CHP+

Child Health Plan *Plus*

Fiscal Year 2016–2017 Site Review Report

for

Colorado Choice Health Plans

May 2017

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

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Public Law 111-3, Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, requires that each state's Children's Health Insurance Program (CHIP) apply several provisions of Section 1932 of the Social Security Act in the same manner as the provisions apply under Title XIX of the Act. This requires managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to comply with specified provisions of the Balanced Budget Act of 1997 (BBA), Public Law 105-33. 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 2016–2017 site review activities for the review period of January 1, 2016, through December 31, 2016. For each of the two standard areas reviewed this year, this section contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 2 contains (as available) graphical representations of results for all standards across two three-year cycles. Section 3 describes the background and methodology used for the 2016–2017 compliance monitoring site review. Section 4 describes follow-up on the corrective actions required as a result of the 2015–2016 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the denials record reviews. Appendix C lists HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process the health plan will be required to complete for FY 2016–2017 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 within the compliance monitoring tool receiving a score of *Partially Met* or *Not Met.* HSAG also identified opportunities for improvement with associated recommendations for some elements, regardless of the score. Recommendations for requirements scored as *Met* did not represent noncompliance with contract requirements or federal healthcare regulations.

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

Table 1-1—Summary of Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I. Coverage and Authorization of Services	34	34	31	1	2	0	91%
II. Access and Availability	14	14	11	3	0	0	79%
Totals	**48**	**48**	**42**	**4**	**2**	**0**	**88%**

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

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

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

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Denials	100	50	49	1	50	98%
Totals	**100**	**50**	**49**	**1**	**50**	**98%**

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

Standard I—Coverage and Authorization of Services

Summary of Strengths and Findings as Evidence of Compliance

Colorado Choice had a utilization management (UM) program in place to monitor services and to ensure that services provided were sufficient in amount, scope, and duration to achieve the purpose of the provided services. During the on-site interview, **Colorado Choice** representatives described the process used to review authorization requests. This process began with an administrative review that could be escalated to a nurse review that could also include a review by the in-house primary care physician if warranted. **Colorado Choice** also used a specialist provider and an outside physician peer review service for complicated cases and appeals decisions. While this method may include several steps, HSAG noted, upon service authorization denial review of 10 records, that most denial decisions were made within four days and that many were made within 24 hours.

HSAG found that notices of action for service authorization denials sent to members clearly delineated the action being taken, the reason for the action, information on the member's appeal right, and the right to request a State fair hearing. **Colorado Choice**'s letters were written using language that is easy to understand.

Colorado Choice defined "emergency medical condition" and "emergency services" appropriately. **Colorado Choice** included within its member handbook, to help clarify for members when primary care is warranted and to help reduce unnecessary emergency room visits, an example of a situation that is not an emergency (i.e., removal of stitches and dressing changes).

During the on-site interview, **Colorado Choice** staff members clearly described situations wherein emergencies, including emergencies out of network and out of the coverage area, and related post-stabilization care would be covered.

Summary of Findings Resulting in Opportunities for Improvement

In its notice of action template for denials to the member, **Colorado Choice** had identified its CHP+ plan as a "Commercial" plan, which could be confusing to members. In addition, some documentation provided to HSAG for review was stamped with a note that it had been faxed and mailed, while other records lacked this stamp, resulting in a lack of certainty for the reviewer as to whether the letters were mailed; however, staff did provide evidence of documentation within the electronic record system. HSAG identified variations such as these as some which may benefit from a review of processes to ensure that consistent administrative procedures are being followed.

Summary of Required Actions

Colorado Choice accurately reflected timelines for standard and expedited authorization review in its Policy #3514 UM Review Timeframes and Notification submitted to HSAG; however, **Colorado Choice** had no policy or process to determine which situations justified expedited review and what process would be followed to allow or deny a request for an expedited authorization. HSAG found that most preauthorization requests reviewed on-site exhibited the provider's preference for rapid review, with phrases such as "ASAP, thanks" and "URGENT STAT" written across the front of the requests. While **Colorado Choice** was able to respond to most authorization requests with relatively quick turnarounds, a process must be in place to ensure a consistent application of the time frames, specifically when a provider indicates urgency. Once **Colorado Choice** develops a consistent process, the health plan may wish to consider reaching out to providers to offer some guidance on which conditions are appropriate for expedited authorization review.

HSAG reviewed 10 denial records and found that, while most decisions were turned around within the allotted time, one record with a standard authorization decision to deny a service was reviewed in 14 days rather than in 10 days. **Colorado Choice** had no process to extend decision time frames; however, this late decision could have been avoided had an extension process been in place. **Colorado Choice** must develop and implement a process for extending standard and expedited authorization decisions up to 14 calendar days.

HSAG found that **Colorado Choice** had no process for extending standard and expedited service authorization decisions. **Colorado Choice** must develop a process to extend the time frame for making service authorization decisions, to include providing the member with written notice and informing the member of the right to grieve.

Standard II—Access and Availability

Summary of Strengths and Findings as Evidence of Compliance

Colorado Choice maintained a provider network adequacy report which detailed a county-specific breakdown of the available primary care providers (PCPs) and specialists contracted with **Colorado Choice**. During the on-site interview, **Colorado Choice** staff members reported that **Colorado Choice** had a contract with available PCPs in the service area and most specialists in each county. **Colorado Choice** worked with out-of-network providers through a memorandum of understanding for single cases when necessary, and when possible worked with the providers to add them to the network. **Colorado Choice** described various efforts used to ensure access to care for members within its challenging underserved rural and frontier counties.

Colorado Choice provided HSAG with its Network Access Plan. The plan included a comprehensive review of member access guidelines among all lines of business. Within the plan, **Colorado Choice**

detailed its efforts to maintain the network of providers required to meet the needs of its CHP+ population; standards for timely access to providers; and how to access out-of-network providers.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no findings resulting in opportunities for improvement related to Access and Availability.

Summary of Required Actions

While **Colorado Choice** staff were able to articulate appropriate standards for timely access to care, the provider handbook and Network Access Plan both state that the standard for non-emergency, non-urgent mental health condition appointments is 30 days for diagnosis and treatment. **Colorado Choice** must amend its provider handbook and Network Access Plan to reflect appropriate timely access standards.

Colorado Choice had no formal process for monitoring provider compliance with timely access requirements. During the on-site interview, staff reported that grievances were used to monitor issues with timely access and that **Colorado Choice** was in the process of further developing the role of its provider relations staff to help monitor timely access. **Colorado Choice** must develop a mechanism to regularly monitor provider compliance with timely access requirements and have in place a system for corrective actions in cases of failure to comply.

Colorado Choice addressed cultural competency in a desktop procedure that provided to its customer service staff guidance on how to address inbound calls and inquiries from providers about cultural concerns. **Colorado Choice** did not provide policies, procedures, provider training, or related member communications from the time frame under review. **Colorado Choice** must have policies, procedures, provider training, and member communications related to its efforts to deliver services in a culturally competent manner.

