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

FY 2015–2016 Site Review Report

for

Colorado Choice Health Plans

April 2016

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

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ACKNOWLEDGMENTS AND COPYRIGHTS

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 healthcare regulations and managed care contract requirements. The Department of Health Care Policy & 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 2015–2016 site review activities for the review period of January 1, 2015, through December 31, 2015. 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 four standard areas reviewed this year. Section 2 contains graphical representation of results for all 10 standards across the three-year cycle, as well as trending of required actions. Section 3 describes the background and methodology used for the 2015–2016 compliance monitoring site review. Section 4 describes follow-up on the corrective actions required as a result of the 2014–2015 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 grievance and appeal 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 2015–2016 and the required template for doing so. Appendix E contains a detailed description of HSAG's site review activities consistent with the Centers for Medicare & Medicaid Services (CMS) final protocol.

Summary of Results

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

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

Table 1-1—Summary of Scores for the Standards

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
III Coordination and Continuity of Care	12	12	6	1	5	0	50%
IV Member Rights and Protections	5	5	4	1	0	0	80%
VIII Credentialing and Recredentialing	48	39	30	9	0	9	77%
X Quality Assessment and Performance Improvement	15	15	11	2	2	0	73%
Totals	**80**	**71**	**51**	**13**	**7**	**9**	**72%**

Table 1-2 presents the scores for **Colorado Choice** for the credentialing and recredentialing 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)
Credentialing	90	89	79	10	1	89%
Recredentialing	90	87	84	3	3	97%
Totals	**180**	**176**	**163**	**13**	**4**	**93%**

Standard III—Coordination and Continuity of Care

Summary of Strengths and Findings as Evidence of Compliance

As discussed below, HSAG identified many areas for improvement within coordination and continuity of care. However, it is of note that prior to the site visit **Colorado Choice** had self-identified deficiencies in many of these areas and had begun action. A newly hired quality director appeared goal-oriented and demonstrated such with a self-imposed case management corrective action plan that **Colorado Choice** presented to HSAG during the site review. HSAG reviewers noted a sense of enthusiasm about the development of new systems and processes to better serve the member population.

Summary of Findings Resulting in Opportunities for Improvement

Colorado Choice provided HSAG with a self-imposed corrective action plan that appeared to be the first step in addressing areas where **Colorado Choice** has fallen short. The plan identified areas of need as well as objectives but did not yet include processes or a plan to achieve the stated objectives. This is a first step in developing a long-term plan and relevant policies; however, **Colorado Choice** anticipated implementation in June 2016 at the earliest. HSAG strongly suggested that **Colorado Choice** develop and implement methods for reaching out to new members with special healthcare needs in the interim period—while the new processes are being developed. Examples of outreach may include a brief health analysis telephone call to all new members or a newsletter provided to all members explaining types of high risk/special needs conditions and how to access services if a parent or guardian suspects a child may be affected.

While the health assessment survey tool used by **Colorado Choice** for initial new member assessments meets the minimum federal requirements, many areas exist wherein member information may not be sufficiently captured. HSAG recommended that **Colorado Choice** enhance the process for collecting health assessment information. For example, **Colorado Choice** may wish to consider using a specially developed script for the follow-up calls to further elaborate on the questions in the health assessment—even when the member indicates no issues. Areas that may benefit from additional clarification include determining cultural needs and further assessing whether the enrolled child has mental health needs.

Summary of Required Actions

During the on-site interview, **Colorado Choice** staff openly acknowledged that they had not been providing coordination of care as described in the Case Management policy and UM Pre-Certification Review policy and procedure or as mandated by State contract and federal regulations. **Colorado Choice**'s newly hired quality improvement director began developing a self-imposed corrective action plan for **Colorado Choice** that identified areas for improvement and program objectives. However, the plan had not advanced to the point of including processes to achieve the stated objectives. Staff explained that they intended to fully assess the requirements and available

resources before developing new policies and procedures. While this plan is a first step in developing long-term systemic changes, **Colorado Choice** did not anticipate implementation until June 2016. **Colorado Choice** must develop and implement comprehensive written policies and procedures to address the coordination and provision of covered services in conjunction with other medical and behavioral health plans and promote service accessibility, attention to individual needs, continuity of care, maintenance of health, and independent living. Health plan leadership must ensure accountability to the new policies and addressing of members' specific needs.

Colorado Choice's policies and procedures described the process of mailing new members a health assessment survey that could be used to identify and assess special healthcare needs; however, staff members stated they did not follow up with members who returned the form—regardless of any identified condition or need. Case management staff reassessed risk levels based on what they felt they could manage rather than on member need. Staff estimated that only ten of **Colorado Choice**'s 1600 CHP+ members were receiving care management services, and **Colorado Choice** had no process to identify or refer additional members for care management services. **Colorado Choice** must develop and implement procedures to address members who require complex coordination of benefits and services and who may require services from multiple providers and/or other community resources. The procedures need to address all components of the requirement. Health plan leadership must ensure accountability to the new procedures and ensure that members' complex care coordination needs are addressed.

Colorado Choice staff members stated that they had not implemented a comprehensive procedure for providing individual needs assessments. Although they mailed new members a health assessment survey upon enrollment, **Colorado Choice** had not been reviewing returned forms or following up with members who self-identify areas of need. **Colorado Choice** also did not have alternative procedures for assessing members that did not return the health assessment survey. **Colorado Choice** must develop and implement procedures to provide members an individual needs assessment within 30 days of enrollment and at any other necessary time. The assessment must identify ongoing conditions that require a course of treatment or regular care monitoring. Health plan leadership must ensure accountability to the new procedures.

Colorado Choice staff noted during the interview that they did not feel they had the capacity to reach out to members who returned the health assessment survey mailed to members at time of enrollment. As such, **Colorado Choice** did not develop individual treatment plans for its members. **Colorado Choice** must develop and implement comprehensive procedures to create an individual treatment plan based on the needs assessment. The treatment plan must address treatment objectives, treatment follow-up, and monitoring of outcomes and be revised as necessary. Health plan leadership must ensure accountability to the new policies.

The health assessment survey form is mailed to new members in both English and Spanish. This form includes a check box for members to identify cultural or linguistic needs; however, the form does not explain what is implied by a "cultural" need. Regardless, during the on-site interview **Colorado Choice** noted not following up on health assessment surveys returned by members; thus, **Colorado Choice** is not taking action on members' self-identified cultural needs. Members do have direct access to specialists, as needed, when those members reach out to specialists independently. **Colorado Choice** must develop procedures to identify and accommodate members' cultural needs.

Colorado Choice did not directly inform new members with special healthcare needs or who are pregnant of their option to see previous providers for a certain time frame before they would be required to see in-network providers. **Colorado Choice** informed networked providers of this provision. **Colorado Choice** must develop a process wherein the health plan is directly responsible for informing new members who are pregnant or have special healthcare needs of the option to continue care with their current providers for a specified period.

Standard IV—Member Rights and Protections

Summary of Strengths and Findings as Evidence of Compliance

Colorado Choice's Member Rights and Responsibilities policy described the processes used to educate staff, providers, and members about member rights and **Colorado Choice**'s responsibility to ensure adherence to member rights. **Colorado Choice** informed members about their rights in the member handbook and reminded them of their rights in an annual letter. **Colorado Choice** informed providers of their responsibility to uphold member rights in the professional services agreement and included member rights in the provider manual. **Colorado Choice** also informed staff about member rights during new hire orientation and again annually.

Summary of Findings Resulting in Opportunities for Improvement

HSAG suggested that **Colorado Choice** could enhance its commitment to ensuring member rights by adding articles and statements related to member rights to the regularly published provider newsletter. HSAG also suggested that a biannual or quarterly member newsletter could be used to remind members of their rights as well as other information such as the importance of timely immunizations and well-child exams.

Summary of Required Actions

In addition to the list of member rights, **Colorado Choice**'s member handbook and its provider manual included a section titled "Refusal to Follow Recommended Treatment." This section strongly encouraged members to adhere to their providers' recommended treatments and implied that if a member refused recommended treatment his or her doctor could refuse to treat that member. During the on-site interview, staff members appeared unaware that the language was included in either document and assured HSAG reviewers that **Colorado Choice** allows members to refuse treatment without repercussion. **Colorado Choice** must remove from its member handbook and its provider manual language implying that members are required to follow recommended treatments.

Standard VIII—Credentialing and Recredentialing

Summary of Strengths and Findings as Evidence of Compliance

Colorado Choice demonstrated having a well-defined credentialing and recredentialing process. The credentialing plan specified the types of providers subject to being credentialed and recredentialed, verification sources used, and processes followed—and included measures to ensure a nondiscriminatory program. Procedures and documents described the range of actions available to **Colorado Choice** against practitioners who failed to meet its quality standards as well as the two-tiered appeal process available to practitioners and delineated the process for reporting actions to the appropriate authorities. Staff members described the process for monthly monitoring of the State licensing board for sanctions, restrictions, and limitations as well as the process for monthly monitoring of Medicare and Medicaid sanctions.

Summary of Findings Resulting in Opportunities for Improvement

The documents **Colorado Choice** submitted to HSAG as evidence of compliance represented opportunities for improvement. Overall, the documents were poorly written and the structure was inconsistent. Procedures were often too vague to provide an accurate description of what was expected, did not appear to follow a logical order, and often used language that addressed members rather than staff. Information was repeated throughout and across documents, but with seemingly minor inconsistencies that lead to confusion as well as noncompliance. Staff members accessed multiple versions of documents without a clear indication of the revision date or if the document had been approved and adopted by appropriate boards and/or committees. The "objective" statement on several desktop procedures was not applicable to the information provided (e.g., the desktop procedure for application review listed the objective as maintaining files in a secure manner). Furthermore, HSAG learned during on-site interviews that procedures implemented by staff members were not consistent with **Colorado Choice**'s written procedures.

HSAG recommended that, as **Colorado Choice** revises its corporate documents, it spend extra time reviewing each document to ensure proper grammar; complete sentences; logical order; and consistent structure, voice, and audience. **Colorado Choice** should ensure that information presented is consistent within and across documents, relevant, and parallel with processes implemented by staff. HSAG also recommended that **Colorado Choice** develop a system to track versions of documents as they undergo revision as well as a dependable method for documenting dates that documents are approved by the governing body.

Summary of Required Actions

The **Colorado Choice** Credentialing Plan listed acceptable primary and secondary verification sources; however, it allowed a provider's application as an acceptable source for verifying a provider's Drug Enforcement Agency (DEA) certificate. The Desktop Procedure: Credentialing File Verification indicated that DEA certification could be verified with a provider's application. However, the provider application is not a National Committee for Quality Assurance (NCQA)

accepted verification source for DEA certification. On-site record reviews demonstrated that **Colorado Choice** was collecting copies of DEA certificates as verification, which is acceptable under NCQA guidelines. **Colorado Choice** must update its credentialing plan and desktop procedure to include NCQA-approved verification sources for DEA certification.

The credentialing plan listed the criteria for credentialing and recredentialing decisions; however, the criteria (referred to in the plan as "guidelines") were not congruent with the guidelines described by staff members during the on-site interview. **Colorado Choice** must carefully review and revise its credentialing plan to accurately describe the criteria used for making credentialing and recredentialing decisions.

The **Colorado Choice** Credentialing Plan addressed the process for delegating credentialing and recredentialing; however, the process described was intended to meet Utilization Review Accreditation Commission (URAC) requirements and did not include all elements required by NCQA. **Colorado Choice** must revise its credentialing plan to ensure that its process for delegating credentialing and recredentialing is compliant with NCQA requirements.

The Credentialing Plan, Desktop Procedure: Credentialing File Maintenance, and Desktop Procedure: Credentialing File Verification addressed the process for ensuring confidentiality of information obtained; however, the process was not clearly described or consistent across the three documents. **Colorado Choice** must revise applicable documents to convey a consistent procedure for ensuring the confidentiality of information obtained in the credentialing process.

The **Colorado Choice** Credentialing Plan required that providers complete an application or attest to complete and accurate information in the Council for Affordable Quality Healthcare (CAQH) system. Seven of 10 credentialing records and two of 10 recredentialing records included a CAQH data summary in lieu of a credentialing application. The data summary stated that it was for provider information purposes only and not to be submitted as an application. **Colorado Choice** staff members indicated that for a period of time applications downloaded from CAQH were in the data summary format and that CAQH has since changed its format to accommodate the Colorado Health Care Professional Credentials Application. **Colorado Choice** must be sure to collect practitioner applications in an acceptable format that includes required elements and attestation.

Colorado Choice's Desktop Procedure for Office Site Visit described the procedures for performing an office site visit within 12 months of an initial application and again at least once every 36 months. During the on-site interview, staff members stated that **Colorado Choice** had changed its processes and was not conducting site visits for individual practitioners. Staff indicated that while they still adhered to the standards outlined in the policy, **Colorado Choice** had not yet defined a process for ensuring compliance with these standards. **Colorado Choice** must update its desktop procedure for office site visits to describe a process to ensure that practitioner offices meet stated standards. **Colorado Choice** must also describe interventions to be implemented in instances when provider sites do not meet its standards.

The Facility Credentialing and Recredentialing policy and procedure did not include a process for ensuring that unaccredited organizational providers credential their practitioners. Also, the site review tool used to conduct on-site quality assessments did not include an element for confirming

the process for credentialing. **Colorado Choice** must revise its policies and procedures to describe a process to ensure that organizational providers credential their practitioners.

The Facility Credentialing and Recredentialing policy stated that **Colorado Choice** will perform a site visit for organizational providers that are unaccredited or have not passed a CMS or State review. The policy did not specify that the CMS or State review could be no more than three years old, nor did it specify that **Colorado Choice** must obtain a copy of the survey report or letter from CMS or the State showing that the facility was reviewed and passed inspection as well as a copy of the criteria or standards used. On-site record reviews demonstrated that **Colorado Choice** collected copies of letters stating that the facility was reviewed and passed; however, staff did not know the criteria or standards used for the CMS or State site reviews. **Colorado Choice** must revise its policy and procedures to specify the circumstances under which it may substitute a CMS or State site visit in lieu of conducting its own site visit.

Standard X—Quality Assessment and Performance Improvement

Summary of Strengths and Findings as Evidence of Compliance

Colorado Choice's Quality Assurance Committee (QAC) met regularly to make recommendations regarding quality assurance/quality improvement (QA/QI) processes to the **Colorado Choice** Board of Directors (BoD). The BoD was ultimately responsible for reviewing and approving the activities related to the quality improvement program.

Colorado Choice adopted perinatal, prenatal, and postpartum practice guidelines as well as practice guidelines for diabetes care, asthma, heart failure, pediatric immunizations, and preventive pediatric healthcare. These guidelines were easily accessible on the **Colorado Choice** website. The guidelines were adopted from a myriad of reliable sources and formally approved by the **Colorado Choice** Physician Advisory Committee (PAC).

Colorado Choice calculated HEDIS and CAHPS measures and submitted results, as required.

Colorado Choice reported no quality of care (QOC) allegations against its networked providers during 2015; however, a process is in place in the event of such a report. **Colorado Choice** discussed this process during the on-site review.

