COLORADO

Department of Health Care Policy & Financing

Fiscal Year 2019–2020 Site Review Report

for

Colorado Access

Region 5

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

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Introduction

In accordance with its authority under Colorado Revised Statute 25.5-1-101 et seq. and pursuant to Request for Proposals 2017000265, the Department of Healthcare Policy and Financing (the Department) executed contracts with the Regional Accountable Entities for the Accountable Care Collaborative (ACC) program, effective July 1, 2018. The Regional Accountable Entities (RAEs) are responsible for integrating the administration of physical and behavioral healthcare and will manage networks of fee-for-service (FFS) primary care providers and capitated behavioral health (BH) providers to ensure access to care for Medicaid members. Per the Code of Federal Regulations, Title 42 (42 CFR)—federal Medicaid managed care regulations published May 6, 2016—RAEs qualify as both Primary Care Case Management (PCCM) entities and Prepaid Inpatient Health Plans (PIHPs). 42 CFR requires PCCM entities and PIHPs to comply with specified provisions of 42 CFR 438—managed care regulations—and requires that states conduct a periodic evaluation of their PCCM entities and PIHPs to determine compliance with federal Medicaid managed care regulations published May 6, 2016. The Department has elected to complete this requirement for the RAEs by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This report documents results of the fiscal year (FY) 2019–2020 site review activities for **Colorado Access Region 5** (**COA R5**). For each of the three standard areas reviewed this year, this section contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 2 describes the background and methodology used for the FY 2019–2020 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2018–2019 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the denials of authorization of services (denials), grievances, and appeals record reviews. Appendix C lists HSAG, RAE, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process that the health plan will be required to complete for FY 2019–2020 and the required template for doing so. Appendix E contains a detailed description of HSAG's site review activities consistent with the Centers for Medicare & Medicaid Services (CMS) final protocol. Appendix F includes the summary of the focus topic interviews with RAE staff members used to gather information for assessment of statewide trends related to the FY 2019–2020 focus topic selected by the Department. Appendix G includes compliance monitoring results for the managed care organization (MCO).

Summary of Compliance Results

Based on conclusions drawn from the review activities, HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable.* HSAG assigned required actions to any requirement receiving a score of *Partially Met* or *Not Met.* HSAG also identified opportunities for improvement with associated recommendations for some elements, regardless of the score.

Table 1-1 presents the scores for **COA R5** for each of the standards. Findings for all requirements are summarized in this section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* follow in Appendix A—Compliance Monitoring Tool.

Table 1-1—Summary of Scores for Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
I. Coverage and Authorization of Services	34	30	24	6	0	4	80%
II. Access and Availability	16	16	16	0	0	0	100%
VI. Grievances and Appeals	35	35	29	6	0	0	83%
Totals	**85**	**81**	**69**	**12**	**0**	**4**	**85%**

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

Table 1-2 presents the scores for **COA R5** for the denials, grievances, and appeals record reviews. Details of the findings for the record reviews are in Appendix B—Record Review Tools.

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Denials	90	60	40	20	30	67%
Grievances	60	40	26	14	20	65%
Appeals	60	53	33	20	7	62%
Totals	**210**	**153**	**99**	**54**	**57**	**65%**

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

Standard I—Coverage and Authorization of Services

NOTE: Federal managed care requirements associated with this standard apply only to RAE capitated BH services.

Summary of Strengths and Findings as Evidence of Compliance

COA's *Utilization Management (UM) Program Description* and *Utilization Review (UR) Determinations* policy outlined a thorough and comprehensive approach for review and authorization of covered services using medical necessity and Interqual criteria and operational processes in compliance with regulatory guidelines. **COA** conducted annual interrater reliability testing to ensure that UM staff members applied criteria consistently. **COA**'s UM staff reviewers were licensed BH clinicians. **COA** had established a panel of regularly scheduled psychiatrists to make RAE authorization determinations and had further access to a specialist panel of reviewers through a contract with National Medical Review. **COA**'s *Peer Review Process* policy and on-site denial record reviews documented that BH medical reviewers routinely offered a peer review consultation to the requesting provider prior to making a final adverse benefit determination. Denial record reviews demonstrated 100 percent compliance with requirements for application of criteria, decisions made by a qualified reviewer, and outreach to the requesting provider to obtain additional information when necessary. Policies and procedures addressed the required content of the notice of adverse benefit determination (NABD) and regulatory timelines for making authorization decisions. Per internal policy, **COA**'s required timelines for making authorization decisions also included 30 days for claims and other retrospective requests, as well as 24 hours for concurrent inpatient decisions. **COA** time- and date-stamped all authorization requests and notice of authorization decisions, ensuring that the required 72-hour time frame for expedited decisions was met. **COA** maintained a 24 hours a day, 7 days a week (24/7) hotline and UM review process for the RAEs, enabling inpatient authorizations to be completed within 24 hours of request. While UM policies and procedures accurately addressed all requirements related to termination of previously authorized services, including information related to requests for continuation of benefits during an appeal, staff members stated that **COA** does not ever reduce or terminate previously authorized services. The RAE NABDs to members and providers included all required content and were written in a format and language easy for the member to understand. Whereas on-site record reviews of claims revealed that **COA** overlooked sending a written NABD to members for claims denials, record reviews conversely demonstrated that all UM denials of new requests were fully compliant with: sending notice to the member within required time frames, required content of the letter, and written in easy-to-understand language. **COA** properly extended the authorization decision as necessary to obtain additional information and extension letters sent to members included all required content. Although anticipated mental health parity requirements were included on the HSAG monitoring tool for information only and were not reviewed or scored in this standard, HSAG observed that **COA** has already incorporated applicable mental health parity requirements into its UM policies.

COA's policies and procedures accurately defined "emergency condition," "emergency services," and "post-stabilization services" consistent with regulatory definitions. **COA** did not require authorization for emergency services in or out of network. During on-site interviews, staff members stated that all

emergency services claims are auto-paid by the claims system, and that emergency services claims are never reviewed for medical necessity or denied for any reason (except inaccurate billing processes). **COA**'s *Emergency and Post-Stabilization Care* policy addressed verbatim the requirements pertaining to determining financial responsibilities for post-stabilization care. **COA**'s *Post Stabilization Care Services* desktop procedure outlined some of the procedures for implementing review of post-stabilization services and communicating the results of UM determinations through the claims management system. **COA**'s 24/7 UM process for RAE members ensures that **COA** may be contacted and, within one hour, respond to a request for authorization of a post-stabilization inpatient stay, and that a plan physician is available for consultation with the treating provider, as needed. For post-stabilization services a member receives out of network that are not pre-approved, staff members stated that **COA** does not bill Medicaid members for any charges incurred and that the State prohibits providers from balance billing Medicaid members.

Summary of Findings Resulting in Opportunities for Improvement

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

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

While **COA** clearly documented that **COA** does not bill members for out-of-network post-stabilization services, and staff members explained that the State prohibits Medicaid providers from balance billing members, the intent of the federal requirement extends to the Contractor also making best efforts to ensure that an out-of-network provider does not balance bill members for denied out-of-network post-stabilization services. HSAG recommends that **COA** consider communicating to the out-of-network provider that they may not bill RAE members for unauthorized services and communicating to the member through the NABD that the provider cannot charge the member for services not paid by **COA**.

HSAG's review of sample member NABDs noted that, while the text description of the reason for the denial was generally written in easy-to-understand language, the RAE letters concerning denial of requested BH services appeared to report the specific BH clinical conditions—i.e., "suicide, danger to self or others, gravely disabled"—that would justify hospitalization, rather than simply stating that the member could be cared for at a lower level of care. HSAG finds that using such BH clinical information to describe the reason for denial could potentially be inflammatory or inappropriate for members, and suggests that the RAE consider limiting BH information in the text of the NABD, simplifying the description of the reason for denial, and offering the member access to the specific criteria upon request.

Summary of Required Actions

While **COA**'s *UR Determinations* policy specified that written notice would be sent to the member and provider and denial record reviews demonstrated that members and providers were notified in writing of adverse benefit determinations made by UM, NABDs for claims denials were sent only to the provider. Therefore, five of 10 RAE Region 5 denial record reviews (related to claims) were scored *Not Met* for "notice sent to provider and member." **COA** must ensure that RAE members receive written notification of any decision to deny a service, including denial or partial denial of a claim.

COA demonstrated that the RAE NABDs used for UM denials were written in language easy to understand and informed the member of the availability of the letter in other languages and alternative formats. However, **COA** sent no notice to members regarding denial of a claim; therefore, five of 10 RAE Region 5 denial record reviews (related to claims) were scored *Not Met* for "correspondence with the member was easy to understand." **COA** must ensure that RAE members receive written notification of any decision to deny a service, including denial or partial denial of a claim. **COA** must ensure that the NABD regarding a claim is written in language that is easy for the member to understand.

COA demonstrated that the RAE NABD letters used for UM denials included all required content. However, **COA** sent no notice to members regarding denial of a claim; therefore, five of 10 RAE Region 5 denial record reviews (related to claims) were scored *Not Met* for "notice includes required content." **COA** must ensure that RAE members receive written notification of any decision to deny a service, including denial or partial denial of a claim. **COA** must ensure that the NABD regarding a claim includes all required content.

While **COA**'s *UR Determinations* policy addressed all required time frames for mailing the NABD to the member, the formatting of the information in the policy resulted in inaccurate information regarding required time frames. Specifically, several of the time frames applicable to all NABDs were listed as

exceptions to the time frame for notice of reduction or termination of previously authorized services. In addition, **COA** sent no notice to members regarding denial of a claim; therefore, five of 10 RAE Region 5 denial record reviews (related to claims) were scored *Not Met* for "notice sent within required time frame." **COA** must:

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

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

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

Standard II—Access and Availability

Summary of Strengths and Findings as Evidence of Compliance

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

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

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

Summary of Findings Resulting in Opportunities for Improvement

Although requests for second opinions are rare, **COA**'s communication with providers regarding second opinions could be improved. The provider manual informed providers that they may not charge

[1-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[1-2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

members for helping to arrange for a second opinion. HSAG recommends that this language be revised to let providers know that members also may not be charged for provision of second opinions. This may be an important distinction given that BH services are capitated under the RAE contract. Even though there are no co-pays for BH services, best practice would be to ensure providers understand that billing may not occur under the unique circumstance to a second opinion. **COA** may also want to consider adding "at no cost" to the right to a second opinion on the rights list on the member rights section of its website (https://www.coaccess.com/members/services/rights/).

Summary of Required Actions

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

Standard VI—Grievances and Appeals

NOTE: Federal requirements related to appeals apply only to RAE BH capitated services. The Department contract requires that regulations related to grievances apply to all RAE members.

Summary of Strengths and Findings as Evidence of Compliance

COA had a well-defined process in place to respond to Medicaid member grievances and appeals and assist members with accessing the State fair hearing process. Policies and procedures addressed all required regulations, contained accurate time frames, and generally were clear and concise. The software system used by **COA** included fields to capture the required reporting elements and data and time stamped the receipt notification date of grievances and appeals. During the on-site review, **COA** reported a recent training initiative to ensure that the organization captures all expressions of satisfaction as grievances.

COA had an expedited review process in place to extend resolution time frames when needed to obtain additional information for resolving the grievance or appeal. On-site record reviews demonstrated that **COA** included as parties to the appeal the member and the member's authorized representatives and allowed providers to represent members in filing grievances and appeals, with written permission. The on-site record reviews also demonstrated that individuals who made decisions on grievances and appeals had not been involved in any previous level of review, and that individuals who made grievance and appeal decisions had the requisite clinical expertise in treating the member's condition. All appeals reviewed on-site were resolved, with notice provided to the members within the required time frames, whether expedited or standard resolutions. **COA** provided information about the Medicaid member grievance and appeal system to contracted providers via the provider manual and the **COA** website.

Summary of Findings Resulting in Opportunities for Improvement

During on-site record review, HSAG found that, in two appeal cases, the denial of the appeal related to substance use disorder (SUD) benefits not covered by **COA**; however, the appeal resolution letter did

not direct the member to FFS contact information. HSAG suggests that **COA** also include this information in the denial letter so the provider attempting to treat a substance use issue can go directly to the FFS claims process instead of wasting time appealing the decision.

During the on-site record review, HSAG found that all appeal resolution letters included language that would not be easily understood by the member due to the medical opinion rendered by the physician being copied into the reason portion of the letter. Examples of words found in the appeal resolution letters included "stimulant" and "psychological testing/evaluation." HSAG recommends that, if **COA** chooses to use the physician text in the letter, it follow with an explanation that may be more easily understood by the member.

Summary of Required Actions

During the on-site grievance record review, HSAG found that, in two cases, the acknowledgement letter was not sent within the two-working day time frame. **COA** must develop a mechanism to ensure that acknowledgement letters are sent within the required two-working day time frame.

In one grievance record reviewed on-site, **COA** documented that the member could not be reached after leaving a message complaining about a Health Insurance Portability and Accountability Act (HIPAA) incident. No further investigation pursued. **COA** must ensure it uses both phone and written attempts to contact members to process grievances. If the member cannot be reached, investigation based on information first given should proceed as much as possible and provide a resolution letter with information to the extent possible.

HSAG found that grievance and appeal resolution letters were not consistently written at a readability level easy for members to understand. **COA** must develop a mechanism to ensure that grievance and appeal resolution letters are written in language that may be easily understood by the average Medicaid member.

While **COA** had a process to extend both grievances and appeals when needed, the grievance extension template letter did not include the member's right to file a grievance related to an extension of the resolution time frame. **COA** must ensure that any extension of grievance time frames sent to the member includes the member's right to file a grievance if the member disagrees with the extension.

The appeal resolution letters reviewed on-site included results of the resolution processes and dates completed. For those resolutions not in favor of the members, **COA** used an attachment to the letter that explained both appeal and State fair hearing rights. As the member has at the point of appeal resolution exhausted **COA** internal appeal rights, it is inaccurate to include information in the appeal resolution letter that refers to the member's appeal rights. **COA** must revise its appeal resolution letter to ensure that only information pertaining to the member's right to a State fair hearing is included.

COA's *Member Appeal Process* policy depicted the process for members to request continuation of services following the appeal resolution; however, it did not include the process for initially requesting the continuation of services following the adverse benefit determination. **COA** must clarify the *Member*

Appeal Process policy and any other applicable policies, procedures, and documents to accurately depict the member's right to request the continuations of benefits (services) during the appeal within 10 days following the adverse benefit determination—or before the intended effective date of the action—and again request continuation of the disputed services during the State fair hearing within 10 days following the notice of appeal resolution that is adverse to the member.

2. Overview and Background

Overview of FY 2019–2020 Compliance Monitoring Activities

For the FY 2019–2020 site review process, the Department requested a review of three areas of performance. HSAG developed a review strategy and monitoring tools consisting of three standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services; Standard II—Access and Availability; and Standard VI—Grievances and Appeals. Compliance with applicable federal managed care regulations and managed care contract requirements was evaluated through review of all three standards. In addition, the Department requested that HSAG conduct on-site group interviews with key RAE staff members to explore individual RAE experiences related to one focus topic. The focus topic chosen by the Department for 2019–2020 was *Region-specific Initiatives Related to the Health Neighborhood.*

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the three standards, HSAG used the RAE contract requirements and regulations specified by the federal Medicaid managed care regulations published May 6, 2016. HSAG assigned each requirement in the compliance monitoring tool a score of *Met, Partially Met, Not Met, or Not Applicable.* The Department determined that the review period was January 1, 2019, through December 31, 2019. 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 RAE personnel to determine compliance with applicable 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 each of denials of authorization, grievances, and appeals.

HSAG reviewed a sample of the RAE's administrative records related to RAE denials of authorization, grievances, and appeals to evaluate implementation of applicable federal and State healthcare regulations. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records (to the extent that a sufficient number existed) for each of denials, grievances, and appeals. Using a random sampling technique, HSAG selected the samples from all RAE denial records, all grievance records, and all appeal records that occurred between January 1, 2019, and December 31, 2019. For the record review, the health plan received a score of M (*Met*), NM (*Not Met*), or NA (*Not Applicable*) for each required element. HSAG separately calculated a record review score for each record and an overall record review score. Results of record reviews were considered in the review of applicable requirements in Standard I—Coverage and Authorization of Services and Standard VI—Grievances and Appeals.

To facilitate the focus topic interviews, HSAG used a semi-structured qualitative interview methodology to explore with RAE staff members information pertaining to the Department's interests related to the focus topic selected. The qualitative interview process encourages interviewees to describe experiences, processes, and perceptions through open-ended discussions and is useful in analyzing system issues and associated outcomes. Focus topic discussions were not scored. HSAG and the Department collaborated to develop the *Focus Topic Interview Guide*. Appendix F contains the summarized results of the on-site focus topic interviews.

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[2-3] Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The three standards chosen for the FY 2019–2020 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, Standard X—Quality Assessment and Performance Improvement, and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment.

Objective of the Site Review

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

- The RAE's compliance with federal healthcare regulations and managed care contract requirements in the three areas selected for review.
- Strengths, opportunities for improvement, and actions required to bring the RAE into compliance with federal healthcare regulations and contract requirements in the standard areas reviewed.
- The quality and timeliness of, and access to, services furnished by the RAE, as assessed by the specific areas reviewed.
- Possible interventions recommended to improve the quality of the RAE's services related to the standard areas reviewed.
- Information related to the specific focus topic area to provide insight into statewide trends, progress, and challenges in implementing the RAE and ACC programs.

[2-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Aug 5, 2019.

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

FY 2018–2019 Corrective Action Methodology

As a follow-up to the FY 2018–2019 site review, each RAE 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 RAE 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 RAE and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **COA R5** until it completed each of the required actions from the FY 2018–2019 compliance monitoring site review.

Summary of FY 2018–2019 Required Actions

NOTE: The summary of FY 2018–2019 required actions for the Region 5 MCO is included in Appendix G.

For FY 2018–2019, HSAG reviewed Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services.

Related to coordination and continuity of care, **COA R5** was required to clearly outline procedures for coordinating BH services being received by individual members with the services the member receives from Denver Health MCO.

Related to member information, **COA R5** was required to ensure that information on its website includes updated and correct information regarding appeals procedures.

Related to EPSDT, **COA R5** was required to expedite the planning and implementation process with the Denver County Healthy Communities contractor to create an annual plan for onboarding of Medicaid children and families.

Summary of Corrective Action/Document Review

COA R5 submitted a proposed CAP in June 2019. HSAG and the Department reviewed and approved the proposed plan and responded to **COA R5**. **COA R5** submitted initial documents as evidence of completion of one corrective action in September 2019 and documents as evidence of completion of the remainder of the CAP in November 2019. HSAG and the Department reviewed and approved **COA R5**'s documents submitted as evidence of completion and responded to **COA R5** in November 2019.

Summary of Continued Required Actions

COA R5 successfully completed the FY 2018–2019 CAP, resulting in no continued corrective actions.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor ensures that the services are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished. *42 CFR 438.210(a)(3)(i)* Contract: Exhibit B-2—14.6.2	**Both R3 and R5:** • Utilization Management Program Description o Philosophy Section o Program Framework Section **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42 CFR 438.210(a)(3)(ii)* Contract: Exhibit B-2—14.6.4	**Both R3 and R5:** • CCS307 Utilization Review Determinations o Policy Statement Bullet 7 **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor may place appropriate limits on services— • On the basis of criteria applied under the Medicaid State plan (such as medical necessity). • For the purpose of utilization control, provided that the services furnished can reasonably achieve their purpose. *42 CFR 438.210(a)(4)* Contract: Exhibit B-2—14.6.5, 14.6.5.1–2	**Both R3 and R5:** • CCS307 Utilization Review Determinations o Definition Section • Utilization Management Program Description o Program Framework o Goals and Objectives o Program Components **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. The Contractor may place appropriate limits on services for utilization control, provided that any financial requirement or treatment limitation applied to mental health or substance use disorder (SUD) benefits in any classification is no more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to members (whether or not the benefits are furnished by the same Contractor). *HB19-1269: Section 3–10-16-104(3)(B)* Contract: Exhibit B-2—14.6.5.2.1	Inform health plan on-site of forthcoming information from the Department regarding implementation by RAEs's. (No desk review documentation from health plan needs to be submitted)	*For Information Only*

