Pages 6-11and 31-62. (Common Documents folder) 2. Policy 3504-Precertification Procedures for Authorizations and Referrals (Standard I Folder) 3. Network Access Plan (Common Documents Folder) **Narrative:** Colorado Choice has a Member Handbook that includes benefits and services offered to members. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services. Colorado Choice follows Policy 3504 in assuring that services provided to plan members are covered benefits that are medically necessary, appropriate, and applicable to the diagnosis or condition being treated. This language is also incorporated into the Network Access Plan.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor provides the same standard of care for all Members regardless of eligibility category and makes all Covered Services as accessible in terms of timeliness, amount, duration and scope, to Members, as those services are to non-CHP+ Member recipients within the same area. *42CFR438.210(a)(2)* Contract: Amendment 02, Exhibit A-2, 2.6.3.9	**Documents:** 1. CHP+ Member Handbook- Section I. Pages 6-11 and pages 31-62. (Common Documents Folder) 2. Network Access Plan, Page 9 (Common Documents Folder) 3. Sample Contract (Standard I Folder) **Narrative:** Colorado Choice has a Member Handbook that includes a summary comparison benefit form for members as well as a section outlining benefits and services. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	reference guide that is followed by Colorado Choice when dealing with members and furnishing services. Colorado Choice's Network Access Plan, that is available publicly states that CO Choice strives to ensure that all covered services are available to all enrollees, regardless of sex, race, color, religion, physical/mental disability, sexual orientation, age, marital status, national origin/ancestry, genetic information, health status, status as a Member, or participation in a publicly financed program. CO Choice's Professional Services Agreement and Hospital Services Agreement contains similar such clauses.	
3. The Contractor has a Utilization Management Program that includes: ◆ Prospective, concurrent, and retrospective review ◆ Preauthorization system ◆ Medical Management Team oversight ◆ Transplant coordination ◆ On-site reviews ◆ Discharge planning ◆ Case management ◆ Appeals and grievances ◆ Mechanisms to detect over- and under-utilization Contract: Amendment 02, Exhibit A-2, 2.9.4.4 and Exhibit K, 1.1.1.2	**Documents:** 1. Utilization Management Program (Standard I Folder) **Narrative:** Colorado Choice has a Utilization Management Program that includes prospective, concurrent and retrospective reviews. The UM program has pre-authorization reviews with medical management team oversight, discharge planning, and case management. **Additional Documents Submitted On-site:** • Care Coordination and Case Management (NO. 3000 CHP+) • Transplant procedure	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: Colorado Choice had a Utilization Management (UM) Program Description that included processes for prospective and retrospective review, medical team oversight of the program, and appeals and grievances. Colorado Choice had a separate Transplant policy/procedure and a separate Care Coordination and Case Management policy. The UM Program Description and the Care Coordination and Case Management policy both discussed the importance of discharge planning, but neither described processes or procedures. In addition, neither document addressed Colorado Choice's procedures for concurrent review. Colorado Choice may want to consider developing or enhancing specific policies and procedures for each of the required UM Program components, incorporating the policies and procedures into the UM Program Description by reference.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: Colorado Choice must ensure that its UM Program Description clearly describes processes for on-site utilization review, concurrent review, and discharge planning.		
4. Utilization Management shall be conducted under the auspices of a qualified clinician. Contract: Amendment 02, Exhibit A-2, 2.8.1.	**Documents:** 1. Utilization Management Program, Pages 3 and 4. (Standard I Folder) **Narrative:** Colorado Choice follows a Utilization Management Program that is physician-driven. Medical Director is a licensed physician and the Nurse Manager is a registered nurse.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. The Contractor does not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42CFR438.210(a)(3)(ii)* Contract: Amendment 02, Exhibit A-2, 2.6.3.10	**Documents:** 1. CHP+ Member Handbook- Pages 6-11 and pages 31-62. (Common Documents Folder) 2. Policy 3504-Precertification Procedures for Authorizations and Referrals (Standard I Folder) **Narrative:** Colorado Choice affords all CHP+ members the benefits as listed in the CHP+ comparison benefit form covered services and co-payments. CHP+ members receive the summary comparison benefit form in their member handbook. The handbook also has a section that provides detailed information about benefits and services. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services. Policy 3504 outlines Colorado Choice's procedures to ensure that services provided to plan members are covered benefits that are medically necessary, appropriate and applicable to the diagnosis or condition being treated.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: Although Colorado Choice staff members reported that Colorado Choice's policy is to use established criteria including Milliman UM review criteria, there were several records in the denials record review for which Colorado Choice could not justify the reason for the denial. For Record #1, Colorado Choice's system included a Current Procedural Terminology (CPT) code explanation that differed from the explanation provided in the CPT code book. The CPT code book explanation described a covered service. There was no information in the system that justified why this service was denied. Record #4 was related to an inpatient hospitalization for transfusion and hematology services. The authorization system contained documentation that the hospitalization was covered and paid, but that the provider services were denied. There was no documentation in the system why the services were denied. Colorado Choice staff was unable to determine the reason for the denial. The explanation of benefits (EOB) indicated that the member was responsible for the cost of the services. If the services were denied due to issues with claim submission, Colorado Choice must ensure that the member and the provider are informed that the provider, not the member is responsible. Record #9 was a claim for preventive services. Colorado Choice was unable to determine the reason why the claim was denied, and there was no documentation in the system explaining the reason. In addition, several records involved claims that were denied due to no prior authorization obtained. The EOBs indicated that the members were responsible for the cost of the services provided. Members may not be held responsible for the provider's failure to obtain prior authorization.		
Required Actions: Colorado Choice must review its coding and claims systems and processes, making required revisions to ensure that services are not denied arbitrarily, and that documentation exists to indicate that authorizations and denial decisions are based on established criteria.		
6. If the Contractor places limits on services, it is: ◆ On the basis of criteria applied under the State plan (medical necessity). ◆ For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose. *42CFR438.210(a)(3)(iii)* Contract: Amendment 02, Exhibit A-2, 2.6.2 and 2.6.3	**Documents:** 1. CHP+ Member Handbook- Section III. Pages 15 & 16 (Common Documents Folder) 2. Utilization Management Program (Standard I Folder) **Narrative:** Colorado Choice has a Member Handbook that includes utilization review process for members. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services. Colorado Choice has a Utilization Management Program that is used for monitoring, evaluating, and improving the quality appropriateness of health services provided to members.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Additional Documents Submitted On-site: Denial of Services for Lack of Medical Necessity or Investigational Status (NO. 3502)	
7. The Contractor specifies what constitutes "medically necessary services" in a manner that: ◆ Is no more restrictive than that used in the State CHP+ program. ◆ Addresses the extent to which the Contractor is responsible for covering services related to the following: • The prevention, diagnosis, and treatment of health impairments. • The ability to achieve age-appropriate growth and development. • The ability to attain, maintains, or regains functional capacity. *42CFR438.210(a)(4)* Contract: Amendment 02, Exhibit A-2, 2.8.1.1 and 1.1.1.56	**Documents:** 1. Member Handbook- Section III. Pages 15 & 16, 31-62 (Common Documents Folder) 2. Utilization Management Program (Standard I Folder) **Narrative:** Colorado Choice has a Member Handbook that includes our utilization review processes for services to members that are medically necessary services. The handbook also addresses the extent of services available to the members. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services. Colorado Choice has established a Utilization Management Program in order to focus on appropriate utilization of health care resources for its entire plan membership.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. The Contractor has written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42CFR438.210(b)* Contract: Amendment 02, Exhibit A-2, 2.8.1.2	**Documents:** 1. Policy 3504-Precertification Procedures for Authorizations and Referrals (Standard I Folder) **Narrative:** Colorado Choice follows Policy 3504 in processing the requests for initial and continuing authorization of services.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The Pre-certification Procedures for Authorizations and Referrals did not address continuing authorizations of services.		
Required Actions: Colorado Choice must either revise or develop policies and procedures to address continuing authorization of services.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor has in place and follows written policies and procedures that include mechanisms to ensure consistent application of review criteria for authorization decisions. *42CFR438.210(b)(2)(i)* Contract: Amendment 02, Exhibit A-2, 2.8.1.3	**Documents:** 1. Policy 3504-Precertification Procedures for Authorizations and Referrals (Standard I Folder) **Narrative:** Colorado Choice follows Policy 3504 in processing the requests for initial and continuing authorization of services that includes consistent application of review criteria for authorization decisions.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: The policy submitted did not address interrater reliability or other mechanisms to ensure consistent application of review criteria. On-site, Colorado Choice staff members reported that UM staff were trained using Milliman/Interqual guidelines, but they were unable to provide evidence that processes were in place to ensure consistent application of utilization review criteria.		
Required Actions: Colorado Choice must develop and implement policies and procedures designed to ensure consistent application of review criteria to authorization decisions.		
10. The Contractor has in place and follows written policies and procedures that include a mechanism to consult with the requesting provider when appropriate. *42CFR438.210(b)(2)(ii)* Contract: Amendment 02, Exhibit A-2, 2.8.1.3	**Documents:** 1.Policy 3504-Precertification Procedures for Authorization and referrals (Standard I Folder) **Narrative:** Colorado Choice follows Policy 3504 in processing the requests for initial and continuing authorization of services. The processes include a mechanism to consult with the requesting provider when appropriate.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The member handbook informed members that medical necessity determination may include discussing treatment alternatives and approaches with the provider requesting the service. While the UM Program Description listed consultation with the attending physician as a potential source of information for determining medical necessity, a policy statement or procedural component was not stated in the UM Program Description. The Precertification Procedures for Authorization and Referrals policy included procedures for the UM staff member to request additional records from the requesting provider when needed; however, there were no procedures for offering a peer-to-peer consultation, or other mechanism for direct consultation between the physician reviewer and the requesting provider.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: Colorado Choice must have and follow written policies and procedures that include a mechanism to consult with the requesting provider when appropriate.		