Colorado Choice has an electronic health information system that collects data on member and provider characteristics. The system was capable of analyzing, integrating and reporting data.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified only opportunities for improvement resulting in required actions.

Summary of Required Actions

Colorado Choice's ongoing Quality Assessment and Performance Improvement (QAPI) Program addressed only basic federal and State requirements and was not robust in nature. For example, member concerns identified in the CAHPS survey ranked **Colorado Choice** below the 25th percentile on four measures on NCQA's 2015 HEDIS Benchmarks and Thresholds for Accreditation, yet **Colorado Choice** implemented no quality initiatives to address these issues. **Colorado Choice** must evolve its QAPI program to ensure that it includes processes for reviewing areas identified as needing improvement and take action to improve these areas.

While **Colorado Choice** had some methods in place for identifying underutilization and overutilization, staff noted during the interview that there was no system in place (e.g., functional case management) to allow for comprehensive utilization management, quality assurance, or improvement. **Colorado Choice** must expand its QAPI program to ensure that mechanisms are in place to effectively detect both underutilization and overutilization of services.

The Quality Assurance Program description and Quality Improvement Program (QAP/QIP) document provided an overview of the program goals; however, it did not at any point address persons with special healthcare needs. **Colorado Choice** must expand its QAPI program to include mechanisms to assess the quality and appropriateness of care for persons with special healthcare needs.

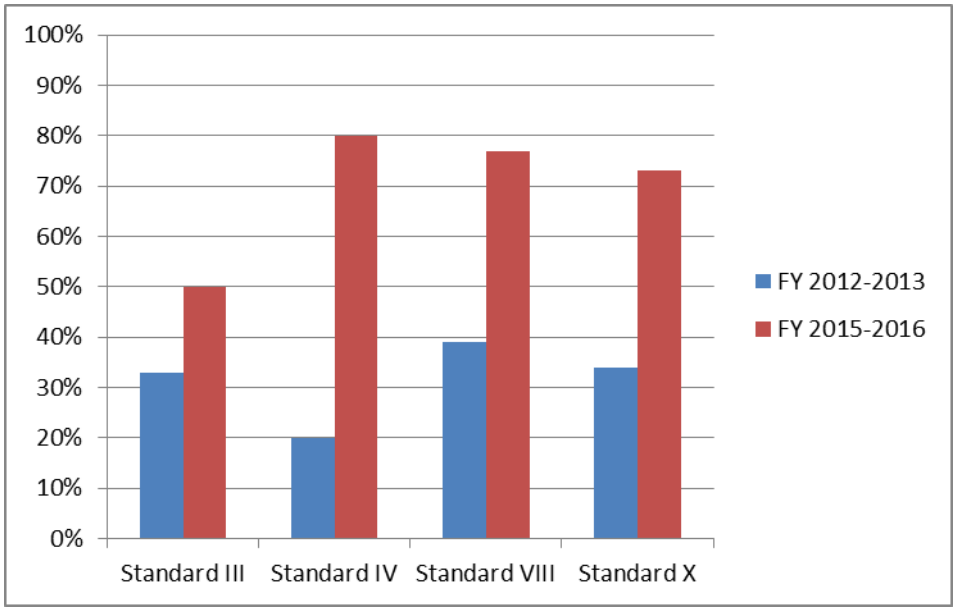
While **Colorado Choice** participated in CAHPS, its QAC meeting minutes did not document that the committee evaluated or addressed—from a QAPI perspective—instances wherein results were below the 25th percentile. In addition, **Colorado Choice** did not define grievances as any expression of dissatisfaction (as required by federal and State regulations). **Colorado Choice** collected and categorized some expressions of dissatisfaction as "complaints" and others, as discussed during the on-site interview, were not collected at all. As such, **Colorado Choice** had not been recording grievances appropriately for trending and QAPI action. **Colorado Choice** must develop a process to ensure that all expressions of dissatisfaction, no matter how "small" or how quickly remedied, are captured by staff and used for periodic trending. All areas where trends are identified—whether via the grievance and appeals system, CAHPS reports, anecdotal information, or enrollment and disenrollment information—must be monitored by the appropriate committee and assessed for appropriate action.

Comparison of Results

Comparison of FY 2012–2013 Results to FY 2015–2016 Results

Figure 2-1 shows the scores from the FY 2012–2013 site review (when Standard III, Standard IV, Standard VIII, and Standard X were previously reviewed) compared with the results from this year's review. The results show the overall percent of compliance with each standard. Although the federal language did not change with regard to requirements, **Colorado Choice**'s contract with the State may have changed and may have contributed to performance changes.

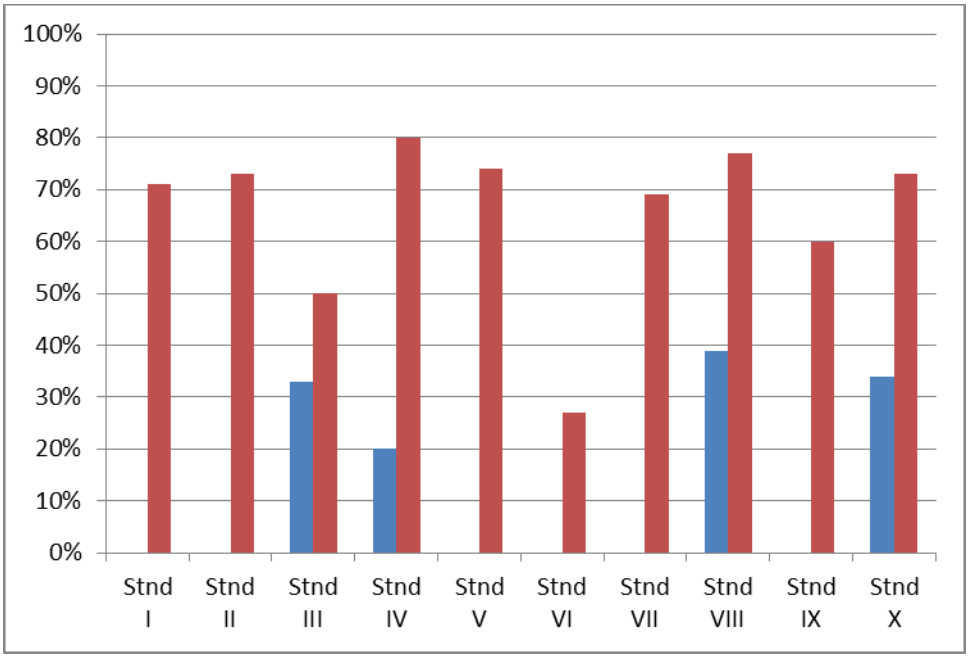
Figure 2-1—Comparison of FY 2012–2013 Results to FY 2015–2016 Results



Review of Compliance Scores for All Standards

Figure 2-2 shows the scores for all standards reviewed over the past four years of compliance monitoring. Table 2-1 shows which standards were reviewed each year. The figure compares the score for each standard across two review periods, as applicable, and may be an indicator of overall improvement.

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



Note: Results shown in blue are from FY 2012–2013. Results shown in red are from FY 2013–2014, FY 2014–2015, and FY 2015–2016.

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

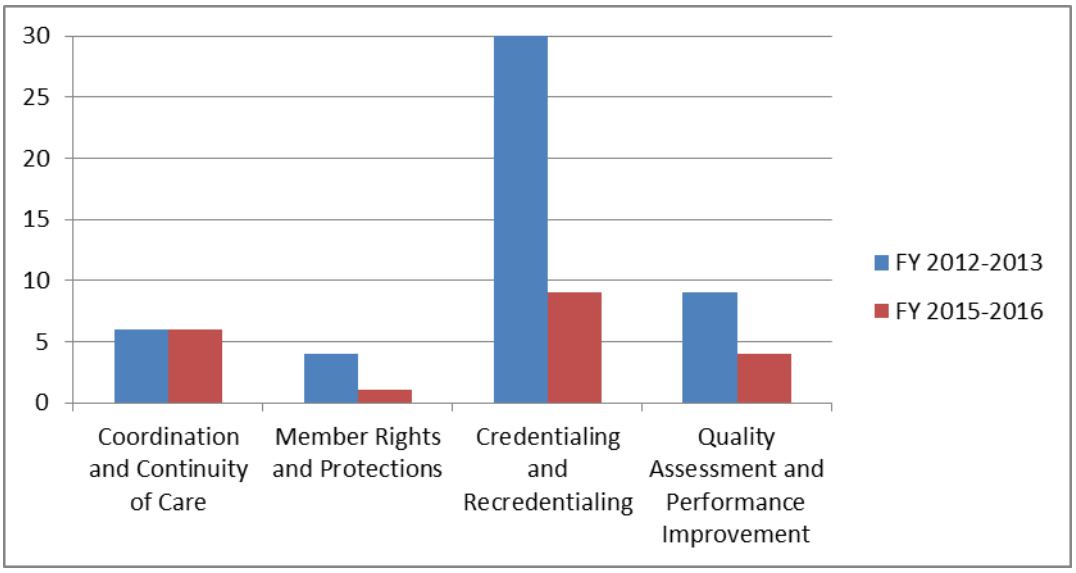
Table 2-1—List of Standards by Review Year

Standard	2012–13	2013–14	2014–15	2015–16
I—Coverage and Authorization of Services		X		
II—Access and Availability		X		
III—Coordination and Continuity of Care	X			X
IV—Member Rights and Protections	X			X
V—Member Information			X	
VI—Grievance System			X	
VII—Provider Participation and Program Integrity			X	
VIII—Credentialing and Recredentialing	X			X
IX—Subcontracts and Delegation			X	
X—Quality Assessment and Performance Improvement	X			X

Trending the Number of Required Actions

Figure 2-3 shows the number of requirements with required actions from the FY 2012–2013 site review (when Standard III, Standard IV, Standard VIII, and Standard X were previously reviewed) compared to the results from this year's review. Although the federal requirements did not change for the standards, **Colorado Choice**'s contract with the State may have changed and may have contributed to performance changes.

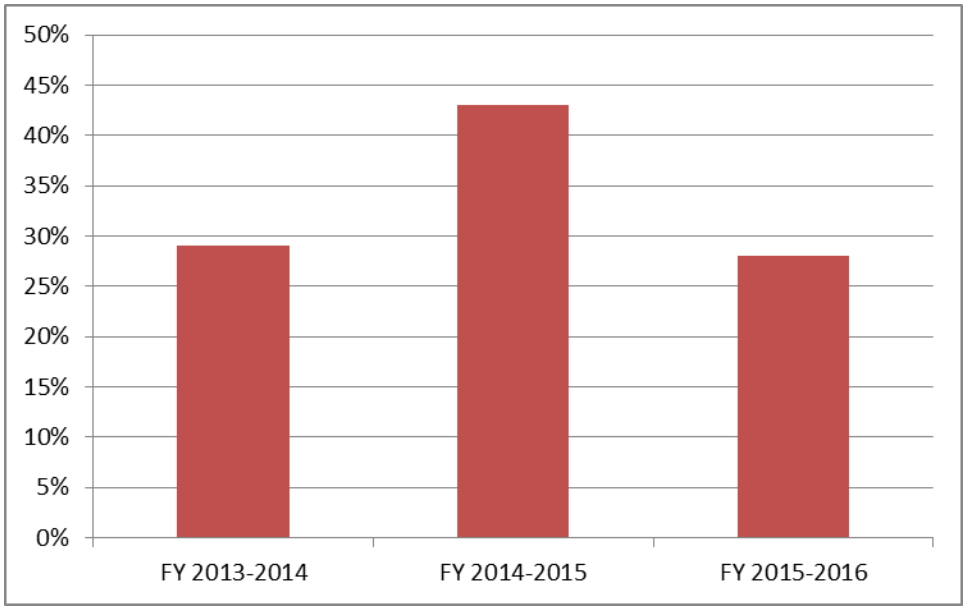
Figure 2-3—Number of FY 2012–2013 and FY 2015–2016 Required Actions per Standard



Trending the Percentage of Required Actions

Figure 2-4 shows the percentage of requirements that resulted in required actions over the past three-year cycle of compliance monitoring. Each year represents the results for review of different standards, as indicated in Table 2-1.

Figure 2-4—Percentage of Required Actions—All Standards Reviewed



Overview of FY 2015–2016 Compliance Monitoring Activities

For the fiscal year (FY) 2015–2016 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement. Compliance with federal managed care regulations and managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the health plan's contract requirements and regulations specified by the 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+ credentialing and recredentialing. HSAG documented detailed findings in the Compliance Monitoring tool for any requirement receiving a score *Partially Met* or *Not Met*.

A sample of the health plan's administrative records related to CHP+ credentialing and recredentialing were also reviewed to evaluate implementation of federal healthcare regulations and compliance with National Committee for Quality Assurance (NCQA) requirements, effective July 2015. HSAG used standardized monitoring tools to review records and document findings. Using a random sampling technique, HSAG selected a sample of 10 records with an oversample of five records from all CHP+ credentialing and recredentialing records that occurred between January 1, 2015, and December 31, 2015, to the extent available at the time of the site-review request. HSAG reviewed a sample of 10 credentialing records and 10 recredentialing records, to the extent possible. For the record review, the health plan received a score of *M* (met), *N* (not met), or *NA* (not applicable) for each of the required elements. Results of record reviews were considered in the review of applicable requirements in Standard VIII—Credentialing and Recredentialing. HSAG also separately calculated a credentialing record review score, a recredentialing record review score, and an overall record review score.

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The four standards chosen for

the FY 2015–2016 site reviews represent a portion of the CHP+ managed care requirements. These standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

Objective of the Site Review

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

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

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

for **Colorado Choice Health Plans**

FY 2014–2015 Corrective Action Methodology

As a follow-up to the FY 2014–2015 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 2014–2015 compliance monitoring site review.

Summary of 2014–2015 Required Actions

As a result of the FY 2014–2015 site review, **Colorado Choice** was required to address six *Partially Met* findings for Standard V—Member Information, 19 *Partially Met* findings for Standard VI—Grievance System, three *Partially Met* and two *Not Met* findings for Standard VII—Provider Participation and Program Integrity, and two *Partially Met* findings for Standard IX—Subcontracts and Delegation.

Summary of Corrective Action/Document Review

Colorado Choice submitted its CAP to HSAG and the Department in May 2015 and began submitting documents to demonstrate implementation of the planned interventions in September 2015. HSAG and the Department worked closely with **Colorado Choice** throughout the remainder of 2015 to monitor implementation of **Colorado Choice**'s CAP.

Summary of Continued Required Actions

At the time of the FY 2015–2016 site review, **Colorado Choice** had completed two of the 32 required actions. The majority of outstanding issues were pending approval of revised policies and procedures by appropriate governing bodies and comprehensive staff training; however, **Colorado Choice** continued to misinterpret the time frames related to continuation of services during an appeal and/or State fair hearing. HSAG and the Department will continue to monitor **Colorado Choice**'s progress to ensure appropriate implementation and full compliance with all required actions.

Appendix A. Compliance Monitoring Tool for Colorado Choice Health Plans

The completed compliance monitoring tool follows this cover page.