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: Although HB19-1269 requirements were for information only and not scored, COA's *Criteria for Utilization Review* policy addresses the requirements specified in elements #4, #5, and #6 of this tool as follows: "COA ensures that any UM criteria or service limitations for mental health disorders and substance use disorders are no more restrictive than the predominant UM criteria or service limitations under the medical/surgical benefits for the same treatment classification. The presence of a non-covered diagnosis does not preclude a member from receiving covered services for a co-occurring covered diagnosis; all medically necessary covered services for covered diagnoses are covered, regardless of any co-occurring condition."		
5. The Contractor must ensure that the diagnosis of an intellectual or developmental disability, a neurological or neurocognitive disorder, or a traumatic brain injury does not preclude an individual from receiving a covered behavioral health (BH) service. *HB19-1269: Section 12—25.5-5-402(3)(h)*	Inform health plan on-site of forthcoming information from the Department regarding implementation by RAEs. (No desk review documentation from health plan needs to be submitted)	*For Information Only*
6. The Contractor covers all medically necessary covered treatments for covered BH diagnoses, regardless of any co-occurring conditions. *HB19-1269: Section 12—25.5-5-402(3)(i)*	Inform health plan on-site of forthcoming information from the Department regarding implementation by RAEs. (No desk review documentation from health plan needs to be submitted)	*For Information Only*
7. The RAE defines medical necessity for services as a program, good, or service that: • Will or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all. • Is provided in accordance with generally accepted professional standards for health care in the United States.	**Both R3 and R5:** • CCS302 Criteria for Utilization Review o Definitions Section • COA Provider Manual o Section 9 Utilization Management Program ▪ Medical Necessity	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Is clinically appropriate in terms of type, frequency, extent, site, and duration. • Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider. • Is delivered in the most appropriate setting(s) required by the client's condition. • Is not experimental or investigational. • Is not more costly than other equally effective treatment options. *42 CFR 438.210(a)(5)* Contract: Exhibit B-2—2.1.62 10 CCR 2505-10 8.076.1.8	**R3-specific:** • NA **R5-specific:** • NA	
8. The Contractor and its subcontractors have in place and follow written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42 CFR 438.210(b)(1)* Contract: Exhibit B-2—14.8.2	**Both R3 and R5:** • CCS307 Utilization Review Determinations • COA Provider Manual o Section 9 Utilization Management Program ▪ Prior Authorization Request Process **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor and its subcontractors have in place and follow written policies and procedures that include mechanisms to ensure consistent application of review criteria for authorization decisions. *42 CFR 438.210(b)(2)(i)* Contract: Exhibit B-2—None	**Both R3 and R5:** • CCS302 Criteria for Utilization Review • 2018 Inter-Rater Reliability Report **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. The Contractor and its subcontractors have in place and follow written policies and procedures to consult with the requesting provider for medical services when appropriate. *42 CFR 438.210(b)(2)(ii)* Contract: Exhibit B-2—14.8.2.5	**Both R3 and R5:** • CCS307 Utilization Review Determinations o Section 2 D • CCS316 Peer Review Process • COA Provider Manual o Section Utilization Management Program ▪ Peer Review **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the member's BH needs. *42 CFR 438.210(b)(3)* Contract: Exhibit B-2—14.6.6	**Both R3 and R5:** • CCS301 Qualifications for Staff Engaged in Utilization Management Activities **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor notifies the requesting provider and gives the member written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. *42 CFR 438.210(c)* Contract: Exhibit B-2—8.6.1 10 CCR 2505-10 8.209.4.A.1	**Both R3 and R5:** • CCS307 Utilization Review Determinations o Section 7 • ACC Denial Adverse Benefit Decision **R3-specific:** • NA **R5-specific:** • NA	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: COA's *UR Determinations* policy specified that written notice would be sent to the member and provider. COA demonstrated having NABD templates for RAE members and denial record reviews demonstrated that members and providers were notified in writing of adverse benefit determinations made by UM. However, NABDs for claims denials were sent only to the provider. No NABD was sent to the member regarding a claims denial; therefore, five of 10 RAE Region 5 denial record reviews (related to claims) were scored *Not Met* for "notice sent to provider and member."		
Required Actions: COA must ensure that RAE members receive written notification of any decision to deny a service, including denial or partial denial of a claim.		
13. The Contractor adheres to the following time frames for making standard and expedited authorization decisions: • For standard authorization decisions—as expeditiously as the member's condition requires and not to exceed 10 calendar days following the receipt of the request for service. • If the provider indicates, or the Contractor determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service. *42 CFR 438.210(d)(1–2)* Contract: Exhibit B-2—8.6.6, 8.6.8 10 CCR 2505-10 8.209.4.A.3(c)	**Both R3 and R5:** • CCS307 Utilization Review Determinations o Section 3.B o Section 4.A **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor may extend the time frame for making standard or expedited authorization decisions by up to 14 additional calendar days if: • The member or the provider requests an extension, or • The Contractor justifies a need for additional information and how the extension is in the member's interest. *42 CFR 438.210(d)(1)(i–ii) and (d)(2)(ii)* Contract: Exhibit B-2—8.6.6.1, 8.6.8.1	**Both R3 and R5:** • CCS307 Utilization Review Determinations o Section 3.F.a **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
15. The notice of adverse benefit determination must be written in language easy to understand, available in prevalent non-English languages in the region, and available in alternative formats for persons with special needs. *42 CFR 438.404(a)* *42 CFR 438.10 (c)* Contract: Exhibit B-2—8.6.1–8.6.1.4 10 CCR 2505-10 8.209.4.A.1	Inform the health plan on-site that proposed federal rule changes include eliminating the 18-point requirement for taglines on denial notices. (Reviewed in Member Information standard.) **Both R3 and R5:** • ADM206 Culturally Sensitive Services for Diverse Populations • ADM207 Effective Communication with LEP and SI-SI Persons • ADM208 Member Materials • CCS307 Utilization Review Determinations o Section 7.C **R3-specific:** • NA **R5-specific:** • NA	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: COA demonstrated that the RAE NABDs used for UM denials were written in language easy to understand and informed the member of availability of the notice in other languages and alternative formats. However, COA sent no notice to members regarding denial of a claim; therefore, five of 10 RAE Region 5 denial record reviews (related to claims) were scored *Not Met* for "correspondence with the member was easy to understand."		
Required Actions: COA must ensure that RAE members receive written notification of any decision to deny a service, including denial or partial denial of a claim. COA must ensure that the NABD regarding a claim is written in language that is easy for the member to understand.		
16. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to and copies of all documents and records relevant to the adverse benefit determination (includes medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits). • The member's right to request one level of appeal with the Contractor and the procedures for doing so. • The date the appeal is due. • The member's right to request a State fair hearing after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State fair hearing. • The circumstances under which an appeal process can be expedited and how to make this request.	**Both R3 and R5:** • CCS307 Utilization Review Determinations o Section 7.B a-o • ACC Adverse Benefit Determination Letter **R3-specific:** • NA **R5-specific:** • NA	☐ 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 rights to have benefits/services continue (if applicable) pending the resolution of the appeal, how to request that benefits continue, and the circumstances (consistent with State policy) under which the member may be required to pay the cost of these services. *42 CFR 438.404(b)(1–6)* Contract: Exhibit B-2—8.6.1.5–8.6.1.12 10 CCR 2505-10 8.209.4.A.2		
Findings: COA demonstrated that the RAE NABDs used for UM denials included all required content. However, COA sent no notice to members regarding denial of a claim; therefore, five of 10 RAE Region 5 denial record reviews (related to claims) were scored *Not Met* for "notice includes required content."		
Required Actions: COA must ensure that RAE members receive written notification of any decision to deny a service, including denial or partial denial of a claim. COA must ensure that the NABD regarding a claim includes all required content.		
17. Notice of adverse benefit determination for denial of behavioral, mental health, or SUD benefits includes, in plain language: • A statement explaining that members are protected under the federal Mental Health Parity and Addiction Equity Act (MHPAEA), which provides that limitations placed on access to mental health and SUD benefits may be no greater than any limitations placed on access to medical and surgical benefits. • A statement providing information about contacting the office of the ombudsman for BH care if the member believes his or her rights under the MHPAEA have been violated. • A statement specifying that members are entitled, upon request to the Contractor and free of charge, to a copy of the medical necessity criteria for any behavioral, mental, and SUD benefit. *HB19-1269: Section 6—10-16-113 (I), (II), and (III)* Contract: None	Inform health plan on-site of forthcoming information from the Department regarding implementation by RAEs. (No desk review documentation from health plan needs to be submitted) • CCS307 Utilization Review Determinations o Section 7.B.f-g • ACC Adverse Benefit Determination letter	*For Information Only*

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: Although requirements of HB19-1269 were *for information only* and not scored, COA's *UR Determinations* policy stated: "For mental health, behavioral health, or substance use disorder benefits, the Notice of Adverse Benefit Determination will also include a statement explaining that members are protected under the federal Mental Health Parity and Addiction Equity Act (MHPAEA), which provides that limitations placed on access to mental health and substance use disorder benefits may be no greater than any limitations placed on access to medical and surgical benefits. The statement also includes information about contacting the office of the ombudsman for behavioral health care if the member believes his or her rights under MHPAEA have been violated." Staff members stated that COA is currently revising its NABD template to include this information. HSAG recommended that COA consider waiting for forthcoming instructions from the Department and/or ensure that information in the NABD is written in language easy for the member to understand.		
18. The Contractor mails the notice of adverse benefit determination within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, as defined in 42 CFR 431.211, 431.213 and 431.214 (see below). • For denial of payment, at the time of any denial affecting the claim. • For standard service authorization decisions that deny or limit services, within 10 calendar days following the receipt of the request for service. • For expedited service authorization decisions, within 72 hours after receipt of the request for service. • For extended service authorization decisions, no later than the date the extension expires. • For service authorization decisions not reached within the required time frames, on the date the time frames expire. *42 CFR 438.404(c)* Contract: Exhibit B-2—8.6.3.1, 8.6.5–8.6.8 10 CCR 2505-10 8.209.4.A.3	**Both R3 and R5:** • CCS307 Utilization Review Determination o Section 7.A.a,b 1-4 **R3-specific:** • NA **R5-specific:** • NA	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: COA's *UR Determinations* policy addressed all required time frames for mailing the NABD to the member. However, the formatting of the information in the policy (section 7.A) resulted in inaccurate information regarding required time frames. Specifically, several of the above time frames (bullets 2 through 5 of the requirement) were listed as *exceptions* to the time frame for notice of reduction or termination of previously authorized services. These required time frames are independent requirements applicable to all NABDs, not related to previously authorized services. In addition, COA sent no notice to members regarding denial of a claim; therefore, five of 10 RAE Region 5 denial record reviews (related to claims) were scored *Not Met* for "notice sent within required time frame."		
Required Actions: COA must correct information in its *UR Determinations* policy to accurately address all required time frames for mailing the NABD to the member. COA must also ensure that RAE members receive written notification of any decision to deny a service, including denial or partial denial of a claim, and that the NABD regarding denial of payment is sent at the time of any denial affecting the claim.		
19. For reduction, suspension, or termination of a previously authorized Medicaid-covered service, the Contractor gives notice at least ten (10) days before the intended effective date of the proposed adverse benefit determination except: • The Contractor gives notice on or before the intended effective date of the proposed adverse benefit determination if: – The Agency has factual information confirming the death of a member. – The Agency receives a clear written statement signed by the member that he/she no longer wishes services or gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information. – The member has been admitted to an institution where he/she is ineligible under the plan for further services.	**Both R3 and R5:** • CCS307 Utilization Review Determination o Section 7.A.c 1-8 **R3-specific:** • NA **R5-specific:** • NA	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– The member's whereabouts are unknown, and the post office returns Agency mail directed to him/her indicating no forwarding address. – The Agency establishes that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth. – A change in the level of medical care is prescribed by the member's physician. – The notice involves an adverse benefit determination made with regard to the preadmission screening requirements. • If probable member fraud has been verified, the Contractor gives notice five (5) calendar days before the intended effective date of the proposed adverse benefit determination. *42 CFR 438.404(c)* *42 CFR 431.211* *42 CFR 431.213* *42 CFR 431.214* Contract: Exhibit B-2—8.6.3.1–8.6.3.2, 8.6.4.1–8.6.4.1.8 10 CCR 2505-10 8.209.4.A.3 (a)		
Findings: COA's *UR Determinations* policy addressed all required time frames for mailing the NABD to the member. However, the formatting of the information in the policy (section 7.A) resulted in inaccurate information regarding required time frames. Specifically, the circumstances related to the above exceptions to the 10-day time frame for notifying the member regarding the reduced or terminated previously authorized services were not listed in the policy as only associated with the reduction, suspension, or termination of previously authorized services.		
Required Actions: COA must correct information in its *UR Determination*s policy to accurately address the exceptions to the time frames for mailing the NABD related to reduction or termination of previously authorized services, as stated in 42 CFR 431.211, 431.213, and 431.214.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
20. If the Contractor extends the time frame for standard authorization decisions, it must give the member written notice of the reason for the extension and inform the member of the right to file a grievance if he or she disagrees with that decision. *42 CFR 438.404(c)(4)* Contract: Exhibit B-2—8.6.6.2 10 CCR 2505-10 8.209.4.A.3 (c)(1)	**Both R3 and R5:** • CCS307 Utilization Review Determinations o Section 3.F.b-c **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
21. The Contractor provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42 CFR 438.210(e)* Contract: Exhibit B-2—14.8.6	**Both R3 and R5:** • CCS301 Qualifications for Staff Engaged in Utilization Management Activities o Section 1.A. **R3-specific:** • NA **R5-specific:** • NA	☒ 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 defines emergency medical condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part. *42 CFR 438.114(a)* Contract: Exhibit B-2—2.1.33	**Both R3 and R5:** • CCS307 Utilization Review Determinations o Definitions Section • CCS309 Emergency and Post-Stabilization Care o Definitions Section • COA Provider Manual o Section 9 Utilization Management Program ▪ Emergency and Urgent Care **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
23. The Contractor defines emergency services as covered inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title and are needed to evaluate or stabilize an emergency medical condition. *42 CFR 438.114(a)* Contract: Exhibit B-2—2.1.34	**Both R3 and R5:** • CCS307 Utilization Review Determinations o Definitions Section • CCS309 Emergency and Post-Stabilization Care o Definitions Section	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	R3-specific: • NA **R5-specific:** • NA	
24. The Contractor defines poststabilization care services as covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or provided to improve or resolve the member's condition. *42 CFR 438.114(a)* Contract: Exhibit B-2—2.1.74	**Both R3 and R5:** • CCS309 Emergency and Post- Stabilization Care o Definitions Section **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
25. 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)* Contract: Exhibit B-2—14.5.6.2.2	**Both R3 and R5:** • CCS309 Emergency and Post-Stabilization Care o Section 1.C. **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
26. The Contractor may not deny payment for treatment obtained under either of the following circumstances: • A member had an emergency medical condition, including cases in which the absence of immediate medical attention would *not* have had the following outcomes: – Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; – Serious impairment to bodily functions; or – Serious dysfunction of any bodily organ or part. *(Note: The Contractor bases its coverage decisions for emergency services on the severity of the symptoms at the time of presentation and covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. 42 CFR 438.114—Preamble)* • A representative of the Contractor's organization instructed the member to seek emergency services. *42 CFR 438.114(c)(1)(ii)* Contract: Exhibit B-2—14.5.6.2.6	**Both R3 and R5:** • CCS309 Emergency and Post-Stabilization Care o Definitions Section o Section 1.D. **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
27. The Contractor does not: • Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms. • Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent failing to notify the member's primary care provider or the Contractor of the member's screening and treatment within 10 calendar days of presentation for emergency services.	**Both R3 and R5:** • CCS309 Emergency and Post-Stabilization Care o Section 1.E **R3-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.114(d)(1) Contract: Exhibit B-2—14.5.7.2.8	**R5-specific:** • NA	
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)* Contract: Exhibit B-2—14.5.6.2.9	**Both R3 and R5:** • CCS309 Emergency and Post-Stabilization Care o Section 1.G **R3-specific:** • NA **R5-specific:** • NA	☒ 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)* Contract: Exhibit B-2—14.5.6.2.10	**Both R3 and R5:** • CCS309 Emergency and Post-Stabilization Care o Section 1.F **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
30. The Contractor is financially responsible for poststabilization services that are prior authorized by an in-network provider or Contractor representative, regardless of whether they are provided within or outside the Contractor's network of providers. *42 CFR 438.114(e)* *42 CFR 422.113(c)(i)* Contract: Exhibit B-2—14.5.6.2.11	**Both R3 and R5:** • CCS309 Emergency and Post-Stabilization Care o Section 2.A.1 **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
31. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition within one (1) hour of a request to the organization for pre-approval of further poststabilization care services. *42 CFR 438.114(e)* *42 CFR 422.113(c)(ii)* Contract: Exhibit B-2—14.5.6.2.12	**Both R3 and R5:** • CCS309 Emergency and Post-Stabilization Care o Section 2.A.2 **R3-specific:** • NA **R5-specific:** • NA	☒ 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 are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the member's stabilized condition if: • The organization does not respond to a request for pre-approval within 1 hour. • The organization cannot be contacted. • The organization's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the organization must give the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with care of the patient until a plan provider is reached or one of the criteria in 422.113(c)(3) is met. *42 CFR 438.114(e)* *42 CFR 422.113(c)(iii)* Contract: Exhibit B-2—14.5.6.2.12	**Both R3 and R5:** • CCS309 Emergency and Post-Stabilization Care o Section 2.A.3.a-c **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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, or • The member is discharged.	**Both R3 and R5:** • CCS309 Emergency and Post-Stabilization Care o Section 2.B **R3-specific:** • NA **R5-specific:** • NA	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.114(e) *42 CFR 422.113(c)(3)* Contract: Exhibit B-2—14.5.6.2.14		
Findings: COA's *Emergency and Post-Stabilization Care* policy stated verbatim the requirements related to when financial responsibility ends for post-stabilization care that was not pre-approved by COA; however, the policy included no procedures for implementation. COA's *Post Stabilization Care Services* desktop procedure outlined procedures related to UM processes applied to RAE post-stabilization care requests for authorization but did not clearly address how the application of the criteria specified in 42 CFR 422.113(c)(3) are applied in determining when financial responsibility (i.e., payment of a claim) ends for post-stabilization services not pre-approved.		
Required Actions: COA must develop or enhance its UM and claims payment procedures applicable to post-stabilization care to clarify processes for applying the criteria outlined in 42 CFR 422.113(c)(3) to determine when financial responsibility ends for payment of post-stabilization services that were not pre-approved.		
34. If the member receives poststabilization services from a provider outside the Contractor's network, the Contractor does not charge the member more than he or she would be charged if he or she had obtained the services through an in-network provider. *42 CFR 438.114(e)* *42 CFR 422.113(c)(iv)* Contract: Exhibit B-2—14.5.6.2.13	**Both R3 and R5:** • Not applicable for RAE members. Members are not charged a copay for any behavioral health services. Additionally, HCPF regulations prohibit any provider from billing members directly for Medicaid covered services **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	24	X	1.00	=	24
	Partially Met	=	6	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	4	X	NA	=	NA
Total Applicable		=	30	**Total Score**		=	24
				Total Score ÷ Total Applicable		=	80%

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor maintains and monitors a PCMP and BH network of providers sufficient to provide access to all covered services to all members, including those with limited English proficiency or physical or mental disabilities. The provider network includes the following provider types and areas of expertise: • Adult primary care providers • Pediatric primary care providers • OB/GYNs • Adult mental health providers • Pediatric mental health providers • SUD providers • Psychiatrists • Child psychiatrists • Psychiatric prescribers • Family planning providers *42 CFR 438.206(b)(1)* Contract: Exhibit B-2—9.5.1.1, 9.5.1.3	**Both R3 and R5:** • PNS202 Selection and Retention of Providers • PNS217 Single Case Agreement Policy • Provider Contract Appendix 1 **R3-specific:** • R3 NetworkRpt_Q1FY19-20 • R3 _NetworkAdequacyPln_FY19-20 **R5-specific:** • R5 NetworkRpt_Q1FY19-20 • R5_NetworkAdequacyPln_FY19-20	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. In establishing and maintaining the network adequacy standards, the Contractor considers: • The anticipated Medicaid enrollment. • The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the Contractor's service area. • The numbers, types, and specialties of network providers required to furnish the contracted Medicaid services.	**Both R3 and R5:** • PNS202 Selection and Retention of Providers **R3-specific:** • R3 NetworkRpt_Q1FY19-20 • R3 _NetworkAdequacyPln_FY19-20 • RAE 3 BH Geo Access Q1 Time v1	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The number of network providers accepting/not accepting new Medicaid members. • The geographic location of providers in relationship to where Medicaid members live, considering distance, travel time, and means of transportation used by members. • The ability of providers to communicate with limited-English-proficient members in their preferred language. • The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for members with physical or mental disabilities. • The availability of triage lines or screening systems, as well as use of telemedicine, e-visits, and/or other technology solutions. *42 CFR 438.206(a); 438.68(c)(i)–(ix)* Contract: Exhibit B-2—9.1.4, 9.1.5, 9.1.7.1, 9.5.1.2, 9.5.1.4-6	• RAE 3 BH Geo Access Q1 Distance v1 • RAE 3 PH Geo Access Q1 Time v1 • RAE 3 PH Geo Access Q1 Distance v1 **R5-specific:** • R5 NetworkRpt_Q1FY19-20 • R5_NetworkAdequacyPln_FY19-20 • RAE 5 BH Geo Access Q1 Time v1 • RAE 5 BH Geo Access Q1 Distance v1 • RAE 5 PH Geo Access Q1 Time v1 • RAE 5 PH Geo Access Q1 Distance v1	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor ensures that its PCMP provider network complies with time and distance standards as follows: • Adult primary care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Pediatric primary care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Obstetrics or gynecology: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes *42 CFR 438.206(a); 438.68(b)* Contract: Exhibit B-2—9.4.7	**Both R3 and R5:** • PNS202 Selection and Retention of Providers **R3-specific:** • RAE 3 BH Geo Access Q1 Time v1 • RAE 3 BH Geo Access Q1 Distance v1 • RAE 3 PH Geo Access Q1 Time v1 • RAE 3 PH Geo Access Q1 Distance v1 **R5-specific:** • RAE 5 BH Geo Access Q1 Time v1 • RAE 5 BH Geo Access Q1 Distance v1 • RAE 5 PH Geo Access Q1 Time v1 • RAE 5 PH Geo Access Q1 Distance v1	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. The Contractor ensures that its BH provider network complies with time and distance standards as follows: • Acute care hospitals: – Urban counties—20 miles or 20 minutes – Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes • Psychiatrists and psychiatric prescribers for both adults and children:	**Both R3 and R5:** • PNS202 Selection and Retention of Providers **R3-specific:** • RAE 3 BH Geo Access Q1 Time v1 • RAE 3 BH Geo Access Q1 Distance v1 • RAE 3 PH Geo Access Q1 Time v1	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes • Mental health providers for both adults and children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes • SUD providers for both adults and children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes *Note: If there are no BH providers that meet the BH provider standards within the defined area for a specific member, then the Contractor shall not be bound by the time and distance requirements. (Exhibit B2—9.4.10.1)* *42 CFR 438.206(a); 438.68(b)* Contract: Exhibit B-2—9.4.9	• RAE 3 PH Geo Access Q1 Distance v1 **R5-specific:** • RAE 5 BH Geo Access Q1 Time v1 • RAE 5 BH Geo Access Q1 Distance v1 • RAE 5 PH Geo Access Q1 Time v1 • RAE 5 PH Geo Access Q1 Distance v1	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor provides female members with direct access to a women's health care specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health care specialist. *42 CFR 438.206(b)(2)* Contract: Exhibit B-2—9.2.7	**Both R3 and R5:** This requirement is only partially applicable to the RAE. The RAE does not pay any physical health care claims rendered by providers and therefore does not build a physical health care network beyond contracting with PCMPs. PCMPs may be women's health care specialists. Colorado Access relies on the Department's provider network for members who wish to seek care from women's' health care specialists that are not the member's PCMP. We assist members if they contact COA directly and we also make the State's provider network directory available on our website. **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
6. The Contractor provides for a second opinion from a network provider or arranges for the member to obtain one outside the network (if there is no qualified provider within the network), at no cost to the member. *42 CFR 438.206(b)(3)* Contract: Exhibit B-2—9.7.6	**Both R3 and R5:** • CCS310 Access to Primary and Secondary Care • COA Provider Manual o Section 4 Provider Responsibilities ▪ Second Opinion	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	R3-specific: • NA **R5-specific:** • NA	
7. If the provider network is unable to provide necessary covered services to a particular member in network, the Contractor must adequately and in a timely manner cover the services out of network for as long as the Contractor is unable to provide them. *42 CFR 438.206(b)(4)* Contract: Exhibit B-2—14.6.1.1	**Both R3 and R5:** • PNS217 Single Case Agreement Policy • CCS310 Access to Primary and Secondary Care **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. The Contractor requires out-of-network providers to coordinate with the Contractor for payment and ensures that the cost to the member is no greater that it would be if the services were furnished within the network. *42 CFR 438.206(b)(5)* Contract: Exhibit B-2—14.7.11.1	**Both R3 and R5:** • PNS217 Single Case Agreement Policy • Not applicable for RAE members. Members are not charged a copay for any behavioral health services. Additionally, HCPF regulations prohibit any provider from billing members directly for Medicaid covered services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	R3-specific: • NA **R5-specific:** • NA	
9. The Contractor demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services. *42 CFR 438.206(b)(7)* Contract: 9.5.1.1, 9.5.1.3.10	**Both R3 and R5:** This requirement is only partially applicable to the RAE. The RAE does not pay any physical health care claims rendered by providers and therefore does build a physical health care network, beyond contracting with PCMPs. PCMPs may provide family planning services even if they are not OB-GYNs. Colorado Access relies on the Department's provider network for physical health care. We assist members if they contact COA directly and we also make the State's provider network directory available on our website. **R3-specific:** • 2019 Region 3 Network Adequacy Report **R5-specific:** • 2019 Region 5 Network Adequacy Report	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor must meet, and require its providers to meet, the State standards for timely access to care and services, taking into account the urgency of the need for services. The Contractor ensures that services are available as follows: • Emergency BH care: – By phone within 15 minutes of the initial contact. – In-person within 1 hour of contact in urban and suburban areas. – In-person within 2 hours of contact in rural and frontier areas. • Urgent care within 24 hours from the initial identification of need. • Non-urgent symptomatic care visit within 7 days after member request. • Well-care visit within 1 month after member request. • Outpatient follow-up appointments within 7 days after discharge from hospitalization. • Members may not be placed on waiting lists for initial routine BH services. *42 CFR 438.206(c)(1)(i)* Contract: Exhibit B1—9.4.13	**Both R3 and R5:** • COA Website o Member Services Quality https://www.coaccess.com/members/services/quality • Provider Communication re: December 2019 Access to Care Standards • Navigator-Provider Newsletter from Colorado Access • COA Provider Manual o Section 3 Quality Management ▪ Accessibility and Availability of Services **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor and its providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service. The Contractors network provides: • Minimum hours of provider operation from 8 a.m. to 5 p.m. Monday through Friday. • Extended hours on evenings and weekends. • Alternatives for emergency department visits for after-hours urgent care. *42 CFR 438.206(c)(1)(ii)* Contract: Exhibit B-2—9.4.2–9.4.4	**Both R3 and R5:** • Provider Contract Appendix 1 • PNS306 Provider Availability • Provider Manual o Sections 4 Provider Responsibilities ▪ Primary Care Providers ▪ Specialist Care Providers • COA Website (can search provider directory for urgent care providers) o Find A Provider: https://coadirectory.info/search-member Provider Contract **R3-specific:** • **NA** **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor makes services included in the contract available 24 hours a day, 7 days a week, when medically necessary. *42 CFR 438.206(c)(1)(iii)* Contract: Exhibit B-2—9.4.6	**Both R3 and R5:** • PNS306 Provider Availability • COA Provider Manual o Section 4 Provider Responsibilities ▪ Primary Care Providers ▪ Specialist Care Providers	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	R3-specific: • NA **R5-specific:** • NA	
13. The Contractor ensures timely access by: • Establishing mechanisms to ensure compliance with access (e.g., appointment) standards by network providers. • Monitoring network providers regularly to determine compliance. • Taking corrective action if there is failure to comply. *42 CFR 438.206(c)(1)(iv)–(vi)* Contract: Exhibit B-2—9.5.1.8	**Both R3 and R5:** • PNS306 Provider Availability • PR DP01Complaints Regarding Access to Care • COA Quality Assessment and Performance Improvement Program Description o Accessibility and Availability of Services **R3-specific:** • R3 QualityRptFY18-19 o Secret Shopper **R5-specific:** • R5 QualityRptFY18-19 o Secret Shopper	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. This includes: • Making written materials that are critical to obtaining services available in prevalent non-English languages. • Providing cultural and disability competency training programs, as needed, to network providers and health plan staff regarding: – Health care attitudes, values, customs and beliefs that affect access to and benefit from health care services. – Medical risks associated with the member population's racial, ethnic, and socioeconomic conditions. • Identifying members whose cultural norms and practices may affect their access to health care. These efforts shall include, but are not limited to, inquiries conducted by the Contractor of the language proficiency of individual members. • Providing language assistance services for all Contractor interactions with members. *42 CFR 438.206(c)(2)* Contract: Exhibit B-2—7.2.1–7.2.6	**Both R3 and R5:** • ADM206 Culturally Sensitive Services for Diverse Populations • ADM207 Communications for LEP and SI-SI Persons • ADM208 Member Materials • Cultural Competency for Providers • COA Cultural Competency for Staff • COA Provider Manual o Section 2 Colorado Access Policies ▪ Diversity and Cultural Competency Training Program ▪ Effective Communication and Language Assistance **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The Contractor must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities. *42 CFR 438.206(c)(3)* Contract: Exhibit B-2—9.1.4.5, 9.1.7.1, 9.5.1.2	**Both R3 and R5:** • Provider Contract Appendix 1 • COA Provider Agreement o Section B2 o Section H6 • COA Website o Find A Provider: https://coadirectory.info/search-member Provider Contract • COA Provider Manual o Section 2 Colorado Access Policies ▪ Effective Communication and Language Assistance ▪ Non-Discrimination **R3-specific:** • **NA** **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
16. The Contractor submits to the State (in a format specified by the State) documentation to demonstrate that the Contractor offers an appropriate range of preventive, primary care, and specialty services that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. • A Network Adequacy Plan is submitted to the State annually. • A Network Adequacy Report is submitted to the State quarterly.	**Both R3 and R5:** • NA **R3-specific:** • R3 NetworkRpt_Q1FY19-20	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.207(b) Contract: Exhibit B-2—9.5.1–9.5.4	• R3 _NetworkAdequacyPln_FY19-20 **R5-specific:** • R5 NetworkRpt_Q1FY19-20 • R5_NetworkAdequacyPln_FY19-20	