Comparison of Results

Comparison of FY 2013–2014 Results to FY 2016–2017 Results

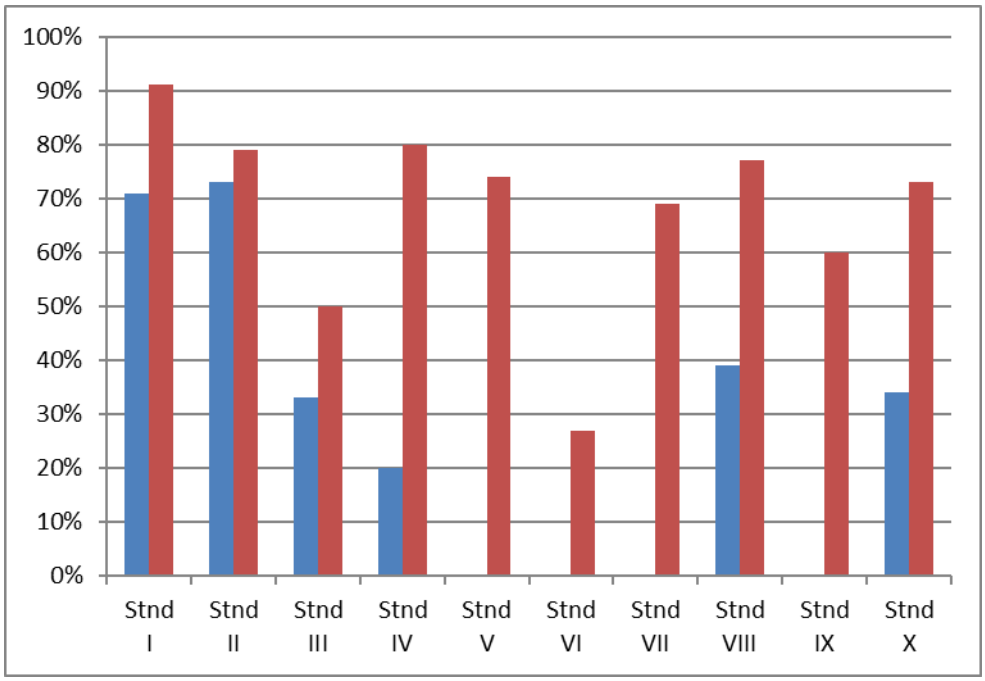
Figure 2-1 shows the scores from the FY 2013–2014 site review (when Standard I and Standard II were previously reviewed) compared with the results from this year's review. The results show the overall percent of compliance with each standard. Although the federal language did not change with regard to requirements, **Colorado Choice**'s contract with the State may have changed, and may have contributed to performance changes.

Figure 2-1—Comparison of FY 2013–2014 Results to FY 2016–2017 Results

Review of Compliance Scores for All Standards

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

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



Note: Results shown in blue are from FY 2012–2013 and FY 2013–2014. Results shown in red are from FY 2014–2015, FY 2015–2016, and FY 2016–2017.

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	2016–17
I—Coverage and Authorization of Services		X			X
II—Access and Availability		X			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	

3. Overview and Background

Overview of FY 2016–2017 Compliance Monitoring Activities

For the fiscal year (FY) 2016–2017 site review process, the Department requested a review of two areas of performance. HSAG developed a review strategy and monitoring tools consisting of two standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. Compliance with federal managed care regulations and managed care contract requirements was evaluated through review of the two standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the two standards, HSAG used the health plan's contract requirements and regulations specified by the BBA, with revisions issued May 6, 2016. HSAG conducted a desk review of materials submitted prior to the on-site review activities: a review of records, documents, and materials provided on-site; and on-site interviews of key health plan personnel to determine compliance with federal managed care regulations and contract requirements. Documents submitted for the desk review and on-site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to CHP+ service and claims denials.

A sample of the health plan's administrative records related to CHP+ service and claims denials was reviewed to evaluate implementation of managed care regulations related to member denials and notices of action. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records. Using a random sampling technique, HSAG selected the samples from all applicable health plan CHP+ service and claims denials that occurred between January 1, 2016, and December 31, 2016. For the record review, the health plan received a score of *C* (compliant), *NC* (not compliant), or *NA* (not applicable) for each required element. Results of record reviews were considered in the scoring of applicable requirements in Standard I—Coverage and Authorization of Services. HSAG also separately calculated an overall record review score.

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[3-1] Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The two standards chosen for the FY

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Aug 24, 2016.

2016–2017 site reviews represent a portion of the Medicaid managed care requirements. The following standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, and Standard X—Quality Assessment and Performance Improvement.

Objective of the Site Review

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

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

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

FY 2015–2016 Corrective Action Methodology

As a follow-up to the FY 2015–2016 site review, each health plan that received one or more *Partially Met* or *Not Met* scores was required to submit a corrective action plan (CAP) to the Department addressing those requirements found not to be fully compliant. If applicable, the health plan was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the health plan and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **Colorado Choice** until it completed each of the required actions from the FY 2015–2016 compliance monitoring site review.

Summary of FY 2015–2016 Required Actions

As a result of the FY 2015–2016 site review, **Colorado Choice** was required to implement corrective actions for each of the four standards reviewed: Coordination and Continuity of Care, Member Rights and Protections, Credentialing and Recredentialing, and Quality Assessment and Performance Improvement. **Colorado Choice** was required to:

- Develop and implement comprehensive written policies and procedures to address requirements related to identifying members with special health care needs and ensuring that all identified needs are addressed.
- Align policies and procedures and desktop procedures related to credentialing to ensure clear, consistent messaging that aligns with the National Committee for Quality Assurance (NCQA) requirements.
- Make significant revisions to its quality assessment and performance improvement program.

Summary of Corrective Action/Document Review

Colorado Choice submitted its proposed plan in June 2016. HSAG and the Department required that **Colorado Choice** make revisions. HSAG and the Department worked closely with **Colorado Choice** throughout the remainder of 2016 to monitor implementation of **Colorado Choice**'s CAP.

Summary of Continued Required Actions

As of January 2017, **Colorado Choice** completed two of the 20 required actions. HSAG and Department approval of an additional 14 required actions was pending **Colorado Choice**'s governing board's approval of changes to policies and procedures and documentation of having trained staff members. **Colorado Choice** had two required actions that required additional revision. HSAG and the Department determined that HSAG would re-review two elements related to Standard X—Quality Assessment and Performance Improvement during the FY 2016–2017 site review.