Standard III—Coordination and Continuity of Care

Requirement	Evidence as Submitted by Health Plan	Score
1. The Contractor has written policies and procedures to address the coordination and provision of covered services in conjunction with other medical and behavioral health plans and to promote: ◆ Service accessibility. ◆ Attention to individual needs. ◆ Continuity of care. ◆ Maintenance of health. ◆ Independent living. *42CFR438.208(b)(2)* Contract: Exhibit A4—2.7.4.1	**Documents:** 1. Case Management Policy, No. 3000 2. UM Pre-Certification Review Policy and Procedure, No. 3504 3. Health Assessment Survey **Narrative:** Colorado Choice follows the Case Management Policy for assessing member needs, developing care plans, assisting with provision of services for accessibility and to promote continuity of care. In following the Pre-Certification Review Policy and Procedure, Colorado Choice's goals is to ensure appropriate utilization of health care resources, increase efficiencies of financial and personnel resources and to maintain quality patient care. The processes ensure that appropriate evaluation of requested services and associated level of care for 'pre-service' requested services. A health assessment survey is sent to members to determine the need for a case manager and case management. Upon return of the assessment the Case Manager will conduct an initial telephonic assessment to determine whether CM services are appropriate and, if so, to develop a care plan that includes the coordination with external entities such as providers to include therapies and/or home health care agencies, or mental health agencies.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A

Findings: During the on-site interview, Colorado Choice staff openly acknowledged that they had not been providing coordination of care as described in the Case Management policy and UM Pre-Certification Review policy and procedure or as mandated by State contract and federal regulations. Colorado Choice's newly hired quality improvement director began developing a self-imposed corrective action plan for Colorado Choice that identified areas for improvement and program objectives. However, the plan had not advanced to the point of including processes to achieve the stated objectives. Staff explained that they intended to fully assess the requirements and available resources before developing new policies and procedures. While this plan is a first step in developing long-term systemic changes, Colorado Choice did not anticipate implementation until June 2016.

Required Actions: Colorado Choice must develop and implement comprehensive written policies and procedures to address the coordination and provision of covered services in conjunction with other medical and behavioral health plans and promote service accessibility, attention to individual needs, continuity of care, maintenance of health, and independent living. Health plan leadership must ensure accountability to the new policies and addressing of members' specific needs.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
2. The Contractor's procedures are designed to address those members who require complex coordination of benefits and services and may require services from multiple providers, facilities and agencies, ancillary or nonmedical services, including social services and other community resources. Procedures also address: ◆ Coordinating services for children with special healthcare needs with other agencies or entities such as those dealing with mental health and substance abuse, public health, home and community-based care, developmental disabilities, local school districts, child welfare, IDEA programs, Title V, families, caregivers, and advocates. ◆ Criteria for making referrals and coordinating care by specialists, subspecialists, and community-based organizations. Contract: Exhibit A4—2.7.4.3.2; 2.7.4.3.3; 2.7.4.3.5; 2.7.5.5	**Documents:** 1. Case Management Policy, No. 3000, pages 4 – 6, 4. Assigning CM Program Severity Level 2. Health Assessment Survey **Narrative:** A health assessment survey is sent to members to determine the need for a case manager and case management. Upon return of the assessment the Case Manager will conduct an initial telephonic assessment to determine whether CM services are appropriate and, if so, to develop a care plan that includes the coordination with external entities such as providers to include therapies and/or home health care agencies, or mental health agencies.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: Colorado Choice's policies and procedures described the process of mailing new members a health assessment survey that could be used to identify and assess special healthcare needs; however, staff members stated they did not follow up with members who returned the form—regardless of any identified condition or need. Case management staff reassessed risk levels based on what they felt they could manage rather than on member need. Staff estimated that only ten of Colorado Choice's 1600 CHP+ members were receiving care management services, and Colorado Choice had no process to identify or refer additional members for care management services.		
Required Actions: Colorado Choice must develop and implement procedures to address members who require complex coordination of benefits and services and who may require services from multiple providers and/or other community resources. The procedures need to address all components of the requirement. Health plan leadership must ensure accountability to the new procedures and ensure that members' complex care coordination needs are addressed.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
3. The Contractor has a mechanism to ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating covered services furnished to the member. ◆ Upon enrollment, the Contractor makes at least one attempt to contact the member with information on options for selecting a PCP. ◆ If the member does not select a PCP within 10 days, the Contractor assigns the member to a PCP and notifies the member, by telephone or in writing, of his/her facility's or PCP's name, location, and office telephone number. ◆ The Contractor notifies the PCP of newly assigned members in a timely manner. ◆ The Contractor grants a member's request to change his/her PCP, as reasonable and practical. *42CFR438.208(b)(1)* Contract: Exhibit A4—2.5.8.2	**Documents:** 1. Case Management Policy, No. 3000 2. DTP: CHP+ Primary Care Physician (PCP) Selection 3. Network Access Plan 4. New Member Routing Sheet 5. Selection of PCP 6. Notification of PCP Assignment letter **Narrative:** Upon notification of enrollment, Colorado Choice will attempt to contact by phone, the member/guardian within 2 calendar days to discuss PCP selection. Colorado Choice will also send a "Selection of PCP" form to all members in their enrollment packet. If Colorado Choice fails to receive any feedback from member/guardian regarding the PCP selection, Colorado Choice will automatically assign PCPs by taking into consideration such factors as current Provider relationships, language needs (to the extent they are known), and area of residence. Contractor will then send the member the Notification of PCP assignment letter to notify the member of his/her PCP's name, location and office telephone number, and how to change PCP's if desired. Case Management Policy will also be followed in determining the appropriate person responsible for member's care coordination depending on the severity level. A member may change his or her Primary Care Physician by calling Customer Service at 719-589-3696 or 800-475-8466. The new selection will become effective the first day of the month following the change. To ensure a quality physician-patient relationship, a Member's Primary Care Physician may be changed at the Member's request no more than three times in any calendar year.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
4. The Contractor implements procedures to provide an individual needs assessment after enrollment and at any other necessary time, including the screening for special healthcare needs (e.g., mental health, high risk health problems, functional problems, language or comprehension barriers, and other complex health problems). The assessment mechanisms must use appropriate healthcare professionals. ◆ The Contractor will assess members with special healthcare needs within 30 days in order to identify ongoing conditions that require a course of treatment or regular care monitoring. *42CFR438.208(c)(2)* Contract: Exhibit A4—2.7.4.3.1.1; 2.7.5.3	**Documents:** 1. Case Management Policy, No. 3000, page 3, 2. Assessment for CM Program 2. Health Assessment Survey **Narrative:** A health assessment survey is sent to members to determine the need for a case manager and case management. Upon return of the assessment the Case Manager will conduct an initial telephonic assessment to determine whether CM services are appropriate and, if so, to develop a care plan that includes the coordination with external entities such as providers to include therapies and/or home health care agencies, or mental health agencies.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: Colorado Choice staff members stated that they had not implemented a comprehensive procedure for providing individual needs assessments. Although they mailed new members a health assessment survey upon enrollment, Colorado Choice had not been reviewing returned forms or following up with members who self-identify areas of need. Colorado Choice also did not have alternative procedures for assessing members that did not return the health assessment survey.		
Required Actions: Colorado Choice must develop and implement procedures to provide members an individual needs assessment within 30 days of enrollment and at any other necessary time. The assessment must identify ongoing conditions that require a course of treatment or regular care monitoring. Health plan leadership must ensure accountability to the new procedures.		
5. The Contractor shares with other healthcare organizations serving the member with special healthcare needs, the results of its identification and assessment of that member's needs, to prevent duplication of those activities. *42CFR438.208(b)(3)* Contract: Exhibit A4—2.7.5.2	**Documents:** 1. Case Management Policy, No. 3000, page 6 **Narrative:** Colorado Choice follows the Case Management Policy to share information with other healthcare organizations serving the member with special healthcare needs. This is accomplished during the referral process to determine use and overuse through prior authorization. This also aids in communication with the PCP, referrals to community resources, if and	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	when health benefits have been exhausted, and coordination with external entities such as providers to include therapies and/or home health care agencies, or mental health agencies. Case Management system also identifies areas for communication between providers. When care plans are developed they may also be faxed to PCP and any relevant specialty care providers to help prevent duplication of those activities.	
6. The Contractor implements procedures to develop an individual treatment plan based on the needs assessment. The treatment plan addresses treatment objectives, treatment follow-up, monitoring of outcomes, and is revised as necessary. *42CFR438.208(c)(3)* Contract: Exhibit A4—2.7.4.3.1.2; 2.7.4.3.1.3	**Documents:** 1. Case Management Policy, No. 3000, page 6, #5. Care Plans **Narrative:** Colorado Choice follows the Case Management Policy along with the Flow Diagram of documentation elements in the implementation and development of individual treatment plans. The Case Manager develops a care plan, based on the assessment completed with the member. Care plans will be member- and family-centered, and includes attainable, measurable, and timely long term and short-term goals.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: Colorado Choice staff noted during the interview that they did not feel they had the capacity to reach out to members who returned the health assessment survey mailed to members at time of enrollment. As such, Colorado Choice did not develop individual treatment plans based on the needs assessment.		
Required Actions: Colorado Choice must develop and implement comprehensive procedures to create an individual treatment plan based on the needs assessment. The treatment plan must address treatment objectives, treatment follow-up, and monitoring of outcomes and be revised as necessary. Health plan leadership must ensure accountability to the new procedures.		
7. The Contractor's procedures for individual needs assessment and treatment planning are designed to: ◆ Accommodate the specific cultural and linguistic needs of the members. ◆ Allow members with special healthcare needs direct access to a specialist as appropriate to the member's conditions and needs. *42CFR438.208(c)(3)(iii)* Contract: Exhibit A4—2.7.4.3.1.4	**Documents:** 1. Case Management Policy, No. 3000, page 3, 2. Assessment for CM Program 2. Health Assessment Survey 3. Provider Manual, Page 15 **Narrative:** The Health Assessment Survey is provided in both English and Spanish to accommodate specific cultural and linguistic needs of the members.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	In the Case Management Policy, page 3, 2. Assessment for CM Program one of the elements that is included when determining the CM services is cultural and linguistic needs. Consultations with specialist do not require prior authorization, so the member can have direct access to appropriate specialists. The Provider Manual outlines that Colorado Choice provides for the direct access to specialists for those CHP+ members with special health care needs. Persons with special health care needs who use specialists frequently for their health care are also allowed direct access or a standing referral to specialists for the needed care.	
Findings: The health assessment survey form is mailed to new members in both English and Spanish. This form includes a check box for members to identify cultural or linguistic needs; however, the form does not explain what is implied by a "cultural" need. Regardless, during the on-site interview Colorado Choice noted not following up on health assessment surveys returned by members; thus, Colorado Choice is not taking action on members' self-identified cultural needs. Members do have direct access to specialists, as needed, when those members reach out to specialists independently.		
Required Actions: Colorado Choice must develop procedures to identify and accommodate members' cultural needs.		
8. The Contractor ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that they are applicable. In all other operations as well, the Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42CFR438.208(b)(4)* *42CFR438.224* Contract: Exhibit A4—2.7.4.1, 3.1.4.3	**Documents:** 1. HIPAA Confidentiality, Uses & Disclosures of Protected Health Information 2. Privacy Notice 3. Authorization for Release of Protected Health Information Policy and Procedure 4. Colorado Choice Confidentiality Agreement 5. Provider Manual, page 29 **Narrative:** Colorado Choice follows the HIPAA confidentiality, Uses & Disclosures of Protected Health Information Policy and Procedure. The policies address confidentiality, use and disclosure of protected health information (PHI) "minimum necessary" requirements, and verification of identification. The Privacy Notice is distributed to members upon	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	enrollment and informs the member about the use of PHI for internal health operations and for external communications. The Privacy Notice informs members of the type of information that may be shared, with what entities, and for what purpose, without permission from the member. This notice outlined that Colorado Choice may share PHI with doctors, hospitals, or others to help manage the member's health care. This notice also informs members that written permission from the member will be obtained for releasing information in any other circumstance. The Authorization for Release of PHI form is used in order to obtain member permission for the release of PHI to specific providers or other entities when necessary. The Confidentiality Agreement is signed by new employees upon hire and is then reviewed and signed annually by all current employees, and in signing this document employees agree that they would not discuss or disclose information except as necessary for business purposes. The Provider Manual notified providers that they are bound to compliance with HIPAA laws.	
9. The Contractor's procedures include a strategy to ensure that all members and/or authorized family members are involved in treatment planning and consent to medical treatment. Contract: Exhibit A4—2.7.4.3.4	**Documents:** 1. Case Management Policy, Attachment F, Assessment and Care Plan General **Narrative:** In following the Case Management Policy, the Case Manager will develop a care plan, based on the assessment as completed with the member. Care plans will be member- and family-centered, and include attainable, measurable and timely long term and short-term goals. The Case Manager will document goals and member's verbal agreement of his or her willingness to comply with the care plan.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
10. The Contractor's procedures provide for continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services. ◆ The Contractor informs new members with special healthcare needs involved in an ongoing course of treatment that he/she: ▪ May continue to receive covered services for 60 calendar days from his/her current provider. ▪ May continue to receive covered services from ancillary or non-network providers for a period of 75 calendar days. ◆ The Contractor informs a new member who is in her second or third trimester of pregnancy that she may continue to see her current provider until the completion of postpartum care. Contract: Exhibit A4—2.7.4.3.6; 2.7.5.1.1; 2.7.5.1.2; 2.7.5.1.3	**Documents:** 1. Provider Manual, page 15 **Narrative:** The Provider Manual Page 15, outlines specific to the care of CHP+ members, Continuity of Care that new members may continue to receive covered services from ancillary, or non-network providers at the same level of care received prior to enrollment in Colorado Choice for a period of 75 calendar days. For a new member in an ongoing treatment, the member with special health care needs may continue to see a current provider who is providing covered services for 60 calendar days after enrollment in Colorado Choice CHP+ program. All new CHP+ members who are in the second or third trimester of pregnancy may continue to see their provider of obstetric care.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: Colorado Choice did not directly inform new members with special healthcare needs or who are pregnant of their option to see previous providers for a certain time frame before they would be required to see in-network providers. Colorado Choice informed networked providers of this provision.		
Required Actions: Colorado Choice must develop a process wherein the health plan is directly responsible for informing new members who are pregnant or have special healthcare needs of the option to continue care with their current providers for a specified period.		
11. If necessary primary or specialty care cannot be provided to members with special healthcare needs within the Contractor's plan, the Contractor makes arrangements for members to access these providers outside the network. Contract: Exhibit A4—2.7.5.2	**Documents:** 1. Memorandum of Understanding **Narrative:** In circumstances where primary or specialty care cannot be provided to members with special healthcare needs within the Contractor's plan, the Contractor makes arrangements for members to access these providers outside the network. This is accomplished through the signing of a Memorandum of Understanding that is member specific.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
12. The Contractor allows members with special healthcare needs direct access to a specialist (for example, through a standing referral), as appropriate for the member's condition, and/or to maintain these types of specialists as PCPs. *42CFR438.208(c)(4)* Contract: Exhibit A4—2.7.5.4	**Documents:** 1. Standing Referrals Policy and Procedure, No. 3506. **Narrative:** Colorado Choice, in an effort to provide continuous and uninterrupted medical care to members requiring medically necessary, ongoing and frequent treatment for chronic conditions and reduce the paperwork burden on referring and treating providers follows the Standing Referrals process. Colorado Choice allows a member to receive a standing referral for medically necessary care to a specialist or a specialized center in the event of the member needing treatment for a chronic disease or condition requiring frequent and ongoing care.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	1	X	.00	=	0
	Not Met	=	5	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	12	**Total Score**		=	6