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

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an internal grievance and appeal system in place for members. A grievance and appeals system means the processes the Contractor implements to handle grievances and appeals of an adverse benefit determination, as well as processes to collect and track information about grievances and appeals. *42 CFR 438.400(b)* *42 CFR 438.402(a)* Contract: Exhibit B2—8.1 10 CCR 2505-10—8.209.1	Note: Federal requirements related to appeals apply only to MCOs and PIHPs (BH services of RAEs). The contract requires that regulations related to grievances apply to all RAE members. **Both R3 and R5:** • ADM203 Member Grievance Process • ADM219 Member Appeal Process **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor defines adverse benefit determination as: • The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. • The reduction, suspension, or termination of a previously authorized service. • The denial, in whole, or in part, of payment for a service. • The failure to provide services in a timely manner, as defined by the State.	Inform plan on-site that proposed federal rule changes include: Clarification that denial, in whole or in part, of a payment for a service does not include denial of a claim because it is not a "clean claim" and is not an adverse benefit determination. **Both R3 and R5:** • CCS307 Utilization Review Determinations o Definitions section	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The failure to act within the time frames defined by the State for standard resolution of grievances and appeals. • The denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other member financial liabilities). *42 CFR 438.400(b)* Contract: Exhibit B2—2.1.3 10 CCR 2505-10—8.209.2.A	**R3-specific:** • NA **R5-specific:** • NA	
3. The Contractor defines an appeal as a review by the Contractor of an adverse benefit determination. *42 CFR 438.400(b)* Contract: Exhibit B2—2.1.5 10 CCR 2505-10—8.209.2.B	**Both R3 and R5:** • ADM219 Member Appeals Process o Definitions Section **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. The Contractor defines a grievance as an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the	**Both R3 and R5:** • AMD203 Member Grievance Process o Definitions Section	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
member's rights regardless of whether remedial action is requested. A grievance includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision. *42 CFR 438.400(b)* Contract: Exhibit B2—2.1.42, 8.6.6.2 10 CCR 2505-10—8.209.2.D, 8.209.4.A.3.c.(i)	**R3-specific:** • NA **R5-specific:** • NA	
5. The Contractor has provisions for who may file: • A member may file a grievance or a Contractor-level appeal and may request a State fair hearing. • With the member's written consent, a provider or authorized representative may file a grievance or a Contractor-level appeal and may request a State fair hearing on behalf of a member. *Note: Throughout this standard, when the term "member" is used it includes providers and authorized representatives (with the exception that providers cannot exercise the member's right to request continuation of benefits under 42 CFR 438.420).* *42 CFR 438.402(c)* Contract: Exhibit B2—8.5.1, 8.5.3, 8.7.1, 8.7.15.1, 8.7.5	**Both R3 and R5:** • AMD203 Member Grievance Process o Policy Section • ADM219 Member Appeal Process o Policy Section, first paragraph **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
6. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, as well as providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability. *42 CFR 438.406(a)* Contract: Exhibit B2—8.3	**Both R3 and R5:** • ADM 203 Member Grievance Process o Section 9 • ADM 207 Effective Communication with LEP and SI-SI Persons • ADM 219 Member Appeal Process o Policy Statement 2nd Paragraph • COA Website-Member Services	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10 CCR 2505-10 8.209.4.C	o Appeals: https://www.coaccess.com/members/services/appeals/ o Grievances: https://www.coaccess.com/members/services/grievances/ **R3-specific:** • NA **R5-specific:** • NA	
7. The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who: • Were not involved in any previous level of review or decision-making nor a subordinate of any such individual. • Have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding any of the following: – An appeal of a denial that is based on lack of medical necessity. – A grievance regarding the denial of expedited resolution of an appeal. – A grievance or appeal that involves clinical issues. *42 CFR 438.406(b)(2)* Contract: Exhibit B2—8.5.4, 8.7.4 10 CCR 2505-10 8.209.5.C, 8.209.4.E	**Both R3 and R5:** • ADM 203 Member Grievance Process o Section 4 • ADM 219 Member Appeal Process o Section 2 A-B **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor ensures that the individuals who make decisions on grievances and appeals: • Take into account all comments, documents, records, and other information submitted by the member or the member's representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. *42 CFR 438.406(b)(2)* Contract: Exhibit B2—None	**Both R3 and R5:** • ADM203 Member Grievance Process o Section 5 • ADM219 Member Appeal Process o Section 2.C **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor accepts grievances orally or in writing. *42 CFR 438.402(c)(3)(i)* Contract: Exhibit B2—8.5.3 10 CCR 2505-10—8.209.5.D	**Both R3 and R5:** • ADM203 Member Grievance Process o Section 1 **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. Members may file a grievance at any time. *42 CFR 438.402(c)(2)(i)* Contract: Exhibit B2—8.5.3 10 CCR 2505-10—8.209.5.A	**Both R3 and R5:** • ADM203 Member Grievance Process o Section 2 **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11. The Contractor sends the member written acknowledgement of each grievance within two (2) working days of receipt. *42 CFR 438.406(b)(1)* Contract: Exhibit B2—8.1 10 CCR 2505-10 8.209.5.B	**Both R3 and R5:** • ADM203 Member Grievance Process o Section 2 • GA DP07 Grievance Workflow o Section 3 • AG Acknowledgement Letter **R3-specific:** • NA **R5-specific:** • NA	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: During the on-site grievance record review, HSAG found that, in two cases, the acknowledgement letter was not sent within the two-working day time frame.		
Required Actions: COA must develop a mechanism to ensure that acknowledgement letters are sent within the required two-working day time frame.		

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor must resolve each grievance and provide notice as expeditiously as the member's health condition requires, and within 15 working days of when the member files the grievance. • Notice to the member must be in a format and language that may be easily understood by the member. *42 CFR 438.408(a) and (b)(1) and (d)(1)* Contract: Exhibit B2—8.5.5, 7.2.7.3, 7.2.7.5 10 CCR 2505-10 8.209.5.D	Inform the health plan on-site that proposed federal rule changes include eliminating the 18-point requirement for taglines on grievance resolution notices. (Reviewed in Member Information standard.) **Both R3 and R5:** • ADM203 Member Grievance Process o Section 6 • ADM208 Member Materials • GA DP07 Grievance Workflow o Section 7 • AG Resolution Letter **R3-specific:** • NA **R5-specific:** • NA	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: In one grievance record reviewed on-site, COA documented that the member could not be reached after leaving a message complaining about a HIPAA incident. No further investigation was pursued. In addition, HSAG found that grievance resolution letters were not consistently written at a readability level easy for members to understand.		
Required Actions: COA must use both phone and written attempts to contact members to process grievances. If the member cannot be reached, an investigation based on information first given should proceed as much as possible and a resolution letter with information should be provided to the extent possible. In addition, COA must develop a mechanism to ensure that grievance and appeal resolution letters are written in language that may be easily understood by the average Medicaid member.		

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The written notice of grievance resolution includes: • Results of the disposition/resolution process and the date it was completed. Contract: Exhibit B2—8.1 10 CCR 2505-10 8.209.5.G	**Both R3 and R5:** • AMD203 Member Grievance Process o Section 6 • GA DP07 Grievance Workflow o Section 7 • AG Resolution Letter **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
14. The Contractor may have only one level of appeal for members. *42 CFR 438.402(b)* Contract: Exhibit B2—None	**Both R3 and R5:** • ADM 219 Member Appeal Process o Section 3.C **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. A member may file an appeal with the Contractor within 60 calendar days from the date on the adverse benefit determination notice. *42 CFR 438.402 (c)(2)(ii)* Contract: Exhibit B2—8.7.5.1 10 CCR 2505 10 8.209.4.B	**Both R3 and R5:** • ADM 219 Member Appeal Process o Section 1.B **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
16. The member may file an appeal either orally or in writing, and must follow the oral request with a written, signed appeal (unless the request is for expedited resolution). *42 CFR 438.402(c)(3)(ii)* Contract: Exhibit B2—8.7.5.2 10 CCR 2505-10 8.209.4.F	Inform health plan on-site that proposed federal rule changes include: Eliminate the requirement that an oral appeal must be followed by a written, signed appeal (must continue to treat oral appeals the same as written appeals). **Both R3 and R5:** • ADM219 Member Appeal Process o Section 1.A • ACC Denial Adverse Benefit Decision o Appeal Section **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The Contractor sends written acknowledgement of each appeal within two (2) working days of receipt, unless the member or designated client representative requests an expedited resolution. *42 CFR 438.406(b)(1)* Contract: Exhibit B2—8.1, 8.7.2 10 CCR 2505-10 8.209. 4.D	**Both R3 and R5:** • ADM219 Member Appeal Process o Section 1.C • ACC_CHP HMO Ack Letter **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
18. The Contractor's appeal process must provide: • That oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date). • That if the member orally requests an expedited appeal, the Contractor shall not require a written, signed appeal following the oral request. • That included, as parties to the appeal, are: – The member and his or her representative, or – The legal representative of a deceased member's estate. *42 CFR 438.406(b)(3) and (6)* Contract: Exhibit B2—8.7.6, 8.7.7, 8.7.11 10 CCR 2505-10 8.209. 4.F, 8.209.4.I	**Both R3 and R5:** • ADM219 Member Appeal Process o Section 1.A **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
19. The Contractor's appeal process must provide: • The member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. (The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution time frame in the case of expedited resolution.) • The member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional documents considered, relied upon, or generated by the Contractor in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame. *42 CFR 438.406(b)(4-5)* Contract: Exhibit B2—8.7.8–8.7.10 10 CCR 2505-10 8.209. 4.G, 8.209.4.H	**Both R3 and R5:** • ADM219 Member Appeal Process o Policy Statement 4th Paragraph o Section 1.D **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
20. The Contractor maintains an expedited review process for appeals when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life; physical or mental health; or ability to attain, maintain, or regain maximum function. The Contractor's expedited review process includes that: • The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. *42 CFR 438.410(a–b)* Contract: Exhibit B2—8.7.14.2.1, 8.7.12 10 CCR 2505-10 8.209.4.Q-R	**Both R3 and R5:** • ADM219 Member Appeals Process o Policy Statement 3rd Paragraph o Section 4.B **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
21. If the Contractor denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the time frame for standard resolution. • Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and within two (2) calendar days provide the member written notice of the reason for the decision and inform the member of the right to file a grievance if he or she disagrees with that decision. *42 CFR 438.410(c)* Contract: Exhibit B2—8.7.14.2.2 10 CCR 2505-10 8.209.4.S	**Both R3 and R5:** • ADM219 Member Appeal Process o Section 4.B.1 **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
22. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)* *42 CFR 438.408(d)(2)* *42 CFR 438.10* Contract: Exhibit B2—8.7.14.1. 7.2.7.3, 7.2.7.5 10 CCR 2505-10 8.209.4.J.1	Inform the health plan on-site that proposed federal rule changes include to eliminate the 18-point requirement for taglines on appeal resolution notices. (Reviewed in Member Information standard.) **Both R3 and R5:** • ADM219 Member Appeal Process o Section 3.A o Section 4.A **R3-specific:** • NA **R5-specific:** • NA	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: During the on-site record review, HSAG found that all appeal resolution letters included language that would not be easily understood by the member. Staff members reported that the medical opinion rendered by the physician was copied into the reason portion of the letter. Examples of words found in the appeal resolution letters included "stimulant" and "psychological testing/evaluation."		
Required Actions: COA must develop a mechanism to ensure that appeal resolution letters are written in language that may be easily understood by the average Medicaid member. HSAG recommended that, if COA chooses to use the physician text in the letter, it follow with an explanation that may be more easily understood by the member.		
23. For expedited appeal, the Contractor must resolve the appeal and provide written notice of disposition to affected parties within 72 hours after the Contractor receives the appeal. • For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. *42 CFR 438.408(b)(3) and (d)(2)(ii)* Contract: Exhibit B2—8.7.14.2.3, 8.7.14.2.6 10 CCR 2505-10 8.209.4.J.2, 8.209.4.L	**Both R3 and R5:** • ADM219 Member Appeal Process o Section 4.B.2,4 **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
24. The Contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: • The member requests the extension; or • The Contractor shows (to the satisfaction of the Department, upon request) that there is need for additional information and how the delay is in the member's interest.	**Both R3 and R5:** • ADM203 Member Grievance Process o Section 7 • ADM219 Member Appeal Process o Section 4.C • GA DP07 Grievance Workflow o Section 7 • ACC_CHP HMO 14 Day Extension	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.408(c)(1) Contract: Exhibit B2—8.7.14.2, 8.7.14.2.4, 8.5.6 10 CCR 2505-10 8.209.4.K, 8.209.5.E	• AG Extension Letter **R3-specific:** • NA **R5-specific:** • NA	
25. If the Contractor extends the time frames, it must—for any extension not requested by the member: • Make reasonable efforts to give the member prompt oral notice of the delay. • Within two (2) calendar days, give the member written notice of the reason for the delay and inform the member of the right to file a grievance if he or she disagrees with that decision. • Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. *42 CFR 438.408(c)(2)* Contract: Exhibit B2—8.5.7, 8.7.14.1, 8.7.14.2.1, 8.7.14.2.5-6	**Both R3 and R5:** • ADM203 Member Grievance Process o Section 7 A-B • ADM219 Member Appeal Process o Section 4.C.1-2 • GA DP07 Grievance Workflow o Section 7 • AG Extension Letter **R3-specific:** • NA **R5-specific:** • NA	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: While COA had a process to extend both grievances and appeals when needed, the grievance extension template letter did not include the member's right to file a grievance related to an extension of the resolution time frame.		
Required Actions: COA must ensure that any grievance extension letter sent to the member includes the member's right to file a grievance if the member disagrees with the extension.		

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
26. The written notice of appeal resolution must include: • The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. – The right to request that benefits/services continue* while the hearing is pending, and how to make the request. – That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's adverse benefit determination. **Continuation of benefits applies only to previously authorized services for which the Contractor provides 10-day advance notice to terminate, suspend, or reduce.* *42 CFR 438.408(e)* Contract: Exhibit B2—8.7.14.3, 8.7.14.4 10 CCR 2505-10 8.209.4.M	**Both R3 and R5:** • ADM219 Member Appeal Process o Section 3.A.1-3 • ACC Appeal Upheld • ACC Appeal Overturned **R3-specific:** • NA **R5-specific:** • NA	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The appeal resolution letters reviewed on-site included results of the resolution processes and dates completed. For those resolutions not in favor of the members, COA used an attachment to the letter that explained both appeal and State fair hearing rights. As the member has at the point of appeal resolution exhausted COA internal appeal rights, it is inaccurate to include information in the appeal resolution letter that refers to the member's appeal rights.		
Required Actions: COA must revise its appeal resolution letter to ensure that only information pertaining to the member's right to a State fair hearing is included.		

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
27. The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of resolution. • If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. *42 CFR 438.408(f)(1–2)* Contract: Exhibit B2—8.7.15.1–8.7.15.2 10 CCR 2505-10 8.209.4.N and O	**Both R3 and R5:** • ADM219 Member Appeal Process o Section 5.A **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
28. The parties to the State fair hearing include the Contractor as well as the member and his or her representative or the representative of a deceased member's estate. *42 CFR 438.408(f)(3)* Contract: Exhibit B2—8.7.15.3	**Both R3 and R5:** • ADM219 Member Appeal Process o Section 5.B **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
29. The Contractor provides for continuation of benefits/services (when requested by the member) while the Contractor-level appeal and the State fair hearing are pending if: • The member files in a timely manner* for continuation of benefits—defined as on or before the later of the following:	**Both R3 and R5:** • ADM219 Member Appeal Process o Section 6.A.1-5	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Within 10 days of the Contractor mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal in accordance with required time frames. ** This definition of timely filing only applies for this scenario—i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced. (Note: The provider may not request continuation of benefits on behalf of the member.)* *42 CFR 438.420(a) and (b)* Contract: Exhibit B2—8.7.13.1 10 CCR 2505-10 8.209.4.T	**R3-specific:** • NA **R5-specific:** • NA	
Findings: COA's *Member Appeal Process* policy depicted the process for members to request continuation of services following the appeal resolution; however, it did not include the process for initially requesting the continuation of services following the adverse benefit determination.		
Required Actions: COA must clarify the *Member Appeal Process* policy and any other applicable policies, procedures, and documents to accurately depict the member's right to request the continuations of benefits (services) during the appeal within 10 days following the adverse benefit determination—or before the intended effective date of the action—and again request continuation of the disputed services during the State fair hearing within 10 days following the notice of appeal resolution that is adverse to the member.		