Appendix A. Compliance Monitoring Tool

The completed compliance monitoring tool follows this cover page.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor must ensure that the services provided are sufficient in amount, duration, or scope to reasonably be expected to achieve the purposes for which the services are furnished. *42 CFR 438.210(a)(3)(i)* Contract: Amendment 6, Exhibit A-5—2.6.3	**Documents:** 1. CHP+ Member Handbook – Section I, Summary Comparison Benefit Form, Pages 6 – 11; Section VII. Your Colorado Choice Benefits and Services, Pages 35 - 65 2. Policy 3504 – Precertification Procedures for Authorizations and referrals 3. Network Access Plan **Narrative:** Colorado Choice has a Member Handbook that includes benefits and services offered to members. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services. Colorado Choice follows Policy 3504 in assuring that services provided to plan members are covered benefits that are medically necessary, appropriate, and applicable to the diagnosis or condition being treated. This language is also incorporated into the Network Access Plan.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor provides the same standard of care for all members regardless of eligibility category and furnishes services in an amount, duration, and scope no less than services provided to non-CHP+ recipients within the same area. *42 CFR 438.210(a)(2)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-5—2.6.3.9	**Documents:** 1. CHP+ Member Handbook – Section I, Summary Comparison Benefit Form, Pages 6 – 11; Section VII. Your Colorado Choice Benefits and Services, Pages 35 – 65. 2. Network Access Plan, page 10 **Narrative:** Colorado Choice has a Member Handbook that includes a summary comparison benefit form for members as well as a section outlining benefits and services. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services. Colorado Choice's Network Access Plan, that is available publicly states that CO Choice strives to ensure that all covered services are available to all enrollees, regardless of sex, race, color, religion, physical/mental disability, sexual orientation, age, marital status, national origin/ancestry, genetic information, health status, status as a Member, or participation in a publicly financed program. CO Choice's Professional Services Agreement and Hospital Services Agreement contains similar such clauses.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. Utilization Management shall be conducted under the auspices of a qualified clinician. Contract: Amendment 6, Exhibit A-5—2.8.1.1	**Documents:** 1. Utilization Management Program, page 10 **Narrative:** Colorado Choice follows a Utilization Management Program that is physician-driven. Medical Director is a licensed physician and the Nurse Manager is a registered nurse.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42 CFR 438.210(a)(3)(ii)* Contract: Amendment 6, Exhibit A-5—2.6.3.10	**Documents:** 1. CHP+ Member Handbook– Section I, Summary Comparison Benefit Form, Pages 6 – 11; Section VII. Your Colorado Choice Benefits and Services, Pages 35 – 65. 2. Policy 3504 UM Pre-Certification Review **Narrative:** Colorado Choice affords all CHP+ members the benefits as listed in the CHP+ comparison benefit form covered services and co-payments. CHP+ members receive the summary comparison benefit form in their member handbook. The handbook also has a section that provides detailed information about benefits and services. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services. Policy 3504 outlines Colorado Choice's procedures to ensure that services provided to plan members are covered benefits that are medically necessary, appropriate and applicable to the diagnosis or condition being treated.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor may place appropriate limits on a service: • On the basis of criteria applied under the State plan (medical necessity). • For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose. *42 CFR 438.210(a)(3)(iii)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-5—2.8.1.1	**Documents:** 1. CHP+ Member Handbook – Section III. Process for Getting Covered Services, Pages 18 & 19, 35-65 2. Utilization Management Program **Narrative:** Colorado Choice has a Member Handbook that includes utilization review process for members. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services. Colorado Choice has a Utilization Management Program that is used for monitoring, evaluating, and improving the quality appropriateness of health services provided to members.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
6. The Contractor specifies what constitutes "medically necessary services" in a manner that: • Is no more restrictive than that used in the State Medicaid program. – Is consistent with the symptoms, diagnosis, and treatment of a member's medical condition. – Is widely accepted by the practitioner's peer group as effective and reasonably safe based upon scientific evidence. – Is not experimental, investigational, unproven, unusual, or uncustomary. – Is not solely for cosmetic purposes.	**Documents:** 1. CHP+ Member Handbook – Section III. Process for Getting Covered Services, Pages 18 & 19, 35-65 2. Utilization Management Program **Narrative:** Colorado Choice has a Member Handbook that includes our utilization review processes for services to members that are medically necessary services. The handbook also addresses the extent of services available to the members. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Is not solely for the convenience of the member, subscriber, physician, or other provider. – Is the most appropriate level of care that can be safely provided to the member. – Failure to provide the covered service would adversely affect the member's health. – When applied to inpatient care, "medically necessary" further means that covered services cannot be safely provided in an ambulatory setting. • Addresses the extent to which the Contractor is responsible for covering services related to the following: – The prevention, diagnosis, and treatment of health impairments. – The ability to achieve age-appropriate growth and development. – The ability to attain, maintain, or regain functional capacity. *42 CFR 438.210(a)(5)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-5—1.1.1.58	Colorado Choice has established a Utilization Management Program in order to focus on appropriate utilization of health care resources for its entire plan membership.	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor has in place written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42 CFR 438.210(b)* Contract: Amendment 6, Exhibit A-5—2.8.1.2	**Documents:** 1. Policy 3504 – Precertification Procedures for Authorizations and Referrals 2. Policy 3516, UM Concurrent Review Policy and Procedure **Narrative:** Colorado Choice follows Policy 3504 and Policy 3516 in processing the requests for initial and continuing authorization of services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. The Contractor has in place and follows written policies and procedures that include effective mechanisms to ensure consistent application of review for authorizing decisions. *42 CFR 438.210(b)(2)(i)* Contract: Amendment 6, Exhibit A-5—2.8.1.3	**Documents:** 1. Policy 3504 – Precertification Procedures for Authorizations and Referrals **Narrative:** Colorado Choice follows Policy 3504 in processing the requests for initial and continuing authorization of services that includes consistent application of review criteria for authorization decisions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor has in place and follows written policies and procedures that include a mechanism to consult with the requesting provider when appropriate. *42 CFR 438.210(b)(2)(ii)* Contract: Amendment 6, Exhibit A-5—2.8.1.3	**Documents:** 1. Policy 3504 – Precertification Procedures for Authorizations and Referrals **Narrative:** Colorado Choice follows Policy 3504 in processing the requests for initial and continuing authorization of services. The processes include a mechanism to consult with the requesting provider when appropriate.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor's UM Program ensures that any decision to deny a service authorization request or to authorize a service in the amount, duration, or scope that is less than requested, be made by a healthcare professional who has appropriate clinical expertise in treating the member's condition or disease. *42 CFR 438.210(b)(3)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-5—2.8.1.3.1	**Documents:** 1. Policy 3504 – Precertification Procedures for Authorizations and Referrals **Narrative:** Colorado Choice follows Policy 3504 in processing the requests for initial and continuing authorization of services, including a process that any decision to deny a service authorization request is made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11. The Contractor has processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested (notice to the provider need not be in writing). *42 CFR 438.210(c)* Contract: Amendment 6, Exhibit A-5—2.8.1.3.3	**Documents:** 1. Policy 3504 – Precertification Procedures for Authorizations and Referrals **Narrative:** Colorado Choice follows Policy 3504 in processing the requests for initial and continuing authorization of services. The processes include notifying the requesting provider and giving the member written notice of any decision.