Total Score ÷ Total Applicable	=	50%

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
1. The Contractor has written policies and procedures regarding member rights. *42CFR438.100(a)(1)* Contract: Exhibit A4—3.1.1.1	**Documents:** 1. Member Rights and Responsibilities Policy & Procedure, No. 2100 **Narrative:** Colorado Choice Health Plans follows the Member Rights and Responsibilities policy and procedure, No. 2100 with regard to member rights.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor ensures that its staff and affiliated and network providers take member rights into account when furnishing services to members. *42CFR 438.100(a)(2)* Contract: Exhibit A4—3.1.1.1.1	**Documents:** 1. Member Rights and Responsibilities Policy & Procedure, No. 2100 2. Professional Services Agreement, page 4, 3.1 **Narrative:** Colorado Choice Health Plans follows the Member Rights and Responsibilities policy and procedure in order to provide a uniform method for ensuring that all members in all lines of business have access to information on their rights and responsibilities and those rights are taken into account when furnishing services to members. Professional Services Agreement contains protectionary language to ensure members rights. Colorado Choice has a method of tracking member grievances, so that if an issue arises regarding member rights an investigation can be completed.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
3. The Contractor's policies and procedures ensure that each member is treated by staff and affiliated providers in a manner consistent with the following specified rights: ◆ Receive information in accordance with information requirements (42CFR438.10). ◆ Be treated with respect and with due consideration for his or her dignity and privacy. ◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.	**Documents:** 1. Member Rights and Responsibilities Policy & Procedure, No. 2100 2. Professional Services Agreement, page 4, 3.1 **Narrative:** Colorado Choice Health Plans follows the Member Rights and Responsibilities policy and procedure to ensure that each member is treated by staff and affiliated providers in a manner consistent with their specified rights. Colorado Choice does follow what is outlined in the Professional Services Agreement. Professional services agreement contains protectionary language to ensure member rights.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
◆ Participate in decisions regarding his or her healthcare, including the right to refuse treatment. ◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. ◆ Request and receive a copy of his or her medical records and request that they be amended or corrected. ◆ Obtain family planning services from any duly licensed provider in or out of network without a referral. ◆ Be furnished healthcare services in accordance with federal healthcare regulations for access and availability, care coordination, and quality. *42CFR438.100(b)(2) and (3)* Contract: Exhibit A4—3.1.1.1.2–3.1.1.1.6; 3.1.1.3.2		
4. The Contractor ensures that each member is free to exercise his or her rights and that exercising those rights does not adversely affect the way the Contractor or its providers treat the member. *42CFR438.100(c)* Contract: Exhibit A4—3.1.1.1.7	**Documents:** 1. Member Rights and Responsibilities Policy and procedure, Page 2 #3 2. Professional Services Agreement, page 4, 3.1 **Narrative:** Colorado Choice Health Plans follows the Member Rights and Responsibilities policy and procedure to ensure that each member is free to exercise his or her rights and that exercising those rights does not adversely affect the way the Contractor or its providers treat the member. Colorado Choice does have in place a Grievance system that allows Colorado Choice to monitor any and all member grievances, in order to ensure member rights are not violated. Colorado Choice's Professional Services Agreement does have protectionary language regarding treatment options.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
Findings: Immediately following the list of member rights, the Colorado Choice member handbook and the provider manual both included a section titled "Refusal to Follow Recommended Treatment." Language within this section implies that if a member refuses recommended treatment his or her doctor could refuse to treat him or her. This is in direct conflict with the member's right to refuse treatment.		
Required Actions: Colorado Choice must remove the section titled "Refusal to Follow Recommended Treatment" from its member handbook and the provider manual. Members must be free to refuse treatment without the threat of being refused services by a provider.		
5. The Contractor complies with any other federal and State laws that pertain to member rights including Title VI of the Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act, and titles II and III of the Americans with Disabilities Act. *42CFR438.100(d)* Contract: 21.A	**Documents:** 1. Member Rights and Responsibilities Policy and Procedure, page 2, #1 **Narrative:** Colorado Choice Health Plans follows the Member Rights and Responsibilities policy and procedure in adherence to federal and state laws pertaining to member rights. Colorado Choice does comply with federal and state laws. Colorado Choice goes through state (Division of Insurance) and federal (CMS) audits upon state/federal request.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard IV—Member Rights and Protections							
Total	Met	=	4	X	1.00	=	4
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	5	**Total Score**		=	4

Total Score ÷ Total Applicable	=	80%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. ◆ The Contractor's credentialing program shall comply with the standards of the National Committee for Quality Assurance (NCQA) for initial credentialing and recredentialing of participating providers. NCQA CR1 CHP+ Contract: Exhibit A4—3.2.1.1; 3.2.1.3	**Documents:** 1. Credentialing Plan **Narrative:** Colorado Choice follows the credentialing plan for evaluating and selecting licensed independent practitioners to provide care to its members. The credentialing plan complies with the standards for NCQA for initial credentialing and recredentialing of participating providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners to credential and recredential. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. (Examples include MDs, DOs, podiatrists, nurse practitioners, and each type of behavior health provider.) *42CFR438.214(a)* NCQA CR1—Element A1	**Documents:** 1. Credentialing Plan, Page 1, 1. Who is Credentialed: **Narrative:** Colorado Choice follows the credentialing plan that outlines the types of practitioners to credential and recredential. Colorado Choice does not discriminate in its willingness to credential providers. Colorado Choice is dedicated to expanding our provider network and maintaining provider relationships.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.B. The verification sources used. NCQA CR1—Element A2	**Documents/Sources:** 1. Credentialing Plan, Pages 5-6, 5. Primary and Secondary Verification Sources: National Practitioner Data Bank - http://www.npdb-hipdb.hrsa.gov/ CMS Sanctions - http://exclusions.oig.hhs.gov/search.aspx ABMS - http://www.certifacts.org/ DO Certification - https://www.doprofiles.org/	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
	P.A. Certification – https://www.nccpa.net/pa/CredentialPublicSend.aspx Colorado License & Discipline Action - https://www.colorado.gov/dora/licensing/ **Narrative:** Colorado Choice follows the Credentialing Plan regarding verification sources used for the selection and retention of providers. The above sources are used to verify credentialing and recredentialing information. In following the credentialing plan, Co Choice's credentialing staff shall use accepted primary sources to verify the following for all individual providers: Licensure (licensing board), Certification for PA-Cs (National Commission on the Certification of Physician Assistants), Education (licensing board if the board primary-source verifies education prior to issuing a license; or from the school/program directly); Board certification (American Board of Medical Specialties or AOA) and Medicare/Medicaid sanctions and exclusions from Federal programs (OIG and GSA's EPLS websites)	
Findings: The Colorado Choice Credentialing Plan listed acceptable primary and secondary verification sources; however, it allowed a provider's application as an acceptable source for verifying a provider's DEA certificate. The Desktop Procedure: Credentialing File Verification indicated that DEA certification could be verified with a provider's application. However, the provider application is not an NCQA-accepted verification source for DEA certification. On-site record reviews demonstrated that Colorado Choice was collecting copies of DEA certificates as verification, which is acceptable under NCQA guidelines.		
Required Actions: Colorado Choice must update its credentialing plan and desktop procedure to include NCQA-approved verification sources for DEA certification.		
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	**Documents:** 1. Credentialing Plan, Guidelines Page 9, 8. Credentialing Guidelines **Narrative:** Colorado Choice follows criteria found in its Credentialing Plan for selection and retention of providers.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
Findings: The credentialing plan listed the criteria for credentialing and recredentialing decisions; however, the criteria (referred to in the plan as "guidelines") were not congruent with the guidelines described by staff members during the on-site interview. The written guidelines required current continuing education units (CEUs); however, the process described in the credentialing plan did not require providers to report CEUs, nor did it require staff to collect information regarding CEUs. Additionally, the guidelines required that a provider have no malpractice claims filed against him or her within the previous five years whereas staff members explained that, in practice, Colorado Choice's credentialing committee reviews providers with malpractice claims and makes decisions case by case.		
Required Actions: Colorado Choice must carefully review and revise its credentialing plan to accurately describe the criteria used for making credentialing and recredentialing decisions.		
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	**Documents:** 1. Credentialing Plan, Page 2, 3. Initial Credentialing: and Page 4, 4. Recredentialing **Narrative:** Colorado Choice follows criteria found in its Credentialing Plan when making credentialing and recredentialing decisions during the selection and retention of provider process. Upon completion of credentialing application, it is reviewed by the "PAC" for final approval or denial of providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.E. The process for managing credentialing/ recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	**Documents:** 1. Credentialing Plan, Page 10, 11. Credentialing File Maintenance and Confidentiality 2. Desktop Procedure: Credentialing File Maintenance 3. Desktop Procedure Credentialing Application Review **Narrative:** Colorado Choice follows the Credentialing Plan, the DTP Credentialing File Maintenance and DTP for Credentialing Application Review for managing credentialing/recredentialing files that meet the established criteria. The credentialing analyst utilizes a checklist, to ensure that all files are complete, accurate and do not contain conflicting information, before the files are presented to the Physician Advisory Committee (PAC).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
2.F. The process for delegating credentialing or recredentialing (if applicable). NCQA CR1—Element A6	**Documents:** 1. Credentialing Plan, Page 11, 12. Credentialing Delegation **Narrative:** Colorado Choice follows the Credentialing Plan in delegating credentialing or recredentialing.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The Colorado Choice Credentialing Plan addressed the process for delegating credentialing and recredentialing; however, the process described was intended to meet URAC requirements and did not include all elements required by NCQA.		
Required Actions: Colorado Choice must revise its credentialing plan to ensure that its process for delegating credentialing and recredentialing is compliant with NCQA requirements. (See elements 19–25.)		
2.G. The process for ensuring that credentialing and recredentialing are conducted in a nondiscriminatory manner, (i.e., must describe the steps the Contractor takes to ensure that it does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes; and that it takes proactive steps to prevent and monitor discriminatory practices). NCQA CR1—Element A7	**Documents:** 1. Credentialing Plan, Page 1 2. Desktop Procedure, Credentialing Application Review 3. DTP Credentialing File Verification 4. Non-Discrimination Statement **Narrative:** Colorado Choice in its credentialing plan outlines that it does not discriminate against any provider seeking qualification as a participating provider for CO Choice. Colorado choice follows the DTPs Credentialing Application Review and Credentialing File Verification for all requests regardless of race, ethnic/national identity, gender, age, sexual orientation, or types of procedures or patients in which the practitioner specializes. Members of the Physician Advisory Committee also sign a Non-Discrimination Statement outlining that credentialing review follows the Credentialing Plan.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
2.H. The process for notifying practitioners if information obtained during the Contractor's credentialing/recredentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A8	**Documents:** 1. Credentialing Plan, Page 12, 15. Discrepancies and Missing Information **Narrative:** Colorado Choice follows the Credentialing Plan process for notifying practitioners if information obtained during the Contractor's credentialing/recredentialing process varies substantially from the information they provided to the Contractor. Colorado Choice will contact the provider to explain the discrepancy.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.I. The process for ensuring that practitioners are notified of credentialing and recredentialing decisions within 60 calendar days of the credentialing committee's decision. NCQA CR1—Element A9	**Documents:** 1. Credentialing Plan, Page 9, Notification to Providers **Narrative:** Colorado Choice follows the Credentialing Plan for notification of credentialing and receredentialing decisions. Providers are notified whether they were approved or denied/terminated by the PAC within 10 business days of the meeting, or by the deadlines set forth in the appeals processes.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.J. The medical director or other designated physician's direct responsibility and participation in the credentialing/ recredentialing program. NCQA CR1—Element A10	**Documents:** 1. Credentialing Plan, Page 7, Medical Director Oversight 2. Desktop Procedure: Credentialing Application Review 3. Physician Advisory Committee (PAC) Charter **Narrative:** Colorado Choice follows the Credentialing Plan and DTP Credentialing Application Review regarding medical director direct responsibility and participating in the credentialing/recredentialing program. Medical Director reviews the credentialing or recredentialing application and signs the internal checklist. The Medical Director is also a member of the PAC Committee, and as such conducts the meetings, signs and reviews the letters sent to providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
2.K. The process for ensuring the confidentiality of all information obtained in the credentialing/ recredentialing process. NCQA CR1—Element A11	**Documents:** 1. Credentialing, Plan, Page 10, 11. Credentialing File Maintenance and Confidentiality 2. Desktop Procedure: Credentialing File Maintenance **Narrative** All credentialing files are kept by the Credentialing Coordinator who prepares a confidential file for each provider. Provider credentialing and recredentialing files are kept in a locked cabinet and available for the PAC and Medical Director to review. The Credentialing department utilized security passwords that are never shared, credentialing files are not viewed by unauthorized personnel and authorized personnel includes Credentialing staff and PAC members.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The Credentialing Plan, Desktop Procedure: Credentialing File Maintenance, and Desktop Procedure: Credentialing File Verification addressed the process for ensuring confidentiality of information obtained; however, the process was not clearly described or consistent across the three documents. The file verification document indicated that Colorado Choice maintained hard copies of credentialing files and the file maintenance document references the credentialing file room; however, staff members stated that Colorado Choice does not maintain paper copies of credentialing records. The credentialing plan stated that only credentialing staff, designated medical staff, and designated provider relations staff would have access to view electronic credentialing files while Desktop Procedure: Credentialing File Maintenance stated that only credentialing staff and PAC members have access to electronic files. Elsewhere in the document, the Desktop Procedure: Credentialing File Maintenance also listed credentialing staff, network management staff, and medical management staff as being authorized to view credentialing files but did not indicate if these staff members were authorized to view electronic or paper files or both.		
Required Actions: Colorado Choice must revise applicable documents to convey a consistent procedure for ensuring the confidentiality of information obtained in the credentialing process.		
2.L. The process for ensuring that listings in provider directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty. NCQA CR1—Element A12	**Documents:** 1. DTP: Provider Directory Maintenance **Narrative:** Colorado Choice follows the Desktop Procedure: Provider Directory Maintenance for maintaining the Provider Directory.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
2.M. The Contractor notifies practitioners about their rights: ◆ The right to review information submitted to support their credentialing or recredentialing application. NCQA CR1—Element B1	**Documents:** 1. Credentialing Plan, Page 10, Provider Review of Credentialing Information and Request for Status. 2. Colorado Health Care Professional Credentials Application, Page 23, #12 **Narrative:** Colorado Choice follows the Credentialing Plan in its credentialing and recredentialing process. Providers are informed of their right to review credentialing information via a statement that accompanies the credentialing/recredentialing applications (Colorado Health Care Professional Credentials Application).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.N. The right to correct erroneous information. NCQA CR1—Element B2	**Documents:** 1. Credentialing Plan, Page 10, 9. Provider Review of Credentialing Information and Request for Status 2. Colorado Health Care Professional Credentials Application, Page 23, #12 **Narrative:** Colorado Choice follows the Credentialing Plan in its credentialing and recredentialing process. Providers are informed of their right to correct erroneous information via a statement that accompanies the credentialing/recredentialing applications (Colorado Health Care Professional Credentials Application).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.O. The right to receive the status of their credentialing or recredentialing application, upon request. NCQA CR1—Element B3	**Documents:** 1. Credentialing Plan, Page 10, 9. Provider Review of Credentialing Information and Request for Status 2. Colorado Health Care Professional Credentials Application, Page 23, #12 **Narrative:** Colorado Choice follows the Credentialing Plan in its credentialing and	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
	recredentialing process. Providers are informed of their right to receive the status of their credentialing or receredentialing application, upon request. Provider is informed of this right in the Colorado Health Care Professional Credentials Application.	
2.P. How the Contractor accomplishes ongoing monitoring of practitioner sanctions, complaints, and adverse events between recredentialing cycles including: ◆ Collecting and reviewing Medicare and Medicaid sanctions. ◆ Collecting and reviewing sanctions or limitations on licensure. ◆ Collecting and reviewing complaints. ◆ Collecting and reviewing information from identified adverse events. ◆ Implementing appropriate interventions when it identified instances of poor quality related to the above. NCQA CR6—Element A	**Documents:** 1. Ongoing Monitoring of Participating Providers, Policy and Procedure No. 3302 **Narrative:** Colorado Choice follows the Ongoing Monitoring of Participating Providers for ongoing monitoring. A notebook of sanctions is kept in the Medical Department showing all sanctions and actions found by Colorado Choice.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.Q. The range of actions available to the Contractor against the practitioner (for quality reasons). NCQA CR7—Element A1	**Documents:** 1. Professional Quality of Care or Service Concern Review, Suspension or Termination Determinations and Provider Dispute Process, Policy and Procedure No. 6000, Page 8, C. **Narrative:** Colorado Choice uses the Professional Quality of Care or Service Concern Review, Suspension or Termination Determinations and Provider Dispute Process, Policy and Procedure No. 6000 to determine the range of actions available against the Practitioner.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
2.R. If the Contractor has taken action against a practitioner for quality reasons, the Contractor reports the action to the appropriate authorities (including State licensing agencies for each practitioner type and the National Practitioner Data Bank [NPDB]). NCQA CR7—Elements A2 and B	**Documents:** 1. Professional Quality of Care or Service Concern Review, Suspension or Termination Determinations and Provider Dispute Process, Policy and Procedure No. 6000, Page10, Reporting Requirement **Narrative:** Colorado Choice follows the Professional Quality of Care or Service Concern Review, Suspension or Termination Determinations and Provider Dispute Process for reporting actions for quality reasons to the appropriate authorities. Medical Director will report the final action to the National Practitioner Data Bank (NPDB) and the Colorado State Board of Medical Examiners (CSBME).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.S. A well-defined appeal process for instances in which the Contractor has taken action against a practitioner for quality reasons, which includes: ◆ Providing written notification indicating that a professional review action has been brought against the practitioner, reasons for the action, and a summary of the appeal rights and process. ◆ Allowing the practitioner to request a hearing and the specific time period for submitting the request. ◆ Allowing at least 30 days after the notification for the practitioner to request a hearing. ◆ Allowing the practitioner to be represented by an attorney or another person of the practitioner's choice. ◆ Appointing a hearing officer or panel of the individuals to review the appeal. ◆ Providing written notification of the appeal decision that contains the specific reasons for the decision. NCQA CR7—Elements A3and C	**Documents:** 1. Professional Quality of Care or Service Concern Review, Suspension or Termination Determinations and Provider Dispute Process, Policy and Procedure No. 6000, Pages 4-7 **Narrative:** Colorado Choice follows the Professional Quality of Care or Service Concern Review, Suspension or Termination Determinations and Provider Dispute Process in notifying the providers of the action taken for quality reasons and to notify them of the appeal process for those instances. The Medical Director notifies the practitioner in writing, be certified mail, of the recommendation of the PAC. This notification informs the practitioner that they may submit a written request, within thirty (30) business days of the date of the letter for a first-level appeal panel hearing. Colorado Choice after setting the date requests that practitioner notify the plan of any attorney he/she intends to have at the hearing. Medical Director will select a panel of three qualified individuals for the hearing process. Within fifteen (15) business days after the completion of the hearing the Medicare Director notifies the practitioner in writing, by certified mail, of the findings and recommendation of the first level panel.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
2.T. Making the appeal process known to practitioners. NCQA CR7—Elements A4 and C	**Documents:** 1. Provider Manuel, Page 25 2. Professional Quality of Care or Service Concern Review, Suspension or Termination Determinations and Provider Dispute Process, Policy and Procedure No. 6000, pages 4, **Narrative:** Colorado Choice follows the Professional Quality of Care or Service Concern Review, Suspension or Termination Determinations and Provider Dispute Process in making the appeal process known to practitioners. Practitioners are notified in writing of the appeal process through the Provider Manual.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
3. The Contractor designates a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions. The committee includes representation from a range of participating practitioners. NCQA CR2—Element A1	**Documents:** 1. Credentialing Plan, pages 6-7, 7. PAC Credentialing Program Oversight 2. Physician Advisory Committee (PAC) Charter, page 2 V. Membership **Narrative:** Colorado Choice follows the Credentialing Plan in designating a Committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions. Colorado Choice's committee is the Physician Advisory Committee. Colorado Choice has outlined in the Physician Advisory Committee how the membership is comprised. Membership of the committee includes the Co Choice Medical Director, Participating Community Providers, and Nurse Manager (who is a non-voting member).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence Submitted by the Health Plan**	**Score**
4. The credentialing committee: ◆ Reviews credentials for practitioners who do not meet established thresholds. ◆ Ensures that files which meet established criteria are reviewed and approved by a medical director or designated physician. NCQA CR2—Elements A2 and A3	**Documents:** 1. Credentialing Plan, page 4 **Narrative:** Providers are listed on the "PAC" Meeting Agenda and are reviewed by the Committee. Approved files are signed off by the Medical Director (Committee Chair).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. The Contractor conducts timely verification (at credentialing) of information, using primary sources, to ensure that practitioners have the legal authority and relevant training and experience to provide quality care. Verification is within the prescribed time limits and includes: ◆ A current, valid license to practice (verification time limit is 180 calendar days). ◆ A valid Drug Enforcement Administration (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (effective at the time of the credentialing decision). ◆ Education and training, including board certification, if applicable (verification of the highest of graduation from medical/ professional school, residency, or board certification—board certification time limit is 180 calendar days). ◆ Work history (verification time limit is 365 calendar days; nonprimary verification is most recent five years). ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (verification time limit is 180 calendar days). NCQA CR3—Element A	**Documents:** 1. Colorado Health Care Professional Credentials Application, page 3 2. Desktop Procedure: Credentialing File Verification **Narrative:** The Colorado Health Care Professional Credentials Application is used, which includes on Page 3, the list of documents that should be included with the application. We also provide a checklist to providers which lists the documents that must be included: valid license, DEA certificate, education and training certificates, work history, professional claims history. Our verification time limit is 180 days which is also listed on the letter we send with application materials. A checklist is provided to the provider to ensure that all necessary and required items are provided to Colorado Choice for the credentialing / recredentialing process. An internal checklist is prepared and reviewed to ensure the criteria were met for credentialing/recredentialing. Colorado Choice follows the DTP Credentialing File Verification in conducting the verification of information.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence Submitted by the Health Plan**	**Score**
6. Practitioners complete an application for network participation (at initial credentialing and recredentialing) that includes a current and signed attestation and addresses the following: ◆ Reasons for inability to perform the essential functions of the position, with or without accommodation. ◆ Lack of present illegal drug use. ◆ History of loss of license and felony convictions. ◆ History of loss or limitation of privileges or disciplinary actions. ◆ Current malpractice/professional liability insurance coverage (minimums= physician—0.5mil/1.5mil; facility—0.5mil/3mil). ◆ The correctness and completeness of the application. NCQA CR3—Element C CHP+ Contract: Exhibit A4—3.2.2.1.1; 3.2.2.1.2	**Documents:** 1. Credentialing Plan, pages 2, 2. Credentialing Application 2. Colorado Health Care Professional Credentials Application, Pages 17, 20 Section F, 21, 25 and 26 **Narrative:** Colorado Choice follows the Credentialing Plan for credentialing and recredentialing practitioners. The Colorado Health Care Professional Credentials Application is the credentialing application used by Colorado Choice. Page 26, Item 2, covers reasons for inability to perform the essential functions of the position, with or without accommodation. Page 25, items 3 and 4 of the application cover lack of present illegal drug use, Page 20, covers history of loss of license and felony convictions, Page 17 covers history of loss or limitation of privileges or disciplinary actions and current insurance coverage. Page 21, outlines the attestation for correctness and completeness of the application.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The Colorado Choice Credentialing Plan required that providers complete an application or attest to complete and accurate information in the Council for Affordable Quality Healthcare (CAQH) system. Seven of 10 credentialing records and two of 10 recredentialing records included a CAQH data summary in lieu of a credentialing application. The data summary stated that it was for provider information purposes only and was not to be submitted as an application. Colorado Choice staff members indicated that for a period of time applications downloaded from CAQH were in the data summary format and that CAQH has since changed its format to accommodate the Colorado Health Care Professional Credentials Application.		
Required Actions: Colorado Choice must be sure to collect practitioner applications in an acceptable format that includes the required elements and attestation.		