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
30. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of the following occurs: • The member withdraws the appeal or request for a State fair hearing. • The member fails to request a State fair hearing and continuation of benefits within 10 calendar days after the Contractor sends the notice of an adverse resolution to the member's appeal. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR 438.420(c)* Contract: Exhibit B2—8.7.13.2 10 CCR 2505-10 8.209.4.U	**Both R3 and R5:** • ADM219 Member Appeal Process o Section 6.B 1-3 **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
31. Member responsibility for continued services: • If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's adverse benefit determination, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. *42 CFR 438.420(d)* Contract: Exhibit B2—8.7.13.3 10 CCR 2505-10 8.209.4.V	**Both R3 and R5:** • ADM219 Member Appeal Process o Section 6.C **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
32. If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services as promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. *42 CFR 438.424(a)* Contract: Exhibit B2—8.7.13.4 10 CCR 2505-10 8.209.4.W	**Both R3 and R5:** • ADM219 Member Appeal Process o Section 3.E o Section 5.D **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
33. If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the Contractor must pay for those services. *42 CFR 438.424(b)* Contract: Exhibit B2—8.7.13.5 10 CCR 2505-10 8.209.4.X	**Both R3 and R5:** • ADM219 Member Appeal Process o Section 3.E o Section 5.D **R3-specific:** • NA **R5-specific:** • NA	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
34. The Contractor maintains records of all grievances and appeals. The records must be accurately maintained in a manner accessible to the State and available on request to CMS. • The record of each grievance and appeal must contain, at a minimum, all of the following information: – A general description of the reason for the grievance or appeal. – The date received. – The date of each review or, if applicable, review meeting. – Resolution at each level of the appeal or grievance. – Date of resolution at each level, if applicable. – Name of the person for whom the appeal or grievance was filed. • The Contractor quarterly submits to the Department a Grievance and Appeals report including this information. *42 CFR 438.416* Contract: Exhibit B2—8.9.1–8.9.1.6 10 CCR 2505-10 8.209.3.C	**Both R3 and R5:** • ADM 203 Member Grievance Process o Section 10 • ADM219 Member Appeal Process o Section 7.A1-7 • GA DP07 Grievance Workflow o Section 5 **R3-specific:** • R3_GrieveAppealQ4FY19 **R5-specific:** • R5_GrieveAppealQ4FY19	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
35. The Contractor provides the information about the grievance, appeal, and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals.	**Both R3 and R5:** • COA Website o Appeals and State Fair Hearing: ▪ https://www.coaccess.com/providers/resources/um/ o Grievances: ▪ https://www.coaccess.com/providers/forms/	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. – The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member. *42 CFR 438.414* *42 CFR 438.10(g)(xi)* Contract: Exhibit B2—8.4 10 CCR 2505-10 8.209.3.B	• Provider Manual o Section 2 Colorado Access Policies ▪ Member Grievances and Appeals **R3-specific:** • NA **R5-specific:** • NA	

Results for Standard VI—Grievances and Appeals							
Total	Met	=	29	X	1.00	=	29
	Partially Met	=	6	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	35	**Total Score**		=	29
				Total Score ÷ Total Applicable		=	83%

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Denials Record Review Tool
for Colorado Access (Region 5)

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

Requirements	File 1	File 2	File 3	File 4	File 5
Member ID	****	****	****	****	****
Date of initial request	1/28/19	2/1/19	2/28/19	4/23/19	OMIT
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	CL	CL	NR	
(Standard [S], Expedited [E], or Retrospective [R])	E	R	R	E	
Date notice of adverse benefit determination (NABD) sent	1/29/19	2/5/19	3/5/19	4/24/19	
Notice sent to provider and member? (M or NM)*	M	NM	NM	M	
Number of days for decision/notice	1	4	5	1	
Notice sent within required time frame? (M or NM) (S = 10 Cal days after; E = 72 hours after; T = 10 Cal days before)*	M	NM	NM	M	
Was authorization decision timeline extended? (Y or N)	N	N	N	N	
If extended, extension notification sent to member? (M, NM, or NA)*	NA	NA	NA	NA	
If extended, extension notification includes required content? (M, NM, or NA)*	NA	NA	NA	NA	
NABD includes required content? (M or NM)*	M	NM	NM	M	
Authorization decision made by qualified clinician? (M, NM, or NA)*	M	NA	NA	M	
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (M, NM, or NA)*	M	NA	NA	M	
Was the decision based on established authorization criteria (i.e., not arbitrary)? (M or NM)*	M	M	M	M	
Was correspondence with the member easy to understand? (M or NM)*	M	NM	NM	M	
Total Applicable Elements	**7**	**5**	**5**	**7**	
Total Met Elements	**7**	**1**	**1**	**7**	
Score (Number Met / Number Applicable) = %	**100%**	**20%**	**20%**	**100%**	

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

Comments:

File 1: Member inpatient stay request was determined to be not medically necessary. Medical reviewer had peer consultation with requesting provider, which also resulted in denial of medical necessity.

File 2: This was a claims denial. Per internal policy, all claims are processed within 30 days. For all claims denials, COA sent notice only to the provider in the weekly remittance report. No NABD was sent to the member; therefore, all requirements related to the member NABD—i.e., notice sent to member, sent in required time frame, included required content, and correspondence easy to understand—were scored *Not Met*. The claim was denied because the provider was not a validated Medicaid provider.

File 3: This was a claims denial. Per internal policy, all claims are processed within 30 days. For all claims denials, COA sent notice only to the provider in the weekly remittance report. No NABD was sent to the member; therefore, all requirements related to the member NABD—i.e., notice sent to member, sent in required time frame, included required content, and correspondence easy to understand—were scored *Not Met*. The claim was denied because a school-based Federally Qualified Health Center (FQHC) provider billed two services on the same day. An FQHC may only bill one service per day (paid a daily rate).

File 4: Inpatient stay was approved through April 22, 2019. The request was for continued stay beginning on April 23, 2019. The requesting provider was supposed to call COA on April 23, 2019, for peer review consultation but did not do so; therefore, the request was denied on April 23, 2019.

File 5: OMIT—This was a concurrent review of an inpatient stay. Peer review consultation resulted in approval. No denial was processed; therefore, the file was omitted.

Appendix B. Colorado Department of Health Care Policy and Financing FY 2019–2020 Denials Record Review Tool for Colorado Access (Region 5)

Requirements	File 6	File 7	File 8	File 9	File 10
Member ID	****	****	****	****	****
Date of initial request	6/20/19	8/29/19	8/1/19	11/18/19	11/20/19
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	CL	CL	NR	NR	CL
(Standard [S], Expedited [E], or Retrospective [R])	R	R	E	E	R
Date notice of adverse benefit determination (NABD) sent	7/3/19	9/3/19	8/7/19	11/18/19	12/3/19
Notice sent to provider and member? (M or NM)*	NM	NM	M	M	NM
Number of days for decision/notice	13	5	6	0	13
Notice sent within required time frame? (M or NM) (S = 10 Cal days after; E = 72 hours after; T = 10 Cal days before)*	NM	NM	M	M	NM
Was authorization decision timeline extended? (Y or N)	N	N	Y	N	N
If extended, extension notification sent to member? (M, NM, or NA)*	NA	NA	M	NA	NA
If extended, extension notification includes required content? (M, NM, or NA)*	NA	NA	M	NA	NA
NABD includes required content? (M or NM)*	NM	NM	M	M	NM
Authorization decision made by qualified clinician? (M, NM, or NA)*	NA	NA	M	M	NA
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (M, NM, or NA)*	NA	NA	M	NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (M or NM)*	M	M	M	M	M
Was correspondence with the member easy to understand? (M or NM)*	NM	NM	M	M	NM
Total Applicable Elements	**5**	**5**	**9**	**6**	**5**
Total Met Elements	**1**	**1**	**9**	**6**	**1**
Score (Number Met / Number Applicable) = %	**20%**	**20%**	**100%**	**100%**	**20%**

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

**** = Redacted Member ID

Comments:

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

File 7: This was a claims denial. Per internal policy, all claims are processed within 30 days. For all claims denials, COA sent notice only to the provider in the weekly remittance report. No NABD was sent to the member; therefore, all requirements related to the member NABD—i.e., notice sent to member, sent in required time frame, included required content, and correspondence easy to understand—were scored *Not Met*. This claim was denied, then subsequently corrected and resubmitted by the provider and paid.

File 8: Member was hospitalized for an approved three-day inpatient stay and was concurrently reviewed for continued stay from August 1, 2019, forward. Additional information was requested from provider on August 1, 2019, but the provider did not respond until August 6, 2019. COA extended the decision pending receipt of information from provider. Additional information did not justify continued stay and the case was denied retrospectively from August 1, 2019 to August 6, 2019.

File 9: This was an after-hours request (8 p.m.) for approval of an inpatient hospitalization. The request was denied on the same day as requested due to lack of medical necessity.

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

Requirements	OS 1	OS 2	OS 3	OS 4	OS 5
Member ID	****				
Date of initial request	5/10/19				
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR				
(Standard [S], Expedited [E], or Retrospective [R])	E				
Date notice of adverse benefit determination (NABD) sent	5/13/19				
Notice sent to provider and member? (M or NM)*	M				
Number of days for decision/notice	3				
Notice sent within required time frame? (M or NM) (S = 10 Cal days after; E = 72 hours after; T = 10 Cal days before)*	M				
Was authorization decision timeline extended? (Y or N)	N				
If extended, extension notification sent to member? (M, NM, or NA)*	NA				
If extended, extension notification includes required content? (M, NM, or NA)*	NA				
NABD includes required content? (M or NM)*	M				
Authorization decision made by qualified clinician? (M, NM, or NA)*	M				
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (M, NM, or NA)*	NA				
Was the decision based on established authorization criteria (i.e., not arbitrary)? (M or NM)*	M				
Was correspondence with the member easy to understand? (M or NM)*	M				
Total Applicable Elements	**6**				
Total Met Elements	**6**				
Score (Number Met / Number Applicable) = %	**100%**				

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

Comments:

File OS 1: This was a new request for inpatient hospitalization denied due to no medical necessity. The decision was made on the same day as the request (May 10, 2019), with notice sent on May 13, 2019.

Total Record Review Score*	Total Applicable Elements:	Total Met Elements:	Total Record Review Score:
	60	40	67%

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

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Grievance Record Review Tool
for Colorado Access (Region 5)

Review Period:	January 1, 2019–December 31, 2019
Date of Review:	February 4, 2020
Reviewer:	Gina Stepuncik
Participating Health Plan Staff Member(s):	Reyna Garcia

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame*	Decision Maker Not Previous Level	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
1	****	01/07/2019	M ☒ N ☐ N/A ☐	01/14/2019	5w	M ☒ N ☐	M ☐ N ☐ N/A ☒	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☐ N ☒ N/A ☐
Comments: The member was balance billed by a provider. The resolution letter was written at a reading level well above sixth grade.										
2	****	01/17/2019	M ☐ N ☒ N/A ☐	01/18/2019	NA	M ☐ N ☒	M ☐ N ☐ N/A ☒	M ☐ N ☐ N/A ☒	M ☐ N ☒ N/A ☐	M ☐ N ☒ N/A ☐
Comments: The member left a voicemail regarding a HIPAA concern. COA attempted to call the member. When the member could not be reached via telephone, outreach attempts ended. COA did not send an acknowledgement letter to the address on file. There was no evidence in the electronic record that any further action was taken by COA. As the voicemail constitutes filing the grievance (expression of dissatisfaction), COA should have sent the acknowledgement letter as another attempt to encourage the member to contact COA to participate in resolving the grievance.										
3	****	04/08/2019	M ☒ N ☐ N/A ☐	04/18/2019	8w	M ☒ N ☐	M ☐ N ☐ N/A ☒	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☐ N ☒ N/A ☐
Comments: The member alleged that a provider was discriminating against their family by refusing treatment because the member did not vaccinate their children. The resolution letter was written at a reading level well above sixth grade.										
4	****	04/25/2019	M ☒ N ☐ N/A ☐	05/14/2019	13w	M ☒ N ☐	M ☐ N ☐ N/A ☒	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☐ N ☒ N/A ☐
Comments: The provider and member grieved about a billing issue. The resolution letter was written at a reading level well above sixth grade.										
5	OMIT		M ☐ N ☐ N/A ☐			M ☐ N ☐	M ☐ N ☐ N/A ☐	M ☐ N ☐ N/A ☐	M ☐ N ☐ N/A ☐	M ☐ N ☐ N/A ☐
Comments: This case was removed from the sample, as this was not a member grievance.										
6	****	08/19/2019	M ☒ N ☐ N/A ☐	08/20/2019	1w	M ☒ N ☐	M ☐ N ☐ N/A ☒	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☐ N ☒ N/A ☐
Comments: The member complained about their case manager and was reassigned to a new case manager. The resolution letter was written at a reading level well above sixth grade.										
7	****	10/10/2019	M ☒ N ☐ N/A ☐	10/30/2019	14w	M ☒ N ☐	M ☐ N ☐ N/A ☒	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☐ N ☒ N/A ☐
Comments: The member wanted to be called by a different name than his legal name by his provider's staff members. Staff members continued to use his name of record accidently. The member became enraged and had to be escorted from the facility by security. The resolution letter was written at a reading level well above sixth grade.										
8	****	10/14/2019	M ☒ N ☐ N/A ☐	10/25/2019	9w	M ☒ N ☐	M ☐ N ☐ N/A ☒	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☐ N ☒ N/A ☐
Comments: The provider's facility lost lengthy registration paperwork. The member's services were delayed due to the loss of paperwork. The resolution letter was written at a reading level well above sixth grade.										

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Grievance Record Review Tool
for Colorado Access (Region 5)

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame*	Decision Maker Not Previous Level	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
9	****	11/04/2019	M ☐ N ☒ N/A ☐	11/13/2019	7w	M ☒ N ☐	M ☐ N ☐ N/A ☒	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☐ N ☒ N/A ☐
Comments: The member needed an Arabic interpreter and one could not be found. The resolution letter was written at a reading level well above sixth grade.										
10	****	11/25/2019	M ☒ N ☐ N/A ☐	11/25/2019	0	M ☒ N ☐	M ☐ N ☐ N/A ☒	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☐ N ☒ N/A ☐
Comments: The member grieved about their provider group. The resolution letter was written at a reading level well above sixth grade.										
OS 1	OMIT		M ☐ N ☐ N/A ☐			M ☐ N ☐	M ☐ N ☐ N/A ☐	M ☐ N ☐ N/A ☐	M ☐ N ☐ N/A ☐	M ☐ N ☐ N/A ☐
Comments: This case was removed from the sample.										
OS 2	OMIT		M ☐ N ☐ N/A ☐			M ☐ N ☐	M ☐ N ☐ N/A ☐	M ☐ N ☐ N/A ☐	M ☐ N ☐ N/A ☐	M ☐ N ☐ N/A ☐
Comments: This case was removed from the sample.										
OS 3	****	06/07/2019	M ☒ N ☐ N/A ☐	06/27/2019	14w	M ☒ N ☐	M ☐ N ☐ N/A ☒	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☐ N ☒ N/A ☐
Comments: The member grieved about their behavioral health physician group. The resolution letter was written at a reading level well above sixth grade.										
Do not score shaded columns below.										
Column Subtotal of Applicable Elements			**10**			**10**	**0**	**0**	**10**	**10**
Column Subtotal of Compliant (Met) Elements			**8**			**9**	**NA**	**NA**	**9**	**0**
Percent Compliant (Divide Met by Applicable)			**80%**			**90%**	**NA**	**NA**	**90%**	**0%**

Key: M = Met; N = Not Met
N/A = Not Applicable

Total Applicable Elements	**40**
Total Compliant (Met) Elements	**26**
Total Percent Compliant	**65%**

* Grievance timeline for resolution and notice sent is 15 working days (unless extended).
**Grievance resolution letter required content includes (1) results of the disposition/resolution process and (2) the date the disposition/resolution process was completed.
**** = Redacted Member ID

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Appeals Record Review Tool
for Colorado Access (Region 5)

Review Period:	January 1, 2019–December 31, 2019
Date of Review:	February 4, 2020
Reviewer:	Gina Stepuncik
Participating Health Plan Staff Member(s):	Christine Gillaspie

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame*	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
1	****	02/20/2019	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	2/26/2019	M ☒ N ☐	M ☐ N ☒	M ☐ N ☒
Comments: An extra inpatient day was requested so the member could go directly from inpatient care to their suboxone appointment. The denial was upheld due to lack of medical necessity. The language in the appeal resolution letter was not at the sixth-grade reading level. The attachment to the appeal resolution letter inaccurately informed members that they may file an "appeal, a quick appeal, or a State fair hearing." At the point the member is receiving an appeal resolution letter, the member's appeal rights are exhausted and the only option at that point is a State fair hearing (SFH).											
2	****	02/20/2019	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	2/21/2019	M ☒ N ☐	M ☐ N ☒	M ☐ N ☒
Comments: Psychological testing was denied as it was deemed not medically necessary. No acknowledgement letter was required. The HSAG reviewer and COA staff member agreed that the language in the appeal resolution letter was not at the sixth-grade reading level. The attachment to the appeal resolution letter inaccurately informed members that they may file an "appeal, a quick appeal, or a State fair hearing." At the point the member is receiving an appeal resolution letter, the member's appeal rights are exhausted and the only option at that point is an SFH.											
3	****	03/05/2019	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	3/11/2019	M ☒ N ☐	M ☐ N ☒	M ☐ N ☒
Comments: Psychological testing was denied as it was deemed not medically necessary. The HSAG reviewer and COA staff member agreed that the language in the appeal resolution letter was not at the sixth-grade reading level. The attachment to the appeal resolution letter inaccurately informed members that they may file an "appeal, a quick appeal, or a State fair hearing." At the point the member is receiving an appeal resolution letter, the member's appeal rights are exhausted and the only option at that point is an SFH.											
4	****	04/22/2019	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	4/30/2019	M ☒ N ☐	M ☐ N ☒	M ☐ N ☒
Comments: The member appealed the denial of intensive outpatient care and the denial was upheld. The HSAG reviewer and COA staff member agreed that the language in the appeal resolution letter was not at the sixth-grade reading level. The attachment to the appeal resolution letter inaccurately informed members that they may file an "appeal, a quick appeal, or a State fair hearing." At the point the member is receiving an appeal resolution letter, the member's appeal rights are exhausted and the only option at that point is an SFH.											
5	****	OMIT	M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: This was not a clinical appeal.											

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame*	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
6	****	07/03/2019	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	7/5/2019	M ☒ N ☐	M ☐ N ☒	M ☐ N ☒
Comments: COA denied SUD care since it is not a covered benefit of COA; however, the letter did not direct the member to FFS contact information. HSAG suggests that COA include this information in the denial letter so the provider attempting to treat a substance use issue can go directly to the FFS claims process instead of wasting their time appealing the decision. No acknowledgement letter was required. The HSAG reviewer and COA staff member agreed that the language in the appeal resolution letter was not at the sixth-grade reading level. The attachment to the appeal resolution letter inaccurately informed members that they may file an "appeal, a quick appeal, or a State fair hearing." At the point the member is receiving an appeal resolution letter, the member's appeal rights are exhausted and the only option at that point is an SFH.										
7	****	07/18/2019	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	7/20/2019	M ☒ N ☐	M ☐ N ☒	M ☐ N ☒
Comments: The member appealed the denial of inpatient care. The denial decision was upheld. No acknowledgement letter was required. The HSAG reviewer and COA staff member agreed that the language in the appeal resolution letter was not at the sixth-grade reading level. The attachment to the appeal resolution letter inaccurately informed members that they may file an "appeal, a quick appeal, or a State fair hearing." At the point the member is receiving an appeal resolution letter, the member's appeal rights are exhausted and the only option at that point is an SFH.											
8	****	OMIT	M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: This was not a clinical appeal.											
9	****	10/04/2019	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	10/4/2019	M ☒ N ☐	M ☐ N ☒	M ☐ N ☒
Comments: The member appealed the denial of short-term residential care. The denial decision was upheld. No acknowledgement letter was required. The HSAG reviewer and COA staff member agreed that the language in the appeal resolution letter was not at the sixth-grade reading level. The attachment to the appeal resolution letter inaccurately informed members that they may file an "appeal, a quick appeal, or a State fair hearing." At the point the member is receiving an appeal resolution letter, the member's appeal rights are exhausted and the only option at that point is an SFH.											
10	****	OMIT	M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: This was not a clinical appeal.											
OS1	****	03/20/2019	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	3/22/2019	M ☒ N ☐	M ☐ N ☒	M ☐ N ☒
Comments: The member appealed the denial of extended inpatient days. The denial decision was upheld. No acknowledgement letter was required. The HSAG reviewer and COA staff member agreed that the language in the appeal resolution letter was not at the sixth-grade reading level. The attachment to the appeal resolution letter inaccurately informed members that they may file an "appeal, a quick appeal, or a State fair hearing." At the point the member is receiving an appeal resolution letter, the member's appeal rights are exhausted and the only option at that point is an SFH.											
OS2	****	09/23/2019	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	9/23/2019	M ☒ N ☐	M ☐ N ☒	M ☐ N ☒
Comments: The member appealed the denial of inpatient care. The denial decision was upheld. No acknowledgement letter was required. The HSAG reviewer and COA staff member agreed that the language in the appeal resolution letter was not at the sixth-grade reading level. The attachment to the appeal resolution letter inaccurately informed members that they may file an "appeal, a quick appeal, or a State fair hearing." At the point the member is receiving an appeal resolution letter, the member's appeal rights are exhausted and the only option at that point is an SFH.											

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Appeals Record Review Tool
for Colorado Access (Region 5)

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame*	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
OS3	****	08/06/2019	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	8/8/2019	M ☒ N ☐	M ☐ N ☒	M ☐ N ☒

Comments: The member appealed the denial of SUD inpatient care. In the appeal resolution letter, COA did not direct the member to FFS contact information. HSAG suggests that COA include this information in the denial letter so the provider attempting to treat a substance use issue can go directly to the FFS claims process instead of wasting their time appealing the decision. The denial decision was upheld. No acknowledgement letter was required. The HSAG reviewer and COA staff member agreed that the language in the appeal resolution letter was not at the sixth-grade reading level. The attachment to the appeal resolution letter inaccurately informed members that they may file an "appeal, a quick appeal, or a State fair hearing." At the point the member is receiving an appeal resolution letter, the member's appeal rights are exhausted and the only option at that point is an SFH.

Do not score shaded columns below.

Column Subtotal of Applicable Elements	**3**	**10**	**10**				**10**	**10**	**10**
Column Subtotal of Compliant (Met) Elements	**3**	**10**	**10**				**10**	**0**	**0**
Percent Compliant (Divide Met by Applicable)	**100%**	**100%**	**100%**				**100%**	**0%**	**0%**

Key: M = Met; N = Not Met
N/A = Not Applicable
Yes; No = Not scored—information only

Total Applicable Elements	**53**
Total Compliant (Met) Elements	**33**
Total Percent Compliant	**62%**

***Appeal resolution letter time frame** does not exceed 10 working days from the day the health plan receives the appeal (unless expedited—three calendar days; or unless extended—+14 calendar days).

****Appeal resolution letter required content** includes (1) the result of the resolution process; (2) the date the resolution was completed; (3) if the appeal is not resolved wholly in favor of the member, the right to request a State fair hearing and how to do so; (4) if the appeal is not resolved wholly in favor of the member, the right to request that benefits/services continue while the hearing is pending, and how to make that request.

**** = Redacted Member ID

Appendix C. Site Review Participants

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

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

HSAG Review Team	Title
Barbara McConnell	Executive Director
Katherine Bartilotta	Associate Director
COA Participants	**Title**
Aaron Brotherson	Director of Provider Relations
Amanda Fitzsimons	Senior Privacy Analyst
Bethany Himes	Vice President of Provider Engagement
Christine E. Gillaspie	Manager of Physical Health Utilization Management
Eileen Barker	Senior Director of Behavioral Health
Elise Cooper	Senior Practice Facilitator
Elizabeth Strammiello	Chief Compliance Officer
George Roupas	Manager of Telehealth Programs
Janet Milliman	Director of CHP+ Payment Reform
Jason Smith	Senior Provider Contract Manager
Joseph Anderson	Director of Care Management
Josette Hizon	Behavioral Health Utilization Management Supervisor
Kelly Marshall	Director of Community and External Relations
Kevin Lawrence	Claims Operations Supervisor
Krista Beckwith	Senior Director of Population Health and Quality
Lindsay Cowee	Director of Utilization Management and Pharmacy
Lisa Steller	Behavioral Health Utilization Management Supervisor
Marty Janssen	Senior Program Director
Michelle Tomsche	Director of Claims Operations
Mika Gans	Senior Manager of Quality
Reyna Garcia	Senior Director of Customer Service
Sarrah Knause	Program Manager, CHP+
Shelby Kiernan	Director of Practice Support and Integration
Thomas Freunt	Supervisor of Utilization Management
Department Observers	**Title**
Elizabeth Mattes	Program Coordinator—HCPF
Jeff Appleman	Program Specialist—HCPF

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

If applicable, the RAE 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 RAE 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 RAE 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 RAE 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 RAE 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 RAE is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.
Step 3	**Department approval**
	Following review of the CAP, the Department and HSAG will: • Approve the planned interventions and instruct the RAE to proceed with implementation, or • Instruct the RAE to revise specific planned interventions and/or documents to be submitted as evidence of completion and also to proceed with implementation.
Step 4	**Documentation substantiating implementation**
	Once the RAE has received Department approval of the CAP, the RAE will have a time frame of 90 days (three months) to complete proposed actions and submit documents. The RAE will submit documents as evidence of completion one time only on or before the three-month deadline for all required actions in the CAP. (If necessary, the RAE will describe in the CAP document any revisions to the planned interventions that were required in the initial CAP approval document or determined by the RAE within the intervening time frame.) If the RAE is unable to submit documents of completion for any required action on or before the three-month deadline, it must obtain approval in writing from the Department to extend the deadline.