11. The Contractor has in place and follows written policies and procedures that include the provision that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease. *42CFR438.210(b)(3)* Contract: Amendment 02, Exhibit A-2, 2.8.1.6 and 2.8.1.3.1	**Documents:** 1.Policy 3504-Precertification Procedures for Authorizations and Referrals (Standard I Folder) **Narrative:** Colorado Choice follows Policy 3504 in processing the requests for initial and continuing authorization of services, including a process that any decision to deny a service authorization request is made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease. **Additional Documents Submitted On-site:** • Precertification of Referrals and Authorizations by Designee of the Medical Director (NO. 3507)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor has in place and follows written policies and procedures that include processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested (notice to the provider need not be in writing). *42CFR438.210(c)* Contract: Amendment 02, Exhibit A-2, 2.8.1.3.2 and 2.8.1.3.3	**Documents:** 1.Policy 3504 – Precertification Procedures for Authorizations and Referrals (Standard I Folder) **Narrative:** Colorado Choice follows Policy 3504 in processing the requests for initial and continuing authorization of services. The processes include notifying the requesting provider and giving the member written notice of any decision.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor has in place and follows written policies and procedures that include the following time frames for making standard and expedited authorization decisions as expeditiously as the member's health condition requires not to exceed: ◆ For standard authorization decisions—10 calendar days. ◆ For expedited authorization decisions—3 business days. *42CFR438.210(d)* Contract: Amendment 02, Exhibit A-2, 2.8.1.3.3.1 and 2.8.1.3.3.2.1 10CCR2505—10, Sec 8.209.4.B	**Documents:** 1. Policy 3504 – Precertification Procedures for Authorizations and Referrals (Standard I Folder) **Narrative:** Colorado Choice follows Policy 3504 in processing the requests for initial and continuing authorization of services including the following of time frames for making standard and expedited authorization decisions. **Additional Documents Submitted On-site:** • Draft Timeframes for Referrals and Authorizations policy	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The Precertification Procedures for Authorization and Referrals policy stated that when requests for services are received with insufficient information to make an authorization decision, the request is held until all appropriate material is received and is then processed with three working days. Colorado Choice may want to consider stating specifically that the three working days are counted from the date the additional materials are received. The policy also stated that requests must be completed or extended within 14 days, regardless of whether all information has been received. Since the three-working-day time frame referenced above is counted from the date the material is received, Colorado Choice should clarify that the time frame for completing or extending begins when the initial request is made. In addition, the 14-day time frame stated does not comply with the 8.209 requirement to make standard preservice authorization decisions within 10 calendar days of receiving the request. The policy stated that urgent care requests are completed within 72 hours of the request for service.		
Required Actions: Colorado Choice must revise its applicable policies and procedures to state that CHP+ standard preservice authorization decisions are made, with notice to the member, within 10 calendar days of the request for service.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. Notices of action must meet the language and format requirements of 42CFR438.10 to ensure ease of understanding (6th grade reading level wherever possible and available in the prevalent non-English language for the service area). *42CFR438.404(a)* Contract: Amendment 02, Exhibit A-2, 2.4.3.1.6 10CCR2505—10, Sec 8.209.4.A.1	**Documents:** 1. Denial Letter for CHP+ (Standard I Folder) 2. Appeal Rights Medical Necessity (Standard I Folder) 3. Appeal Rights Excluded Benefit (Standard I Folder) 4. Telephone Services for Special Needs Desktop Procedure (Standard I Folder) **Narrative:** Colorado Choice maintains denial letters (notice of action) specific to CHP+ and distributes them to members and providers as required. Colorado Choice makes every attempt to follow health literacy guidelines in our member facing material. In the event we need translation services, CO Choice has contracted with Translation Plus to provide interpreter services for Members who do not speak English. These translation services are available 24 hours a day, 7 days a week. Customer Service procedure is attached.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The appeal information included with the notices of action (NOAs) was difficult to understand. It did not include a clear explanation of what service or services were being denied or the reason why the service or services were denied. The service listed was a general category of services (e.g., preventive services) and did not indicate the specific service that was requested. In addition, the information included incorrect information regarding time frames for filing the appeal and 2nd-level appeal information. During the on-site interview, Colorado Choice staff stated that Colorado Choice does not track language preference in order to communicate NOAs or other member-specific information in non-English languages.		
Required Actions: Colorado Choice must review and revise its NOA templates to ensure that correct information is provided in an easy-to-understand format. Colorado Choice must also develop a mechanism to ensure that NOAs are available to members in the prevalent non-English language for its service area.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. Notices of action must contain: ◆ The action the Contractor (or its delegate) has taken or intends to take. ◆ The reasons for the action. ◆ The member's, authorized representatives, and provider's (on behalf of the member) right to file an appeal and procedures for filing. ◆ The date the appeal is due. ◆ The member's right to a State fair hearing. ◆ The procedures for exercising the right to a State fair hearing. ◆ The circumstances under which expedited resolution is available and how to request it. ◆ The member's right to have benefits continue pending resolution of the appeal and how to request that the benefits be continued. ◆ The circumstances under which the member may have to pay for the costs of services (if continued benefits are requested). *42CFR438.404(b)* Contract: Amendment 02, Exhibit A-2, 2.5.5 10CCR2505—10, Sec 8.209.4.A.2	**Documents:** 1.Denial Letter for CHP+ (Standard I Folder) 2. Appeal Rights Medical Necessity (Standard I Folder) 3. Appeal Rights Excluded Benefit (Standard I Folder) **Narrative:** Colorado Choice maintains denial letters (notice of action) specific to CHP+ members and distributes them to members and providers as required. Rights to appeal are included with the mailing. **Additional Documents Submitted On-site:** Denial Notification Template - revised	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The denial notifications submitted for desk review did not include State fair hearing or continuation of benefits information. The denials records reviewed on-site did not clearly describe the service denied or the reason for the denial, included incorrect information about time frames for filing an appeal, and did not contain information about the State fair hearing process or continuation of benefits/services. On-site, Colorado Choice staff provided a revised denial notification template that included fields for the action taken and the reason for the action. However, the notification template stated that the time frame for filing an appeal is 180 days (CHP+ requirement is 30 days) and that the appeal would be decided in 30 days (CHP+ requirement is 10 calendar days). The revised template also did not include State fair hearing rights or continuation of benefits/services information.		
Required Actions: Colorado Choice must ensure that all NOAs, whether using a letter format for UM denials or an EOB format for claims denials, include the required and accurate information.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The notices of action must be mailed within the following time frames: ◆ For termination, suspension, or reduction of previously authorized covered services, within the time frames specified in 431.211: • The notice of action must be mailed at least 10 days before the date of the intended action unless exceptions exist (see 42CFR431.213 and 214). ◆ For denial of payment, at the time of any action affecting the claim. ◆ For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires but within 10 calendar days following receipt of the request for services. ◆ For service authorization decisions not reached within the required time frames on the date time frames expire. ◆ For expedited service authorization decisions, as expeditiously as the member's health condition requires but within 3 business days after receipt of the request for services. *42CFR438.404(c)* *42CFR438.400(b)(5)* Contract: Amendment 02, Exhibit A-2, 2.8.1.3.3.1 and 2.8.1.3.3.2.1 10CCR2505—10, Sec 8.209.4.A.3	**Documents:** 1. Denial Letter for CHP+ (Standard I Folder) 2. Appeal Rights Medical Necessity (Standard I Folder) 3. Appeal Rights Excluded Benefit (Standard I Folder) **Narrative:** Denials (notice of action) are mailed within one business day of the decision to deny. The decision to approve or deny is made within 10 days of receipt of the request Approvals are generated by the computer system and are faxed immediately or mailed out to the member and the provider the day following the approval.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The Contactor may extend the authorization decision time frame if the enrollee requests an extension, or if the Contractor justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest. The Contractor's written policies and procedures include the following time frames for possible extension of time frames for authorization decisions: ◆ Standard authorization decisions—up to 14 calendar days. ◆ Expedited authorization decisions—up to 14 calendar days. *42CFR438.210(d)* Contract: Amendment 02, Exhibit A-2, 2.8.1.3.3.1 and 2.8.1.3.3.2. 10CCR2505—10, Sec 8.209.4.A.3	**Documents:** N/A **Narrative:** Colorado Choice currently has no documented policy on extending authorization decisions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
18. If the Contractor extends the time frame for making a service authorization decision, it: ◆ Provides the member written notice of the reason for the decision to extend the time frame. ◆ Informs the member of the right to file a grievance if the member disagrees with the decision to extend the time frame. ◆ Carries out the determination as expeditiously as the member's health condition requires and no later than the date the extension expires. *42CFR438.404(c)(4) and 438.210(d)(2)(ii)* Contract: Amendment 02, Exhibit A-2, 2.8.1.3.3 10CCR2505—10, Section 8.209.4.A.3	**Documents:** N/A **Narrative:** Colorado Choice currently has no documented policy on extending authorization decisions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
19. The Contractor has in place and follows written policies and procedures that provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42CFR438.210(e)* Contract: Amendment 02, Exhibit A-2, 2.8.1.1	**Documents:** Utilization Management Program – Page 3 (Standard I Folder) **Narrative:** Colorado Choice Health Plans uses Advanced Medical Reviews for utilization management activities. Colorado Choice has a Utilization Management Program that is followed to ensure that individuals providing Utilization Management activities are based on medical necessity and appropriateness of care. **Additional Documents Submitted On-site:** • Attestation Statement Template	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
20. The Contractor provides pharmacy medical management. Contract: Amendment 02, Exhibit K, 1.1	**Documents:** Network Access Plan –Pages 7- 8 (Common Documents Folder) **Narrative:** Colorado Choice contracts with OptumRx, a pharmacy benefits manager to coordinate and monitor a prior authorization program and which includes injectables.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
21. The Contractor defines Emergency Medical Condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: ◆ Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. ◆ Serious impairment to bodily functions.	**Documents:** 1. CHP+ Member Handbook- Section VII. Page 39 (Common Documents Folder) **Narrative:** Colorado Choice has a Member Handbook that defines emergency medical condition for members. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
◆ Serious dysfunction of any bodily organ or part. *42CFR438.114(a)* Contract: Amendment 02, Exhibit A-2, 1.1.1.27		
22. The Contractor defines Emergency Services as inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title, and are needed to evaluate or stabilize an emergency medical condition. *42CFR438.114(a)* Contract: Amendment 02, Exhibit A-2, 1.1.1.28	**Documents:** 1. CHP+ Member Handbook- Section VII. Page 39 (Common Documents Folder) **Narrative:** Colorado Choice has a Member Handbook that defines emergency services for members. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
23. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. *42CFR438.114(c)(1)(i)* Contract: Amendment 02, Exhibit A-2,2.6.6.1.4	**Documents:** 1. CHP+ Member Handbook- Section VII. Page 40 (Common Documents Folder) **Narrative:** Colorado Choice has a Member Handbook that includes covered services and payment for emergency services for members that states the contractor covers and pays for emergency services regardless of whether the emergency care is provided by in-network and out-of-network provider. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
24. The Contractor does not require prior authorization for emergency or urgently needed services. *42CFR438.10(f)(6)(viii)(B)* Contract: Amendment 02, Exhibit A-2, 2.6.6.1.3	**Documents:** 1. CHP+ Member Handbook- Section VII. Page 40 (Common Documents Folder) 2. Network Access Plan – Pages 5-6 (Common Documents Folder) **Narrative:** Colorado Choice has a Member Handbook that includes a section of covered services for emergency care for members not requiring prior authorization for emergency or urgently needed services. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services. Colorado Choice's Network Access Plan states that Prior Authorization is not required, regardless of whether the emergency services facility or Provider is a Participating facility or Provider, or is considered out-of-network. CO Choice will ensure that the Member obtains the covered emergency services benefit at no greater cost to the Member than if the benefit had been obtained through a Participating Provider or facility.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Findings:
The member handbook informed members that there is no prior authorization required for emergency care and explained how to access urgent care services. The member handbook stated, "Urgent/after-hours care provided more than 50 miles from the service area [is not covered] if you knew you might need care before you left, or if you could have traveled to the PCP's office without medically harmful results." Although during the on-site interview, Colorado Choice staff members clarified that prior authorization is not required for emergency services or urgent care, the Precertification Procedures for Authorizations and Referrals policy described authorization procedures for emergency service requests. In addition, Colorado Choice may want to consider clarifying the policy to delineate the difference between urgent requests for services that require prior authorization and urgent care provided to prevent the onset of the need for emergency care.