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Requirement	**Evidence Submitted by the Health Plan**	**Score**
7. The Contractor verifies the following sanction activities for initial credentialing and recredentialing: ◆ State sanctions, restrictions on licensure, or limitations on scope of practice. ◆ Medicare and Medicaid sanctions. NCQA CR3—Element B	**Documents:** 1. Credentialing Plan, page 3 2. Ongoing Monitoring of Participating Providers, Policy and Procedure No. 3302 **Narrative:** Colorado Choice follows the Credentialing Plan and Ongoing Monitoring of Participating Providers Policy and Procedure to verify DORA and CMS sanctions for the initial credentialing and recredentialing process. A notebook of sanctions is kept in the Medical Department showing all sanctions and actions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. The Contractor has a process to ensure that the offices of all practitioners meet its office-site standards. The organization sets standards and performance thresholds for: ◆ Physical accessibility. ◆ Physical appearance. ◆ Adequacy of waiting and examining room space. ◆ Adequacy of treatment record-keeping. NCQA CR5—Element A	**Documents:** 1. Office Site Visit Procedure and Checklist **Narrative:** Colorado Choice follows the Desktop Procedure to ensure that the offices of all practitioners meet its office-site standards. The DTP outlines the performance standards and thresholds.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: Colorado Choice's Desktop Procedure for Office Site Visit described the procedures for performing an office site visit within 12 months of an initial application and again at least once every 36 months. During the on-site interview, staff members stated that Colorado Choice had changed its processes and was not conducting site visits for individual practitioners. Staff indicated that while they still adhered to the standards outlined in the policy, Colorado Choice had not yet defined a process for ensuring compliance with these standards.		
Required Actions: Colorado Choice must update its desktop procedure for office site visits to describe a process to ensure that practitioner offices meet stated standards.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
9. The Contractor implements appropriate interventions by: ◆ Conducting site visits of offices about which it has received member complaints. ◆ Instituting actions to improve offices that do not meet thresholds. ◆ Evaluating effectiveness of the actions at least every six months, until deficient offices meet the thresholds. ◆ Continually monitoring member complaints for all practitioner sites and performing a site visit within 60 days of determining a complaint threshold was met. ◆ Documenting follow-up visits for offices that had subsequent deficiencies. NCQA CR5—Element B	**Documents:** 1. Office Site Visit Procedure and Checklist, page 1, 8. Customer Service **Narrative:** Colorado Choice follows the Office Site Visit Procedure and Checklist for complaints involving practitioner sites and Provider Relations will arrange for that site to be visited and scored within sixty (60) days of determining its complaint threshold was met. If the site still does not pass after being re-visited Provider Relations will develop and implement a corrective action plan.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: Colorado Choice's Desktop Procedure for Office Site Visit described a process to implement appropriate interventions which was compliant with the requirement; however, during the on-site interview, staff members stated that Colorado Choice no longer adhered to the process described in the desktop procedure. Colorado Choice was not conducting site visits or implementing interventions in instances when sites do not meet its standards.		
Required Actions: Colorado Choice must update its desktop procedure to describe the interventions to be implemented in instances when provider sites do not meet its standards.		
10. The Contractor formally recredentials its practitioners at least every 36 months. NCQA CR4	**Documents:** 1. Credentialing Plan, page 4 **Narrative:** Colorado Choice follows the Credentialing Plan for both credentialing and recredentialing of practitioners. Colorado Choice uses same format for recredentialing as credentialing and primary sources are validated.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
11. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of (organizational) providers with which it contracts, which include: 11.A. The Contractor confirms—initially and at least every three years—that the provider is in good standing with state and federal regulatory bodies. NCQA CR8—Element A1	**Documents:** 1. Credentialing Plan, Pages 13-15, Item 17., Institutional Credentialing 2. Facility Credentialing and Recredentialing P&P 3303 **Narrative:** Colorado Choice follows the Credentialing Plan and the Facility Credentialing and Recredentialing P&P for the initial and ongoing assessment of (organizational) providers. Contractor confirms that the provider is in good standing with state and federal regulatory bodies.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11.B. The Contractor confirms—initially and at least every three years— that the provider has been reviewed and approved by an accrediting body. NCQA CR8—Element A2	**Documents:** 1. Credentialing Plan, Pages 13-15, Item 17., Institutional Credentialing 2. Facility Credentialing and Recredentialing P&P 3303, pages 1-2 **Narrative:** Colorado Choice follows the Credentialing Plan and the Facility Credentialing and Recredentialing P&P for the initial and ongoing assessment of (organizational) providers. As part of the Application process the provider submits accreditation information.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11.C. The Contractor conducts—initially and at least every three years—an on-site quality assessment if there is no accreditation status. NCQA CR8—Element A3	**Documents:** 1. Credentialing Plan, Pages 13-15, Item 17., Institutional Credentialing 2. Facility Credentialing and Recredentialing P&P 3303, page 3 **Narrative:** Colorado Choice follows the Credentialing Plan and the Facility Credentialing and Recredentialing P&P for the on-site quality assessment if there is no accreditation status. Site visits will be performed for organizational providers that are unaccredited or have not passed a CMS or state review. A site visit Checklist will be used to assess the organizational provider.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
11.D. The Contractor's policies specify the sources used to confirm: ◆ That providers are in good standing with state and federal requirements. ◆ The provider's accreditation status. (Includes applicable state or federal agency or applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, copies of credentials—e.g., licensure, accreditation report or letter—from the provider.) NCQA CR8—Element A, Factors 1 and 2	**Documents:** 1. Credentialing Plan, pages 13-15, Item 17., Institutional Credentialing **Narrative:** Colorado Choice follows the Credentialing Plan for organizational credentialing. The primary source verification that is completed is with the Colorado Department of Health Services (DHS) license (primary source verification of DS license) on the DSH website.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11.E. The Contractor's policies and procedures include: ◆ On-site quality assessment criteria for each type of unaccredited organizational provider. ◆ A process for ensuring that the provider credentials its practitioners. NCQA CR8—Element A, Factor 3	**Documents:** 1. Facility Credentialing and Recredentialing, Policy and Procedure, No. 3303, attachment B 2. Credentialing Delegation Addendum **Narrative:** Colorado Choice follows the Facility Credentialing and Recredentialing Policy and Procedure for the on-site quality assessment criteria for unaccredited organizational providers. Through the Delegation Agreement Addendum, Colorado Choice ensures that the provider credentials its practitioners.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The Facility Credentialing and Recredentialing policy and procedure did not include a process for ensuring that unaccredited organizational providers credential their practitioners. Also, the site review tool used to conduct on-site quality assessments did not include an element for confirming the process for credentialing.		
Required Actions: Colorado Choice must revise its policies and procedures to describe a process to ensure that organizational providers credential their practitioners.		