Step	Action
Step 5	**Technical Assistance**
	At the RAE's request, HSAG will schedule an interactive, verbal consultation and technical assistance session during the three-month time frame. The session may be scheduled at the RAE's discretion at any time the RAE determines would be most beneficial. HSAG will not document results of the verbal consultation in the CAP document.
Step 6	**Review and completion**
	Following a review of the CAP and all supporting documentation, the Department or HSAG will inform the RAE as to whether or not the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements. Any documentation that is considered unsatisfactory to complete the CAP requirements at the three-month deadline will result in a continued corrective action with a new date for completion established by the Department. HSAG will continue to work with the RAE until all required actions are satisfactorily completed.

The CAP template follows.

Table D-2—FY 2019–2020 Corrective Action Plan for COA R5

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
12. The Contractor notifies the requesting provider and gives the member written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. *42 CFR 438.210(c)* Contract: Exhibit B-2—8.6.1 10 CCR 2505-10 8.209.4.A.1	COA's *UR Determinations* policy specified that written notice would be sent to the member and provider. Denial record reviews demonstrated that members and providers were notified in writing of adverse benefit determinations made by UM. However, NABDs for claims denials were sent only to the provider. No NABD was sent to the member regarding a claims denial; therefore, five of 10 RAE Region 5 denial record reviews (related to claims) were scored *Not Met* for "notice sent to provider and member."	COA must ensure that RAE members receive written notification of any decision to deny a service, including denial or partial denial of a claim.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
15. The notice of adverse benefit determination must be written in language easy to understand, available in prevalent non-English languages in the region, and available in alternative formats for persons with special needs. *42 CFR 438.404(a)* *42 CFR 438.10 (c)* Contract: Exhibit B-2—8.6.1–8.6.1.4 10 CCR 2505-10 8.209.4.A.1	COA demonstrated that the RAE NABDs used for UM denials were written in language easy to understand and informed the member of availability of the notice in other languages and alternative formats. However, COA sent no notice to members regarding denial of a claim; therefore, five of 10 RAE Region 5 denial record reviews (related to claims) were scored *Not Met* for "correspondence with the member was easy to understand."	COA must ensure that RAE members receive written notification of any decision to deny a service, including denial or partial denial of a claim. COA must ensure that the NABD regarding a claim is written in language that is easy for the member to understand.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
16. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to and copies of all documents and records relevant to the adverse benefit determination (includes medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits). • The member's right to request one level of appeal with the Contractor and the procedures for doing so. • The date the appeal is due. • The member's right to request a State fair hearing after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State fair hearing.	COA demonstrated that the RAE NABDs used for UM denials included all required content. However, COA sent no notice to members regarding denial of a claim; therefore, five of 10 RAE Region 5 denial record reviews (related to claims) were scored *Not Met* for "notice includes required content."	COA must ensure that RAE members receive written notification of any decision to deny a service, including denial or partial denial of a claim. COA must ensure that the NABD regarding a claim includes all required content.

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
• The circumstances under which an appeal process can be expedited and how to make this request. • The member's rights to have benefits/services continue (if applicable) pending the resolution of the appeal, how to request that benefits continue, and the circumstances (consistent with State policy) under which the member may be required to pay the cost of these services. *42 CFR 438.404(b)(1–6)* Contract: Exhibit B-2—8.6.1.5–8.6.1.12 10 CCR 2505-10 8.209.4.A.2		
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. The Contractor mails the notice of adverse benefit determination within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, as defined in 42 CFR 431.211, 431.213 and 431.214 (see below). • For denial of payment, at the time of any denial affecting the claim. • For standard service authorization decisions that deny or limit services, within 10 calendar days following the receipt of the request for service. • For expedited service authorization decisions, within 72 hours after receipt of the request for service. • For extended service authorization decisions, no later than the date the extension expires. • For service authorization decisions not reached within the required time frames, on the date the time frames expire. *42 CFR 438.404(c)* Contract: Exhibit B-2—8.6.3.1, 8.6.5–8.6.8 10 CCR 2505-10 8.209.4.A.3	COA's *UR Determinations* policy addressed all required time frames for mailing the NABD to the member. However, the formatting of the information in the policy resulted in inaccurate information regarding required time frames. Specifically, several of the time frames (bullets 2 through 5 of the requirement) were listed as *exceptions* to the time frame for notice of reduction or termination of previously authorized services. In addition, COA sent no notice to members regarding denial of a claim; therefore, five of 10 RAE Region 5 denial record reviews (related to claims) were scored *Not Met* for "notice sent within required time frame."	COA must correct information in its *UR Determinations* policy to accurately address all required time frames for mailing the NABD to the member. COA must also ensure that RAE members receive written notification of any decision to deny a service, including denial or partial denial of a claim, and that the NABD regarding denial of payment is sent at the time of any denial affecting the claim.

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

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

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
– The member's whereabouts are unknown, and the post office returns Agency mail directed to him/her indicating no forwarding address. – The Agency establishes that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth. – A change in the level of medical care is prescribed by the member's physician. – The notice involves an adverse benefit determination made with regard to the preadmission screening requirements. • If probable member fraud has been verified, the Contractor gives notice five (5) calendar days before the intended effective date of the proposed adverse benefit determination. *42 CFR 438.404(c)* *42 CFR 431.211* *42 CFR 431.213* *42 CFR 431.214* Contract: Exhibit B-2—8.6.3.1–8.6.3.2, 8.6.4.1–8.6.4.1.8 10 CCR 2505-10 8.209.4.A.3 (a)		

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

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
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, or • The member is discharged. *42 CFR 438.114(e)* *42 CFR 422.113(c)(3)* Contract: Exhibit B-2—14.5.6.2.14	COA's *Emergency and Post-Stabilization Care* policy stated verbatim the requirements related to when financial responsibility ends for post-stabilization care that was not pre-approved by COA; however, the policy included no procedures for implementation. COA's *Post Stabilization Care Services* desktop procedure did not clearly address how the application of the criteria specified in 42 CFR 422.113(c)(3) are applied in determining when financial responsibility (i.e., payment of a claim) ends for post-stabilization services not pre-approved.	COA must develop or enhance its UM and claims payment procedures applicable to post-stabilization care to clarify processes for applying the criteria outlined in 42 CFR 422.113(c)(3) to determine when financial responsibility ends for payment of post-stabilization services that were not pre-approved.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
11. The Contractor sends the member written acknowledgement of each grievance within two (2) working days of receipt. *42 CFR 438.406(b)(1)* Contract: Exhibit B2—8.1 10 CCR 2505-10 8.209.5.B	During the on-site grievance record review, HSAG found that, in two cases, the acknowledgement letter was not sent within the two-working day time frame.	COA must develop a mechanism to ensure that acknowledgement letters are sent within the required two-working day time frame.
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 VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
12. The Contractor must resolve each grievance and provide notice as expeditiously as the member's health condition requires, and within 15 working days of when the member files the grievance. • Notice to the member must be in a format and language that may be easily understood by the member. *42 CFR 438.408(a) and (b)(1) and (d)(1)* Contract: Exhibit B2—8.5.5, 7.2.7.3, 7.2.7.5 10 CCR 2505-10 8.209.5.D	In one grievance record reviewed on-site, COA documented that the member could not be reached after leaving a message complaining about a HIPAA incident. No further investigation was pursued. In addition, HSAG found that grievance resolution letters were not consistently written at a readability level easy for members to understand.	COA must use both phone and written attempts to contact members to process grievances and, if the member cannot be reached, proceed with investigation based on information first given. In addition, COA must develop a mechanism to ensure that grievance and appeal resolution letters are written in language that may be easily understood by the average Medicaid member.
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 VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
22. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)* *42 CFR 438.408(d)(2)* *42 CFR 438.10* Contract: Exhibit B2—8.7.14.1. 7.2.7.3, 7.2.7.5 10 CCR 2505-10 8.209.4.J.1	During the on-site record review, HSAG found that all appeal resolution letters included language that would not be easily understood by the member. Staff members reported that the medical opinion rendered by the physician was copied into the reason portion of the letter.	COA must develop a mechanism to ensure that appeal resolution letters are written in language that may be easily understood by the average Medicaid member.
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 VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
25. If the Contractor extends the time frames, it must—for any extension not requested by the member: • Make reasonable efforts to give the member prompt oral notice of the delay. • Within two (2) calendar days, give the member written notice of the reason for the delay and inform the member of the right to file a grievance if he or she disagrees with that decision. • Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. *42 CFR 438.408(c)(2)* Contract: Exhibit B2—8.5.7, 8.7.14.1, 8.7.14.2.1, 8.7.14.2.5-6	While COA had a process to extend both grievances and appeals when needed, the grievance extension template letter did not include the member's right to file a grievance related to an extension of the resolution time frame.	COA must ensure that any grievance extension letter sent to the member includes the member's right to file a grievance if the member disagrees with the extension.
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 VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
26. The written notice of appeal resolution must include: • The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. – The right to request that benefits/services continue* while the hearing is pending, and how to make the request. – That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's adverse benefit determination. **Continuation of benefits applies only to previously authorized services for which the Contractor provides 10-day advance notice to terminate, suspend, or reduce.* *42 CFR 438.408(e)* Contract: Exhibit B2—8.7.14.3, 8.7.14.4 10 CCR 2505-10 8.209.4.M	For appeal resolutions not in favor of the members, COA used an attachment to the appeal resolution letter that explained both appeal and State fair hearing rights. As the member has at the point of appeal resolution exhausted COA internal appeal rights, it is inaccurate to include information in the appeal resolution letter that refers to the member's appeal rights.	COA must revise its appeal resolution letter to ensure that only information pertaining to the member's right to a State fair hearing is included.

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
29. The Contractor provides for continuation of benefits/services (when requested by the member) while the Contractor-level appeal and the State fair hearing are pending if: • The member files in a timely manner* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the Contractor mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal in accordance with required time frames. ** This definition of timely filing only applies for this scenario—i.e., when the member requests continuation of benefits for previously authorized services proposed to be*	COA's *Member Appeal Process* policy depicted the process for members to request continuation of services following the appeal resolution; however, it did not include the process for the member to initially request the continuation of services following the adverse benefit determination.	COA must clarify the *Member Appeal Process* policy and any other applicable policies, procedures, and documents to accurately depict the member's right to request the continuations of benefits (services) during the appeal within 10 days following the adverse benefit determination—or before the intended effective date of the action—and again request continuation of the disputed services during the State fair hearing within 10 days following the notice of appeal resolution that is adverse to the member.

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
terminated, suspended, or reduced. (Note: The provider may not request continuation of benefits on behalf of the member.) *42 CFR 438.420(a) and (b)* Contract: Exhibit B2—8.7.13.1 10 CCR 2505-10 8.209.4.T		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review Protocol Activities

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

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal managed care regulations and contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, on-site agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all site reviewers to ensure consistency in scoring across plans.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided group technical assistance and training, as needed. • Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the RAE 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 three standards and on-site activities. Thirty days prior to the review, the RAE 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 RAE's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The RAEs also submitted lists of denials of authorization of services (denials), grievances, and appeals that occurred between January 1, 2019, and December 31, 2019 (to the extent available at the time of the site visit). HSAG used a random sampling technique to select records for review during the site visit. • The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct Site Visit**
	• During the on-site portion of the review, HSAG met with the RAE's key staff members to obtain a complete picture of the RAE's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the RAE's performance. • HSAG reviewed a sample of administrative records to evaluate denials, grievances, and appeals. • While on-site, HSAG collected and reviewed additional documents as needed. • At the close of the on-site portion of the site review, HSAG met with RAE staff and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2019–2020 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. • HSAG analyzed the findings. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the Department**
	• HSAG populated the report template. • HSAG submitted the draft site review report to the RAE and the Department for review and comment. • HSAG incorporated the RAE's and Department's comments, as applicable, and finalized the report. • HSAG distributed the final report to the RAE and the Department.

Appendix F. Focus Topic Discussion

Overview of FY 2019–2020 Focus Topic Discussion

For the FY 2019–2020 site review process, the Department requested that HSAG conduct open-ended on-site interviews with RAE staff members to gather information on each RAE's experience regarding *Region-Specific Initiatives Related to the Health Neighborhood.* Focus topic interviews were designed to provide the Department with a better understand of the infrastructure and strategies the RAEs are implementing to actively build, support, and monitor Health Neighborhood providers, particularly those serving members with complex health needs. HSAG collaborated with the Department to develop an interview guide to facilitate discussions and gather similar information from each RAE. Information gathered during the interviews will be analyzed in the FY 2019–2020 RAE Aggregate Report to determine and document statewide trends related to RAE region-specific activities to integrate with community partners and build Health Neighborhoods. This section of the report contains a summary of the focus topic discussion for **COA R5**.

Infrastructure and Strategies

As Region 3 and Region 5 combined encompass most of the Denver metropolitan area, most of **COA**'s Health Neighborhood initiatives engage providers and other partners from both Region 3 and Region 5. **COA** described their concept of the Health Neighborhood as concentric circles or multiple layers of the continuum of healthcare providers surrounding the member at the core and interfacing with one another at the points of common intersection impacting the health of members. Using a linear (rather than concentric circle) perspective from member to community, the continuum might be illustrated as follows: member>>primary care providers>>specialists>>hospital-type facilities>>health agencies>>social determinant community providers. **COA**'s Health Neighborhood definition encompasses the full continuum of providers.

Staff members described that **COA** both initiates and convenes Health Neighborhood collaboratives as well as responds to many invitations to participate in other organizations' initiatives. **COA** provided examples of ongoing involvement in the leadership (Board of Directors or Steering Committees) of established health alliances, such as the Mile High Health Alliance, or participation in specific issue alliances. In addition, staff members stated that **COA** responds to requests for speaking engagements or to share access to Medicaid member data. **COA**-organized initiatives were often associated with achieving performance incentive measures, deliverables of RAE contact, or other Department priorities. In either case, staff members stated that there are far more collaborative Health Neighborhood opportunities than **COA** has available resources. Therefore, **COA** has established a thoughtful approach to screening and prioritizing its involvement in Health Neighborhood initiatives, which considers multiple criteria, including: (A) alignment with health strategy priorities—i.e., linked to existing work or priorities, opportunity to reach further into the community to build collective impact, benefits from saying "yes"; or (B) political or relationship management—i.e., specific state agency(s) involved, political ramifications, impact of saying "no," effect on overall good standing with partners, opportunity

for **COA** recognition; and (C) resource implications—i.e., talent/skill set in organization, time and availability to meet the demand, financial resources required.

To manage and oversee **COA**'s Health Neighborhood initiatives, **COA** has developed a robust internal infrastructure for engaging Health Neighborhood partners through the **COA** Health Strategy Steering Committee (HSSC), Governing Councils (Councils) of Region 3 and Region 5, and initiative-specific subcommittees. The HSSC considers and establishes the priority Health Neighborhood strategies and activities of **COA**. The regional RAE Councils consider the structural approaches for implementing the strategies. The Councils meet monthly and have membership consisting of the major medical neighborhood providers. Region 5 Council participants include organizations such as Children's Hospital of Colorado (Children's Hospital), UCHealth, Kaiser Permanente of Colorado (Kaiser), University of Colorado Medicine (CU Medicine), Mental Health Centers of Denver, Denver Health, Colorado Coalition for the Homeless, and Every Child Pediatrics. The RAE is an equal and facilitating participant. These organizations share in serving the majority of the RAE membership. Staff members reported that the primary Council objectives and activities to date have consisted of relationship building, forming a shared vision regarding the potential of ongoing Health Neighborhood collaboration, and discovering how to work together in a meaningful way. Council representatives must be leaders in their organizations with the authority to make decisions. Recognizing the complexity of health system relationships and potential political or competitive issues among organizations, the Councils have adopted the principals of the "Collective Impact Model" (Civic Canopy), which address how communities can work together to solve major social issues. A central theme of this model is the need to identify a common self-interest among the partners in order to be successful—i.e., outcomes have to benefit all. In addition, financial incentives—i.e., resources available to accomplish objectives—and outcomes must align with a positive business model for the participants. The RAE Councils are currently examining and creating value-based payment models to pay for performance. **COA** is simultaneously evaluating the establishment of an innovation pool, which would commit some of the RAE's key performance indicator (KPI) payments to support Health Neighborhood initiatives. Staff members reported that other forms of stimulus for Health Neighborhood participation or identifying shared goals include the chronicity of an issue and the intrigue of finding new collective problem-solving approaches for long standing "pain points" in the system. While measurable outcomes of the Councils' activities are premature, staff members reported that the Councils are experiencing an 85 percent participation rate at every meeting and perceived that the organizational and development processes among the Health Neighborhood partners are building a sustainable operational foundation for ongoing RAE Health Neighborhood initiatives. Supporting the HSSC and Councils, **COA** has organized numerous health strategy task forces that engage Health Neighborhood partners in examining and implementing strategies to impact the RAE KPIs. Six of 12 RAE KPI measures are currently being addressed through these task forces, which include: Dental Wellness, Health Neighborhood, 7-day follow-up of BH inpatient care, foster care, potentially avoidable costs (PACs) (adults and pediatrics), and management of members with complex needs (see "Other Health Neighborhood Initiatives" section).

Improving Access to Specialist Providers

COA has identified a "Behavioral Health in Primary Care" initiative to expand access to BH specialists. The initiative includes two primary components:

- **COA** implemented an encounter rate model for its high-volume Medicaid PCMPs, which provides enhanced reimbursement for BH services delivered in the primary care setting. Staff members explained that the limitation on BH codes reimbursed by the Department do not allow enough volume or flexibility for PCMPs to be able to engage an on-site BH clinician and, therefore, allowable BH services are often not implemented by the PCMPs. **COA** is aware that many members who are referred to external BH providers do not follow-through with seeking services and are much more inclined to receive services offered through the PCMP. Enhanced reimbursement for additional BH services provided in primary care offices in turn allows PCMPs to affordably hire and pay BH clinicians to provide services in their offices. There are 12 PCMP sites in which this model has been implemented. **COA** worked collaboratively with its RAE Community Mental Health Centers (CMHCs) to identify and train appropriate practitioners to successfully operate in a PCMP environment. **COA**'s provider contracting team ensures that BH providers are contracted expeditiously. **COA** uses its BH data for member-level tracking and to evaluate costs of services. **COA** reported that the encounter rate model program has affordably expanded member access to BH services beyond those services that could have been delivered through the Department's BH expansion strategy.
- In addition, through its telehealth subsidiary AccessCare Services (ACS), **COA** has developed a "Virtual Care Collaboration and Integration" (VCCI) program, which provides both psychiatric consultations and BH telehealth services to 34 PCMP sites. VCCI offers PCMPs access to three ACS-employed BH clinicians, including two psychiatrists. The VCCI was described by staff members as a "work-force multiplier" for psychiatric consultations and medication management for Medicaid members being treated in PCMP offices. Similar to the enhanced reimbursement model, The VCCI objectives are to maintain patient engagement in the BH services they need by offering services through the PCMP. The VCCI also provides continuity of care for BH members when BH practitioners leave or rotate out of a PCMP practice. Staff members stated that implementation of VCCI requires extensive office staff training and work-flow modifications and is, therefore, not appropriate for all PCMPs. Initiated in July 2017 through a Rose Community Foundation grant, ACS has been learning through the grant how to collect available data points—such as data on changes in prescribed medications—that will allow for evaluation of the outcomes of the project later in 2020. Staff members reported that feedback obtained from providers has been very positive. Staff members also reported that there has been increasing interest expressed by the Department of Corrections (DOC) and school-based healthcare programs regarding potential application of VCCI in those settings.

In addition, **COA**'s care coordination programs continue to work with members to improve access to specialist services. At the most basic level, **COA** attempts to connect members to a PCMP as quickly as possible to manage their healthcare needs, including referrals to needed specialists. Members receiving **COA** care coordination are facilitated in obtaining transportation and provided instructions on

preparation for a specialist appointment; similar services are provided by **COA**'s Enhanced Clinical Partners (ECPs), who are advanced practice PCMPs that perform all care coordination services for members of their practices. **COA** continues to explore mechanisms to reduce Medicaid member "no-shows" for appointments, whether related to primary care, specialty care, or behavioral health care. **COA** has been meeting with PCMPs, members, and BH providers to determine reasons for no-shows. Care coordinators and ECPs provide appointment reminders and **COA** is exploring technology designed to reduce no-shows. While these care coordination processes have been in place for some time, **COA** lacks access to data to determine referrals to specific specialists, track specialist no-show rates, or target specific member offenders.

COA described several circumstances that present challenges for individual RAEs to be able to improve access to medical specialty providers:

- The RAE does not contract with medical specialist providers for Medicaid members. Contracting with specialists is performed by the Department.
- The Department sets the payment rates for specialist care and pays claims for services provided by specialists. As such, RAEs have no financial influence or access to data regarding members' access to specialists.
- In the Denver metro area, most medical specialists are either owned by or financially affiliated with hospital systems. Any negotiations related to improving Medicaid member access to specialists would need to be conducted through hospitals rather than with individual specialist practices.
- Specialists are in demand to serve patients of the entire payor population. Specialists typically limit access to a number of "slots" available for Medicaid members due to lower Medicaid reimbursement rates and other administrative issues. In addition, Medicaid members from all RAEs across the state access specialists in the Denver area, competing for the limited slots available.
- Since the RAE does not contract with specialists and only has access to claims for its own members, the RAE is unable to determine specific specialist access patterns across regions that may impact all members.
- PCMPs manage access to specialists for their patients (of all payor types) through referrals. Referral patterns of PCMPs are influenced by long-standing interpersonal relationships with specific specialist providers. Due to the competition among providers for access to specific specialists, PCMPs are unwilling to share information regarding their preferred specialists or how they are able to successfully obtain access.
- PCMPs and specialists alike are unwilling to sign or abide by a written "compact" agreement that outlines predefined parameters of the referral relationship. Staff members stated that referrals between providers are often based on long-term interprofessional and qualitative relationships and that PCMPs are generally unwilling to risk disruption from Medicaid agencies in their interpersonal referral relationships with specialists.
- Through its care coordinators' involvement with complex members or through its ECPs, **COA** has identified that there is a shortage of nephrologists (most of whom are associated with and in demand from dialysis centers), neurologists, and orthopedists available to serve Medicaid members. However, specialist contracting is performed by the Department.

- Staff members reported that anecdotal information from care coordinators indicates that the Department's prior issues with untimely payments to providers have continued to negatively impact specialists' perceptions regarding expansion of access to Medicaid members.

All of these factors combined result in major barriers for an individual RAE to be able to improve access to medical specialists. **COA** reported that it has no measurable or perceived positive outcomes related to improving access to specialists and that **COA** has little or no leverage to impact overall improvements in access to specialist care. As such, the Department's Health Neighborhood KPI (related to specialty services) cannot be proactively addressed or measured by the RAEs. **COA** offered recommendations to the Department regarding possible solutions (see "What the Department Can Do" section).