Required Actions:
Colorado Choice must clarify any applicable policies to state that precertification requests or prior authorization is not required for emergency or urgent care services. Colorado Choice must also revise member materials, removing any qualification to providing urgent care services.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
25. The Contractor may not deny payment for treatment obtained under the following circumstances: ◆ A member had an emergency medical condition, and the absence of immediate medical attention would ***have*** had the following outcomes: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. • Serious impairment to bodily functions. • Serious dysfunction of any bodily organ or part. ◆ Situations which a reasonable person outside the medical community would perceive as an emergency medical condition but the absence of immediate medical attention would ***not*** have had the following outcomes: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. • Serious impairment to bodily functions. • Serious dysfunction of any bodily organ or part. ◆ A representative of the Contractor's organization instructed the member to seek emergency services. *42CFR438.114(c)(1)(ii)* Contract: Amendment 02, Exhibit A-2, 2.6.6.1.4, 2.6.6.3.1, and 2.6.6.4.1.3	**Documents:** 1. CHP+ Member Handbook- Section VII. Page 39 & 40 (Common Documents Folder) **Narrative:** Colorado Choice has a Member Handbook that states an emergency medical condition will not be denied for payment. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
26. The Contractor does not: ◆ Limit what constitutes an emergency medical condition on the basis of a list of diagnoses or symptoms. ◆ Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the Contractor or State agency of the member's screening and treatment within 10 days of presentation for emergency services. *42CFR438.114(d)(1)* Contract: Amendment 02, Exhibit A-2, 2.6.6.6.2.1 and 2.6.6.1.6	**Documents:** 1. Chp+ Member Handbook, Page 39-40 (Common Documents Folder) **Narrative:** Colorado Choice has a member handbook that states that Colorado Choice covers emergency services necessary to screen and stabilize a member without precertification. The handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services. **Additional Documents Submitted On-site:** • Claims Edits Flow Sheets	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
27. The Contractor will be responsible for Emergency Services when: ◆ The member's primary diagnosis is medical in nature, even when the medical diagnosis includes some psychiatric conditions or procedures. ◆ The primary diagnosis is psychiatric in nature even when the psychiatric diagnosis includes some procedures to treat a secondary medical diagnosis. Contract: Amendment 02, Exhibit A-2, 2.6.6.6.2	**Documents:** 1. CHP+ Member Handbook- Section VII. Page 40 (Common Documents Folder) **Narrative:** Colorado Choice has a Member Handbook that includes contractor's responsibility for emergency services. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
28. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42CFR438.114(d)(2)* Contract: Amendment 02, Exhibit A-2, 2.6.6.1.7	**Documents:** 1. CHP+ Member Handbook- Section VII. Page 40 & 41 (Common Documents Folder) **Narrative:** Colorado Choice has a Member Handbook that states contractor covers emergency services necessary to screen and stabilize a member as well as post stabilization services. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: Although the member handbook adequately informed members of the definition of *emergency care*, that emergency care is covered in- or out-of-network, and that prior authorization is not required, the handbook also stated that "services related to the non-compliance of care if the member leaves a hospital or facility against the medical advice of the provider" are not covered. There was one case during the on-site denials record review in which Colorado Choice denied payment for the emergency care because the member left the facility against medical advice.		
Required Actions: To the extent that the initial presentation for emergency care meets the definition of *emergency medical condition* (using the prudent layperson standard), Colorado Choice must pay for the emergency treatment obtained.		
29. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment. *42CFR438.114(d)(3)* Contract: Amendment 02, Exhibit A-2, 2.6.6.1.5	**Documents:** 1. CHP+ Member Handbook- Section VII. Page 40 & 41 (Common Documents Folder) **Narrative:** Colorado Choice has a member handbook that defines post stabilization care services when obtained in or out of network and administered to maintain a member's stabilized condition. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
30. The Contractor defines Poststabilization Care as covered services, related to an emergency medical condition, that are provided after a member is stabilized in order to maintain the stabilized condition, or provided to improve or resolve the member's condition. *42CFR438.114(a)* Contract: Amendment 02, Exhibit A-2, 1.1.1.67	**Documents:** 1. CHP+ Member Handbook- Section VII. Page 40 (Common Documents Folder) **Narrative:** Colorado Choice has a Member Handbook that defines post-stabilization care services as related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or to improve or resolve the member's condition. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
31. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that ***have been*** pre-approved by a plan provider or other organization representative. *42CFR438.114(e)* *42CFR422.113(c)* Contract: Amendment 02, Exhibit A-2, 2.6.6.4.1.4	**Documents:** 1. CHP+ Member Handbook- Section VII. Page 41-42 (Common Documents Folder) **Narrative:** Colorado Choice has a Member Handbook that states contractor is responsible for post-stabilization care services obtained in or out of network if those services are pre-approved. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
32. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that ***have not been*** pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition under the following circumstances: ◆ Within 1 hour of a request to the organization for pre-approval of further poststabilization care services. ◆ The Contractor does not respond to a request for pre-approval within 1 hour. ◆ The Contractor cannot be contacted. ◆ The Contractor's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a plan physician, and the treating physician may continue with care of the patient until a plan physician is reached, or the Contractor's financial responsibility for poststabilization care services it ***has not*** pre-approved ends. *42CFR438.114(e)* *42CFR422.113(c)* Contract: Amendment 02, Exhibit A-2, 2.6.6.4.1.5 and 6	**Documents:** 1. CHP+ Member Handbook- Section VII. Page 40 & 41 (Common Documents Folder) **Narrative:** Colorado Choice has a Member Handbook that states contractor is responsible for post-stabilization care services obtained in or out of network if those services are not pre-approved, but are administered to maintain, improve, or resolve the member's stabilized condition. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
33. The Contractor's financial responsibility for poststabilization care services it ***has not*** pre-approved ends when: ◆ A plan physician with privileges at the treating hospital assumes responsibility for the member's care. ◆ A plan physician assumes responsibility for the member's care through transfer. ◆ A plan representative and the treating physician reach an agreement concerning the member's care, ◆ The member is discharged. *42CFR438.114(e)* *42CFR422.113(c)* Contract: Amendment 02, Exhibit A-2, 2.6.6.4.1.8	**Documents:** 1. CHP+ Member Handbook- Section VII. Page 41 (Common Documents Folder) **Narrative:** Colorado Choice has a member handbook that includes not covered/excluded post-stabilizations services informing members that Colorado Choice is no longer financially responsible. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
34. The Contractor must limit charges to members for poststabilization care services to an amount no greater than what the Contractor would charge the member if he or she had obtained the services through the Contractor. *42CFR438.114(e)* *42CFR422.113(c)* Contract: Amendment 02, Exhibit A-2, 2.6.6.4.1.7	**Documents:** 1. Network Access Plan – Page 5 (Common Documents Folder) **Narrative:** Colorado Choice's Network Access Plan states that Prior Authorization is not required, regardless of whether the emergency services facility or Provider is a Participating facility or Provider, or is considered out-of-network. CO Choice will ensure that the Member obtains the covered emergency services benefit at no greater cost to the Member than if the benefit had been obtained through a Participating Provider or facility.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	24	X	1.00	=	24
	Partially Met	=	9	X	.00	=	0
	Not Met	=	1	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	34	**Total Score**		=	24