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor provides notice of standard authorization decisions as expeditiously as the member's health condition requires and not to exceed 10 calendar days from receipt of the request for service. *42 CFR 438.210(d)(1)* 10CCR2505—10, Sec 8.209.4.A.3(c) Contract: Amendment 6, Exhibit A-5—2.8.1.3.3.1	**Documents:** 1. P&P #3514 UM Review Timeframes and Notification **Narrative:** Colorado Choice follows Policy 3514 in processing the requests for initial and continuing authorization of services including the following time frames for making standard and expedited authorization decisions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. For cases in which a provider indicates, or the Contractor determines, that the standard authorization timeframe could seriously jeopardize a member's life or health or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization decision and provides notice as expeditiously as the member's health condition requires and not to exceed 3 working days from receipt of the request for service. *42 CFR 438.210(d)(2)* *(Requirement to be updated 7/2017—see appendix)* 10CCR2505—10, Sec 8.209.4.A.3(c) Contract: Amendment 6, Exhibit A-5—2.8.1.3.3.2 and 2.8.1.3.3.2.1	**Documents:** 1. P&P #3514 UM Review Timeframes and Notification **Narrative:** Colorado Choice follows Policy #3514 with regard to expediting the standard authorization request.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: Colorado Choice accurately reflected timelines for standard and expedited authorization review in its Policy #3514 UM Review Timeframes and Notification; however, Colorado Choice did not have a policy or process to determine which situations justified expedited review and what process would be followed to allow or deny a request for an expedited authorization. HSAG found that most preauthorization requests reviewed on-site exhibited the provider's preference for rapid review, with phrases such as "ASAP, thanks" and "URGENT STAT" written across the front of the requests. While Colorado Choice was able to respond to most authorization requests with relatively quick turnarounds, a process must be in place to ensure a consistent application of the time frames, specifically when a provider indicates urgency.		
Required Actions: Colorado Choice must develop a procedure to determine when an expedited review is warranted and how an expedited review will be processed.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. Notices of action must meet the language and format requirements of 42 CFR 438.10 to ensure ease of understanding (6th-grade reading level wherever possible and available in the prevalent non-English language for the service area). *42 CFR 438.404(a); 438.10 (b) and (c)(2)* *(Requirement to be updated 7/2017—see appendix)* 10CCR2505—10, Sec 8.209.4.A.1 Contract: Amendment 6, Exhibit A-5—2.4.3.1.6	**Documents:** 1. Denial Letter for CHP+ **Narrative:** Colorado Choice maintains denial letters (notice of action) specific to CHP+ and distributes them to members and providers as required. Colorado Choice makes every attempt to follow health literacy guidelines in our member facing material. In the event we need translation services, CO Choice has contracted with Translation Plus to provide interpreter services for Members who do not speak English. These translation services are available 24 hours a day, 7 days a week.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
15. Notices of action must contain: • The action the Contractor (or its delegate) has taken or intends to take. • The reasons for the action. • The member's or provider's (on behalf of the member) right to file an appeal and procedures for filing. • The date the appeal is due. • The member's right to request a State fair hearing. • The procedures for exercising the right to a State fair hearing. • The circumstances under which expedited resolution is available and how to request it.	**Documents:** 1. Denial Letter for CHP+ **Narrative:** Colorado Choice maintains denial letters (notice of action) specific to CHP+ members and distributes them to members and providers as required. Rights to appeal are included with the mailing	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The member's right to have benefits continue pending resolution of the appeal and how to request that the benefits be continued. • The circumstances under which the member may have to pay for the costs of services (if continued benefits are requested). *42 CFR 438.404(b)* *(Requirement to be updated 7/2017—see appendix)* 10CCR2505—10, Sec 8.209.4.A.2 Contract: Amendment 6, Exhibit A-5—2.8.1.3.3		
16. The notices of action must be mailed within the following time frames: • For termination, suspension, or reduction of previously authorized CHP+-covered services, the notice of action must be mailed at least 10 days before the date of the intended action except— – In as few as 5 days prior to the date of action if the Contractor has verified information indicating probable beneficiary fraud. – No later than the date of action when: o The member has died. o The member submits a signed written statement requesting service termination. o The member submits a signed written statement including information that requires termination or reduction and indicates that the member understands	**Documents:** 1. Denial Letter for CHP+ **Narrative:** Denials (notice of action) are mailed within one business day of the decision to deny. The decision to approve or deny is made within 10 days of receipt of the request. Approvals are generated by the computer system and are faxed immediately or mailed out to the member and the provider the day following the approval.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
that service termination or reduction will occur. o The member has been admitted to an institution in which the member is ineligible for CHP+ services. o The member's address is determined unknown based on returned mail with no forwarding address. o The member is accepted for CHP+ services by another local jurisdiction, state, territory, or commonwealth. o A change in the level of medical care is prescribed by the member's physician. o The notice involves an adverse determination with regard to preadmission screening requirements. • For denial of payment, at the time of any action affecting the claim. • For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires but within 10 calendar days following receipt of the request for services. • For expedited service authorization decisions, as expeditiously as the member's health condition requires but within 3 working days after receipt of the request for services.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• For service authorization decisions not reached within the required time frames on the date time frames expire. • If the Contractor extends the timeframe, as expeditiously as the member's health condition requires, and no later than the date the extension expires. *42 CFR 438.210 (d)* *42 CFR 438.404(c)* *42 CFR 431.211*, *431.213*, and *431.214* 10CCR2505—10, Sec 8.209.4.A.3(a-c) Contract: Amendment 6, Exhibit A-5—2.8.1.3.3		
17. The Contractor may extend the standard or expedited authorization decision time frame up to 14 calendar days if the member requests an extension, or if the Contractor justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest. *42 CFR 438.210(d)(1)(2)* Contract: Amendment 6, Exhibit A-5—2.8.1.3.3.2	**Documents:** N/A **Narrative:** Colorado Choice currently has no documented policy on extending authorization decisions.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: HSAG reviewed 10 denial records and found that, while most decisions were turned around within the allotted time, one record with a standard authorization to deny a service was reviewed in 14 days rather than in 10 days. Colorado Choice did not have a process to extend decision time frames; however, this late decision could have been avoided had an extension process been in place.		
Required Actions: Colorado Choice must develop and implement a process for extending standard and expedited authorization decisions up to 14 calendar days.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. If the Contractor extends the time frame for making a service authorization decision, it: • Provides the member written notice of the reason for the decision to extend the time frame. • Informs the member of the right to file a grievance if the member disagrees with the decision to extend the time frame. *42 CFR 438.404(c)(4)(i)* 10CCR2505—10, Section 8.209.4.A.3(c)(i) Contract: Amendment 6, Exhibit A-52.8.1.3.3	**Documents:** N/A **Narrative:** Colorado Choice currently has no documented policy on extending authorization decisions.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: HSAG found that Colorado Choice did not have a process for extending standard and expedited service authorization decisions.		
Required Actions: Colorado Choice must develop a process to extend the time frame for making service authorization decisions, to include providing the member with written notice and informing the member of the right to grieve.		
19. The Contractor provides that compensation to individuals or entities that conduct utilization management (UM) activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42 CFR 438.210(e)* Contract: Amendment 6, Exhibit A-5—2.8.1.1	**Documents:** 1. Utilization Management Program, Page 13 **Narrative:** Colorado Choice Health Plans uses Advanced Medical Reviews for utilization management activities. Colorado Choice has a utilization Management Program that is followed to ensure that individuals providing Utilization Management activities are based on medical necessity and appropriateness of care. The UMPD provides that CO Choice does not have a system for reimbursement, bonuses or incentives to staff or providers that is based directly on consumer utilization of health care services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
20. The Contractor defines "emergency medical condition" as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. • Serious impairment to bodily functions. • Serious dysfunction of any bodily organ or part. *42 CFR 438.114(a)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-5—1.1.1.28	**Documents:** 1. CHP+ Member Handbook, Page 43 **Narrative:** Colorado Choice has a Member Handbook that defines emergency medical condition for members. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