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Requirement	**Evidence Submitted by the Health Plan**	**Score**
12. The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: ◆ The CMS or state review is no more than three years old. ◆ The organization obtains a survey report or letter from CMS or the state, from either the provider or from the agency, stating that the facility was reviewed and passed inspection. ◆ The report meets the organization's quality assessment criteria or standards. NCQA CR8—Element A, Factor 3	**Documents:** 1. Facility Credentialing and Recredentialing, Policy and Procedure, No. 3303, page 3, Site Visits **Narrative:** Colorado Choice follows the Facility Credentialing and Recredentialing P&P outlines the policy and process for substituting a CMS or State quality review in lieu of a site visit.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The Facility Credentialing and Recredentialing policy stated that Colorado Choice would perform a site visit for organizational providers that are unaccredited or have not passed a CMS or State review. The policy did not specify that the CMS or State review could be no more than three years old, nor did it specify that it must obtain a copy of the survey report or letter from CMS or the State showing that the facility was reviewed and passed inspection as well as a copy of the criteria or standards used. On-site record reviews demonstrated that Colorado Choice collected copies of letters stating that the facility was reviewed and passed; however, staff did not know the criteria or standards used for the CMS or State site reviews.		
Required Actions: Colorado Choice must revise its policy and procedures to specify the circumstances under which it may substitute a CMS or State site visit in lieu of conducting its own site visit.		
13. The Contractor's organizational provider assessment policies and process include assessment of at least the following medical providers: ◆ Hospitals. ◆ Home health agencies. ◆ Skilled nursing facilities. ◆ Free-standing surgical centers. NCQA CR8—Element B	**Documents:** 1. Facility Credentialing and Recredentialing, Policy and Procedure, No. 3303 **Narrative:** Colorado Choice follows the Facility Credentialing and Recredentialing P&P for assessing organizational providers. The assessment of organizational providers includes but is not limited to hospitals, home health agencies, skilled nursing facilities, free-standing surgical centers; inpatient, residential, or ambulatory behavioral healthcare facilities	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence Submitted by the Health Plan**	**Score**
	providing mental health or substance abuse services; diagnostic, laboratory, and imaging centers; and rehabilitation and other therapeutic health settings.	
14. The Contractor's organizational provider assessment policies and process include assessment of at least the following behavioral health and substance abuse settings: ◆ Inpatient. ◆ Residential. ◆ Ambulatory. NCQA CR8—Element C	**Documents:** 1. Facility Credentialing and Recredentialing, Policy and Procedure, No. 3303 **Narrative:** Colorado Choice follows the Facility Credentialing and Recredentialing P&P for assessing organizational providers. The assessment of organizational providers includes but is not limited to hospitals, home health agencies, skilled nursing facilities, free-standing surgical centers; inpatient, residential, or ambulatory behavioral healthcare facilities providing mental health or substance abuse services; diagnostic, laboratory, and imaging centers; and rehabilitation and other therapeutic health settings.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
15. The Contractor has documentation that it has assessed contracted medical healthcare (organizational) providers. NCQA CR8—Element D	**Documents:** 1. Files available upon site review (checklist) **Narrative:** All credentialing files are kept by the Credentialing Coordinator who prepares a confidential file for each organizational provider. Files are kept in a locked cabinet and available for the PAC and Medical Director to review. These files include those of medical healthcare (organizational) providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
16. The Contractor has documentation that it has assessed contracted behavioral healthcare (organizational) providers. NCQA CR8—Element E	**Documents:** 1. Files available upon site review (checklist) **Narrative:** All credentialing files are kept by the Credentialing Coordinator who prepares a confidential file for each organizational provider. Files are kept in a locked cabinet and available for the PAC and Medical Director to review. These files include those of contracted behavioral healthcare (organizational) providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence Submitted by the Health Plan**	**Score**
17. If the Contractor delegates any NCQA-required credentialing activities, there is evidence of oversight of the delegated activities. NCQA CR9	**Documents:** 1. Delegation Oversight Policy & Procedure, No. 3702, page 5 2. Delegated Entity Annual Review Summary **Narrative:** Colorado Choice follows the Delegation Oversight Policy for any NCQA-required credentialing activities and prepares as a method of oversight, the Delegated Entity Annual Review Summary for any delegated NCQA-required credentialing activities.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
Findings: Colorado Choice stated that it delegated credentialing activities; however, these activities did not qualify as "delegation" based on NCQA criteria.		
18. The Contractor has a written delegation document with the delegate that: ◆ Is mutually agreed upon. ◆ Describes the delegated activities and responsibilities of the Contractor and the delegated entity. ◆ Requires at least semiannual reporting by the delegated entity to the Contractor. ◆ Describes the process by which the Contractor evaluates the delegated entity's performance. ◆ Describes the remedies available to the Contractor (including revocation of the delegation agreement) if the delegate does not fulfill its obligations. NCQA CR 9—Element A	**Documents:** 1. Credentialing Delegation Addendum **Narrative:** Colorado Choice has a written Credentialing Delegation Addendum for those delegates who provide any NCQA-required credentialing activities. These agreements are mutually agreed upon (Page 4, C.). The Delegation Addendum describes the delegated activities (credentialing). The Delegation Addendum Exhibit 1 outlines that the provider will submit to Plan performance quarterly reports no later than the 15th of the month following the close of each quarter. The Delegation addendum also outlines that If provider fails to comply with Plan's credentialing requirements, PLAN reserves the right to assume credentialing of providers.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
Findings: Colorado Choice stated that it delegated credentialing activities; however, these activities did not qualify as "delegation" based on NCQA criteria.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
19. If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes: ◆ A list of allowed use of PHI. ◆ A description of delegate safeguards to protect the information from inappropriate use or further disclosure. ◆ A stipulation that the delegate will ensure that subdelegates have similar safeguards. ◆ A stipulation that the delegate will provide members with access to their PHI. ◆ A stipulation that the delegate will inform the Contractor if inappropriate uses of the information occur. ◆ A stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends. NCQA CR9—Element B	**Documents:** N/A **Narrative:** Colorado Choice's delegation agreement does not contain the use of protected health information (PHI) by the delegate.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
Findings: Colorado Choice stated that it delegated credentialing activities; however, these activities did not qualify as "delegation" based on NCQA criteria.		
20. The Contractor retains the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision making. This right is reflected in the delegation agreement. NCQA CR9—Element C	**Documents:** 1. Credentialing Delegation Addendum, page 1 **Narrative:** Colorado Choice through the Credentialing Delegation Addendum, retains the final authority and right to approve providers for participation and to terminate or suspend providers who do not meet PLAN's credentialing standards. This right is reflected in the Colorado Choice Health Plans Credentialing Delegation Addendum that is executed by the Provider as well as the Plan.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
Findings: Colorado Choice stated that it delegated credentialing activities; however, these activities did not qualify as "delegation" based on NCQA criteria.		
21. For delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity before the delegation document was signed. NCQA CR9—Element D	**Documents:** N/A **Narrative:** Colorado Choice has no new delegation agreements that have been entered into in the last 12 months.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
Findings: Colorado Choice stated that it delegated credentialing activities; however, these activities did not qualify as "delegation" based on NCQA criteria.		
22. For delegation agreements in effect 12 months or longer, the Contractor audits credentialing files against NCQA standards for each year that the delegation has been in effect. NCQA CR9—Element E1	**Documents:** 1. Credentialing Delegation Addendum, page 3 Audits. **Narrative:** Colorado Choice audits the consistency of applications of credentialing and recredentialing policies and procedures at least annually and shall forward a report showing the outcome of such audit to Plan. Provider will allow Plan to audit five percent (55) or 50 files, whichever is less in order to evaluate Provider's compliance with its credentialing and recredentialing policies and procedures.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
Findings: Colorado Choice stated that it delegated credentialing activities; however, these activities did not qualify as "delegation" based on NCQA criteria.		
23. For delegation arrangements in effect 12 months or longer, the Contractor performs an annual substantive evaluation of delegated activities against NCQA standards and organization expectations. NCQA CR9—Element E2	**Documents:** 1. Delegated Entity Annual Review Summary **Narrative:** Colorado Choice in its oversight efforts, completed the Delegated Entity Annual Review Summary for any delegated NCQA-required credentialing activities.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
Findings: Colorado Choice stated that it delegated credentialing activities; however, these activities did not qualify as "delegation" based on NCQA criteria.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
24. For delegation arrangements in effect 12 months or longer, the Contractor evaluates regular reports (at least semiannually). NCQA CR9—Element E3	**Documents:** 1. Credentialing Delegation Addendum, Exhibit 1 **Narrative:** In the Credentialing Delegation Addendum, it is agreed that the Provider will submit the Plan performance quarterly reports no later than the 15th of the month following the close of each quarter. Colorado Choice reviews and sign off on the vendor's audit tool to verity that it covers relevant standards.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
Findings: Colorado Choice stated that it delegated credentialing activities; however, these activities did not qualify as "delegation" based on NCQA criteria.		
25. The Contractor identified and followed up on opportunities for improvement (at least once in each of the past two years), if applicable. NCQA CR9—Element F	**Documents:** N/A **Narrative:** There were no areas in which the Contractor identified and follows up on opportunities for improvement.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
Findings: Colorado Choice stated that it delegated credentialing activities; however, these activities did not qualify as "delegation" based on NCQA criteria.		

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	30	X	1.00	=	30
	Partially Met	=	9	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	N/A	=	9	X	NA	=	0
Total Applicable		=	39	**Total Score**		=	30

Total Score ÷ Total Applicable	=	77%

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
1. The Contractor has an ongoing Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. 42CFR438.*240*(a) Contract: Exhibit A4—2.9.1	**Documents:** 1. Quality Assurance Program Description and Quality Improvement Program (QAP/QIP). **Narrative:** Colorado Choice's Quality Assurance Program Description and Quality Improvement Program is reviewed and updated annually. The Medical Department analyzes the quality progress and amends as needed. It is then reviewed by the "QAC", where a recommendation is made to the Colorado Choice Board of Directors, who ultimately approves, denies or amends the Quality Assurance Program Description and Quality Improvement Program (QAP/QIP)	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: Colorado Choice's ongoing Quality Assessment and Performance Improvement (QAPI) Program addressed only basic federal and State requirements and was not robust in nature. For example, member concerns identified in the CAHPS survey ranked Colorado Choice below the 25th percentile on four of the measures on NCQA's 2015 HEDIS Benchmarks and Thresholds for Accreditation, yet Colorado Choice implemented no quality initiatives to address these issues.		
Required Actions: Colorado Choice must evolve its QAPI program to ensure that it includes processes for reviewing areas identified as needing improvement and take action to improve these areas.		
2. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42CFR438.240(b)(3)* Contract: Exhibit A4—2.9.4.4.1	**Documents:** 1. Quality Assurance Program Description and Quality Improvement program (QAP/QIP), page 3, III. Objective/Policy Statement 2. Utilization Management Program Description, Page 1, II Scope, a. Program Definition **Narrative:** Colorado Choice's QAP/QIP incorporates Utilization Management (UM), practices and guidelines. Overutilization is detected through the review process (outpatient and ER), referral process, and authorization process. Underutilization is detected through the Quality Improvement Projects and the case management program. Upon staff request, specific claims data for the detection of under underutilization and overutilization is pulled by the IT.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
Findings: While Colorado Choice had some methods for identifying under- and over-utilization, staff noted during the interview that there was no system in place (e.g., functional case management) to allow for comprehensive utilization management, quality assurance, and improvement.		
Required Actions: Colorado Choice must expand its QAPI program to ensure that mechanisms are in place to more effectively detect both underutilization and overutilization of services.		
3. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care for persons with special healthcare needs. *42CFR438.240(b)(4)* Medicaid Contract: Exhibit A—2.7.2.4.4 CHP+ Contract: Exhibit A4—None	**Documents:** 1. Quality Assurance Program Description and Quality Improvement program (QAP/QIP), Page 1 **Narrative:** The guiding principal for the Quality Assurance Program Description and Quality Improvement Program is to document the oversight and the principle of continuous quality improvement within Colorado Choice. The goals of the program are to demonstrate quantitate and qualitative excellence organization-wide to include every line of business using a collaborative approach of clinical and non-clinical subjective matter experts and analysis for all populations, including those populations with special healthcare needs.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: While the Quality Assurance Program Description and Quality Improvement program (QAP/QIP) document provided an overview of the goals for the program, it did not at any point address persons with special healthcare needs.		
Required Actions: Colorado Choice must expand its QAPI program to include mechanisms to assess the quality and appropriateness of care for persons with special healthcare needs.		
4. The Contractor adopts practice guidelines for the following: ◆ Perinatal, prenatal, and postpartum care for women. ◆ Conditions related to persons with a disability or special healthcare needs. ◆ Well child care. Contract: Exhibit A4—2.9.2.1.1	**Documents:** 1. Practice Guidelines Perinatal, Prenatal for women. 2. Practice Guidelines Post-Partum Care 3. Practice Guidelines Diabetes Care Flow Sheet 4. Practice Guidelines Asthma Management for Children and Adults (age 5+ years) 5. Practice Guidelines Heart Failure Management 6. Practice Guidelines Pediatric Immunization Schedule 7. Practice Guidelines Preventive Pediatric Health Care	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	Narrative: Colorado Choice's Physician Advisory Committee (PAC) has approved the adoption of the clinical practice guidelines referenced above. These guidelines are published on Colorado Choice's website for public access.	
5. The Contractor ensures that practice guidelines comply with the following requirements: ◆ Are based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field. ◆ Consider the needs of the Contractor's members. ◆ Are adopted in consultation with contracting healthcare professionals. ◆ Are reviewed and updated annually. *42CFR438.236(b)* Contract: Exhibit A4—2.9.2.1.2	**Documents:** 1. Utilization Management Program Description, page 1 **Narrative:** Colorado Choice ensures that practice guidelines are based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field, as they are prepared by the Medical director with input and approval by the PAC. These guidelines are prepared considering the needs of the members, are adopted in consultation with contracting healthcare professionals and are reviewed and updated annually. The Physician Advisory Committee conducts the oversight and adoption of the clinical practice guidelines. CO Choice UM Staff	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
6. The Contractor disseminates the guidelines to all affected providers, and upon request to members, the Department, other nonmembers, and the public, at no cost. *42CFR438.236(c)* Contract: Exhibit A4—2.9.2.1.3	**Documents:** 1. Website Screenshot guidelines **Narrative:** The guidelines used to make decisions are available upon request to anyone. These guidelines are published on Colorado Choice's website for public access.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
7. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42CFR438.236(d)* Contract: Exhibit A4—2.9.2.1.4	**Documents:** 1. Utilization Management Program Description, Page 1 **Narrative:** CO Choice UM Staff utilize Milliman Guidelines as well as clinical practice guidelines in the decision making process. The Medical Director and Nurse Manager verify and research on case by case basis.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
8. The Contractor calculates and submits specified HEDIS measures determined by collaboration between the Department and the Contractors quality improvement committee. The Contractor: ◆ Analyzes and responds to results indicated in the HEDIS measures. ◆ Calculates additional mandatory federal performance measures when they are required by CMS. Contract: Exhibit A4—2.9.4.1.1; 2.9.4.1.2; 2.9.4.2.1	**Documents:** 1. HSAG FTP Upload screenshot 2. Reporting Template 3. Final HEDIS Audit Report **Narrative:** Colorado Choice conducted HEDIS pursuant to the requirements provided by the State. Colorado Choice submitted the necessary reports to HSAG through the FTP site along with the Final HEDIS Audit Report. The internal quality committee analyzes and responds to the results.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor monitors member perceptions of accessibility and adequacy of services provided. Tools shall include: ◆ Member Surveys (CAHPS). ◆ Anecdotal information. ◆ Grievance and appeals data. ◆ Enrollment and disenrollment information. Contract: Exhibit A4—2.9.4.3.2	**Documents:** 1. Member Satisfaction Policy & Procedure **Narrative:** Colorado Choice follows the Member Satisfaction Policy & Procedure to determine current levels of satisfaction of programs and services among members and to evaluate and trend performance against industry, survey, or contractual benchmarks; and identify opportunities for improving the member experience. The Department of Health Care Policy & Financing on behalf of each plan, administers the CAHPS Health Plan Survey. The department then provides the results to the plans. CAHPS are conducted on an annual basis. Colorado Choice through the Internal Quality Committee Meetings analyze the results and prepares a corrective action plan for quality improvement. Appeals and Grievance data is reported on a quarterly basis to CHP+ per contract deliverables. Appeals and grievances are maintained in the operating system (Xpress) in the customer service module which logs all member and provider calls. Enrollment and disenrollment is also tracked in Xpress. Upon notice from CHP+ Colorado Choice will add or term members.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Findings: While Colorado Choice participated in CAHPS, its QAC meeting minutes did not document that the committee evaluated or addressed —from a QAPI perspective —instances wherein results were below the 25th percentile. In addition, Colorado Choice did not define grievances as "any expression of