Total Score ÷ Total Applicable	=	71%

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
The Contractor ensures that all covered services are available and accessible to members through compliance with the following requirements:		
1. The Contractor maintains and monitors a network of providers that is supported by written agreements and is sufficient to provide adequate access to all covered services. In order for the Contractor's plan to be considered to provide adequate access, the Contractor includes the following provider types and ensures a minimum provider-to-member caseload ratio as follows: ◆ Appropriate access to certified nurse practitioners and certified nurse midwives. ◆ 1:2000 primary care physician-to-member ratio. PCP includes physicians designated to practice family medicine and general medicine. ◆ 1:2000 physician specialist-to-members ratio. Physician specialist includes physicians designated to practice cardiology, otolaryngology/ENT, endocrinology, gastroenterology, neurology, orthopedics, pulmonary medicine, general surgery, ophthalmology, and urology. ◆ Physician specialists designated to practice internal medicine, infectious disease, OB/GYN and pediatrics shall be counted as either PCP or physician specialist, but not both. *42CFR438.206(b)(1)* Contract: Amendment 02, Exhibit A-2, 2.7.1.1.5, 2.7.1.1.6, and 2.7.1.1.9	**Documents:** 1. Provider Network Adequacy Reporting (Standard II Folder) 2. Network Access Plan – Page 2 (Common Documents Folder) **Narrative:** Through our Provider Network Adequacy reporting on a quarterly basis, we have documented our providers that are available to CHP+ members with appropriate ratios well under 1:2000 for primary care and specialists. Colorado Choice follows a Network Access Plan to provide a network of providers in order to provide adequate access to all covered benefits. This Network Access Plan is designed to meet the criteria outlined in C.R.S. §10-16-704(9) for fully-insured commercial business and the State of Colorado Children's Health Plan contract. This Plan is also intended to address 42 CFR §422.112 Access to Services for the Medicare Cost contract. Additionally, as a Qualified Health Plan (QHP) offering health benefit plans on the Connect for Health Colorado health insurance exchange, CO Choice is subject to the Patient Protection and Affordable Care Act regulations, including §156.230 (network adequacy standards) and section 2702(c) of the Public Health Service Act, as they relate to the types of providers that must be accessible to health benefit plan enrollees.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. In establishing and maintaining the network, the Contractor considers: ◆ The anticipated CHP+ enrollment. ◆ The expected utilization of services, taking into consideration the characteristics and health care needs of specific CHP+ populations represented in the Contractor's service area. ◆ The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted CHP+ services. ◆ The numbers of network providers who are not accepting new CHP+ patients. ◆ The geographic location of providers and CHP+ members, considering distance, travel time, the means of transportation ordinarily used by CHP+ members, and whether the location provides physical access for CHP+ members with disabilities. *42CFR438.206(b)(1)(i) through (v)* Contract: Amendment 02, Exhibit A-2, 2.5.10.1	**Documents:** 1. Network Access Plan – Page 3 (Common Documents Folder) 2. Desktop Procedure PR-001: Provider Office Site Evaluation (Standard II Folder) **Narrative:** Colorado Choice Health Plans (CO Choice) maintains a network of Providers and facilities sufficient to assure that all covered benefits are available to Members without unreasonable delay as is possible given the rural nature of the service area. Our contracting strategy is broad-based and personalized at the same time, meaning that we make every attempt to contract with every facility and every provider located in the communities we serve, while also working with employers and brokers to identify and address individual needs in underserved areas. Refer to Network Adequacy Management Section on page 3 of the Network Access Plan. At point of contracting, the standard for physical accessibility is addressed with the prospective provider via the Provider Handbook. During the provider or facility onsite evaluation, this is addressed in Office Site Quality Checklist Factor 1. Site visits are performed on initial application, within 12 months and randomly thereafter in a timely manner not to exceed 36 months. Sites with a non-passing score following review by the Peer Review Committee, will receive a letter of correction from the Provider Relations Department. Another site evaluation will be done within 6 months. Customer Service will notify Provider Relations of any complaints relative to scheduling and wait times. Provider Relations will arrange for a visit and scoring within 60 days from the date of the complaint. Through our Quality Management Program, the Peer Review Committee has the responsibility of routine monitoring of complaints or grievances related to access as	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	well as routine monitoring of member satisfaction surveys/data. A process is in place for provider communication and corrective action. This can be found in the Provider Handbook.	
3. The Contractor ensures that its members have access to a provider within 30 miles or 30 minutes travel time, whichever is larger, to the extent such services are available and providers are qualified and willing to contract on reasonable terms. Contract: Amendment 02, Exhibit A-2, 2.7.1.3.1	**Documents:** 1.Network Access Plan-Page 12 (Common Documents Folder) **Narrative:** Colorado Choice Health Plans (CO Choice) maintains a network of Providers and facilities sufficient to assure that all covered benefits are available to Members without unreasonable delay as is possible given the rural nature of the service area. Our contracting strategy is broad-based and personalized at the same time, meaning that we make every attempt to contract with every facility and every provider located in the communities we serve, while also working with employers and brokers to identify and address individual needs in underserved areas. Refer to Availability Standards-Geographic Accessibility Section on page 12 of the Network Access Plan.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. The Contractor ensures that members have access to an Essential Community Provider, to the extent such services are available: ◆ Within 30 minutes or 30 miles in urban counties. ◆ Within 45 minutes or 45 miles in suburban counties. ◆ Within 90 minutes or 90 miles in rural counties. Contract: Amendment 02, Exhibit A-2, 2.7.1.3.2	**Documents:** 1. Network Access Plan (Common Documents Folder) **Narrative:** In rural service areas, CO Choice will make a good faith effort to maintain contracts with all locally-based Essential Community Providers (ECPs), such as FQHCs, rural health clinics and Ryan White-funded clinics in the service area. For urban service areas, CO Choice will ensure that the standards specified in the Monitoring section are met or exceeded. Refer to Availability Standards-Geographic Accessibility Section on page 12 of the Network Access Plan.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor provides female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health care specialist. *42CFR438.206(b)(2)* Contract: Amendment 02, Exhibit A-2, 2.7.1.1.7	**Documents:** 1. Network Access Plan – Page 4 (Common Documents Folder) **Narrative:** Female Members may obtain routine and preventive reproductive or gynecological care from Participating obstetricians, gynecologists, or certified nurse midwives without a Referral for the office visit.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
6. The Contractor allows persons with special health care needs who use specialists frequently to maintain these types of specialists as PCPs or be allowed direct access/standing referrals to specialists. *42CFR438.208(c)(4)* Contract: Amendment 02, Exhibit A-2, 2.7.5.4	**Documents:** 1. Provider Handbook – Page 11(Common Documents Folder) **Narrative:** Colorado Choice maintains a Provider Handbook that outline continuity of care specific to the CHP+ Membership.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
7. The Contractor has a mechanism to allow members to obtain a second opinion from a qualified health care professional within the network, or arranges for the member to obtain one outside the network, at no cost to the member. *42CFR438.206(b)(3)* Contract: Amendment 02, Exhibit A-2, 2.7.1.1.8	**Documents:** 1. CHP+ Member Handbook – Page 21 (Common Documents Folder) **Narrative:** Colorado Choice has a Member Handbook that includes members' right to a second opinion. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. If the Contractor is unable to provide necessary primary or specialist services to a member in-network, the Contractor must make special arrangements for members to access out-of-network providers for as long as the Contractor is unable to provide them. *42CFR438.206(b)(4)* Contract: Amendment 02, Exhibit A-2, 2.7.1.2.1	**Documents:** 1. Network Access Plan – Page 5, Paragraph 3. (Common Documents Folder) **Narrative:** Colorado Choice follows the Network Access Plan which outlines that in the rare case where no local Participating Provider or facility provides a covered service (such as endocrinology), CO Choice will arrange for a Referral to a Provider or facility with the necessary expertise and ensure that the Member obtains the covered benefit at no greater cost to the Member than if the benefit had been obtained through a Participating Provider or facility.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor works with out-of-network providers with respect to payment and ensures that the cost to the member is no greater than it would be if the services were furnished within the network. *42CFR438.206(b)(5)* Contract: Amendment 02, Exhibit A-2, 2.7.1.2.2.1	**Documents:** 1. Network Access Plan – Page 5, Paragraph 3. (Common Documents Folder) **Narrative:** Colorado Choice follows the Network Access Plan which outlines that in the rare case where no local Participating Provider or facility provides a covered service (such as endocrinology), CO Choice will arrange for a Referral to a Provider or facility with the necessary expertise and ensure that the Member obtains the covered benefit at no greater cost to the Member than if the benefit had been obtained through a Participating Provider or facility. **Additional Documents Submitted On-site:** • Memorandum of Understanding Template	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor ensures that members within the service area have access to emergency services on a 24-hour, 7 days-a-week basis. *42CFR438.206(c)(1)(iii)* Contract: Amendment 02, Exhibit A-2, 2.6.3.5	**Documents:** 1. CHP+ Member Handbook- Page 5 (Common Documents Folder) 2. Customer Service After Hours and Customer Service ACD Telephone Scripts (Standard II Folder) **Narrative:** Colorado Choice has a Member Handbook that includes Emergency Services are available 24 hours a day, 7 days a week. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services. Telephone Scripts are attached.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The Network Access Plan states that members may access emergency care at any emergency facility and prior authorization is not required, regardless of whether the facility is inside or outside the network. The member handbook informs members of the same, and directs members to the provider directory for a list of facilities. Colorado Choice Customer Service After-hours messaging directs members to go to the nearest facility in case of emergency. Federal regulations require policies and procedures that address the availability of emergency services 24 hours per day, seven days per week.		
Required Actions: Colorado Choice must develop policies and procedures that address the availability of emergency services 24 hours per day, seven days per week.		
11. Members temporarily out of the service area may receive out-of-area emergency services and urgently needed services. Contract: Amendment 02, Exhibit A-2, 2.6.3.5	**Documents:** 1. Network Access Plan-Page 5-6 Emergency Services (Common Documents Folder) 2. CHP+ Member Handbook-Page 41 Covered Services (Common Documents Folder) **Narrative:** Both the Network Access Plan and Member Handbook reference Members being temporarily out of the service area. Member may receive emergency and urgent services when they are temporarily out of the service area.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The Network Access Plan states that out-of-network urgent care and emergency services are covered. The CHP+ Member Handbook informs members that urgent care is covered when the member is temporarily out of the service area. The handbook states that members may receive emergency services from any provider in any location, inside or outside the network. However, federal regulations require policies and procedures that address out-of-area emergency and urgently needed services.		
Required Actions: Colorado Choice must develop policies and procedures that state emergency services and urgently needed services are covered when members are temporarily out of the service area.		
12. The Contractor must require its providers to offer hours of operation that are no less than the hours of operation offered to commercial members. *42CFR438.206(c)(1)(ii)* Contract: Amendment 02, Exhibit A-2, 2.5.1	**Documents:** 1. Sample Contract-Section 3.2 on page 4 (Standard I Folder) **Narrative:** Providers shall provide the same standard of care for our Members as they do for their other patients. Colorado Choice Members are defined in the sample contract section 1.9 on page 2, regardless of whether the Member is commercial or CHP+, they shall receive the same standard of care.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services taking into account the urgency of the need for services: ◆ Urgently needed services are provided within 48 hours of notification of the primary care physician or the Contractor. *42CFR438.206(c)(1)(i)* Contract: Amendment 02, Exhibit A-2, 2.7.1.5.2.1	**Documents:** 1. Provider Handbook-Page 22 Standards of Accessibility 2. Network Access Plan – Page 12 (Common Documents Folder) **Narrative:** Colorado Choice has a Provider Handbook that is distributed to all providers within the Colorado Choice Network. This Provider Handbook outlines that urgently needed services must be provided within 24 hours. The standards are also listed in the Network Access Plan, Page 12 Access Standards- Wait Times.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services taking into account the urgency of the need for services: ◆ Non-urgent, symptomatic health care is scheduled within two weeks. ◆ Non-emergent, non-urgent care for a medical problem is provided within 30 calendar days. ◆ Non-symptomatic well care physical examinations are scheduled within 4 months. *42CFR438.206(c)(1)(i)* Contract: Amendment 02, Exhibit A-2, 2.7.1.5.2–4	**Documents:** 1. Provider Handbook-Page 22 Standards of Accessibility (Common Documents Folder) 2. Network Access Plan – Page 12 (Common Documents Folder) **Narrative:** Colorado Choice has a Provider Handbook that is distributed to all providers within the Colorado Choice Network. This Provider Handbook outlines that urgently needed services must be provided within 24 hours. The standards are also listed in the Network Access Plan, Page 12 Access Standards- Wait Times.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
15. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services taking into account the urgency of the need for services: ◆ Diagnosis and treatment of non-emergency, non-urgent mental health condition scheduled within 30 calendar days. ◆ Diagnosis and treatment of a non-emergent, non-urgent substance abuse condition scheduled within 2 weeks. *42CFR438.206(c)(1)(i)* Contract: Amendment 02, Exhibit A-2, 2.7.1.5.2.5 and 2.7.1.5.2.6	**Documents:** 1. Provider Handbook-Page 22 Standards of Accessibility (Common Documents Folder) 2. Network Access Plan – Page 12 (Common Documents Folder) **Narrative:** Colorado Choice has a Provider Handbook that is distributed to all providers within the Colorado Choice Network. This Provider Handbook outlines that urgently needed services must be provided within 24 hours. The standards are also listed in the Network Access Plan, Page 12 Access Standards- Wait Times.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The Contractor communicates all scheduling guidelines to participating providers and members. Contract: Amendment 02, Exhibit A-2, 2.7.1.4.1, 2.7.1.5.4, Exhibit I-1, 1.1.15	**Documents:** 1. Provider Handbook - Page 22 (Common Documents Folder) **Narrative:** Participating providers are informed of the scheduling guidelines through their respective handbooks.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The provider handbook communicated appointment availability standards to providers for emergent, urgent, non-urgent symptomatic, and preventive care. The handbook did not address mental health and substance abuse standards. The member handbook did not include scheduling guidelines, and Colorado Choice did not provide other documents that communicated scheduling guidelines to members.		