Collaborative Initiatives with Hospitals

In addition to the major hospital systems' ongoing participation in **COA**'s Councils, **COA** has collaborated with all major hospital systems in Region 3 and Region 5 to initiate a Hospital Transformation Program (HTP) committee. Committee participants include six major hospital systems—Centura Health, Children's Hospital, Denver Health, Health One, SCL Health, and UCHealth—representing 19 individual hospitals in the RAE regions. Staff members explained that the Department's HTP puts 30 percent of hospitals' Medicaid reimbursement dollars "at risk" and has issued to hospitals a menu of performance measure metrics. The objective of the committee to date has been to assess common areas of concern and identify priority areas for improvement, as well as to establish a common set of hospital metrics for measurement and reporting of results. Staff members reported that HTP metrics may or may not impact the RAEs; however, the RAE's primary interest has been to provide and receive hospital data in a consistent manner. Hospitals will direct any mutually-defined initiatives of the committee, supported by the RAEs as applicable. Staff members stated that challenges in collaborative initiatives among multiple hospital systems involve competitive or political issues of hospitals, as well as defining a common framework for data collection and sharing of data. Staff members reported that the HTP collaboration was only recently initiated and is currently engaged in the pre-implementation planning process, including establishing common goals and priorities.

Hospital systems and the RAEs are engaged in the collaborative efforts of the Metro Denver Partnership for Health, led by six local public health departments, and addressing community-wide priorities for improving the overall health of the community, including significant efforts related to social determinants of health. Staff members stated that this has also been a forum for discussing the HTP project.

Three hospital systems that serve the majority of the RAEs' members—Children's Hospital, UCHealth, and Denver Health—are also engaged in issue-specific task forces, such as those addressing PACs, complex high-cost members, and ECPs (see below for examples of specific initiatives).

Other Health Neighborhood Initiatives

In order to define "impactable populations," **COA** has examined stratified member cost and care coordination data and determined that approximately one-third of members have high-cost acute needs that will return to baseline without interventions, one-third of members experience no or low cost, and one-third of members have complex needs that can be managed—i.e., impactable populations. **COA** also uses the high-cost utilizer list provided by the Department to identify members of impactable populations and assigns those members to specialized nurse care coordinators. Staff members stated that an important factor in determining "impactable" members is a member's willingness to engage in care coordination, enroll in registries, or enroll in special clinical management programs—e.g., high-risk pregnancy care or diabetes management. **COA** has identified that its ECPs—eight PCMPs and four CMHCs—serve 50 percent of the RAE members and 49 percent of impactable population members. **COA** works with its ECPs and CMHCs in the "members with complex needs" task force to identify subpopulations of impactable members and develop programs to address those specific subpopulations. **COA** has identified and targeted members with asthma, members with chronic obstructive pulmonary disease, and members with diabetes as three impactable populations. **COA** is working with its ECPs, hospitals, and other applicable outpatient providers in defined subcommittees to address coordination of the systems in which these subpopulations are receiving care. For example, Children's Hospital and its affiliated pediatric practices, ECPs, and the RAE specialty care coordinators are examining mechanisms to overcome barriers in transitioning members with asthma among different providers. **COA** has also implemented initiatives to identify and address PACs—e.g., unnecessary emergency room use, unnecessary imaging. **COA** uses any available utilization date to identify over-, under-, or inappropriate utilization and works with provider partners to develop enhanced care coordination systems to impact such costs. At the time of on-site review, PAC Health Neighborhood partners included: Children's Hospital, Denver Health, UCHealth, Clinica, Every Child Pediatrics, Doctor's Care, Kaiser, Pediatric Care Network, Salud, Stride, and Colorado Coalition for the Homeless.

Staff members described a recently implemented school-based clinic initiative to embed ACS behavioral health providers into two Kids First Health Care school-based clinics serving two high schools and two middle schools. Challenges identified included: provision of non-English speaker translation services, initiating parental involvement in consent for BH services (when necessary), and training of school staff members regarding access to services. Initiated in January 2020, staff members reported that the clinics had experienced six behavioral health encounters to date.

COA was leading a community-based Colorado justice reform initiative to provide **COA** specialized care coordination services on-site at county parole offices for members recently released from DOC. The purpose of the initiative is to meet with parolees during their visits to the parole offices; enroll individuals in Medicaid; and coordinate referrals to any behavioral, medical, and community resources needed by the member. Health Neighborhood participants included **COA** specialized criminal justice care coordinators, **COA** "Access Medical" enrollment services, county parole offices, and the Families First program (parenting services). At the time of on-site review, the program had just been implemented with the Englewood, Denver, and Douglas counties' parole offices with four visits experienced to date.

COA's Foster Care task force, 7-Day Follow-Up (BH inpatient care) task force, and Dental Wellness task force were each initiated by **COA** to engage Health Neighborhood partners in developing programs to address the RAEs' Department-defined performance improvement metrics or KPIs.

- Activities of the Foster Care task force were initiated by the RAEs meeting individually with each county Department of Human Services (DHS) Child Welfare Division, and with Denver Health's clinic targeted for foster care children, to discuss issues and challenges of coordinating care for foster children. The task force additionally identified a disconnect between clinical and core services being provided and coding for reimbursement, such that the Department's KPI does not fully represent what is really happening with the members. The task force has determined that this initiative is a long-term, multifaceted challenge and that all partners, including the Department, county DHSs (both within and outside the RAE regions), providers, and schools will need to be engaged in this collaborative initiative.
- The Dental Wellness task force has engaged Colorado Children's Healthcare Assistance Program (CCHAP), pediatric primary care providers—Every Child Pediatrics, Kids First Health Care, and Salud—Community Reach Center, Denver Health, and two dental providers (one from each RAE region) to develop mechanisms to increase dental wellness of children by introducing limited early preventive services in pediatric primary care practices and subsequently referring children to DentaQuest for needed services. The task force will use "increasing dental visits every 12 months" as a measure of results.
- To improve **COA**'s "7-day follow-up of BH inpatient care" performance measure, the RAEs engaged AllHealth Network, Aurora Mental Health Center, Colorado Coalition for the Homeless, Jefferson Center for Mental Health, and Mental Health Center of Denver to identify barriers and develop interventions. Barriers included inability to contact or engage the member. Interventions included enhanced care coordination mechanisms. Interventions were implemented July 2019 and were being tracked through the defined performance measure.

Other examples of specific care coordination initiatives with Health Neighborhood partners included:

- Working with the Women, Infants, and Children (WIC) programs in local public health entities to determine how care coordinators of both programs interface to identify women and children and with special healthcare needs and make interagency referrals.
- Working with the Healthy Communities family health coordinators to outreach to members and coordinate service referrals for members.
- Beginning to develop a process with the Thornton fire department to connect members with BH needs to a **COA** BH care coordinator.

While many of the task force activities initiated by **COA** were driven by desired improvements in the RAE's KPIs, staff members acknowledged that ongoing use of KPIs to instigate Health Neighborhood activities may conflict with **COA**'s Council principles that Health Neighborhood initiatives should be strategically chosen based on the common concerns and shared motivations of all parties involved. **COA** also recognized that outcome measures of any project should be tied to the objectives of the collaborative initiative. As referenced in the description of projects above, **COA** discovered during

several Health Neighborhood projects that the RAE's specific performance measures may or may not be appropriate for measuring the intended outcomes of the initiative or that reliable outcome data are complex or difficult to obtain.

While staff members were enthused about perceived results of all Health Neighborhood processes and initiatives, in most cases it was clearly premature to have measurable results, either due to: recent implementation of collaborative interventions, lack of accessible data sources for tracking and measurement, or recognition that outcomes of multifaceted complex initiatives would require long-term implementation to produce measurable results.

What the Department Can Do

COA believes that solutions regarding access to medical specialists need to be pursued at a higher level than the individual RAEs. **COA** recommends that the Department initiate and lead a statewide initiative at the Department level, involving participation of the RAEs, to comprehensively and thoughtfully evaluate the multifaceted and intertwined issues regarding Medicaid member access to medical specialists. Such an initiative might address:

- Improving Medicaid payment rates for specialist services.
- The Department contracting with additional specialists as needed.
- Working with hospital systems to increase access to specialists with whom they are affiliated.
- Working with hospital systems to determine the potential for attracting new and additional specialists to Colorado or specific regions of Colorado.
- Working with hospital systems to gain access to specialist input regarding real concerns of specialists on the subject of provision of services to Medicaid members and whether those issues are targeted to specific types of specialists.
- Developing tools and survey instruments for widespread specialists to provide direct input to the State regarding concerns of serving more Medicaid members.
- Extracting data from the Department's claims database to identify most frequently used specialists by Medicaid members, assess where each RAE's members seek specialty care, and determine how many specialists are independent practices versus those specialists linked to a larger provider system.
- Determining mechanisms to incent providers to achieve desired outcomes. For example, perhaps the Department's HTP initiative could be a vehicle for addressing specialist access.
- Examining and avoiding potentially conflicting objectives and incentives in executing the Department's objectives at the RAE level. For example:
  - If a singular RAE attempts to improve access to select specialists for only its members, the number of slots available for other RAEs' members may be further diminished.
  - Increasing Medicaid's access to specialists may reasonably be expected to increase the near-term cost of care for Medicaid, thereby conflicting with the Department's objective to show measurable short-term decreases in costs for the Medicaid program. This underscores why it is important to identify which specialty services are most needed.

- Based on statewide collaborative efforts, determining which activities can best be supported or operationalized at the RAE level, and determining whether reasonable, implementable mechanisms for measuring RAE outcomes exist, and when they should be applied.

COA has identified that the Department's definition and expectations surrounding the "Health Neighborhood" seem to be applied inconsistently in Health Neighborhood KPIs and deliverables. For example, both in the contract and previous Health Neighborhood report deliverables, Health Neighborhood is defined to include a broad spectrum of providers and **COA** has implemented a robust structure and process to engage Health Neighborhood partners in multifaceted initiatives to improve the delivery system for Medicaid members. However, more recently, the Health Neighborhood KPI and report deliverables have shifted to a focus on specialty referral and access and appropriate utilization as an apparent "pseudonym" for Health Neighborhood. Furthermore, it seems the Department considers the current Health Neighborhood KPI measure (focused on specialist access) as representative of what the RAEs are doing in the area of overall community engagement and addressing social determinants of health, which require very different approaches. Communications regarding the Health Neighborhood seem to fluctuate and be subject to multiple interpretations by both **COA** and the Department staff members. The inconsistent application of the term "Health Neighborhood" results in significant confusion among staff members, constant changes in direction to respond to expectations from the Department, lack of efficiency in work, and incomplete achievement of goals with Health Neighborhood partners. **COA** recommends that:

- At a minimum, the Department be more clear and consistent over time in its definition of "Health Neighborhood," as well as the guidance and expectations applied, to allow for RAE implementation of work with partner organizations and achievement of results.
- The Department's expectations of results, whether through KPIs or other deliverables, be focused on aspects of the delivery system that are achievable and controllable within the world of the RAE.
- The Department consider that development of the Health Neighborhood should allow for the shared priorities and goals of the regional partners to be identified and operationalized.

As noted above in the reported Health Neighborhood initiatives and experiences, the strategies of the Health Neighborhood partners in the RAE region may be related to multifaceted complex issues that are meaningful to all engaged partners but do not lend themselves to short-term measurement of results. In addition, appropriate outcome measures do not necessarily coincide with the established performance measures of the Department. To that end, **COA** recommends that the Department discontinue attempts to measure short-term outcomes of long-term multifaceted issues, as these measures may penalize or distract RAEs from achieving meaningful success in developing the Health Neighborhood.

COLORADO

Department of Health Care Policy & Financing

Appendix G:

Fiscal Year 2019–2020 Site Review Report

for

Colorado Access Region 5 Managed Care Initiative— Denver Health Medical Plan

April 2020

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

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix G: Table of Contents

1. Executive Summary

Introduction

In accordance with its authority under Colorado Revised Statute 25.5-1-101 et seq. and pursuant to Request for Proposals 2017000265, the Department of Healthcare Policy and Financing (the Department) executed contracts with the Regional Accountable Entities for the Accountable Care Collaborative (ACC) program, effective July 1, 2018. The Regional Accountable Entities (RAEs) are responsible for integrating the administration of physical and behavioral healthcare and will manage networks of fee-for-service primary care providers and capitated behavioral health providers to ensure access to care for Medicaid members. Per the Code of Federal Regulations, Title 42 (42 CFR)—federal Medicaid managed care regulations published May 6, 2016—RAEs qualify as both Primary Care Case Management (PCCM) entities and Prepaid Inpatient Health Plans (PIHPs). In addition, the **Colorado Access** (**COA**) **Region 5** RAE contract incorporates into the RAE a limited managed care initiative for capitated physical health services (managed care organization [MCO]). 42 CFR requires PCCM entities, PIHPs, and MCOs to comply with specified provisions of 42 CFR 438—managed care regulations—and requires that states conduct a periodic evaluation of their PCCM entities, PIHPs, and MCOs to determine compliance with federal Medicaid managed care regulations published May 6, 2016. The Department has elected to complete this requirement for the RAEs by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This report documents results of the fiscal year (FY) 2019–2020 site review activities for the **COA Region 5** limited managed care initiative—**Denver Health Medical Plan** (**DHMP**). For each of the three standard areas reviewed this year, this section contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 2 describes the background and methodology used for the FY 2019–2020 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2018–2019 MCO site review activities. Appendix G1 contains the compliance monitoring tool for the review of the MCO standards. Appendix G2 contains details of the findings for the denials of authorization of services (denials), grievances, and appeals record reviews. Appendix G3 lists HSAG, MCO, and Department personnel who participated in some way in the site review process. Appendix G4 describes the corrective action plan process that the MCO will be required to complete for FY 2019–2020 and the required template for doing so.

Summary of Compliance Results

Based on conclusions drawn from the review activities, HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. HSAG assigned required actions to any requirement receiving a score of *Partially Met* or *Not Met*. HSAG also identified opportunities for improvement with associated recommendations for some elements, regardless of the score.

Table 1-1 presents the scores for **DHMP** for each of the standards. Findings for all requirements are summarized in this section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* follow in Appendix G1—Compliance Monitoring Tool.

Table 1-1—Summary of MCO Scores for Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
I. Coverage and Authorization of Services	30	30	29	1	0	0	97%
II. Access and Availability	15	15	13	2	0	0	87%
VI. Grievances and Appeals	35	35	29	6	0	0	83%
Totals	**80**	**80**	**71**	**9**	**0**	**0**	**89%**

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

Table 1-2 presents the scores for **DHMP** for the denials, grievances, and appeals record reviews. Details of the findings for the record reviews are in Appendix G2—Record Review Tools.

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Denials	90	52	44	8	38	85%
Grievances	60	51	51	0	9	100%
Appeals	60	50	41	9	10	82%
Totals	**210**	**153**	**136**	**17**	**57**	**89%**

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

Standard I—Coverage and Authorization of Services

Summary of Strengths and Findings as Evidence of Compliance

DHMP's *Utilization Review Determination Including Approvals and Action* policy (*Utilization Determinations* policy) accurately addressed processes for ensuring sufficient services are furnished to members and requirements for processing requests for authorization of services, including: definition of "medical necessity," authorization criteria used, ensuring that the medical reviewer has appropriate clinical expertise, consulting with the requesting provider, required time frames for making decisions and providing notification to members and providers, and content of information in the notice of adverse benefit determination (NABD). On-site denial record reviews demonstrated overall 85 percent compliance with procedural requirements. **DHMP** presented two template NABD letters—Medicaid Medical Necessity Denial Letter (used for utilization management [UM] authorizations) and Medicaid Adverse Benefit Determination Letter (used for claims denials)—both of which included all required content. **DHMP** applied the Department's medical necessity criteria, Milliman Care Guidelines, and Hayes, Inc. Knowledge Center Guidelines in making authorization decisions. **DHMP** submitted evidence of annual and new hire inter-rater reliability testing to ensure consistent application of criteria. Staff members stated that **DHMP**'s medical director or a subcontracted All-Med Healthcare Management physician specialist reviewer makes all denial decisions, ensuring that appropriate clinical expertise is applied. The content in the body of the NABD letter—including the text describing the reason for the decision—and attached information pertaining to appeals and a State fair hearing (SFH) were written in language easy for the member to understand and the NABD was available in alternative formats. The template extension letter to the member included the member's right to file a grievance if he or she disagrees with the extension decision. All requests for authorization and notices to the member were time and date stamped to ensure that expedited authorizations were processed within the required 72-hour time frame. **DHMP**'s UM software automatically flagged reviewers for all required time frames and **DHMP** management regularly monitored compliance with time frames through system-generated reports.

DHMP's *Utilization Determinations* policy and *Adjudication of Urgent, Emergency Care, Emergency Observation, and Emergency Admission and Post Stabilization Claims* policy (*Emergency and Post-Stabilization Claims* policy) accurately defined emergency services, emergency condition, and post-stabilization, and addressed requirements for coverage and payment of emergency services. The *Emergency and Post-Stabilization Claims* policy and on-site interviews confirmed that **DHMP** pays all emergency facility claims, regardless of circumstances. The *Utilization Determinations* policy and *Emergency and Post-Stabilization Claims* policy also addressed verbatim the requirements for payment of post-stabilization services. During on-site interviews, staff members stated that all services provided during the first 24 hours of a post-stabilization inpatient stay are paid in full, regardless of circumstances. If a post-stabilization inpatient stay has not been previously authorized, claims are pended and forwarded to the UM department for application of review criteria and an authorization determination for the remainder of the inpatient stay. Staff members stated that adjudication of a post-stabilization claim is not completed until the UM department has issued a determination and instructed the claims department accordingly. For post-stabilization services delivered out of network, the UM

department also engages the Denver Health transfer team to assist the member with transfer to a **DHMP** network facility. Staff members stated that **DHMP** does not balance bill any members for any services delivered in or out of network and communicates to out-of-network providers that they may not balance bill a member.

Summary of Findings Resulting in Opportunities for Improvement

HSAG noted that the Medicaid Medical Necessity Denial Letter informed members of availability in alternative formats; however, this information was included in the Notice of Non-Discrimination attachment to the letter rather than the body of the letter. HSAG suggests that **DHMP** inform the member of the availability of the letter in alternative formats in the body of the letter.

HSAG noted that information in the Medicaid Medical Necessity Denial Letter referred to the "Notice of Action." Whereas the 2016 revisions to managed care regulations changed this term to "Notice of Adverse Benefit Determination," HSAG recommends that **DHMP** update "Notice of Action" to current regulatory language.

Information in attachments to the Medicaid Medical Necessity Denial Letter—specifically, the Designation of Personal Representative form and Notice of Non-Discrimination—included language beyond a sixth-grade reading level. HSAG also noted that this information considerably extends the length of the letter and is not specifically required per managed care regulations to be included in the NABD. HSAG recommends that **DHMP** evaluate the necessity of including these attachments in the NABD and, if retained, correct the attachments to include language that the member can easily understand.

In review of the Medicaid Adverse Benefit Determination Letter and the Medicaid Medical Necessity Denial Letter, HSAG found information in the Adverse Benefit Determination Letter easier for the member to understand and accurate in its entirety. HSAG recommends that **DHMP** consider incorporating similar information and language into its template Medicaid Medical Necessity Denial Letter.

While staff members stated that it is **DHMP**'s policy to pay all post-stabilization claims for the first 24 hours of hospitalization as well as to pend the payment of a post-stabilization inpatient claim until all UM processes and determinations have been completed, these procedures were not clearly stated in the *Emergency and Post-Stabilization Claims* policy. HSAG recommends that **DHMP** describe these procedures in its *Adjudication of Urgent, Emergency Care, Emergency Observation, and Emergency Admission and Post Stabilization Claims* policy, as these processes supersede and account for application of most of the managed care requirements for determining financial responsibility for post-stabilization services.

Summary of Required Actions

While the *Utilization Determinations* policy, as well as the two template NABD letters—one for claims and one for denials of medical necessity—addressed all required content areas, the Medicaid Medical Necessity Denial Letter included several inaccuracies in the detailed content of the appeal, SFH, and continuation of benefits information (specific inaccuracies are listed in the findings of element #13 in the compliance monitoring tool). Due to these inaccuracies, HSAG found 8 of 10 denial record reviews were *Not Met* for required content of the NABD. **DHMP** must correct inaccuracies in the required content of the Medicaid Medical Necessity Denial Letter.

Standard II—Access and Availability

Summary of Strengths and Findings as Evidence of Compliance

The Denver Health and Hospital Authority (DHHA)-employed provider network was **DHMP**'s primary source of practitioners to serve its Medicaid members. **DHMP** provided its network adequacy narrative, GeoAccess reports submitted to the Department, and Network Management Committee minutes as evidence that it monitors its network of clinics to determine adequacy of geographical access and timeliness of appointments for primary and non-urgent physical healthcare. The *Network Adequacy Plan* described use of practitioner-to-member ratios, primary care provider (PCP)-to-member ratios, available specialists, open panels, the DHHA provider database, member satisfaction surveys, geographic accessibility based on GeoAccess maps, and analysis of grievance and appeals data to determine adequacy of the network. Given the geographical service area is only urban, the geographic analysis focused on a distance of 30 miles rather than analyzing travel times. **DHMP**'s *Network Adequacy Plan* and *Network Adequacy Report* included a table depicting types of accessibility and adaptive equipment available at specific DHHA clinics. The *Network Adequacy Report* also included a table listing all DHHA clinics within a quarter mile of a bus stop. **DHMP** had adequate policies, procedures, and processes for providing direct access to family planning services and services via out-of-network providers for second opinions and if needed due to inability to provide timely services. The Medicaid member handbook informed members of all timely access standards and the *Access to Care and Services Standards* policy accurately depicted the timely access standards.

For pharmacy services, **DHMP** members are permitted to use community pharmacies contracted with MedImpact, **DHMP**'s pharmacy benefit manager, in addition to using pharmacies available at most DHHA clinic sites. During the on-site interview, **DHMP** staff members reported recently contracting with a large multi-location primary care clinic, STRIDE Community Health Center, which will provide improved access for **DHMP**'s Medicaid members.

DHMP provided its training program script as evidence of robust training on cultural competency. Although the study had some limitations, **DHMP** provided evidence that it used data collected on member's and provider's primary and secondary languages spoken, member language preference, and

member and provider ethnicity to determine the cultural competency sufficiency of the network. HSAG applauds **DHMP** for engaging in this type of analysis.

DHMP's provider directory's "tips for use," member handbook, and provider directory listing had accurate information regarding language, translation, and adaptive services available; timely access standards; and when services are available from out-of-network providers.

Summary of Findings Resulting in Opportunities for Improvement

DHMP's GeoAccess analysis evaluates distance to clinics using a 30-mile diameter, rather than distance traveled via road access. HSAG recommends that **DHMP** consider assessing distance traveled to determine the percentage of members within 30 miles of **DHMP** providers.

DHMP's *Network Adequacy Plan* included a description of processes that were outdated and not currently employed by **DHMP**'s provider support staff members. HSAG recommends that **DHMP** review its *Network Adequacy Plan* and reports and revise as needed to ensure that these documents reflect current **DHMP** network monitoring processes.

As evidence of monitoring that members receive a follow-up appointment following discharge from an inpatient hospitalization, **DHMP** provided DHHA's *Patient Discharge* policy, which indicated that discharging physicians determine the time frames for follow-up services. The inpatient workflow document indicated that patients are instructed to contact primary care within seven days. **DHMP**'s *Access to Care and Services Standards* policy depicted the required time standard for providing follow-up services; however, it did not adequately provide procedural information **DHMP** uses to ensure compliance with the standard. HSAG recommends that **DHMP** either add procedural information to its existing policies or develop a policy that provides information about how the health plan works with DHHA providers to ensure compliance with the Medicaid-specific access standard for follow-up after hospitalization.