21. The Contractor defines "emergency services" as covered inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title and needed to evaluate or stabilize an emergency medical condition. *42 CFR 438.114(a)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-5—1.1.1.29	**Documents:** 1. CHP+ Member Handbook, Page 43 **Narrative:** Colorado Choice has a Member Handbook that defines emergency services for members. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
22. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. *42 CFR 438.114(c)(1)(i)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-5—2.6.6.1.4	**Documents:** 1. CHP+ Member Handbook, pages 43 - 44 **Narrative:** Colorado Choice has a Member Handbook that includes covered services and payment for emergency services for members that states the contractor covers and pays for emergency services regardless of whether the emergency care is provided by in-network and out-of-network provider. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
23. Members temporarily out of the service area may receive out-of-area emergency services and urgently needed services. Contract: Amendment 6, Exhibit A-5—2.6.6.1.2	**Documents:** 1. CHP+ Member Handbook, Page 45 **Narrative:** Colorado Choice has a Member Handbook that includes that members temporarily out of the service area may receive out-of-area emergency services and urgently needed services. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
24. The Contractor shall not require prior authorization for emergency services or urgently needed services. • The Contractor informs members that prior authorization is not required for emergency services. *42 CFR 438.10(f)(6)(viii)(B)* Contract: Amendment 6, Exhibit A-5—2.6.6.1.3	**Documents:** 1. CHP+ Member Handbook, Page 43 **Narrative:** Colorado Choice has a Member Handbook that includes a section of covered services for emergency care for members not requiring prior authorization for emergency or urgently needed services. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
25. The Contractor may not deny payment for treatment obtained under the following circumstances: • A member had an emergency medical condition, as defined in 42 CFR 438.114(a) (see #20 above). • Situations which a prudent layperson who possesses an average knowledge of health and medicine would perceive as an emergency medical condition but the absence of immediate medical attention would ***not*** have had the following outcomes: – Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. – Serious impairment to bodily functions. – Serious dysfunction of any bodily organ or part.	**Documents:** 1. CHP+ Member Handbook, pages 43 - 45 **Narrative:** Colorado Choice has a Member Handbook that states an emergency medical condition will not be denied for payment. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• A representative of the Contractor's organization instructed the member to seek emergency services. *42 CFR 438.114(c)(ii)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-5—2.6.6.4.1.3 and 2.6.6.1.4		
26. The Contractor does not: • Limit what constitutes an emergency medical condition on the basis of a list of diagnoses or symptoms. • Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the Contractor, or State agency of the member's screening and treatment within 10 days of presentation for emergency services. *42 CFR 438.114(d)(1)(i) and (ii)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-5—2.6.6.3.1, 2.6.6.6.2.1, and 2.6.6.1.6	**Documents:** 1. CHP+ Member Handbook, pagers 43-45 **Narrative:** Colorado Choice has a member handbook that states that Colorado Choice covers emergency services necessary to screen and stabilize a member without precertification. The handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
27. The Contractor will be responsible for emergency services: • When the primary diagnosis is medical in nature, even when the medical diagnosis includes some psychiatric conditions and procedures. • When the primary diagnosis is psychiatric in nature, even when the psychiatric diagnosis includes some procedures to treat a secondary medical diagnosis. Contract: Amendment 6, Exhibit A-5—2.6.6.6.2.1.1–2	**Documents:** 1. CHP+ Member Handbook, pages 43-45 **Narrative:** Colorado Choice has a Member Handbook that includes contractor's responsibility for emergency services. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
28. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42 CFR 438.114(d)(2)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-5—2.6.6.1.7	**Documents:** 1. CHP+ Member Handbook, pages 43 **Narrative:** Colorado Choice has a Member Handbook that states contractor covers emergency services necessary to screen and stabilize a member as well as post stabilization services. The handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
29. The Contractor allows the attending emergency physician or the provider actually treating the member to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor, who is responsible for coverage and payment. *42 CFR 438.114(d)(3)* *(Requirement updated 7/2016—as shown)*	**Documents:** 1. CHP+ Member Handbook, pages 43-45 **Narrative:** Colorado Choice has a member handbook that defines post stabilization care services when obtained in or out of network and administered to maintain a member's stabilized condition. This	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract: Amendment 6, Exhibit A-5—2.6.6.1.5	handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services.	
30. The Contractor defines "poststabilization care services" as covered services, related to an emergency medical condition, that are provided after a member is stabilized to maintain the stabilized condition or provided to improve or resolve the member's condition. *42 CFR 438.114(a)* *(Requirement updated 7/2016—as shown* Contract: Amendment 6, Exhibit A-5—1.1.1.69	**Documents:** 1. CHP+ Member Handbook, pages 44 and 45 **Narrative:** Colorado Choice has a Member Handbook that defines post-stabilization care services as related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or ti improve or resolve the member's condition. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
31. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that ***have been*** pre-approved by a plan provider or other organization representative. *42 CFR 438.114(e)* *42 CFR 422.113(c)(i)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-5—2.6.6.4.1.4	**Documents:** 1. CHP+ Member Handbook, pages 44 and 45 **Narrative:** Colorado Choice has a Member Handbook that states contractor is responsible for post-stabilization care services obtained in or out of network if those services are pre-approved. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
32. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that ***have not been*** pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition under the following circumstances: • Within 1 hour of a request to the organization for pre-approval of further poststabilization care services. • The Contractor does not respond to a request for pre-approval within 1 hour. • The Contractor cannot be contacted. • The Contractor's representative and the treating physician cannot reach an agreement concerning the member's care, and a plan physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a plan physician; and the treating physician may continue with care of the patient until a plan physician is reached or the Contractor's financial responsibility for poststabilization care services it *has not* pre-approved ends. *42 CFR 438.114(e)* *42 CFR 422.113(c)(ii) and (iii)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-5—2.6.6.4.1.5 and 2.6.6.4.1.6.1–3	**Documents:** 1. CHP+ Member Handbook, pages 44-45 **Narrative:** Colorado Choice has a Member Handbook that states contractor is responsible for post-stabilization care services obtained in or out of network if those services are not pre-approved, but are administered to maintain, improve, or resolve the member's stabilized condition. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
33. The Contractor's financial responsibility for poststabilization care services it ***has not*** pre-approved ends when: • A plan physician with privileges at the treating hospital assumes responsibility for the member's care. • A plan physician assumes responsibility for the member's care through transfer. • A plan representative and the treating physician reach an agreement concerning the member's care. • The member is discharged. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-5—2.6.6.4.1.8.1–4	**Documents:** 1. CHP+ Member Handbook, pages 44-45 **Narrative:** Colorado Choice has a member handbook that includes not covered/excluded post-stabilization services informing members that Colorado Choice is no longer financially responsible. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
34. The Contractor must limit charges to members for poststabilization care services to an amount no greater than what the Contractor would charge the member if he or she had obtained the services through the Contractor. *42 CFR 438.114(e)* *42 CFR 422.113(c)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-5—2.6.6.4.1.7	**Documents:** 1. Network Access Plan **Narrative:** Colorado Choice's Network Access Plan states that Prior Authorization is not required, regardless of whether the emergency services facility or Provider is a Participating facility or Provider, or is considered out-of-network. CO Choice will ensure that the member obtains the covered emergency services benefit at no greater cost to the Member than if the benefit had been obtained through a Participating Provider or facility.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	31	X	1.00	=	31
	Partially Met	=	1	X	.00	=	0
	Not Met	=	2	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	34	**Total Score**		=	31