Required Actions: Colorado Choice must develop a mechanism to communicate mental health and substance abuse scheduling guidelines to providers and all scheduling guidelines to members.		
17. The Contractor maintains an effective organizational process for monitoring scheduling and wait times, identifying scheduling and wait time issues that do not comply with its guidelines, and takes appropriate action. The Contractor has mechanisms to ensure compliance by providers regarding timely access to services, has mechanisms to monitor providers regularly to determine compliance, and to take corrective action if there is failure to comply. *42CFR438.206(c)(1)(iv) through (vi)* Contract: Amendment 02, Exhibit A-2, 2.7.1.4.1.1.1, and 2.7.1.5.4	**Documents:** 1. Desktop Procedure PR-001: Provider Office Site Evaluation (Standard II Folder) 2. Desktop Procedure PR-002: Facility Site Evaluation (Standard II Folder) 3. Colorado Choice Health Plans Provider Handbook 2013 (Common Documents Folder) 4. Colorado Choice Health Plans Network Access Plan (Common Documents Folder) **Narrative:** At point of contracting, the standard of scheduling and wait times is addressed with the prospective provider via the Provider Handbook. During the provider or facility onsite evaluation, this is addressed in Office Site Quality Checklist Factor 1. Site visits are performed on initial application, within 12 months and randomly thereafter in a timely manner not to exceed 36 months. Sites with a non-passing score following review by the Peer Review Committee, will receive a letter of correction from the Provider	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Relations Department. Another site evaluation will be done within 6 months. Customer Service will notify Provider Relations of any complaints relative to scheduling and wait times. Provider Relations will arrange for a visit and scoring within 60 days from the date of the complaint. Through our Quality Management Program, the Peer Review Committee has the responsibility of routine monitoring of complaints or grievances related to access as well as routine monitoring of member satisfaction surveys/data. A process is in place for provider communication and corrective action. This can be found in the Provider Handbook.	
Findings: The Provider Office Site Evaluation and Facility Site Evaluation procedures included a checklist for all appointment scheduling and wait time standards. The evaluation forms documented "yes," "no," and "comments" for each standard. The procedures stated that on-site evaluation is done within 12 months of initial application and randomly thereafter, not to exceed 36 months.		
Required Actions: Colorado Choice's current method to monitor provider scheduling wait times is by self-report from the provider. Colorado Choice must develop a mechanism to monitor actual scheduling and wait times. Sampling providers for this monitoring would be acceptable.		
18. The Contractor maintains a comprehensive program of preventive health services for members that includes written policies and procedures, involves providers and members in their development and ongoing evaluation, and includes: ◆ Risk assessment by a member's PCP or other qualified professionals specializing in risk prevention who are part of the Contractor's participating providers or under contract to provide such services, to identify members with chronic or high-risk illnesses, a disability, or the potential for such condition. ◆ Health education and promotion of wellness programs, including the development of appropriate preventive services for members with a disability to	**Documents:** 1. Policy 3000CHP+-Care Coordination and Case Management Program (Standard II Folder) **Narrative:** Colorado Choice maintains a care coordination and case management program to improve the coordination and continuity of medically necessary services, particularly for members with complex, serious or high-cost conditions in a timely and cost efficient manner.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
prevent further deterioration. The Contractor will also include distribution of information to members to encourage member responsibility for following guidelines for preventive health. ◆ Evaluation of the effectiveness of health preventive services, including monitoring and evaluation of the use of select preventive health services by at-risk members. ◆ Procedures to identify priorities and develop guidelines for appropriate preventive services. ◆ Processes to inform and educate participating providers about preventive services, involve participating providers in development of programs, and evaluate the effectiveness of participating providers in providing such services. Contract: Amendment 02, Exhibit A-2, 2.7.8.1		
Findings: The Care Coordination and Case Management Program policy and procedure described multiple mechanisms for identifying members for case management including member referral for disease management programs; utilization data and specific trigger diagnoses (complex or high-risk conditions); and member assessments that identify health status, conditions, and functionality. On-site, Colorado Choice staff provided examples of health education mailings that had occurred. The policy and procedure stated that member care plans and case manager services include member self-management plans and identification and provision of educational materials for effective self-management. None of the documents submitted addressed development of preventive service guidelines for members with disabilities, monitoring/evaluation of the use of preventive services, methods to identify priorities for and development of preventive service guidelines, provider education about preventive services, or provider evaluation of the provision of such services.		
Required Actions: Colorado Choice must develop policies and procedures that address the required elements of a preventive medicine program.		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
19. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner, to all members including those with limited English proficiency or reading skills including those with diverse cultural and ethnic backgrounds by: ◆ Maintaining policies to reach out to specific cultural and ethnic members for prevention, health education, and treatment for diseases prevalent in those groups. ◆ Maintaining policies to provide health care services that respect individual health care attitudes, beliefs, customs, and practices of members related to cultural affiliation. ◆ Making a reasonable effort to identify members whose cultural norms and practices may affect their access to health care. Such efforts may include: • Inquiries conducted by the Contractor of the language proficiency of members during the Contractor's orientation calls. • Being served by participating providers. • Improving access to health care through community outreach and Contractor publications. ◆ Developing and/or providing cultural competency training programs, as needed, to the network providers and Contractor staff regarding: • Health care attitudes, values, customs, and beliefs that affect access to and benefit from health care services, • The medical risks associated with the Client population's racial, ethnic, and socioeconomic conditions.	**Documents:** 1. Policy 3000CHP+-Care Coordination and Case Management Program (Standard II Folder) 2. CHP+ Member Handbook (Common Documents Folder) 3. Telephone Services for Special Needs Desktop Procedure (Standard I Folder) 4. Desktop Procedure PR-001: Provider Office Site Evaluation (Standard II Folder) **Narrative:** Colorado Choice mainatins a care coordination and case management program to improve the coordination and continuity of medically necessary services, particularly for members with complex, serious or high-cost conditions in a timely and cost efficient manner, taking into consideration cultural diversification. Colorado Choice has a member handbook that includes information in spanish to inform members that they may be able to obtain information and services in other languages and formats. Spanish is the only language other than English commonly spoken in the CO Choice service area; many Providers are either conversant in Spanish or employ office staff who are fluent. Additionally, CO Choice has staff members who are fluent in Spanish and available to assist with translation and communications. However, in the event we need translation services, CO Choice has contracted with Translation Plus to provide interpreter services for Members who do not speak English. These translation services are available 24 hours a day, 7 days a week. In the event that a Member is not accommodated as believed necessary, he or she may contact Customer Service at 719-589-3696 or 800-475-8466. TTY functionality is also available at 800-659-2656.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
◆ Making available written translation of Contractor materials, including member handbook, correspondence and newsletters. Written member information and correspondence shall be made available in languages spoken by prevalent non-English-speaking member populations within the Contractor's service area. ◆ Developing policies and procedures, as needed, on how the Contractor shall respond to requests from participating providers for interpreter services by a qualified interpreter. This shall occur particularly in service areas where language may pose a barrier so that Participating Providers can: • Conduct the appropriate assessment and treatment of non-English-speaking members (including Members with a communication disability), • Promote accessibility and availability of covered services, at no cost to Members. ◆ Developing policies and procedures on how the Contractor shall respond to requests from members for interpretive services by a qualified interpreter or publications in alternative formats. ◆ Making a reasonable effort, when appropriate, to develop and implement a strategy to recruit and retain qualified, diverse, and culturally competent clinical providers that represent the racial and ethnic communities being served, ◆ Providing access to interpretative services by a qualified interpreter for members with a hearing impairment in such a way that it shall promote accessibility and availability of covered services,	During the provider or facility onsite evaluation, this is addressed in Office Site Quality Checklist Factor 1. Site visits are performed on initial application, within 12 months and randomly thereafter in a timely manner not to exceed 36 months. Sites with a non-passing score following review by the Peer Review Committee, will receive a letter of correction from the Provider Relations Department. Another site evaluation will be done within 6 months. Customer Service will notify Provider Relations of any complaints relative to providing access and the Americans with Disabilities Act of 1990. Provider Relations will arrange for a visit and scoring within 60 days from the date of the complaint. Through our Quality Management Program, the Peer Review Committee has the responsibility of routine monitoring of complaints or grievances related to access as well as routine monitoring of member satisfaction surveys/data. A process is in place for provider communication and corrective action. This can be found in the Provider Handbook.	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
◆ Developing and maintaining written policies and procedures to ensure compliance with requirements of the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973, ◆ Arranging for Covered Services to be provided through agreements with non-participating providers when the Contractor does not have the direct capacity to provide covered services in an appropriate manner, consistent with independent living, to members with disabilities, ◆ Providing access to TDD or other equivalent methods for members with a hearing impairment in such a way that it will promote accessibility and availability of covered services, ◆ Making member information available upon request for members with visual impairments, including, but not limited to, Braille, large print, or audiotapes. For members who cannot read, member information shall be available on audiotape. *42CFR438.206(c)(2)* Contract: Amendment 02, Exhibit A-2, 2.7.7.2		
Findings: The Care Coordination and Case Management policy and procedure stated that case managers would assess cultural and linguistic needs and address ethnic, religious, or spiritual concerns that may impact the care plan. The Network Access Plan stated that "Colorado Choice strives to ensure that all covered services are available to all enrollees, regardless of sex, race, color, religion, physical/mental disability, sexual orientation, age, marital status, national origin/ancestry, genetic information, health status, status as a Member, or participation in a publicly financed program." The sample provider contracts required providers to provide services in a culturally competent manner. The policy and procedure stated that Spanish is the only significant language other than English in the service area, that many providers and staff are fluent in Spanish, and that contracted interpreter services are available 24 hours per day, seven days per week. The Network Access Plan did not address efforts to assess the cultural diversity of the provider network or to recruit culturally diverse providers.		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
The member handbook stated in English and Spanish that materials are available in other languages, Braille, large print, and audiotape. The handbook instructed members to call customer services to obtain interpreter services in any language and also provided a TTY telephone number. The Telephone Services for Special Needs procedure described the detailed processes for Colorado Choice staff to respond to members who are hearing or speech impaired, or speak another language by accessing TTY, telecommunications relay service (TRS), or Translation Plus interpreter services. Policies and procedures did not address assessment of the cultural norms or practices with respect to their effect on the member's health care needs. The provider handbook does not address cultural responsiveness or describe how providers may access interpreter services for patients. Colorado Choice documents also did not address Cultural Competency training for providers or staff, policies and procedures related to access to interpreter services by providers, or arranging for covered services with non-participating providers when necessary to accommodate independent living of members with disabilities. Colorado Choice may want to consider developing a comprehensive Cultural Competency Program Description to ensure that each of the contract requirements regarding cultural competency are met.		
Required Actions: Colorado Choice must ensure that the required elements are present in its policies and/or practices to promote the State's efforts for delivery of services in a culturally competent manner.		
20. The Contractor analyzes and responds to results of the following HEDIS measures: ◆ Well-Child Visits in the First 15 Months of Life ◆ Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life ◆ Adolescent Well-Care Visits Contract: Amendment 02, Exhibit A-2, 2.9.4.1.2	**Documents:** 1. Quality Management Program (Standard II Folder) **Narrative:** Colorado Choice Health Plans has incorporated a Quality Management Program wherein HEDIS results will be analyzed and brought to a committee for evaluations, comments and recommendations.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
21. The Contractor monitors member perceptions of accessibility and adequacy of services provided by the Contractor. The Contractor uses tools including member surveys, anecdotal information, grievance and appeals data, and enrollment and disenrollment information. Contract: Amendment 02, Exhibit A-2, 2.9.4.3.2	**Documents:** 1. Quality Management Program (Standard II Folder) 2. CAHPS Corrective Action Plan (Standard II Folder) **Narrative:** Colorado Choice monitors member perceptions of accessibility and adequacy through the CHP+ CAHPS Health Plan Survey.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
22. The Contractor develops and implements a corrective action plan for all areas of the CAHPS survey that report a score that is less than the 50th percentile. Contract: Amendment 02, Exhibit A-2, 2.9.4.3.5	**Documents:** 1. Colorado CHP+ Corrective Action Plan (Standard II Folder) **Narrative:** Colorado Choice develops and implements a corrective action plan for all areas of the CAHPS survey that report a score that is less than the 50th percentile. The CAHPS corrective action plan is submitted to state for review and approval. **Additional Documents Submitted On-site:** • CAHPS Corrective Action Plan	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard II—Access and Availability							
Total	Met	=	16	X	1.00	=	16
	Partially Met	=	6	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	22	**Total Score**		=	16