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
dissatisfaction" (as required by federal and State regulations). Colorado Choice collected and categorized some expressions of dissatisfaction as "complaints;" and others, as discussed during the on-site interview, were not collected at all. As such, Colorado Choice had not been recording grievances appropriately for trending and QAPI action.		
Required Actions: Colorado Choice must develop a process to ensure that all expressions of dissatisfaction, no matter how "small" or how quickly remedied, are captured by staff and used for periodic trending. All areas where trends are identified—whether via the grievance and appeals system, CAHPS reports, anecdotal information, or enrollment and disenrollment information—must be monitored by the appropriate committee and assessed for appropriate action.		
10. The Contractor investigates any alleged quality of care concerns. ◆ Upon request, the Contractor shall submit a letter (within 10 business days) to the Department that includes a brief but clear description of the issue, the efforts that the Contractor took to investigate the issue, the outcome of the review, and what action the Contractor intends to take with the providers involved. Contract: Exhibit A4—2.9.4.5.1; 2.9.4.5.2	**Documents:** 1. Professional Quality of Care or Service Concern Review, Suspension or Termination Determinations and Provider Dispute process, No. 6000 **Narrative:** Colorado Choice follows the Professional Quality of Care or Service Concern Review, Suspension or Termination Determinations and Provider Dispute Process in reviewing and investigating any alleged quality of care concern. Although Colorado Choice did not have any quality of care concerns in 2015, should Colorado Choice be notified and should the department request information, Colorado Choice will be sure to provide said notification pursuant to contractual obligations.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis. ◆ The Contractor has a Quality Improvement Committee to assess and implement measures of quality, access, and customer satisfaction. ◆ The annual QAPI report includes: ▪ Specific preventive care priorities, and services covered in and goals of the program over the prior 12-month period. ▪ Status and results of each performance improvement	**Documents:** 1. Quality Assurance Program Description and Quality Improvement program (QAP/QIP), Page 14, XI. Quality Assurance Program Evaluation. 2. Provider Manual, Page 11, Quality Assurance **Narrative:** Colorado Choice's QAC conducts ongoing analysis of the QAP annually and documents the evaluation via a formal written report that is communicated to the Board of Directors. The CHP+ PIP initiative is evaluated quarterly by the medical department and provided to CHP+ upon contracting deliverables. Satisfaction survey results are analyzed and	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
project (PIP) started, continuing, or completed during the prior 12-month period. ▪ Results of member satisfaction surveys completed during the prior 12-month period. ▪ Detailed description of the findings of the program impact analysis. ▪ Techniques used by the Contractor to improve performance. ▪ Overall impact and effectiveness of the QAPI Program during the prior 12-month period. ◆ Upon request, this information shall be made available to providers and members at no cost. *42CFR438.240(e)(2)* Contract: Exhibit A4—2.9.4.7; 2.9.4.6.1	evaluated for quality improvement initiatives through the internal Quality Committee and in turn reported to the QAC. Providers are notified that they may request information regarding the QAPI program at any time.	
12. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data, including, but not limited to, information on utilization, grievances and appeals, encounters, and disenrollment. *42CFR438.242(a)* Contract: Exhibit A4—2.9.4.10.1	**Documents:** N/A **Narrative:** Colorado Choice Health Plans utilizes the Monument Systems Xpress V3.11.2.202 system. With this system Colorado Choice is able to collect, analyze, integrate and report data including but not limited to information on utilization, grievances and appeals, encounters and disenrollment. Information Technologies personal are available for consultations as needed to retrieve necessary data for analysis and integration into care.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
13. The Contractor collects data on member and provider characteristics and on services furnished to members. *42CFR438.242(b)(1)* Contract: Exhibit A4—2.9.4.10.2	**Documents:** 1. Provider characteristics screenshot **Narrative:** Colorado Choice utilizes the Monument Systems Xpress V3.11.2.202 system. With this operating system, Colorado Choice is able to collect data on member and provider characteristics and on services furnished to members.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
14. The Contractor's health information system includes a mechanism to ensure that data received from providers are accurate and complete by: ◆ Verifying the accuracy and timeliness of reported data. ◆ Screening the data for completeness, logic, and consistency. ◆ Collecting service information in standardized formats to the extent feasible and appropriate. *42CFR438.242(b)(2)* CHP+ Contract: None	**Documents:** 1. Provider Credentialing Checklist **Narrative:** Colorado Choice completed the Provider Credentialing Checklist to ensure that data received from providers is accurate and complete. All data is input into the Monument Systems Xpress V3.11.2.202 system once all elements have been met.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
15. The Contractor submits immunization information for all covered members to the Colorado Immunization Information System (CIIS) monthly. Contract: Exhibit A4—2.9.4.10.6	**Documents:** 1. CIIS File Transfer Screenshot **Narrative:** Colorado Choice has been working with the Colorado Immunization Information System personnel to achieve monthly submissions of the CIIS immunization information for all covered members. Colorado Choice is in the testing phase and is currently making requested file changes in order to submit additional test files. Colorado Choice has obtained access to the Enhanced File Transfer site in order to complete the monthly submissions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard X—Quality Assessment and Performance Improvement							
Total	Met	=	11	X	1.00	=	11
	Partially Met	=	2	X	.00	=	0
	Not Met	=	2	X	.00	=	0
	N/A	=	0	X	NA	=	0
Total Applicable		=	15	**Total Score**		=	11

Total Score ÷ Total Applicable	=	73%

Appendix B. Record Review Tools for Colorado Choice Health Plans

The completed record review tools follow this cover page.

Appendix B. Colorado Department of Health Care Policy & Financing
2015–2016 Credentialing Record Review Tool
for Colorado Choice Health Plans

Review Period:	January 1, 2013–December 31, 2015
Date of Review:	January 28–29, 2016
Reviewer:	Gina Stepuncik
Participating Plan Staff Member:	Ashley Palmer

SAMPLE	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Provider ID#	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****
Provider Type (MD, PhD, NP, PA, MSW)	MD	MD	DO	MD	LMFT	MD	MD	MD	MD	DPM
Application/Attestation Date	11/20/13	NA	NA	None	None	NA	NA	10/22/14	02/11/15	None
Credentialing Date (Committee/Medical Director Approval Date)	01/20/14	04/15/14	05/12/14	04/15/14	11/17/14	02/25/14	10/21/14	10/28/14	05/21/15	12/24/14
The Contractor, using primary sources, verifies that the following are present:										
◆ A current, valid license to practice (with verification that no State sanctions exist)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ A valid DEA or CDS certificate (if applicable)	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☐ N☐ NA☒	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐
◆ Education and training, including board certification (if the practitioner states on the application that he or she is board certified)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Work history	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ History of professional liability claims	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Current malpractice insurance in required amount	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Verification that the provider has not been excluded from federal participation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Signed application and attestation	Y☒ N☐	Y☐ N☒	Y☐ N☒	Y☐ N☒	Y☐ N☒	Y☐ N☒	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☒
◆ The provider credentialing was completed within verification time limits (see specific verification element—180/365 days)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☒	Y☒ N☐	Y☐ N☒	Y☐ N☒	Y☒ N☐	Y☒ N☐	Y☐ N☒
# Applicable elements	**9**	**9**	**9**	**9**	**8**	**9**	**9**	**9**	**9**	**9**
# Compliant elements	**9**	**8**	**8**	**7**	**7**	**7**	**8**	**9**	**9**	**7**
Percentage compliant	**100%**	**89%**	**89%**	**78%**	**88%**	**78%**	**89%**	**100%**	**100%**	**78%**

Total Record Review Score					**Total Applicable: 89**		**Total Compliant: 79**		**Total Percentage: 89%**	

Comments: Record Numbers 2, 3, 4, 5, 6, 7, and 10 included a CAQH data summary in lieu of a credentialing application. The data summary stated that it was for provider information purposes only and not to be submitted as an application. Record Number 2 included two attestation statements; however, neither statement appeared to be affiliated with the application. Record Number 7 also had two attestation statements, and both were dated 2012. Record Numbers 4 and 10 did not include attestations.

Review Period:	January 1, 2013–December 31, 2015
Date of Review:	January 28–29, 2016
Reviewer:	Rachel Henrichs and Gina Stepuncik
Participating Plan Staff Member:	Ashley Palmer

SAMPLE	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Provider ID#	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****
Provider Type (MD, PhD, NP, PA, MSW)	MD	MD	CNM	FNP	MD	MD	MD	MD	PA	MD
Application/Attestation Date	NA	01/28/15	NA	11/19/14	02/17/15	08/11/15	11/17/14	02/18/15	12/04/14	08/31/15
Last Credentialing/Recredentialing Date	09/18/12	05/15/12	02/19/13	02/19/13	09/18/12	05/20/13	09/18/12	09/18/12	02/21/13	11/20/12
Recredentialing Date (Committee/Medical Director Approval Date)	04/15/14	04/07/15	08/11/14	03/26/15	03/26/15	09/15/15	03/26/15	04/06/15	04/01/15	09/15/15
The Contractor, using primary sources, verifies that the following are present:										
◆ A current, valid license to practice (with verification that no State sanctions exist)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ A valid DEA or CDS certificate (if applicable)	Y☒ N☐NA☐	Y☒ N☐ NA☐	Y☐ N☐ NA☒	Y☐ N☒ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐
◆ Board certification status (verifies status only if the practitioner states on the application that he/she is board certified)	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐
◆ History of professional liability claims	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Current malpractice insurance in the required amount	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Verification that the provider has not been excluded from federal participation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Signed application and attestation	Y☐ N☒	Y☒ N☐	Y☐ N☒	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ The provider recredentialing was completed within verification time limits (see specific verification element—180/365 days)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Recredentialing was completed within 36 months of last credentialing/recredentialing date	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
# Applicable elements	**9**	**9**	**7**	**8**	**9**	**9**	**9**	**9**	**9**	**9**
# Compliant elements	**8**	**9**	**6**	**7**	**9**	**9**	**9**	**9**	**9**	**9**
Percentage compliant	**89%**	**100%**	**86%**	**88%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Total Record Review Score					**Total Applicable: 87**	**Total Point Score: 84**	**Total Percentage: 97%**

Comments:
Record Numbers 1 and 3 included a CAQH data summary in lieu of a credentialing application. The data summary stated that it was for provider information purposes only and not to be submitted as an application. The provider in record Number 4 indicated he/she had a DEA certificate; however, there was no evidence of verification of a valid DEA or CDS certificate in the record.

Appendix C. Site Review Participants for Colorado Choice Health Plans

Table C-1 lists the participants in the FY 2015–2016 site review of **Colorado Choice**.

Table C-1—HSAG Reviewers and Health Plan Participants

HSAG Review Team	Title
Gina Stepuncik, MHA	Senior Project Manager
Rachel Henrichs	Compliance Auditor
Colorado Choice Participants	**Title**
Ashley Palmer	Manager, Credentialing and Special Projects
Chris Kingston	Manager, Medical Department
Cynthia Palmer	Chief Executive Officer
Dawn Arellano, RN	Nurse Manager
Jennifer Mueller	Director, Quality and Program Development
Manuela Heredia	Manager, Government Programs
Shoshanna Montana	Member/Program Specialist
Department Observers	**Title**
Jerry Ware	Quality and Health Improvement Unit
Teresa Craig (telephonic)	Contract and Program Manager, MCO and SMCN

Appendix D. Corrective Action Plan Template for FY 2015–2016 *for* Colorado Choice Health Plans

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

For this step,	HSAG completed the following activities:
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, persons responsible, 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.

For this step,	HSAG completed the following activities:
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 healthcare regulations and managed care contract requirements.

The template for the CAP follows.