Total Score ÷ Total Applicable	=	91%

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
The Contractor ensures that all covered services are available and accessible to members through compliance with the following requirements:		
1. The Contractor maintains and monitors a network of appropriate providers sufficient to provide adequate access to all services covered under the contract. In order for the Contractor's network to be considered to provide adequate access, the Contractor includes the following provider types and ensures a minimum provider-to-member caseload ratio as follows: • 1:2,000 primary care physician (PCP) provider-to-members ratio. PCP includes physicians designated to practice family medicine and general medicine. • 1:2,000 physician specialist-to-members ratio. Physician specialist includes physicians designated to practice cardiology, otolaryngology, endocrinology, gastroenterology, neurology, orthopedics, pulmonary medicine, general surgery, ophthalmology, and urology. • Appropriate access to certified nurse practitioners and certified nurse midwives. • Physician specialists designated to practice internal medicine, gerontology, obstetrics and gynecology (OB/GYN), and pediatrics shall be counted as either PCP or physician specialist, but not both. *42 CFR 438.206(b)(1)* *(Requirement to be updated 7/2018—see appendix)* Contract: Amendment 6, Exhibit A-5—2.5.10, 2.7.1.1.5, and 2.7.1.1.9	**Documents:** 1. Provider Network Adequacy Reporting 2. Network Access Plan **Narrative:** Through our Provider Network Adequacy reporting on a quarterly basis, we have documented our providers that are available to CHP+ members with appropriate ratios well under 1:3000 for primary care specialists. Colorado Choice follows a Network Access Plan to provide a network of providers in order to provide adequate access to all covered benefits. This Network Access Plan is designed to meet the criteria outlined in C.R.S. §10-16-704(9) for fully-insured commercial business and the State of Colorado Children's Health Plan contract.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. In establishing and maintaining the network, the Contractor considers: • The anticipated CHP+ enrollment. • The expected utilization of services, taking into consideration the characteristics and healthcare needs of specific CHP+ populations represented in the Contractor's service area. • The numbers, types, and specialties of providers required to furnish the contracted CHP+ services. • The number of network providers accepting/not accepting new members. • The geographic location of providers in relationship to where CHP+ members live, considering distance, travel time, and means of transportation used by members. – Members have access to a provider within 30 miles or 30 minutes' travel time, whichever is larger, to the extent such services are available. • Physical access to locations for members with disabilities. *42 CFR 438.206(b)(1)(i) through (v)* *(Requirement to be updated 7/2018—see appendix)* Contract: Amendment 6, Exhibit A-5—2.7.1.3.1 and 2.7.1.1.3.1	**Documents:** 1. Network Access Plan **Narrative:** Colorado Choice Health Plans (CO Choice) maintains a network of Providers and facilities sufficient to assure that all covered benefits are available to Members without unreasonable delay as is possible given the rural nature of the service area. Our contracting strategy is broad-based and personalized at the same time, meaning that we make every attempt to contract with every facility and every provider located in the communities we serve, while also working with employers and brokers to identify and address individual needs in underserved areas. Refer to Network Adequacy Management Section on page ___ of the Network Access Plan. At point of contracting, the standard for physical accessibility is addressed with the prospective provider via the Provider Handbook. Customer Service will notify Provider Relations of any complaints relative to scheduling and wait times.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor provides female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive healthcare services. This is in addition to the member's designated source of primary care if that source is not a women's healthcare specialist. *42 CFR 438.206(b)(2)* Contract: Amendment 6, Exhibit A-5—2.7.1.1.7	**Documents:** 1. Network Access Plan, page 5 **Narrative:** Female Members may obtain routine and preventive reproductive or gynecological care from Participating obstetricians, gynecologists, or certified midwives without a Referral for the office visit.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. The Contractor allows persons with special healthcare needs who use specialists frequently to maintain these types of specialists as PCPs or be allowed direct access/standing referrals to specialists. *42 CFR 438.208(c)(4)* Contract: Amendment 6, Exhibit A-5— 2.7.5.4	**Documents:** 1. Provider Handbook, Page 15 **Narrative:** Colorado Choice maintains a Provider Handbook that outlines continuity of care specific to the CHP+ Membership.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. The Contractor provides for a second opinion from a qualified healthcare professional within the network or arranges for the member to obtain one outside the network if there is no other qualified health care professional within the network, at no cost to the member. *42 CFR 438.206(b)(3)* Contract: Amendment 6, Exhibit A-5—2.7.1.1.8	**Documents:** 1. CHP+ Member Handbook, page 24 **Narrative:** Colorado Choice has a Member Handbook that includes members' right to a second opinion. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. If the Contractor is unable to provide covered services to a particular member within its network, the Contractor adequately and timely provides the covered services out of network for as long as the Contractor is unable to provide them. *42 CFR 438.206(b)(4)* Contract: Amendment 6, Exhibit A-5—2.7.1.2	**Documents:** 1. Network Access Plan, Page 6 **Narrative:** Colorado Choice follows the Network Access Plan which outlines that in the rare case where no local Participating Provider or facility provides a covered services, CO Choice will arrange for a Referral to a Provider or facility with the necessary expertise and ensure that the Member obtains the covered benefit at no greater cost to the Member than if the benefit had been obtained through a Participating Provider or facility.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
7. The Contractor coordinates with out-of-network providers with respect to payment and ensures that the cost to the member is no greater than it would be if the services were furnished within the network. *42 CFR 438.206(b)(5)* Contract: Amendment 6, Exhibit A-5—2.7.1.2.2.1	**Documents:** 1. Network Access Plan, Page 6 **Narrative:** Colorado Choice follows the Network Access Plan which outlines that in the rare case where no local Participating Provider or facility provides a covered service, CO Choice will arrange for a Referral to a Provider or facility with the necessary expertise and ensure that the Member obtains the covered benefit at no greater cost to the Member than if the benefit had been obtained through a Participating Provider or facility.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor ensures that covered services are available 24 hours a day, 7 days a week when medically necessary. *42 CFR 438.206(c)(1)(iii)* Contract: Amendment 6, Exhibit A-5—2.6.3.1, 2.6.3.4, and 2.7.1.4.1.1	**Documents:** 1. CHP+ Member Handbook, Page 60 **Narrative:** Colorado Choice has a Member Handbook that includes Emergency Services are available 24 hours a day, 7 days a week. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Colorado Choice when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor must require its providers to offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to other CHP+ providers. *42 CFR 438.206(c)(1)(ii)* Contract: Amendment 6, Exhibit A-5—2.5.1	**Documents:** 1. Professional Services Agreement, Page 2, Section 1.9 **Narrative:** Providers shall provide the same standard of care for our Members as they do for their other patiens. Colorado Choice Members are defined in the sample contract, at section 1.9 page 2, regardless of whether the Member is commercial or CHP+, they shall receive the same standard of care.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services, taking into account the urgency of the need for services: • Within 48 hours for urgently needed services. • Within 30 calendar days for: – Non-emergent, non-urgent medical problems. – Non-urgent, symptomatic medical problems. – Non-symptomatic well-care physical examinations. *42 CFR 438.206(c)(1)(i)* Contract: Amendment 6, Exhibit A-5—2.6.3.2 and 2.6.3.3.1–4	**Documents:** 1. Provider Handbook, page 28 2. Network Access Plan, Page 13 **Narrative:** Colorado Choice has a Provider Handbook that is distributed to all providers within the Colorado Choice Network. This Provider Handbook outlines that urgently needed services must be provided within 24 hours. The standards are also listed in the Network Access Plan, Page 13 Access Standards – Wait Times.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services, taking into account the urgency of the need for services: • Within 14 calendar days for: – Diagnosis and treatment of a non-emergent, non-urgent substance use disorder. – Diagnosis and treatment of a non-emergent, non-urgent mental health condition. *42 CFR 438.206(c)(1)(i)* Contract: Amendment 6, Exhibit A-5—2.7.1.5.2.5–6	**Documents:** 1. Provider Handbook, page 28 2. Network Access Plan, Page 13 **Narrative:** Colorado Choice has a Provider Handbook that is distributed to all providers within the Colorado Choice Network. This Provider Handbook outlines that urgently needed services must be provided within 24 hours. The standards are also listed in the Network Access Plan, Page 13 Access Standards – Wait Times.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: While Colorado Choice staff were able to articulate appropriate standards for timely access to care, the provider handbook and Network Access Plan both state that the standard for non-emergency, non-urgent mental health conditions is 30 days for diagnosis and treatment.		
Required Actions: Colorado Choice must amend its provider handbook and Network Access Plan to reflect the appropriate timely access standards.		
12. The Contractor communicates all scheduling guidelines in writing to participating providers. Contract: Amendment 6, Exhibit A-5—2.7.1.5.4	**Documents:** 1. Provider Handbook, Page 28 **Narrative:** Colorado Choice communicates all scheduling guidelines in writing to participating providers through the Provider Handbook.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. The Contractor has mechanisms to ensure compliance by providers with standards for timely access, monitors providers regularly to determine compliance with standards for timely access, and takes corrective action if there is a failure to comply with standards for timely access. *42 CFR 438.206(c)(1)(iv) through (vi)* Contract: Amendment 6, Exhibit A-5—2.7.1.5.4	**Documents:** 3. Provider Handbook, page 28 4. Network Access Plan, Page 13 **Narrative:** Colorado Choice has a Provider Handbook that is distributed to all providers within the Colorado Choice Network. This Provider Handbook outlines that urgently needed services must be provided within 24 hours. The standards are also listed in the Network Access Plan, Page 13 Access Standards – Wait Times.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: Colorado Choice did not have a formal process for monitoring provider compliance with timely access requirements. During the on-site interview, staff reported that grievances were used to monitor issues with timely access and that Colorado Choice was in the process of further developing the role of its provider relations staff to help monitor timely access.		
Required Actions: Colorado Choice must develop a mechanism to regularly monitor provider compliance with timely access requirements and have in place a system for corrective actions in cases of failure to comply.		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. (Includes policies and procedures, training, and member communications.) *42 CFR 438.206(c)(2)* *(Requirement to be updated 7/2018—see appendix)* Contract: Amendment 6, Exhibit A-5—2.7.7.2	**Documents:** 1. DTP: Provider Relations Cultural Competency **Narrative:** Colorado Choice follows the DTP: Provider Relations Cultural Competency to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: Colorado Choice addressed cultural competency in a desktop procedure that provided to its customer service staff guidance on how to address inbound calls and inquiries from providers about cultural concerns. Colorado Choice did not provide policies, procedures, provider training, or related member communications from the time frame under review.		
Required Actions: Colorado Choice must have policies, procedures, provider training, and member communications related to its efforts to deliver services in a culturally competent manner.		