Total Score ÷ Total Applicable	=	73%

Appendix B. Record Review Tool *for* Colorado Choice Health Plan

The completed record review tool follows this cover page.

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2013–2014 Denials Record Review Tool
for Colorado Choice Health Plan

Review Period:	January 1, 2013–December 31, 2013
Date of Review:	December 17, 2013
Reviewer:	Barbara McConnell and Rachel Henrichs
Participating Plan Staff Member:	Lynne Nash

Requirement	File 1	File 2	File 3	File 4	File 5
1. Member ID	*****	*****	*****	*****	*****
2. Date of initial request	NA	NA	NA	NA	NA
3. What type of denial? (termination [T], new request [NR], or claim [CL])	CL	CL	CL	CL	CL
4. Standard (S) or Expedited (E)	NA	NA	NA	NA	NA
5. Date notice of action sent	08/30/13	04/25/13	04/04/13	10/04/13	03/21/13
6. Notice sent to provider and member? (C or NC)	C	C	C	C	C
7. Number of days for decision/notice	NA	NA	NA	NA	NA
8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before)	C	C	C	C	C
9. Was authorization decision timeline extended? (Y or N)	NA	NA	NA	NA	NA
a. If extended, extension notification sent to member? (C or NC, or NA)	NA	NA	NA	NA	NA
b. If extended, extension notification includes required content? (C or NC, or NA)	NA	NA	NA	NA	NA
10. Notice of Action includes required content? (C or NC)	NC	NC	NC	NC	NC
11. Authorization decision made by qualified clinician? (C or NC, or NA)	NA	NA	NA	NA	NA
12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA)	NA	NA	NA	NA	NA
13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA)	NA	NA	NA	NA	NA
14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	NC	C	NC	C	C
15. Was correspondence with the member easy to understand? (C or NC)	NC	NC	NC	NC	NC
Total Applicable Elements	5	5	5	5	5
Total Compliant Elements	2	3	2	3	3
Score (Number Compliant / Number Applicable) = %	40%	60%	40%	60%	60%

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

Requirement	File 6	File 7	File 8	File 9	File 10
1. Member ID	*****	*****	*****	*****	*****
2. Date of initial request	NA	NA	NA	NA	NA
3. What type of denial? (termination [T], new request [NR], or claim [CL])	CL	CL	CL	CL	CL
4. Standard (S) or Expedited (E)	NA	NA	S	S	S
5. Date notice of action sent	08/08/13	04/19/13	06/24/13	07/31/13	06/27/13
6. Notice sent to provider and member? (C or NC)	C	C	C	C	C
7. Number of days for decision/notice	NA	NA	NA	NA	NA
8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before)	C	C	C	C	C
9. Was authorization decision timeline extended? (Y or N)	NA	NA	NA	NA	NA
a. If extended, extension notification sent to member? (C or NC, or NA)	NA	NA	NA	NA	NA
b. If extended, extension notification includes required content? (C or NC, or NA)	NA	NA	NA	NA	NA
10. Notice of Action includes required content? (C or NC)	NC	NC	NC	NC	NC
11. Authorization decision made by qualified clinician? (C or NC, or NA)	NA	NA	NA	NA	NA
12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA)	NA	NA	NA	NA	NA
13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA)	NA	NA	NA	NA	NA
14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C	C	NC	C
15. Was correspondence with the member easy to understand? (C or NC)	NC	NC	NC	NC	NC
Total Applicable Elements	5	5	5	5	5
Total Compliant Elements	3	3	3	2	3
Score (Number Compliant / Number Applicable = %)	60%	60%	60%	40%	60%

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

Requirement	File 11	File 12	File 13	File 14	File 15
1. Member ID	*****	*****	*****	*****	*****
2. Date of initial request	NA	NA	NA	NA	NA
3. What type of denial? (termination [T], new request [NR], or claim [CL])	CL	CL	CL	CL	CL
4. Standard (S) or Expedited (E)	S	NA	NA	NA	NA
5. Date notice of action sent	11/15/13	11/15/13	11/17/13	07/18/13	01/31/13
6. Notice sent to provider and member? (C or NC)	C	C	C	C	C
7. Number of days for decision/notice	NA	NA	NA	NA	NA
8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before)	C	C	C	C	C
9. Was authorization decision timeline extended? (Y or N)	NA	NA	NA	NA	NA
a. If extended, extension notification sent to member? (C or NC, or NA)	NA	NA	NA	NA	NA
b. If extended, extension notification includes required content? (C or NC, or NA)	NA	NA	NA	NA	NA
10. Notice of Action includes required content? (C or NC)	NC	NC	NC	NC	NC
11. Authorization decision made by qualified clinician? (C or NC, or NA)	NA	NA	NA	NA	NA
12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA)	NA	NA	NA	NA	NA
13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA)	NA	NA	NA	NA	NA
14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C	C	C	C
15. Was correspondence with the member easy to understand? (C or NC)	NC	NC	NC	NC	NC
Total Applicable Elements	5	5	5	5	5
Total Compliant Elements	3	3	3	3	3
Score (Number Compliant / Number Applicable = %)	60%	60%	60%	60%	60%

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

Total Record Review Score	Total Applicable Elements: 75	Total Compliant Elements: 42	Total Score: 56%

Comments: Appeals information included with all of the notice of action letters was based on Division of Insurance requirements and was not compliant with CHP+/Medicaid requirements. The letters did not include a clear explanation of what service or services were being denied or the reason why the service or services were denied.