Table D-2—FY 2015–2016 Corrective Action Plan *for* Colorado Choice

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
1. The Contractor has written policies and procedures to address the coordination and provision of covered services in conjunction with other medical and behavioral health plans and to promote: ◆ Service accessibility. ◆ Attention to individual needs. ◆ Continuity of care. ◆ Maintenance of health. ◆ Independent living.	Colorado Choice staff openly acknowledged that they had not been providing coordination of care as described in the Case Management policy and UM Pre-Certification Review policy and procedure or as mandated by State contract and federal regulations.	Colorado Choice must develop and implement comprehensive written policies and procedures to address the coordination and provision of covered services in conjunction with other medical and behavioral health plans and promote service accessibility, attention to individual needs, continuity of care, maintenance of health, and independent living. Health plan leadership must ensure accountability to the new policies and addressing of members' specific needs.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
2. The Contractor's procedures are designed to address those members who require complex coordination of benefits and services and may require services from multiple providers, facilities and agencies, ancillary or nonmedical services, including social services and other community resources. Procedures also address: ◆ Coordinating services for children with special healthcare needs with other agencies or entities such as those dealing with mental health and substance abuse, public health, home and community-based care, developmental disabilities, local school districts, child welfare, IDEA programs, Title V, families, caregivers, and advocates. ◆ Criteria for making referrals and coordinating care by specialists, subspecialists, and community-based organizations.	Colorado Choice's policies and procedures described the process of mailing new members a health assessment survey that could be used to identify and assess special healthcare needs; however, staff members stated they did not follow up with members who returned the form—regardless of any identified condition or need. Case management staff reassessed risk levels based on what they felt they could manage rather than on member need. Colorado Choice had no process to identify or refer members for care management services.	Colorado Choice must develop and implement procedures to address members who require complex coordination of benefits and services and who may require services from multiple providers and/or other community resources. The procedures need to address all components of the requirement. Health plan leadership must ensure accountability to the new procedures and ensure that members' complex care coordination needs are addressed.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
4. The Contractor implements procedures to provide an individual needs assessment after enrollment and at any other necessary time, including the screening for special healthcare needs (e.g., mental health, high risk health problems, functional problems, language or comprehension barriers, and other complex health problems). The assessment mechanisms must use appropriate healthcare professionals. ◆ The Contractor will assess members with special healthcare needs within 30 days in order to identify ongoing conditions that require a course of treatment or regular care monitoring.	Colorado Choice staff members stated that they had not implemented a comprehensive procedure for providing individual needs assessments. Although they mailed new members a health assessment survey upon enrollment, Colorado Choice had not been reviewing returned forms or following up with members who self-identify areas of need. Colorado Choice also did not have alternative procedures for assessing members that did not return the health assessment survey.	Colorado Choice must develop and implement procedures to provide members an individual needs assessment within 30 days of enrollment and at any other necessary time. The assessment must identify ongoing conditions that require a course of treatment or regular care monitoring. Health plan leadership must ensure accountability to the new procedures.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
6. The Contractor implements procedures to develop an individual treatment plan based on the needs assessment. The treatment plan addresses treatment objectives, treatment follow-up, monitoring of outcomes, and is revised as necessary.	Colorado Choice staff noted during the interview that they did not feel they had the capacity to reach out to members who returned the health assessment survey mailed to members at time of enrollment. As such, Colorado Choice did not develop individual treatment plans based on the needs assessment.	Colorado Choice must develop and implement comprehensive procedures to create an individual treatment plan based on the needs assessment. The treatment plan must address treatment objectives, treatment follow-up, and monitoring of outcomes and be revised as necessary. Health plan leadership must ensure accountability to the new procedures.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
7. The Contractor's procedures for individual needs assessment and treatment planning are designed to: ◆ Accommodate the specific cultural and linguistic needs of the members. ◆ Allow members with special healthcare needs direct access to a specialist as appropriate to the member's conditions and needs.	The health assessment survey form is mailed to new members in both English and Spanish. This form includes a check box for members to identify cultural or linguistic needs; however, the form does not explain what is implied by a "cultural" need. Regardless, during the on-site interview Colorado Choice noted not following up on health assessment surveys returned by members; thus, Colorado Choice is not taking action on members' self-identified cultural needs. Members do have direct access to specialists, as needed, when those members reach out to specialists independently.	Colorado Choice must develop procedures to identify and accommodate members' cultural needs.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
10 The Contractor's procedures provide for continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services. ◆ The Contractor informs new members with special healthcare needs involved in an ongoing course of treatment that he/she: ▪ May continue to receive covered services for 60 calendar days from his/her current provider. ▪ May continue to receive covered services from ancillary or non-network providers for a period of 75 calendar days. ◆ The Contractor informs a new member who is in her second or third trimester of pregnancy that she may continue to see her current provider until the completion of postpartum care.	Colorado Choice did not directly inform new members with special healthcare needs or who are pregnant of their option to see previous providers for a certain time frame before they would be required to see in-network providers.	Colorado Choice must develop a process wherein the health plan is directly responsible for informing new members who are pregnant or have special healthcare needs of the option to continue care with their current providers for a specified period.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard IV—Member Rights and Protections		
Requirement	**Findings**	**Required Action**
4. The Contractor ensures that each member is free to exercise his or her rights and that exercising those rights does not adversely affect the way the Contractor or its providers treat the member.	Immediately following the list of member rights, the Colorado Choice member handbook and the provider manual both included a section titled "Refusal to Follow Recommended Treatment." Language within this section implies that if a member refuses recommended treatment his or her doctor could refuse to treat him or her. This is in direct conflict with the member's right to refuse treatment.	Colorado Choice must remove the section titled "Refusal to Follow Recommended Treatment" from its member handbook and the provider manual. Members must be free to refuse treatment without the threat of being refused services by a provider.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Findings**	**Required Action**
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.B. The verification sources used.	The Colorado Choice Credentialing Plan listed acceptable primary and secondary verification sources; however, it allowed a provider's application as an acceptable source for verifying a provider's DEA certificate. The Desktop Procedure: Credentialing File Verification indicated that DEA certification could be verified with a provider's application. However, the provider application is not an NCQA-accepted verification source for DEA certification. On-site record reviews demonstrated that Colorado Choice was collecting copies of DEA certificates as verification, which is acceptable under NCQA guidelines.	Colorado Choice must update its credentialing plan and desktop procedure to include NCQA-approved verification sources for DEA certification.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Findings**	**Required Action**
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.C. The criteria for credentialing and recredentialing.	The credentialing plan listed the criteria for credentialing and recredentialing decisions; however, the criteria (referred to in the plan as "guidelines") were not congruent with the guidelines described by staff members during the on-site interview. The written guidelines required current continuing education units (CEUs); however, the process described in the credentialing plan did not require providers to report CEUs, nor did it require staff to collect information regarding CEUs. Additionally, the guidelines required that a provider have no malpractice claims filed against him or her within the previous five years whereas staff members explained that, in practice, Colorado Choice's credentialing committee reviews providers with malpractice claims and makes decisions case by case.	Colorado Choice must carefully review and revise its credentialing plan to accurately describe the criteria used for making credentialing and recredentialing 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:		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Findings**	**Required Action**
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.F. The process for delegating credentialing or recredentialing (if applicable).	The Colorado Choice Credentialing Plan addressed the process for delegating credentialing and recredentialing; however, the process described was intended to meet URAC requirements and did not include all elements required by NCQA.	Colorado Choice must revise its credentialing plan to ensure that its process for delegating credentialing and recredentialing is compliant with NCQA requirements. (See elements 19–25.)
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Findings**	**Required Action**
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.K. The process for ensuring the confidentiality of all information obtained in the credentialing/ recredentialing process.	The Credentialing Plan, Desktop Procedure: Credentialing File Maintenance, and Desktop Procedure: Credentialing File Verification addressed the process for ensuring confidentiality of information obtained; however, the process was not clearly described or consistent across the three documents.	Colorado Choice must revise applicable documents to convey a consistent procedure for ensuring the confidentiality of information obtained in the credentialing process.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Findings**	**Required Action**
6. Practitioners complete an application for network participation (at initial credentialing and recredentialing) that includes a current and signed attestation and addresses the following: ◆ Reasons for inability to perform the essential functions of the position, with or without accommodation. ◆ Lack of present illegal drug use. ◆ History of loss of license and felony convictions. ◆ History of loss or limitation of privileges or disciplinary actions. ◆ Current malpractice/professional liability insurance coverage (minimums= physician—0.5mil/1.5mil; facility—0.5mil/3mil). ◆ The correctness and completeness of the application.	The Colorado Choice Credentialing Plan required that providers complete an application or attest to complete and accurate information in the Council for Affordable Quality Healthcare (CAQH) system. Seven of 10 credentialing records and two of 10 recredentialing records included a CAQH data summary in lieu of a credentialing application. The data summary stated that it was for provider information purposes only and was not to be submitted as an application. Colorado Choice staff members indicated that for a period of time applications downloaded from CAQH were in the data summary format and that CAQH has since changed its format to accommodate the Colorado Health Care Professional Credentials Application.	Colorado Choice must be sure to collect practitioner applications in an acceptable format that includes the required elements and attestation.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Findings**	**Required Action**
8. The Contractor has a process to ensure that the offices of all practitioners meet its office-site standards. The organization sets standards and performance thresholds for: ◆ Physical accessibility. ◆ Physical appearance. ◆ Adequacy of waiting and examining room space. ◆ Adequacy of treatment record-keeping.	Colorado Choice's Desktop Procedure for Office Site Visit described the procedures for performing an office site visit within 12 months of an initial application and again at least once every 36 months. During the on-site interview, staff members stated that Colorado Choice had changed its processes and was not conducting site visits for individual practitioners. Staff indicated that while they still adhered to the standards outlined in the policy, Colorado Choice had not yet defined a process for ensuring compliance with these standards.	Colorado Choice must update its desktop procedure for office site visits to describe a process to ensure that practitioner offices meet stated standards.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Findings**	**Required Action**
9. The Contractor implements appropriate interventions by: ◆ Conducting site visits of offices about which it has received member complaints. ◆ Instituting actions to improve offices that do not meet thresholds. ◆ Evaluating effectiveness of the actions at least every six months, until deficient offices meet the thresholds. ◆ Continually monitoring member complaints for all practitioner sites and performing a site visit within 60 days of determining a complaint threshold was met. ◆ Documenting follow-up visits for offices that had subsequent deficiencies.	Colorado Choice's Desktop Procedure for Office Site Visit described a process to implement appropriate interventions which was compliant with the requirement; however, during the on-site interview, staff members stated that Colorado Choice no longer adhered to the process described in the desktop procedure. Colorado Choice was not conducting site visits or implementing interventions in instances when sites do not meet its standards.	Colorado Choice must update its desktop procedure to describe the interventions to be implemented in instances when provider sites do not meet its standards.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Findings**	**Required Action**
11. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of (organizational) providers with which it contracts, which include: 11.E. The Contractor's policies and procedures include: ◆ On-site quality assessment criteria for each type of unaccredited organizational provider. ◆ A process for ensuring that the provider credentials its practitioners.	The Facility Credentialing and Recredentialing policy and procedure did not include a process for ensuring that unaccredited organizational providers credential their practitioners. Also, the site review tool used to conduct on-site quality assessments did not include an element for confirming the process for credentialing.	Colorado Choice must revise its policies and procedures to describe a process to ensure that organizational providers credential their practitioners.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Findings**	**Required Action**
12. The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: ◆ The CMS or state review is no more than three years old. ◆ The organization obtains a survey report or letter from CMS or the state, from either the provider or from the agency, stating that the facility was reviewed and passed inspection. ◆ The report meets the organization's quality assessment criteria or standards.	The Facility Credentialing and Recredentialing policy stated that Colorado Choice would perform a site visit for organizational providers that are unaccredited or have not passed a CMS or State review. The policy did not specify that the CMS or State review could be no more than three years old, nor did it specify that it must obtain a copy of the survey report or letter from CMS or the State showing that the facility was reviewed and passed inspection as well as a copy of the criteria or standards used. On-site record reviews demonstrated that Colorado Choice collected copies of letters stating that the facility was reviewed and passed; however, staff did not know the criteria or standards used for the CMS or State site reviews.	Colorado Choice must revise its policy and procedures to specify the circumstances under which it may substitute a CMS or State site visit in lieu of conducting its own site visit.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
1. The Contractor has an ongoing Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members.	Colorado Choice's ongoing Quality Assessment and Performance Improvement (QAPI) Program addressed only basic federal and State requirements and was not robust in nature. For example, member concerns identified in the CAHPS survey ranked Colorado Choice below the 25th percentile on four of the measures on NCQA's 2015 HEDIS Benchmarks and Thresholds for Accreditation, yet Colorado Choice implemented no quality initiatives to address these issues.	Colorado Choice must evolve its QAPI program to ensure that it includes processes for reviewing areas identified as needing improvement and take action to improve these areas.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
2. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services.	While Colorado Choice had some methods for identifying under- and over-utilization, staff noted during the interview that there was no system in place (e.g., functional case management) to allow for comprehensive utilization management, quality assurance, and improvement.	Colorado Choice must expand its QAPI program to ensure that mechanisms are in place to more effectively detect both underutilization and overutilization 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:		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
3. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care for persons with special healthcare needs.	While the Quality Assurance Program Description and Quality Improvement program (QAP/QIP) document provided an overview of the goals for the program, it did not at any point address persons with special healthcare needs.	Colorado Choice must expand its QAPI program to include mechanisms to assess the quality and appropriateness of care for persons with special healthcare needs.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
9. The Contractor monitors member perceptions of accessibility and adequacy of services provided. Tools shall include: ◆ Member Surveys (CAHPS). ◆ Anecdotal information. ◆ Grievance and appeals data. ◆ Enrollment and disenrollment information.	While Colorado Choice participated in CAHPS, its QAC meeting minutes did not document that the committee evaluated or addressed—from a QAPI perspective—instances wherein results were below the 25th percentile. In addition, Colorado Choice did not define grievances as "any expression of dissatisfaction" (as required by federal and State regulations). Colorado Choice collected and categorized some expressions of dissatisfaction as "complaints;" and others, as discussed during the on-site interview, were not collected at all. As such, Colorado Choice had not been recording grievances appropriately for trending and QAPI action.	Colorado Choice must develop a process to ensure that all expressions of dissatisfaction, no matter how "small" or how quickly remedied, are captured by staff and used for periodic trending. All areas where trends are identified—whether via the grievance and appeals system, CAHPS reports, anecdotal information, or enrollment and disenrollment information—must be monitored by the appropriate committee and assessed for appropriate action.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review Protocol Activities *for* Colorado Choice Health Plans

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 healthcare 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 email delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and on-site activities. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. ◆ Documents submitted for the desk review and on-site review consisted of the completed desk review form, the compliance monitoring tool with the health plan's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The health plans also submitted lists of all CHP+ credentialing and recredentialing records that occurred between January 1, 2015, and December 31, 2015, to the extent available at the time of the site review request. 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.

For this step,	HSAG completed the following activities:
	◆ HSAG reviewed a sample of administrative records to evaluate implementation of Medicaid managed care regulations related to CHP+ credentialing and recredentialing. ◆ 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 2015–2016 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.