Summary of Required Actions

The **DHMP** fourth quarter *Network Adequacy Report* had analysis for percentage of primary and specialty appointments within 30 days. While the report depicted the number of members that received inpatient hospitalizations, **DHMP** was unable to provide evidence of tracking to ensure compliance with the timeliness standards for non-urgent symptomatic care within seven days or an outpatient follow-up appointment within seven days. Staff members reported during the on-site interview that no appointments are needed to receive urgent care services; therefore, tracking timeliness of urgent care appointments is not applicable. **DHMP** must develop a mechanism to track compliance with timely access to appointments for non-urgent symptomatic care and follow-up care following an inpatient hospitalization.

The *Network Adequacy Report* accurately depicted the timely appointment standards. **DHMP** provided evidence of reviewing timeliness of primary and specialty care appointments made through the Denver

Health Call Center; however, **DHMP** did not have a mechanism to monitor compliance with timely access standards for its contracted organizational providers (University Physicians, Inc. and The Children's Hospital of Colorado). **DHMP** must develop a mechanism to monitor contracted providers regularly to ensure compliance with timely access standards and implement corrective action plans (CAPs) if the providers fail to comply.

Standard VI—Grievances and Appeals

Summary of Strengths and Findings as Evidence of Compliance

DHMP's grievance and appeals policies and procedures were comprehensive, thorough, and largely accurate concerning the requirements for administering grievances and appeals. The *Medicaid Appeals Policy and Procedure* and the *Medicaid Grievance Policy and Procedure* accurately defined "adverse benefit determination," "appeal," and "grievance," and addressed: who may file and filing requirements, who makes appeal decisions and how decisions are made, time frames for resolution, and required content of notices to members and providers. **DHMP** documented and tracked all grievances and appeals in the Altruista Health care management system. The system alerted reviewers to all individual grievance and appeal required time frames to ensure timely response on each case. The system maintained all information submitted by members and providers applicable to the case, all decisions made by reviewers, and all template notices to be provided to members. On-site grievance record reviews demonstrated 100 percent compliance with procedural requirements. On-site appeal record reviews demonstrated overall 82 percent compliance with requirements, with only one element accounting for most deficiencies.

On-site interviews confirmed that staff members thoroughly understood and had processes in place to implement its grievance and appeals policies and procedures. During on-site interviews, staff members described that **DHMP** primarily uses All-Med Healthcare Management external physician reviewers to make initial adverse benefit determinations and uses the **DHMP** medical director and/or Considine & Associates external medical specialists to make appeal decisions, thereby enabling grievance and appeals decisions to be made by someone not involved in a previous review and by a physician who has appropriate clinical expertise. Appeal information included in the NABD accurately informed members of the time frames and processes related to the filing and processing of appeals. SFH information attached to the appeal resolution notice accurately informed members of the time frames and processes associated with filing an SFH. **DHMP** provided mechanisms for the member to designate a personal representative for grievances or appeals and to submit a written appeal following an oral appeal. Staff members stated that **DHMP** processes an oral appeal the same as a written appeal, regardless of receipt of a written appeal. All appeal requests and resolution notices were time and date stamped to ensure that resolution of expedited appeals is completed with the required 72-hour time frame. **DHMP** allowed for a 14-day extension of the grievance or appeal decision time frame to obtain or consider additional information needed to make a decision. **DHMP**'s Notice of Extension Letter included required content, including the member's right to file a grievance if he or she disagrees with the extension. While the appeal policies and procedures thoroughly described all circumstances related to continuing benefits

during an appeal or SFH, as well as effectuation of benefits based on the outcome of an appeal or SFH, staff members stated that **DHMP** rarely receives a request for continuing benefits during an appeal. **DHMP**'s provider manual included an extensive description of **DHMP**'s grievance and appeals policies and procedures.

Summary of Findings Resulting in Opportunities for Improvement

During on-site interviews, staff members explained the process of how **DHMP** coordinates authorization and appeal decisions among **DHMP**'s internal medical director/specialist consultants and All-Med Health Care Management or Considine & Associates external physician reviewers in order to ensure that persons making decisions were not involved in a previous decision on a case, and that appropriate clinical expertise is applied. Whereas grievance and appeals policies and procedures re-state the regulatory requirements but do not include the implementation procedures described on-site, HSAG recommends that **DHMP** consider adding to its grievance and appeals policies its procedures for operationalizing these regulations.

DHMP's Grievance Resolution Letter template appropriately informed the member of the Department's contact information for a second-level review of the grievance if he or she is not satisfied with **DHMP**'s resolution. However, the contact information provided for the Department was inaccurate. HSAG recommends that **DHMP** include the accurate Department contact information for second-level grievance reviews into its Grievance Resolution Letter.

HSAG noted that **DHMP**'s *Medicaid Appeals Policy and Procedure* stated that the written notice to the member of a denial for an expedited appeal resolution includes **DHMP**'s account of the member's oral appeal. However, the *Notice of Expedited Resolution Denial* template did not include such information. HSAG recommends that **DHMP** reconcile differences in the content of the denial letter and **DHMP**'s appeal policy statement.

Whereas appeal record reviews included one case with an Appeal Resolution Letter that included medical terminology not easy for the member to understand, HSAG recommends that **DHMP** consider having a non-clinical staff member review each letter prior to distribution to ensure that the information regarding the reason for the appeal decision is easy for a member to understand.

Summary of Required Actions

The appeals and SFH attachment to the Appeal Resolution Letter offers the member assistance with SFH forms and procedures; however, the appeal information in the Medicaid Medical Necessity Denial Letter does not offer the member assistance with completion of appeals forms and procedures. **DHMP** must incorporate in the NABD appeal information the offer of assistance in completing any forms or procedural steps related to an appeal.

DHMP's procedures and on-site review of appeal records demonstrated in most cases that appeal resolution notices were written in language easy for the member to understand. However, HSAG

identified in appeal record reviews one resolution letter in which the reason for the decision used medical acronyms that were not defined for the member. **DHMP** must ensure that the text description entered into the Appeal Resolution Letter to the member is written in language easy for the member to understand.

The *Notice of Expedited Resolution Denial* template communicated to the member the process for handling a denied expedited appeal and the member's right to file a grievance, however, failed to demonstrate that the reason for the denial was included in the letter. **DHMP** must ensure that the written notice to the member regarding denial of an expedited appeal includes the reason for the denial.

DHMP's Appeal Resolution Letter included all required information; however, the attachment to the letter describing the SFH process also referenced appeals and stated that the member "may file an appeal, a quick appeal, or a State fair hearing." At the point the member is receiving an Appeal Resolution Letter, the member's appeal rights are exhausted and the only option at that point is an SFH. Due to the Appeal Resolution Letter inaccurately including reference to appeals, 7 of 10 appeal records failed to meet the requirement for "resolution letter includes required content." **DHMP** must revise the content of the attachment to the Appeal Resolution Letter to omit references to appeal processes.

The *Appeal Rights and State Fair Hearing Rights* attachment to the Appeal Resolution Letter communicated to the member the required time frame for the member to request continued benefits of previously approved services during an SFH. However, the Medicaid Medical Necessity Denial Letter, used to communicate information regarding appeals, inaccurately informed the member of the time frame for requesting continued benefits during an appeal. **DHMP** must correct the information sent to the member regarding how to request continued benefits during an *appeal* to include the required time frame for requesting continued benefits—i.e., on or before the latter of 10 days after the health plan mails the NABD or the intended effective date of the adverse benefit determination.

DHMP's provider manual, distributed to providers at the time of contracting, included extensive information regarding the grievance and appeals processes; however, the information in the provider manual inadequately addressed some of the time frames for filing grievances and appeals and circumstances applicable to continuation of benefits (specific inadequacies are outlined in the findings of element #35 in the compliance monitoring tool). **DHMP** must update the provider manual to adequately describe all requirements and time frames for filing grievances and appeals and circumstances applicable to the continuation of benefits during an appeal or SFH.

2. Overview and Background

Overview of FY 2019–2020 Compliance Monitoring Activities

For the FY 2019–2020 site review process, the Department requested a review of three areas of performance. HSAG developed a review strategy and monitoring tools consisting of three standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services; Standard II—Access and Availability; and Standard VI—Grievances and Appeals. Compliance with applicable federal managed care regulations and managed care contract requirements was evaluated for the limited managed care initiative (MCO) through review of all three standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the three standards, HSAG used the RAE contract requirements and regulations specified by the federal Medicaid managed care regulations published May 6, 2016. HSAG assigned each requirement in the compliance monitoring tool a score of *Met, Partially Met, Not Met, or Not Applicable.* The Department determined that the review period was January 1, 2019, through December 31, 2019. 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 MCO personnel to determine compliance with applicable 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 each of denials of authorization, grievances, and appeals.

HSAG reviewed a sample of the MCO's administrative records related to denials of authorization, grievances, and appeals to evaluate implementation of applicable federal and State healthcare regulations. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records (to the extent that a sufficient number existed) for each of denials, grievances, and appeals. Using a random sampling technique, HSAG selected the samples from all **DHMP** MCO denial records, all **DHMP** MCO grievance records, and all **DHMP** MCO appeal records that occurred between January 1, 2019, and December 31, 2019. For the record review, the health plan received a score of M (*Met*), NM (*Not Met*), or NA (*Not Applicable*) for each required element. HSAG separately calculated a record review score for each record and an overall record review score. Results of record reviews were considered in the review of applicable requirements in Standard I—Coverage and Authorization of Services and Standard VI—Grievances and Appeals.

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),*

Version 2.0, September 2012.[2-1] The three standards chosen for the FY 2019–2020 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, Standard X—Quality Assessment and Performance Improvement, and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment.

Objective of the Site Review

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

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

[2-1] 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: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Aug 5, 2019.

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

FY 2018–2019 Corrective Action Methodology

As a follow-up to the FY 2018–2019 site review, each MCO that received one or more *Partially Met* or *Not Met* scores was required to submit a CAP to the Department addressing those requirements found not to be fully compliant. If applicable, the MCO 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 MCO and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **COA** and **DHMP** until it completed each of the required actions from the FY 2018–2019 compliance monitoring site review.

Summary of FY 2018–2019 Required Actions

For FY 2018–2019, HSAG reviewed Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services.

Related to coordination and continuity of care, **DHMP** was required to complete three corrective actions, including:

- Providing information to members on how to contact the primary care medical provider (PCMP) responsible for coordinating his or her healthcare services and, as applicable, his or her lead care manager.
- Implementing procedures to actively coordinate services the member receives from the RAE and from external community organizations and social support providers.
- Providing an individual intake assessment and related service plan for each member.

Related to member information, **DHMP** was required to complete three corrective actions, including:

- Ensuring that all member materials critical to obtaining services are member-tested.
- Updating the member handbook to ensure grievance and appeal information reflected revised managed care regulations released in May 2016.
- Including in its member materials and its website, a description of the basic features of the RAE's managed care functions and **DHMP**'s relationship to **COA** as the MCO for the RAE.

Related to EPSDT services, **DHMP** was required to complete one corrective action, which was to create with Denver County Healthy Communities an annual plan for onboarding of Medicaid children and families.

Summary of Corrective Action/Document Review

COA and **DHMP** submitted a proposed CAP in June 2019. HSAG and the Department reviewed and approved the proposed plan and responded to **COA** and **DHMP**. **COA** and **DHMP** submitted initial documents as evidence of completion of one corrective action in September 2019 and documents as evidence of completion of the remainder of the CAP in November 2019. Following review by HSAG and the Department, **COA** and **DHMP** were required to resubmit additional documentation and were given until January 6, 2020, to resubmit documents as evidence of completion for two outstanding **DHMP** proposed interventions.

Summary of Continued Required Actions

As of the date of this FY 2019–2020 compliance report, **DHMP** had two continued required actions pending review of CAP documents resubmitted by **COA** and **DHMP**. HSAG will review **COA** and **DHMP**'s CAP resubmission with the Department and work with the health plan to ensure full implementation of all corrective actions.

Appendix G1. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Compliance Monitoring Tool
for Denver Health Medical Plan (COA Region 5 MCO)

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor ensures that the services are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished. *42 CFR 438.210(a)(3)(i)* R5 MCO Contract: Exhibit M-2—14.4.2	• Utilization Review Determinations Including Approvals and Action- Pg. 5 (F)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42 CFR 438.210(a)(3)(ii)* R5 MCO Contract: Exhibit M-2—14.4.4	• Utilization Review Determinations Including Approvals and Action- Pg. 5 (D)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
3. The Contractor may place appropriate limits on services— • On the basis of criteria applied under the Medicaid State plan (such as medical necessity). • For the purpose of utilization control, provided that the services furnished can reasonably achieve their purpose. *42 CFR 438.210(a)(4)* R5 MCO Contract: Exhibit M-2—14.4.5, 14.4.5.1-2	• Utilization Review Determinations Including Approvals and Action- Pg. 5 (E)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. The RAE defines medical necessity for services as a program, good, or service that: • Will or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all.	• Utilization Review Determinations Including Approvals and Action- Pg. 3, under Definitions • Member Handbook- Pg. 5 under Definition for Medically Necessary	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Is provided in accordance with generally accepted professional standards for health care in the United States. • Is clinically appropriate in terms of type, frequency, extent, site, and duration. • Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider. • Is delivered in the most appropriate setting(s) required by the client's condition. • Is not experimental or investigational. • Is not more costly than other equally effective treatment options. *42 CFR 438.210(a)(5)* R5 MCO Contract: Exhibit M-2—2.1.69 10 CCR 2505-10 8.076.1.8		
5. The Contractor and its subcontractors have in place and follow written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42 CFR 438.210(b)(1)* R5 MCO Contract: Exhibit M-2—14.6.2	• Utilization Review Determinations Including Approvals and Action	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
6. The Contractor and its subcontractors have in place and follow written policies and procedures that include mechanisms to ensure consistent application of review criteria for authorization decisions. *42 CFR 438.210(b)(2)(i)* R5 MCO Contract: Exhibit M-2—None	• Inter-Rater Reliability of Utilization Management- Pg. 1	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor and its subcontractors have in place and follow written policies and procedures to consult with the requesting provider for medical services when appropriate. *42 CFR 438.210(b)(2)(ii)* R5 MCO Contract: Exhibit M-2—14.6.2.5	• Utilization Review Determinations Including Approvals and Action- Pg. 8 (B.1.c)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. The Contractor ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the member's medical or BH needs. *42 CFR 438.210(b)(3)* R5 MCO Contract: Exhibit M-2—14.4.6	• Utilization Review Determinations Including Approvals and Action- Pg. 5 (C)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor notifies the requesting provider and gives the member written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. *42 CFR 438.210(c)* R5 MCO Contract: Exhibit M-2—8.7.13.6 10 CCR 2505-10 8.209.4.A.1	• Utilization Review Determinations Including Approvals and Action- Pg. 11 (C.2.a)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. The Contractor adheres to the following time frames for making standard and expedited authorization decisions: • For standard authorization decisions—as expeditiously as the member's condition requires and not to exceed 10 calendar days following the receipt of the request for service. • If the provider indicates, or the Contractor determines, that following the standard time frames could seriously jeopardize the	• Utilization Review Determinations Including Approvals and Action- Pg. 6 (A.1.b.i & ii), Pg. 7 (A.2.a.i & ii), Pg. 7 (A.4.a) • UM Prior Authorization Request Form 2019	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
member's life or health, or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service. *42 CFR 438.210(d)(1–2)* R5 MCO Contract: Exhibit M-2—8.6.6, 8.6.8 10 CCR 2505-10 8.209.4.A.3(c)		
11. The Contractor may extend the time frame for making standard or expedited authorization decisions by up to 14 additional calendar days if: • The member or the provider requests an extension, or • The Contractor justifies a need for additional information and how the extension is in the member's interest. *42 CFR 438.210(d)(1)(i–ii) and (d)(2)(ii)* R5 MCO Contract: Exhibit M-2—8.6.6.1, 8.6.8.1	• Utilization Review Determinations Including Approvals and Action- Pg. 7 (A.1.iii) (A.4.b.i.A&B)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The notice of adverse benefit determination must be written in language easy to understand, available in prevalent non-English languages in the region, and available in alternative formats for persons with special needs. *42 CFR 438.404(a)* *42 CFR 438.10 (c)* R5 MCO Contract: Exhibit M-2—8.6.1-8.6.1.4 10 CCR 2505-10 8.209.4.A.1	• Utilization Review Determinations Including Approvals and Action- Pg. 11 (C.2.b) • Attachment G - Medicaid Medical Necessity Denial Letter • Creation- Review and Readability of Member Materials	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to and copies of all documents and records relevant to the adverse benefit determination (includes medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits). • The member's right to request one level of appeal with the Contractor and the procedures for doing so. • The date the appeal is due. • The member's right to request a State fair hearing after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State fair hearing. • The circumstances under which an appeal process can be expedited and how to make this request. • The member's rights to have benefits/services continue (if applicable) pending the resolution of the appeal, how to request that benefits continue, and the circumstances (consistent with State policy) under which the member may be required to pay the cost of these services. *42 CFR 438.404(b)(1–6)* R5 MCO Contract: Exhibit M-2—8.6.1.5-8.6.1.12 10 CCR 2505-10 8.209.4.A.2	• Utilization Review Determinations Including Approvals and Action- Pg. 11 (C.3.a.i-ix) • Attachment G - Medicaid Medical Necessity Denial Letter	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The Utilization Determinations policy, as well as the two template NABD letters—one for claims and one for denials of medical necessity—addressed all required content areas. However, the Medicaid Medical Necessity Denial Letter included several inaccuracies in the content of the appeal, SFH, and continuation of benefits information, specifically: • Must file the appeal by **the date listed on the NABD letter** (the only date listed on the letter is the date the NABD was sent; the date for filing an appeal is 60 calendar days after the NABD). • **Will continue services** during your appeal if: you **file your appeal** by the **date listed on your NABD** letter (member must request *continued benefits* within 10 days of the NABD or intended effective date of the proposed adverse benefit determination; member still has 60 days from date on NOBD to file the appeal). • Will keep giving you these services until: **the time period of a previously authorized service has been met** (this criterion has been removed from federal regulations and is no longer applicable). • May request an **SFH** within **120 days of the NABD letter** (may request an SFH within 120 days of the Appeal Resolution Letter). Due to the inaccuracies in content of the Medicaid Medical Necessity Denial Letter, HSAG scored 8 of 10 denial record reviews *Not Met* for required content of the NABD. The information in the content of the Medicaid Adverse Benefit Determination Letter (used for claims denials) was accurate in its entirety.		
Required Actions: DHMP must correct the inaccuracies noted in the required content of the Medicaid Medical Necessity Denial Letter.		
14. The Contractor mails the notice of adverse benefit determination within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, as defined in 42 CFR 431.211, 431.213 and 431.214 (see below). • For denial of payment, at the time of any denial affecting the claim. • For standard service authorization decisions that deny or limit services, within 10 calendar days following the receipt of the request for service.	• Utilization Review Determinations Including Approvals and Action- Pg. 12 & 13	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• For expedited service authorization decisions, within 72 hours after receipt of the request for service. • For extended service authorization decisions, no later than the date the extension expires. • For service authorization decisions not reached within the required time frames, on the date the time frames expire. *42 CFR 438.404(c)* R5 MCO Contract: Exhibit M-2—8.6.3.1, 8.6.5-8.6.8 10 CCR 2505-10 8.209.4.A.3		
15. For reduction, suspension, or termination of a previously authorized Medicaid-covered service, the Contractor gives notice at least ten (10) days before the intended effective date of the proposed adverse benefit determination except: • The Contractor gives notice on or before the intended effective date of the proposed adverse benefit determination if: – The Agency has factual information confirming the death of a member. – The Agency receives a clear written statement signed by the member that he/she no longer wishes services or gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information. – The member has been admitted to an institution where he/she is ineligible under the plan for further services. – The member's whereabouts are unknown, and the post office returns Agency mail directed to him/her indicating no forwarding address.	• Utilization Review Determinations Including Approvals and Action- Pg. 12	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– The Agency establishes that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth. – A change in the level of medical care is prescribed by the member's physician. – The notice involves an adverse benefit determination made with regard to the preadmission screening requirements. • If probable member fraud has been verified, the Contractor gives notice five (5) calendar days before the intended effective date of the proposed adverse benefit determination. *42 CFR 438.404(c)* *42 CFR 431.211* *42 CFR 431.213* *42 CFR 431.214* R5 MCO Contract: Exhibit M-2—8.6.3.1-8.6.3.2, 8.6.4.1-8.6.4.1.8 10 CCR 2505-10 8.209.4.A.3 (a)		
16. If the Contractor extends the time frame for standard authorization decisions, it must give the member written notice of the reason for the extension and inform the member of the right to file a grievance if he or she disagrees with that decision. *42 CFR 438.404(c)(4)* R5 MCO Contract: Exhibit M-2—8.6.6.2 10 CCR 2505-10 8.209.4.A.3 (c)(1)	• Utilization Review Determinations Including Approvals and Action- Pg. 9 (b)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The Contractor provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42 CFR 438.210(e)* R5 MCO Contract: Exhibit M-2—14.6.6	• Utilization Review Determinations Including Approvals and Action- Pg. 5 (H)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
18. The Contractor defines emergency medical condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part. *42 CFR 438.114(a)* R5 MCO Contract: Exhibit M-2—2.1.38	• Utilization Review Determinations Including Approvals and Action- Pg. 2 under Definitions • Member Handbook- Pg. 4	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
19. The Contractor defines emergency services as covered inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title and are needed to evaluate or stabilize an emergency medical condition. *42 CFR 438.114(a)* R5 MCO Contract: Exhibit M-2—2.1.39	• Utilization Review Determinations Including Approvals and Action- Pg. 2 under Definitions	☒ 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 poststabilization care services as covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or provided to improve or resolve the member's condition. *42 CFR 438.114(a)* R5 MCO Contract: Exhibit M-2—2.1.83	• Utilization Review Determinations Including Approvals and Action- Pg. 4 under Definitions	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
21. 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)* R5 MCO Contract: Exhibit M-2—14.2.1.2.1	• Utilization Review Determinations Including Approvals and Action- Pg. 6 (K & M) • Member Handbook- Pg. 4 under "Emergency Room Care" and "Emergency Services", Pg. 12 under "Getting an approval to see a specialist", Pg. 19 under Rights, Pg. 21 under "Emergency Care"	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
22. The Contractor may not deny payment for treatment obtained under either of the following circumstances: • A member had an emergency medical condition, including cases in which the absence of immediate medical attention would *not* have had the following outcomes: – Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; – Serious impairment to bodily functions; or – Serious dysfunction of any bodily organ or part. *(Note: The Contractor bases its coverage decisions for emergency services on the severity of the symptoms at the time of presentation and covers emergency services when the presenting symptoms are of*	• Utilization Review Determinations Including Approvals and Action- Pg. 6 (K&L)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. 42 CFR 438.114—Preamble) • A representative of the Contractor's organization instructed the member to seek emergency services. *42 CFR 438.114(c)(1)(ii)* R5 MCO Contract: Exhibit M-2—14.2.1.2.1.2		
23. The Contractor does not: • Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms. • Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent failing to notify the member's primary care provider or the Contractor of the member's screening and treatment within 10 calendar days of presentation for emergency services. *42 CFR 438.114(d)(1)* R5 MCO Contract: Exhibit M-2—14.2.1.2.1.3, 14.2.1.4.1	• Utilization Review Determinations Including Approvals and Action- Pg.6 (N&O)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
24. 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)* R5 MCO Contract: Exhibit M-2—14.2.1.2.1.4	• Utilization Review Determinations Including Approvals and Action- Pg. 10 (B.4.c)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
25. 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)* R5 MCO Contract: Exhibit M-2—14.2.1.2.1.5	• Concurrent Utilization Management of Inpatient and Observation Stays- Pg. 4&5 (2.h) • Utilization Review Determinations Including Approvals and Action- Pg. 10 (B.4.d&e)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
26. The Contractor is financially responsible for poststabilization services that are prior authorized by an in-network provider or Contractor representative, regardless of whether they are provided within or outside the Contractor's network of providers. *42 CFR 438.114(e)* *42 CFR 422.113(c)(i)* R5 MCO Contract: Exhibit M-2—14.2.1.2.1.6	• Concurrent Utilization Management of Inpatient and Observation Stays- Pg. 4 (2.c) • Utilization Review Determinations Including Approvals and Action- Pg. 10 (B.4.e&f)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
27. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition within one (1) hour of a request to the organization for pre-approval of further poststabilization care services. *42 CFR 438.114(e)* *42 CFR 422.113(c)(ii)* R5 MCO Contract: Exhibit M-2—14.2.1.2.1.7	• Concurrent Utilization Management of Inpatient and Observation Stays- Pg. 4 (2.d) • Utilization Review Determinations Including Approvals and Action- Pg. 10 (B.4.e&f)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
28. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the member's stabilized condition if: • The organization does not respond to a request for pre-approval within 1 hour. • The organization cannot be contacted. • The organization's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the organization must give the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with care of the patient until a plan provider is reached or one of the criteria in 422.113(c)(3) is met. *42 CFR 438.114(e)* *42 CFR 422.113(c)(iii)* R5 MCO Contract: Exhibit M-2—14.2.1.2.1.7	• Concurrent Utilization Management of Inpatient and Observation Stays- Pg. 4 (2.d) • Utilization Review Determinations Including Approvals and Action- Pg. 10 (B.4.f) • Member Handbook- Pg. 22 under "Post Stabilization Care"	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
29. The Contractor's financial responsibility for poststabilization care services it has not pre-approved ends when: • A plan physician with privileges at the treating hospital assumes responsibility for the member's care, • A plan physician assumes responsibility for the member's care through transfer, • A plan representative and the treating physician reach an agreement concerning the member's care, or • The member is discharged.	• Concurrent Utilization Management of Inpatient and Observation Stays- Pg. 4 (2.e) • Utilization Review Determinations Including Approvals and Action- Pg. 10 (B.4.g) • Member Handbook- Pg. 22 under "Post Stabilization Care"	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.114(e) *42 CFR 422.113(c)(3)* R5 MCO Contract: Exhibit M-2—14.2.1.2.1.8		
30. If the member receives poststabilization services from a provider outside the Contractor's network, the Contractor does not charge the member more than he or she would be charged if he or she had obtained the services through an in-network provider. *42 CFR 438.114(e)* *42 CFR 422.113(c)(iv)* R5 MCO Contract: Exhibit M-2—14.2.1.2.1.7.4	• Concurrent Utilization Management of Inpatient and Observation Stays- Pg. 5 (2.j) • Member Handbook- Pg. 22 under "Post-Stabilization Care"	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	29	X	1.00	=	29
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	30	**Total Score**		=	29
Total Score ÷ Total Applicable						=	97%