For Record #1, Colorado Choice's system included a CPT code explanation that differed from the explanation provided in the CPT code book. The CPT code book explanation described a covered service. There was no information in the system that justified why this service was denied.

Record #3 was an emergency room (ER) claim that was denied because the member left the ER against medical advice. The explanation of benefits (EOB) indicated that the member was being held responsible for the costs of emergency services provided.

Record #4 was related to an inpatient hospitalization for transfusion and hematology services. The authorization system contained documentation that the hospitalization was covered and paid, but that the provider services were denied. There was no documentation in the system explaining why the services were denied. The EOB indicated that the member was responsible for the cost of the services. Colorado Choice staff was unable to determine the reason for the denial. If the services were denied due to issues with claim submission, Colorado Choice must ensure that the member and the provider are informed that the provider, not the member, is responsible.

Record #6 was a claim for a magnetic resonance imaging (MRI) under anesthesia. The claim was denied due to no prior authorization obtained. The EOB indicated that the member was responsible for the cost of the services provided. Members may not be held responsible for the provider's failure to obtain prior authorization.

Record #7 involved operating room services under anesthesia. The claim was denied due to no prior authorization obtained. The EOB indicated that the member was responsible for the cost of the services provided. Members may not be held responsible for the provider's failure to obtain prior authorization.

Record #9 was a claim for preventive services. Most preventive services are covered under the CHP+ contract. There was no documentation in the system about the specific service requested or why the service was denied. Colorado Choice was unable to determine the reason why the claim was denied.

Records #10 through #15 were claims for services that were denied due to no prior authorization obtained. The EOBs indicated that the members were responsible for the cost of the services provided. Although most denials were overturned through appeal and the claims were being reprocessed for payment, members may not be held responsible for the provider's failure to obtain prior authorization.

Appendix C. Site Review Participants for Colorado Choice Health Plan

Table C-1 lists the participants in the FY 2013–2014 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
Rachel Henrichs	Project Coordinator
Colorado Choice Participants	**Title**
Julie Bryant	Nurse Manager
Deanna Gylling	CHP+ Specialist
Manuela Heredia	Compliance Analyst
Janet Hornig	Provider Relations
Judith Jung	Chief Operating Officer (COO)
Lynne Nash	Nurse Manager
Cynthia Palmer	Chief Executive Officer (CEO)
Christine Kingston	Lead Referral Coordinator
Department Observers	**Title**
Jerry Ware	Quality and Health Improvement Unit
Teresa Craig (telephonic)	Managed Care Organization (MCO) Contract Manager

Appendix D. Corrective Action Plan Template for FY 2013–2014 *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 compliance monitoring site review report via e-mail or through the file transfer protocol (FTP) site, with an e-mail notification to HSAG and the Department. The health plan must submit the CAP using the template provided. For each element receiving a score of *Partially Met* or *Not Met*, the CAP must describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training and follow-up activities, and documents to be sent following the completion of the planned interventions.
Step 2	**Prior approval for timelines exceeding 30 days**
	If the health plan is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.
Step 3	**Department approval**
	Following review of the CAP, the Department 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 health care regulations and managed care contract requirements.

The template for the CAP follows.

Table D-2—FY 2013–2014 Corrective Action Plan *for* Colorado Choice		
Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
3. The Contractor has a Utilization Management Program that includes: ◆ Prospective, concurrent, and retrospective review ◆ Preauthorization system ◆ Medical Management Team oversight ◆ Transplant coordination ◆ On-site reviews ◆ Discharge planning ◆ Case management ◆ Appeals and grievances ◆ Mechanisms to detect over- and under-utilization	The UM Program Description and the Care Coordination and Case Management policy both discussed the importance of discharge planning, but neither described processes or procedures. In addition, neither document addressed Colorado Choice's procedures for concurrent review. Colorado Choice may want to consider developing or enhancing specific policies and procedures for each of the required UM Program components, incorporating the policies and procedures into the UM Program Description by reference.	Colorado Choice must ensure that it's UM Program Description clearly describes processes for on-site utilization review, concurrent review, and discharge planning.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Table D-3—FY 2013–2014 Corrective Action Plan *for* Colorado Choice		
Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
5. The Contractor does not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of diagnosis, type of illness, or condition of the member.	Although Colorado Choice staff members reported that Colorado Choice's policy is to use established criteria including Milliman UM review criteria, there were several records in the denials record review for which Colorado Choice could not justify the reason for the denial. The EOBs indicated that the members were responsible for the cost of the services provided. Members may not be held responsible for the provider's failure to obtain prior authorization.	Colorado Choice must review its coding and claims systems and processes, making required revisions to ensure that services are not denied arbitrarily, and that documentation exists to indicate that authorizations and denial decisions are based on established criteria.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Table D-4—FY 2013–2014 Corrective Action Plan *for* Colorado Choice		
Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
8. The Contractor has written policies and procedures that address the processing of requests for initial and continuing authorization of services.	The Pre-certification Procedures for Authorizations and Referrals did not address continuing authorizations of services.	Colorado Choice must either revise or develop policies and procedures to address continuing authorization of services.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Table D-5—FY 2013–2014 Corrective Action Plan *for* Colorado Choice		
Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
9. The Contractor has in place and follows written policies and procedures that include mechanisms to ensure consistent application of review criteria for authorization decisions.	The policy submitted did not address interrater reliability or other mechanisms to ensure consistent application of review criteria. On-site, Colorado Choice staff members reported that UM staff was trained using Milliman/Interqual guidelines, but they were unable to provide evidence that processes were in place to ensure consistent application of utilization review criteria.	Colorado Choice must develop and implement policies and procedures designed to ensure consistent application of review criteria to authorization decisions.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Table D-6—FY 2013–2014 Corrective Action Plan *for* Colorado Choice		
Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
10. The Contractor has in place and follows written policies and procedures that include a mechanism to consult with the requesting provider when appropriate.	While the UM Program Description listed consultation with the attending physician as a potential source of information for determining medical necessity, a policy statement or procedural component was not stated in the UM Program Description.	Colorado Choice must have and follow written policies and procedures that include a mechanism to consult with the requesting provider when appropriate.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Table D-7—FY 2013–2014 Corrective Action Plan *for* Colorado Choice		
Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
13. The Contractor has in place and follows written policies and procedures that include the following time frames for making standard and expedited authorization decisions as expeditiously as the member's health condition requires not to exceed: ◆ For standard authorization decisions—10 calendar days. ◆ For expedited authorization decisions—3 business days.	The Precertification Procedures for Authorization and Referrals policy stated that when requests for services are received with insufficient information to make an authorization decision, the request is held until all appropriate material is received and is then processed with three working days. Colorado Choice may want to consider stating specifically that the three working days are counted from the date the additional materials are received. The policy also stated that requests must be completed or extended within 14 days, regardless of whether all information has been received. Since the three-working-day time frame referenced above is counted from the date the material is received, Colorado Choice should clarify that the time frame for completing or extending begins when the initial request is made. In addition, the 14-day time frame stated does not comply with the 8.209 requirement to make standard preservice authorization decisions within 10 calendar days of receiving the request. The policy stated that urgent care requests are completed within 72 hours of the request for service.	Colorado Choice must revise its applicable policies and procedures to state that CHP+ standard preservice authorization decisions are made, with notice to the member, within 10 calendar days of the request for service.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		

Table D-7—FY 2013–2014 Corrective Action Plan *for* Colorado Choice		
Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Table D-8—FY 2013–2014 Corrective Action Plan *for* Colorado Choice		
Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
14. Notices of action must meet the language and format requirements of 42CFR438.10 to ensure ease of understanding (6th grade reading level wherever possible and available in the prevalent non-English language for the service area).	The appeal information included with the notices of action (NOAs) was difficult to understand. It did not include a clear explanation of what service or services were being denied or the reason why the service or services were denied. The service listed was a general category of services (e.g., preventive services) and did not indicate the specific service that was requested. In addition, the information included incorrect information regarding time frames for filing the appeal and 2nd-level appeal information. During the on-site interview, Colorado Choice staff stated that Colorado Choice does not track language preference in order to communicate NOAs or other member-specific information in non-English languages.	Colorado Choice must review and revise its NOA templates to ensure that correct information is provided in an easy-to-understand format. Colorado Choice must also develop a mechanism to ensure that NOAs are available to members in the prevalent non-English language for its service area.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Table D-9—FY 2013–2014 Corrective Action Plan *for* Colorado Choice		
Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
15. Notices of action must contain: ◆ The action the Contractor (or its delegate) has taken or intends to take. ◆ The reasons for the action. ◆ The member's, authorized representatives, and provider's (on behalf of the member) right to file an appeal and procedures for filing. ◆ The date the appeal is due. ◆ The member's right to a State fair hearing. ◆ The procedures for exercising the right to a State fair hearing. ◆ The circumstances under which expedited resolution is available and how to request it. ◆ The member's right to have benefits continue pending resolution of the appeal and how to request that the benefits be continued. ◆ The circumstances under which the member may have to pay for the costs of services (if continued benefits are requested).	The denial notifications submitted for desk review did not include State fair hearing or continuation of benefits information. The denials records reviewed on-site did not clearly describe the service denied or the reason for the denial, included incorrect information about time frames for filing an appeal, and did not contain information about the State fair hearing process or continuation of benefits/services. On-site, Colorado Choice staff provided a revised denial notification template that included fields for the action taken and the reason for the action. However, the notification template stated that the time frame for filing an appeal is 180 days (CHP+ requirement is 30 days) and that the appeal would be decided in 30 days (CHP+ requirement is 10 calendar days). The revised template also did not include State fair hearing rights or continuation of benefits/services information.	Colorado Choice must ensure that all NOAs, whether using a letter format for UM denials or an EOB format for claims denials, include the required and accurate information.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		