Results for Standard II—Access and Availability							
Total	Met	=	11	X	1.00	=	11
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	14	**Total Score**		=	11

Total Score ÷ Total Applicable	=	79%

Appendix B. Record Review Tool

The completed record review tool follows this cover page.

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2016–2017 Denials Record Review Tool
for Colorado Choice Health Plans

Review Period:	January 1, 2016—December 31, 2016
Date of Review:	February 22–23, 2017
Reviewer:	Gina Stepuncik
Participating Plan Staff Member:	Manuela Heredia

Requirements	File 1	File 2	File 3	File 4	File 5
Member ID	******	******	******	******	******
Date of initial request	08/02/16	11/10/16	10/24/16	12/19/16	06/28/16
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	NR	NR	NR	NR/C
Standard (S), Expedited (E), or Retrospective (R)	R	S	S	S	S
Date notice of action sent	08/04/16	11/11/16	10/26/16	12/20/16	07/12/16
Notice sent to provider and member? (C or NC)	C	C	C	C	C
Number of days for decision/notice	2	1	2	1	14
Notice sent within required time frame? (C or NC) (S = 10 Cal days after; E = 3 Bus days after; T = 10 Cal days before)	C	C	C	C	NC
Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
If extended, extension notification sent to member? (C, NC, or NA)	NA	NA	NA	NA	NA
If extended, extension notification includes required content? (C, NC, or NA)	NA	NA	NA	NA	NA
Notice of Action includes required content? (C or NC)	C	C	C	C	C
Authorization decision made by qualified clinician? (C, NC, or NA)	NA	NA	NA	NA	NA
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (C, NC, or NA)	NA	NA	NA	NA	NA
If denied due to *not a covered service* but covered by Medicaid Fee-for-Service/wraparound service, did the notice of action include clear information about how to obtain the service? (C, NC, or N/A)	NA	NA	NA	NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C	C	C	C
Was correspondence with the member easy to understand? (C or NC)	C	C	C	C	C
Total Applicable Elements	**5**	**5**	**5**	**5**	**5**
Total Compliant Elements	**5**	**5**	**5**	**5**	**4**
Score (Number Compliant / Number Applicable) = %	**100%**	**100%**	**100%**	**100%**	**80%**

C = Compliant **NC** = Not Compliant **NA** = Not Applicable **Y** = Yes **N** = No (not scored—informational only)
Cal = Calendar **Bus** = Business **TBD** = To Be Determined (scored NA, referred to Department for additional review)

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2016–2017 Denials Record Review Tool
for Colorado Choice Health Plans

Requirements	File 6	File 7	File 8	File 9	File 10
Member ID	******	******	******	******	******
Date of initial request	10/07/16	12/19/16	08/03/16	09/19/16	06/09/16
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	NR	NR	NR	NR/C
Standard (S), Expedited (E), or Retrospective (R)	R	S	S	S	S
Date notice of action sent	10/07/16	12/20/16	08/04/16	09/23/16	06/09/16
Notice sent to provider and member? (C or NC)	C	C	C	C	C
Number of days for decision/notice	0	1	1	4	0
Notice sent within required time frame? (C or NC) (S = 10 Cal days after; E = 3 Bus days after; T = 10 Cal days before)	C	C	C	C	C
Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
If extended, extension notification sent to member? (C, NC, or NA)	NA	NA	NA	NA	NA
If extended, extension notification includes required content? (C, NC, or NA)	NA	NA	NA	NA	NA
Notice of Action includes required content? (C or NC)	C	C	C	C	C
Authorization decision made by qualified clinician? (C, NC, or NA)	NA	NA	NA	NA	NA
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (C, NC, or NA)	NA	NA	NA	NA	NA
If denied due to *not a covered service* but covered by Medicaid Fee-for-Service/wraparound service, did the notice of action include clear information about how to obtain the service? (C, NC, or N/A)	NA	NA	NA	NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C	C	C	C
Was correspondence with the member easy to understand? (C or NC)	C	C	C	C	C
Total Applicable Elements	**5**	**5**	**5**	**5**	**5**
Total Compliant Elements	**5**	**5**	**5**	**5**	**5**
Score (Number Compliant / Number Applicable) = %	**100%**	**100%**	**100%**	**100%**	**100%**

C = Compliant **NC** = Not Compliant **NA** = Not Applicable **Y** = Yes **N** = No (not scored—informational only)
Cal = Calendar **Bus** = Business **TBD** = To Be Determined (scored NA, referred to Department for additional review)

Total Record Review Score	Total Applicable Elements: 50	Total Compliant Elements: 49	Total Score: 98%

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2016–2017 site review of **Colorado Choice**.