Table D-10—FY 2013–2014 Corrective Action Plan *for* Colorado Choice		
Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
24. The Contractor does not require prior authorization for emergency or urgently needed services.	The member handbook informed members that there is no prior authorization required for emergency care and explained how to access urgent care services. The member handbook stated, "Urgent/after-hours care provided more than 50 miles from the service area [is not covered] if you knew you might need care before you left, or if you could have traveled to the PCP's office without medically harmful results." Although during the on-site interview, Colorado Choice staff members clarified that prior authorization is not required for emergency services or urgent care, the Precertification Procedures for Authorizations and Referrals policy described authorization procedures for emergency service requests. In addition, Colorado Choice may want to consider clarifying the policy to delineate the difference between urgent requests for services that require prior authorization and urgent care provided to prevent the onset of the need for emergency care.	Colorado Choice must clarify any applicable policies to state that precertification requests or prior authorization is not required for emergency or urgent care services. Colorado Choice must also revise member materials, removing any qualification to providing urgent care services.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		

Table D-11—FY 2013–2014 Corrective Action Plan *for* Colorado Choice		
Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
28. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.	Although the member handbook adequately informed members of the definition of *emergency care*, that emergency care is covered in- or out-of-network, and that prior authorization is not required, the handbook also stated that "services related to the non-compliance of care if the member leaves a hospital or facility against the medical advice of the provider" are not covered. There was one case during the on-site denials record review in which Colorado Choice denied payment for the emergency care because the member left the facility against medical advice.	To the extent that the initial presentation for emergency care meets the definition of *emergency medical condition* (using the prudent layperson standard), Colorado Choice must pay for the emergency treatment obtained.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		

Table D-12—FY 2013–2014 Corrective Action Plan *for* Colorado Choice		
Standard II—Access and Availability		
Requirement	**Findings**	**Required Action**
10. The Contractor ensures that members within the service area have access to emergency services on a 24-hour, 7 days-a-week basis.	The Network Access Plan states that members may access emergency care at any emergency facility and prior authorization is not required, regardless of whether the facility is inside or outside the network. The member handbook informs members of the same, and directs members to the provider directory for a list of facilities. Colorado Choice Customer Service After-hours messaging directs members to go to the nearest facility in case of emergency. Federal regulations require policies and procedures that address the availability of emergency services 24 hours per day, seven days per week	Colorado Choice must develop policies and procedures that address the availability of emergency services 24 hours per day, seven days per week.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		

Table D-13—FY 2013–2014 Corrective Action Plan *for* Colorado Choice		
Standard II—Access and Availability		
Requirement	**Findings**	**Required Action**
11. Members temporarily out of the service area may receive out-of-area emergency services and urgently needed services.	The CHP+ Member Handbook informs members that urgent care is covered when the member is temporarily out of the service area. The handbook states that members may receive emergency services from any provider in any location, inside or outside the network. However, federal regulations require policies and procedures that address out-of-area emergency and urgently needed services.	Colorado Choice must develop policies and procedures that state emergency services and urgently needed services are covered when members are temporarily out of the service area.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		

Table D-14—FY 2013–2014 Corrective Action Plan *for* Colorado Choice		
Standard II—Access and Availability		
Requirement	**Findings**	**Required Action**
16. The Contractor communicates all scheduling guidelines to participating providers and members.	The handbook did not address mental health and substance abuse standards. The member handbook did not include scheduling guidelines, and Colorado Choice did not provide other documents that communicated scheduling guidelines to members.	Colorado Choice must develop a mechanism to communicate mental health and substance abuse scheduling guidelines to providers and all scheduling guidelines to members.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		

Table D-15—FY 2013–2014 Corrective Action Plan *for* Colorado Choice		
Standard II—Access and Availability		
Requirement	**Findings**	**Required Action**
17. The Contractor maintains an effective organizational process for monitoring scheduling and wait times, identifying scheduling and wait time issues that do not comply with its guidelines, and takes appropriate action. The Contractor has mechanisms to ensure compliance by providers regarding timely access to services, has mechanisms to monitor providers regularly to determine compliance, and to take corrective action if there is failure to comply.	The Provider Office Site Evaluation and Facility Site Evaluation procedures included a checklist for all appointment scheduling and wait time standards. The evaluation forms documented "yes," "no," and "comments" for each standard. The procedures stated that on-site evaluation is done within 12 months of initial application and randomly thereafter, not to exceed 36 months.	Colorado Choice's current method to monitor provider scheduling wait times is by self-report from the provider. Colorado Choice must develop a mechanism to monitor actual scheduling and wait times. Sampling providers for this monitoring would be acceptable.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		

Table D-16—FY 2013–2014 Corrective Action Plan *for* Colorado Choice		
Standard II—Access and Availability		
Requirement	**Findings**	**Required Action**
18. The Contractor maintains a comprehensive program of preventive health services for members that includes written policies and procedures, involves providers and members in their development and ongoing evaluation, and includes: ◆ Risk assessment by a member's PCP or other qualified professionals specializing in risk prevention who are part of the Contractor's participating providers or under contract to provide such services, to identify members with chronic or high-risk illnesses, a disability, or the potential for such condition. ◆ Health education and promotion of wellness programs, including the development of appropriate preventive services for members with a disability to prevent further deterioration. The Contractor will also include distribution of information to members to encourage member responsibility for following guidelines for preventive health. ◆ Evaluation of the effectiveness of health preventive services, including monitoring and evaluation of the use of select preventive health services by at-risk members. ◆ Procedures to identify priorities and develop guidelines for appropriate preventive services. ◆ Processes to inform and educate participating providers about preventive services, involve participating providers in development of programs, and evaluate the effectiveness of	The policy and procedure stated that member care plans and case manager services include member self-management plans and identification and provision of educational materials for effective self-management. None of the documents submitted addressed development of preventive service guidelines for members with disabilities, monitoring/evaluation of the use of preventive services, methods to identify priorities for and development of preventive service guidelines, provider education about preventive services, or provider evaluation of the provision of such services.	Colorado Choice must develop policies and procedures that address the required elements of a preventive medicine program.

Table D-16—FY 2013–2014 Corrective Action Plan *for* Colorado Choice		
Standard II—Access and Availability		
Requirement	**Findings**	**Required Action**
participating providers in providing such services.		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		

Table D-17—FY 2013–2014 Corrective Action Plan *for* Colorado Choice		
Standard II—Access and Availability		
Requirement	**Findings**	**Required Action**
19. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner, to all members including those with limited English proficiency or reading skills including those with diverse cultural and ethnic backgrounds by: ◆ Maintaining policies to reach out to specific cultural and ethnic members for prevention, health education, and treatment for diseases prevalent in those groups. ◆ Maintaining policies to provide health care services that respect individual health care attitudes, beliefs, customs, and practices of members related to cultural affiliation. ◆ Making a reasonable effort to identify members whose cultural norms and practices may affect their access to health care. Such efforts may include: • Inquiries conducted by the Contractor of the language proficiency of members during the Contractor's orientation calls. • Being served by participating providers. • Improving access to health care through community outreach and Contractor publications. ◆ Developing and/or providing cultural competency training programs, as needed, to the network providers and Contractor staff regarding: • Health care attitudes, values, customs, and beliefs that affect access to and benefit from health care services,	The Network Access Plan did not address efforts to assess the cultural diversity of the provider network or to recruit culturally diverse providers. The member handbook stated in English and Spanish that materials are available in other languages, Braille, large print, and audiotape. Policies and procedures did not address assessment of the cultural norms or practices with respect to their effect on the member's health care needs. The provider handbook does not address cultural responsiveness or describe how providers may access interpreter services for patients. Colorado Choice documents also did not address Cultural Competency training for providers or staff, policies and procedures related to access to interpreter services by providers, or arranging for covered services with non-participating providers when necessary to accommodate independent living of members with disabilities. Colorado Choice may want to consider developing a comprehensive Cultural Competency Program Description to ensure that each of the contract requirements regarding cultural competency are met.	Colorado Choice must ensure that the required elements are present in its policies and/or practices to promote the State's efforts for delivery of services in a culturally competent manner.

Table D-17—FY 2013–2014 Corrective Action Plan *for* Colorado Choice		
Standard II—Access and Availability		
Requirement	**Findings**	**Required Action**
• The medical risks associated with the Client population's racial, ethnic, and socioeconomic conditions.		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		

Appendix E. Compliance Monitoring Review Protocol 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' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal health care regulations and managed care contract requirements: ◆ HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. ◆ HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, on-site agendas; and set review dates. ◆ HSAG submitted all materials to the Department for review and approval. ◆ HSAG conducted training for all site reviewers to ensure consistency in scoring across plans.
Activity 2:	**Perform Preliminary Review**
	◆ HSAG attended the Department's Medical Quality Improvement Committee (MQuIC) meetings and provided group technical assistance and training, as needed. ◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the health plan in writing of the request for desk review documents via 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 two standards and on-site activities. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. ◆ Documents submitted for the desk review and on-site review consisted of the completed desk review form, the compliance monitoring tool with the health plan's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The health plans also submitted a list of all CHP+ service and claims denials that occurred between January 1, 2013, and December 31, 2013 (to the extent possible). HSAG used a random sampling technique to select records for review during the site visit. ◆ The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.
Activity 3:	**Conduct Site Visit**
	◆ During the on-site portion of the review, HSAG met with the health plan's key staff members to obtain a complete picture of the health plan's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan's performance. ◆ HSAG reviewed a sample of administrative records to evaluate implementation of managed care regulations related to CHP+ service denials and notices of action.

Table E-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG completed the following activities:**
	◆ Also while on-site, HSAG collected and reviewed additional documents as needed. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were confidential or proprietary, or were requested as a result of the pre-on-site document review.) ◆ At the close of the on-site portion of the site review, HSAG met with health plan staff and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	◆ HSAG used the FY 2013–2014 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. ◆ HSAG analyzed the findings. ◆ HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the State**
	◆ HSAG populated the report template. ◆ HSAG submitted the 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.