Table C-1—HSAG Reviewers and Colorado Choice and Department Participants

HSAG Review Team	Title
Gina Stepuncik	Project Manager
Colorado Choice Participants	**Title**
Ashley Booth	CHP+ Specialist Government Programs
Ashley Palmer	Credentialing Manager
Chayne Boutillette	Quality Director, CCHP
Cindy Palmer	Chief Executive Officer
Christine Kingston	Manager, Medical Department
Dawn R. Arellano	Registered Nurse, Medical Department
Janet Hornig	Director of Operations, CCHP
Manuela Heredia	Manager, Government Programs
Shoshanna Montoya	Member/Program Specialist
Department Observers	**Title**
Jerry Ware	Contract Administrator
Teresa Craig	CHP+ Contract and Program Manager

Appendix D. Corrective Action Plan Template for FY 2016–2017

If applicable, the health plan is required to submit a CAP to the Department for all elements within each standard scored as *Partially Met* or *Not Met*. The CAP must be submitted within 30 days of receipt of the final report. For each required action, the health plan should identify the planned interventions and complete the attached CAP template. Supporting documents should not be submitted and will not be considered until the CAP has been approved by the Department. Following Department approval, the health plan must submit documents based on the approved timeline.

Table D-1—Corrective Action Plan Process

Step	Action
Step 1	**Corrective action plans are submitted**
	If applicable, the health plan will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final compliance site review report via email or through the file transfer protocol (FTP) site, with an email notification to HSAG and the Department. The health plan must submit the CAP using the template provided. For each element receiving a score of *Partially Met* or *Not Met*, the CAP must describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training and follow-up activities, and documents to be sent following the completion of the planned interventions.
Step 2	**Prior approval for timelines exceeding 30 days**
	If the health plan is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.
Step 3	**Department approval**
	Following review of the CAP, the Department or HSAG will notify the health plan via email 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 email or the FTP site, with an email 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.

Step	Action
Step 6	**Documentation substantiating implementation of the plan 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 healthcare regulations and managed care contract requirements.

The CAP template follows.

Table D-2—FY 2016–2017 Corrective Action Plan for Colorado Choice

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
13. For cases in which a provider indicates, or the Contractor determines, that the standard authorization timeframe could seriously jeopardize a member's life or health or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization decision and provides notice as expeditiously as the member's health condition requires and not to exceed 3 working days from receipt of the request for service. *42 CFR 438.210(d)(2)* *(Requirement to be updated 7/2017—see appendix)* 10CCR2505—10, Sec 8.209.4.A.3(c) Contract: Amendment 6, Exhibit A-5—2.8.1.3.3.2 and 2.8.1.3.3.2.1	Colorado Choice accurately reflected timelines for standard and expedited authorization review in its Policy #3514 UM Review Timeframes and Notification; however, Colorado Choice did not have a policy or process to determine which situations justified expedited review and what process would be followed to allow or deny a request for an expedited authorization. HSAG found that most preauthorization requests reviewed on-site exhibited the provider's preference for rapid review, with phrases such as "ASAP, thanks" and "URGENT STAT" written across the front of the requests. While Colorado Choice was able to respond to most authorization requests with relatively quick turnarounds, a process must be in place to ensure a consistent application of the time frames, specifically when a provider indicates urgency.	Colorado Choice must develop a procedure to determine when an expedited review is warranted and how an expedited review will be processed.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
17. The Contractor may extend the standard or expedited authorization decision time frame up to 14 calendar days if the member requests an extension, or if the Contractor justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest. *42 CFR 438.210(d)(1)(2)* Contract: Amendment 6, Exhibit A-5—2.8.1.3.3.2	HSAG reviewed 10 denial records and found that, while most decisions were turned around within the allotted time, one record with a standard authorization to deny a service was reviewed in 14 days rather than in 10 days. Colorado Choice did not have a process to extend decision time frames; however, this late decision could have been avoided had an extension process been in place.	Colorado Choice must develop and implement a process for extending standard and expedited authorization decisions up to 14 calendar days.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
18. If the Contractor extends the time frame for making a service authorization decision, it: • Provides the member written notice of the reason for the decision to extend the time frame. • Informs the member of the right to file a grievance if the member disagrees with the decision to extend the time frame. *42 CFR 438.404(c)(4)(i)* 10CCR2505—10, Section 8.209.4.A.3(c)(i) Contract: Amendment 6, Exhibit A-52.8.1.3.3	HSAG found that Colorado Choice did not have a process for extending standard and expedited service authorization decisions.	Colorado Choice must develop a process to extend the time frame for making service authorization decisions, to include providing the member with written notice and informing the member of the right to grieve.
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 II—Access and Availability		
Requirement	**Findings**	**Required Action**
11. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services, taking into account the urgency of the need for services: • Within 14 calendar days for: – Diagnosis and treatment of a non-emergent, non-urgent substance use disorder. – Diagnosis and treatment of a non-emergent, non-urgent mental health condition. *42 CFR 438.206(c)(1)(i)* Contract: Amendment 6, Exhibit A-5—2.7.1.5.2.5–6	While Colorado Choice staff were able to articulate appropriate standards for timely access to care, the provider handbook and Network Access Plan both state that the standard for non-emergency, non-urgent mental health conditions is 30 days for diagnosis and treatment.	Colorado Choice must amend its provider handbook and Network Access Plan to reflect the appropriate timely access 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 II—Access and Availability		
Requirement	**Findings**	**Required Action**
13. The Contractor has mechanisms to ensure compliance by providers with standards for timely access, monitors providers regularly to determine compliance with standards for timely access, and takes corrective action if there is a failure to comply with standards for timely access. *42 CFR 438.206(c)(1)(iv) through (vi)* Contract: Amendment 6, Exhibit A-5—2.7.1.5.4	Colorado Choice did not have a formal process for monitoring provider compliance with timely access requirements. During the on-site interview, staff reported that grievances were used to monitor issues with timely access and that Colorado Choice was in the process of further developing the role of its provider relations staff to help monitor timely access.	Colorado Choice must develop a mechanism to regularly monitor provider compliance with timely access requirements and have in place a system for corrective actions in cases of failure to comply.
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 II—Access and Availability		
Requirement	**Findings**	**Required Action**
14. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. (Includes policies and procedures, training, and member communications.) *42 CFR 438.206(c)(2)* *(Requirement to be updated 7/2018—see appendix)* Contract: Amendment 6, Exhibit A-5—2.7.7.2	Colorado Choice addressed cultural competency in a desktop procedure that provided to its customer service staff guidance on how to address inbound calls and inquiries from providers about cultural concerns. Colorado Choice did not provide policies, procedures, provider training, or related member communications from the time frame under review.	Colorado Choice must have policies, procedures, provider training, and member communications related to its efforts to deliver services in a culturally competent manner.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review Protocol Activities

The following table describes the activities performed throughout the compliance monitoring process. The activities listed below are consistent with CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal Medicaid managed care regulations and contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, on-site agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all site reviewers to ensure consistency in scoring across plans.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's 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 two standards and on-site activities. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. • Documents submitted for the desk review and on-site review consisted of the completed desk review form, the compliance monitoring tool with the health plan's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The health plans also submitted a list of all CHP+ service and claims denials that occurred between January 1, 2016, and December 31, 2016 (to the extent possible). HSAG used a random sampling technique to select records for review during the site visit. • The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct Site Visit**
	• During the on-site portion of the review, HSAG met with the health plan's key staff members to obtain a complete picture of the health plan's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan's performance. • HSAG reviewed a sample of administrative records to evaluate implementation of managed care regulations related to CHP+ service and claims denials and notices of action. • 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 2016–2017 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. • HSAG analyzed the findings. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the State**
	• HSAG populated the report template. • HSAG submitted the draft site review report to the health plan and the Department for review and comment. • HSAG incorporated the health plan's and Department's comments, as applicable, and finalized the report. • HSAG distributed the final report to the health plan and the Department.