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor maintains and monitors a network of providers sufficient to provide access to all covered services to all members, including those with limited English proficiency or physical or mental disabilities. The provider network includes the following provider types and areas of expertise: • Adult primary care providers • Pediatric primary care providers • OB/GYNs • Family planning providers • Gerontologists • Internal medicine providers • Physician specialists *42 CFR 438.206(b)(1)* R5 MCO Contract: Exhibit M-2—9.4.1.1, 9.4.1.3	• Provider Contract Template- Under section 3.14 • Provider Manual- Pg. 9 • DHMC Network Adequacy Plan SFY19 • DHMC Network Adequacy SFY19 Q4	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. In establishing and maintaining the network adequacy standards, the Contractor considers: • The anticipated Medicaid enrollment. • The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the Contractor's service area. • The numbers, types, and specialties of network providers required to furnish the contracted Medicaid services. • The number of network providers accepting/not accepting new Medicaid members.	• DHMC Network Adequacy Plan SFY19 • Member Handbook- Pg. 8 highlights the use of MyChart as another electronic avenue, Pg. 21 & 39 highlights the Nurseline • Access to Care- Pg. 2 • Provider Manual- Pg. 54 • Provider Directory Tips Provider Directory Screenshot- the searchable Provider Directory displays provider information like location and specialty as well as languages they speak. Member can also search by language specifically to find a provider that they can communicate with. All	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The geographic location of providers in relationship to where Medicaid members live, considering distance, travel time, and means of transportation used by members. • The ability of providers to communicate with limited-English-proficient members in their preferred language. • The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for members with physical or mental disabilities. • The availability of triage lines or screening systems, as well as use of telemedicine, e-visits, and/or other technology solutions. *42 CFR 438.206(a); 438.68(c)(i)–(ix)* R5 MCO Contract: Exhibit M-2—9.4.1.1-6, 9.4.1.9	DHMC clinics have access to the Language Line which connects interpreters with providers and members.	
3. The Contractor ensures that its provider network complies with time and distance standards as follows: • Adult primary care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Pediatric primary care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Obstetrics or gynecology:	• GeoAccess Medicaid Pharmacies • Access to Care and Service Standards- Pg. 3. Obstetrics and gynecology are considered specialists in this policy. • DHMC Network Adequacy SFY19 Q4- Pg. 7. DHMC counties are all considered Urban counties. If a member is having an emergency, DHMC will pay for their care at any hospital. • Member Handbook- Pg. 21 shows all emergency or urgent care is covered in or out of network, Pg. 21 describes emergency care	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Specialists—adult and pediatric: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Pharmacy: – Urban counties—10 miles or 10 minutes – Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes • Acute care hospitals: – Urban counties—20 miles or 20 minutes – Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes *42 CFR 438.206(a); 438.68(b)* R5 MCO Contract: Exhibit M-2— 9.3.8	• DHMC Network Adequacy Plan SFY19 **DHMC contracts with a number of providers to increase access. Contracts are available upon request.	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor provides female members with direct access to a women's health care specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health care specialist. *42 CFR 438.206(b)(2)* R5 MCO Contract: Exhibit M-2—9.2.8.3.2	• Provider Contract Template- Pg. 4 • Member Handbook- Pg. 12 under "Getting an approval or referral to see a specialist" and Pg. 27 under "Women's Health Care" • Access to Care and Service Standards- Pg. 4 (C.7) & 6 (6)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. The Contractor provides for a second opinion from a network provider or arranges for the member to obtain one outside the network (if there is no qualified provider within the network), at no cost to the member. *42 CFR 438.206(b)(3)* R5 MCO Contract: Exhibit M-2—9.3.14	• Utilization Review Determinations Including Approvals and Action- Pg. 8 (A.1.a) • Member Handbook – Pg. 19 • Access to Care and Service Standards- Pg. 4 (C.8) • Provider Manual- Pg. 96, 104	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
6. If the provider network is unable to provide necessary covered services to a particular member in network, the Contractor must adequately and in a timely manner cover the services out of network for as long as the Contractor is unable to provide them. *42 CFR 438.206(b)(4)* R5 MCO Contract: Exhibit M-2—9.3.10	• Utilization Review Determinations Including Approvals and Action- Pg. 6 (I) • Access to Care and Service Standards- Pg. 4 (C.1)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
7. The Contractor requires out-of-network providers to coordinate with the Contractor for payment and ensures that the cost to the member is no greater that it would be if the services were furnished within the network. *42 CFR 438.206(b)(5)* R5 MCO Contract: Exhibit M-2—None	• OTA- Template • Member Handbook- Pg. 22 • Access to Care and Service Standards- Pg. 4 (C.2)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services. *42 CFR 438.206(b)(7)* R5 MCO Contract: Exhibit M-2—9.4.1.3.4	• DHMC Network Adequacy SFY19 Q4- Members do not require a referral for family planning but can be seen at a variety of provider types (PCP, OB/GYN, nurse practitioner, etc.). • Access to Care and Service Standards- Pg. 4 (C.7.d) • Member Handbook- Pg. 19	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor must meet, and require its providers to meet, the State standards for timely access to care and services, taking into account the urgency of the need for services. The Contractor ensures that services are available as follows: • Urgent care within 24 hours from the initial identification of need. • Non-urgent symptomatic care visit within 7 days after member request. • Well-care visit within 1 month after member request. • Outpatient follow-up appointments within 7 days after discharge from hospitalization. *42 CFR 438.206(c)(1)(i)* R5 MCO Contract: Exhibit M-2—9.3.9.1	• Member Handbook- Pg. 21 • DHMC Network Adequacy SFY19 Q4- shows appointment data for well care visits • Patient Discharge P&P- Pg 2 shows that providers set a discharge plan with follow up that is appropriate to member's condition for hospitalization follow up • Access to Care and Service Standards- Pg. 5 (D) • Provider Manual- Pgs 4&5 shows Provider responsibilities	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The DHMP fourth quarter *Network Adequacy Report* had analysis for percentage of primary and specialty appointments within 30 days. The member handbook informed members of all timely access standards and the *Access to Care and Services Standards* policy accurately depicted the timely access standards. While the report depicted the number of members that received inpatient hospitalizations, DHMP was unable to provide evidence of tracking to ensure compliance with the timeliness standards for non-urgent symptomatic care within seven days or an outpatient follow-up appointment within		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
seven days. Staff members reported during the on-site interview that no appointments are needed to receive urgent care services. Members may go to any urgent care center without an appointment or approval; therefore, tracking timeliness of urgent care appointments is not applicable.		
Required Actions: DHMP must develop a mechanism to track compliance with timely access to appointments for non-urgent symptomatic care and follow-up care following an inpatient hospitalization.		
10. The Contractor and its providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service. The Contractors network provides: • Minimum hours of provider operation from 8 a.m. to 5 p.m. Monday through Friday. • Extended hours on evenings and weekends. • Alternatives for emergency department visits for after-hours urgent care. *42 CFR 438.206(c)(1)(ii)* R5 MCO Contract: Exhibit M-2—9.3.2-9.3.4	• Provider Contract Template- Section 3.24 • DHMC Network Adequacy SFY19 Q4- shows clinics with extended and weekend hours • Member Handbook- shows the Nurseline that members can call as well as MyChart information if their issue can wait. • Access to Care and Service Standards- Pg. 6 (E.7) • DHMC Network Adequacy Plan SFY19	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11. The Contractor makes services included in the contract available 24 hours a day, 7 days a week, when medically necessary. *42 CFR 438.206(c)(1)(iii)* R5 MCO Contract: Exhibit M-2—9.3.7	• Provider Contract Template- Section 3.24 • Member Handbook- Pg. 21 • Access to Care and Service Standards- Pg. 4 (3.f, 3.h, 3.i), 5 (D)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor ensures timely access by: • Establishing mechanisms to ensure compliance with access (e.g., appointment) standards by network providers. • Monitoring network providers regularly to determine compliance. • Taking corrective action if there is failure to comply. *42 CFR 438.206(c)(1)(iv)–(vi)* R5 MCO Contract: Exhibit M-2—9.4.1.8	• Adult and Pediatric Guidelines • DHMC Network Adequacy SFY19 Q4- Pg. 9&10 shows appointment standards	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The *Network Adequacy Report* accurately depicted the timely appointment standards. DHMP provided evidence of reviewing timeliness of primary and specialty care appointments made through the Denver Health Call Center; however, DHMP did not have a mechanism to monitor compliance with timely access standards for its contracted organizational providers (University Physicians, Inc. and The Children's Hospital of Colorado).		
Required Actions: DHMP must develop a mechanism to monitor contracted providers regularly to ensure compliance with timely access standards and implement CAPs if the providers fail to comply.		
13. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. This includes: • Making written materials that are critical to obtaining services available in prevalent non-English languages. • Providing cultural and disability competency training programs, as needed, to network providers and health plan staff regarding: – Health care attitudes, values, customs and beliefs that affect access to and benefit from health care services.	• Evaluating Members Non-English Language Needs for Language Translation Services • Cultural and Linguistic Appropriate Services- Pg. 4-5 • Access to Care and Service Standards- Pg. 4 (3.j), 6 (F) • 2019 Annual - The Denver Health Experience- annual training modules that all DHMP staff, including providers, have to complete	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Medical risks associated with the member population's racial, ethnic, and socioeconomic conditions. • Identifying members whose cultural norms and practices may affect their access to health care. These efforts shall include, but are not limited to, inquiries conducted by the Contractor of the language proficiency of individual members. • Providing language assistance services for all Contractor interactions with members. *42 CFR 438.206(c)(2)* R5 MCO Contract: Exhibit M-2— 7.2.1-7.2.6		
14. The Contractor must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities. *42 CFR 438.206(c)(3)* R5 MCO Contract: Exhibit M-2—9.1.5.5, 9.4.1.2	• Provider Contract Template- Under section 3.14 • Provider Directory Tips- highlights all Accessibility at each DHMC clinic	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
15. The Contractor submits to the State (in a format specified by the State) documentation to demonstrate that the Contractor offers an appropriate range of preventive, primary care, and specialty services that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. • A Network Adequacy Plan is submitted to the State annually. • A Network Adequacy Report is submitted to the State quarterly. *42 CFR 438.207(b)* R5 MCO Contract: Exhibit M-2—9.4.1-9.4.4	• DHMC Network Adequacy SFY19 Q4 • DHMC Network Adequacy Plan SFY19	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard II—Access and Availability							
Total	Met	=	13	X	1.00	=	13
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	15	**Total Score**		=	13
			Total Score ÷ Total Applicable			=	87%

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an internal grievance and appeal system in place for members. A grievance and appeals system means the processes the Contractor implements to handle grievances and appeals of an adverse benefit determination, as well as processes to collect and track information about grievances and appeals. *42 CFR 438.400(b)* *42 CFR 438.402(a)* R5 MCO Contract: Exhibit M-2—8.1 10 CCR 2505-10—8.209.1	• Medicaid Appeal Policy and Procedure • Medicaid Grievance Policy and Procedure	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor defines adverse benefit determination as: • The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. • The reduction, suspension, or termination of a previously authorized service. • The denial, in whole, or in part, of payment for a service. • The failure to provide services in a timely manner, as defined by the State. • The failure to act within the time frames defined by the State for standard resolution of grievances and appeals. • The denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other member financial liabilities).	• Medicaid Appeal Policy and Procedure- Pg. 1 under Definitions	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.400(b) R5 MCO Contract: Exhibit M-2—2.1.3 10 CCR 2505-10—8.209.2.A		
3. The Contractor defines an appeal as a review by the Contractor of an adverse benefit determination. *42 CFR 438.400(b)* R5 MCO Contract: Exhibit M-2—2.1.5 10 CCR 2505-10—8.209.2.B	• Medicaid Appeal Policy and Procedure- Pg. 1 under Definitions	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. The Contractor defines a grievance as an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. A grievance includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision. *42 CFR 438.400(b)* R5 MCO Contract: Exhibit M-2—2.1.47, 8.6.6.2 10 CCR 2505-10—8.209.2.D, 8.209.4.A.3.c.(i)	• Medicaid Grievance Policy and Procedure- Pg. 2 under Definitions	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. The Contractor has provisions for who may file: • A member may file a grievance or a Contractor-level appeal and may request a State fair hearing. • With the member's written consent, a provider or authorized representative may file a grievance or a	• Medicaid Appeal Policy and Procedure- Pg. 2 under Department Protocols • Medicaid Grievance Policy and Procedure- Pg. 3 under Procedures	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contractor-level appeal and may request a State fair hearing on behalf of a member. *Note: Throughout this standard, when the term "member" is used it includes providers and authorized representatives (with the exception that providers cannot exercise the member's right to request continuation of benefits under 42 CFR 438.420).* *42 CFR 438.402(c)* R5 MCO Contract: Exhibit M-2—8.5.1, 8.7.5, 8.7.15.1		
6. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, as well as providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability. *42 CFR 438.406(a)* R5 MCO Contract: Exhibit M-2—8.3 10 CCR 2505-10 8.209.4.C	• Medicaid Appeal Policy and Procedure- Pg. 2 under Policy, Pg. 3 under How an Appeal is Filed • Medicaid Grievance Policy and Procedure- Pg. 1 under Scope, Pg. 3 under How a Grievance is Filed • Attachment K - Appeal Rights and State Fair Hearing Rights	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: DHMP's grievance and appeals policies and procedures addressed providing assistance to members with appeals and grievance forms and procedures. The appeals and SFH attachment to the Appeal Resolution Letter offered the member assistance with the SFH; however, the appeal information in the Medicaid Medical Necessity Denial Letter did not offer the member assistance with completion of appeals forms and procedures.		
Required Actions: DHMP must communicate in the NABD appeal information sent to members the offer of assistance in completing any forms or procedural steps related to an appeal.		

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who: • Were not involved in any previous level of review or decision-making nor a subordinate of any such individual. • Have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding any of the following: – An appeal of a denial that is based on lack of medical necessity. – A grievance regarding the denial of expedited resolution of an appeal. – A grievance or appeal that involves clinical issues. *42 CFR 438.406(b)(2)* R5 MCO Contract: Exhibit M-2—8.5.3, 8.7.4 10 CCR 2505-10 8.209.5.C, 8.209.4.E	• Medicaid Appeal Policy and Procedure- Pg. 6 under Appeal Decisions • Medicaid Grievance Policy and Procedure- Pg. 2 under Scope	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. The Contractor ensures that the individuals who make decisions on grievances and appeals: • Take into account all comments, documents, records, and other information submitted by the member or the member's representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. *42 CFR 438.406(b)(2)* R5 MCO Contract: Exhibit M-2—None	• Medicaid Appeal Policy and Procedure- Pg. 6 under Appeal Decisions • Medicaid Grievance Policy and Procedure- Pg. 4 under Grievance Resolution	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor accepts grievances orally or in writing. *42 CFR 438.402(c)(3)(i)* R5 MCO Contract: Exhibit M-2—8.5.3 10 CCR 2505-10—8.209.5.D	• Medicaid Grievance Policy and Procedure- Pg. 3 under How a Grievance is Filed	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. Members may file a grievance at any time. *42 CFR 438.402(c)(2)(i)* R5 MCO Contract: Exhibit M-2—8.5.3 10 CCR 2505-10—8.209.5.A	• Medicaid Grievance Policy and Procedure- Pg. 3 under How a Grievance is Filed	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11. The Contractor sends the member written acknowledgement of each grievance within two (2) working days of receipt. *42 CFR 438.406(b)(1)* R5 MCO Contract: Exhibit M-2—8.1 10 CCR 2505-10 8.209.5.B	• Medicaid Grievance Policy and Procedure- Pg. 4 under Acknowledgement of Grievance	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor must resolve each grievance and provide notice as expeditiously as the member's health condition requires, and within 15 working days of when the member files the grievance. • Notice to the member must be in a format and language that may be easily understood by the member. *42 CFR 438.408(a) and (b)(1) and (d)(1)* R5 MCO Contract: Exhibit M-2—8.5.4, 7.2.7.3, 7.2.7.5 10 CCR 2505-10 8.209.5.D	• Medicaid Grievance Policy and Procedure- Pg. 3 under Timeframes	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The written notice of grievance resolution includes: • Results of the disposition/resolution process and the date it was completed. R5 MCO Contract: Exhibit M-2—8.1 10 CCR 2505-10 8.209.5.G	• Attachment F - Grievance Disposition	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
14. The Contractor may have only one level of appeal for members. *42 CFR 438.402(b)* R5 MCO Contract: Exhibit M-2—None	• Medicaid Appeal Policy and Procedure	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
15. A member may file an appeal with the Contractor within 60 calendar days from the date on the adverse benefit determination notice. *42 CFR 438.402 (c)(2)(ii)* R5 MCO Contract: Exhibit M-2—8.7.5.1 10 CCR 2505 10 8.209.4.B	• Medicaid Appeal Policy and Procedure- Pg. 3 under Member Timely Filing Requirement	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
16. The member may file an appeal either orally or in writing, and must follow the oral request with a written, signed appeal (unless the request is for expedited resolution). *42 CFR 438.402(c)(3)(ii)* R5 MCO Contract: Exhibit M-2—8.7.5.2 10 CCR 2505-10 8.209.4.F	• Medicaid Appeal Policy and Procedure- Pg. 3 under How an Appeal is Filed	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The Contractor sends written acknowledgement of each appeal within two (2) working days of receipt, unless the member or designated client representative requests an expedited resolution. *42 CFR 438.406(b)(1)* R5 MCO Contract: Exhibit M-2—8.1 10 CCR 2505-10 8.209. 4.D	• Medicaid Appeal Policy and Procedure- Pg. 5 under Receipt and Processing of an Appeal	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
18. The Contractor's appeal process must provide: • That oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date). • That if the member orally requests an expedited appeal, the Contractor shall not require a written, signed appeal following the oral request. • That included, as parties to the appeal, are: – The member and his or her representative, or – The legal representative of a deceased member's estate. *42 CFR 438.406(b)(3) and (6)* R5 MCO Contract: Exhibit M-2—8.7.6, 8.7.7, 8.7.11 10 CCR 2505-10 8.209. 4.F, 8.209.4.I	• Medicaid Appeal Policy and Procedure- Pg. 3 under How an Appeal is Filed, Pg. 6 under Appeal Decisions	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
19. The Contractor's appeal process must provide: • The member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. (The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution time frame in the case of expedited resolution.) • The member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional documents considered, relied upon, or generated by the Contractor in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame. *42 CFR 438.406(b)(4-5)* R5 MCO Contract: Exhibit M-2—8.7.8-8.7.10 10 CCR 2505-10 8.209. 4.G, 8.209.4.H	• Medicaid Appeal Policy and Procedure- Pg. 6 under Appeal Decisions	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
20. The Contractor maintains an expedited review process for appeals when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life; physical or mental health; or ability to attain, maintain, or regain maximum function. The Contractor's expedited review process includes that: • The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. *42 CFR 438.410(a–b)*	• Medicaid Appeal Policy and Procedure- Pg. 4 under When to file an Appeal versus the Standard Resolution Process.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
R5 MCO Contract: Exhibit M-2—8.7.14.2.1, 8.7.12 10 CCR 2505-10 8.209.4.Q-R		
21. If the Contractor denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the time frame for standard resolution. • Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and within two (2) calendar days provide the member written notice of the reason for the decision and inform the member of the right to file a grievance if he or she disagrees with that decision. *42 CFR 438.410(c)* R5 MCO Contract: Exhibit M-2—8.7.14.2.2 10 CCR 2505-10 8.209.4.S	• Medicaid Appeal Policy and Procedure- • Attachment E - Notice of Expedited Resolution Denial	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: DHMP's policy and procedures accurately described processes related to handling a denied request for an expedited appeal. The template letter to members—Notice of Expedited Resolution Denial—communicated to the member the process for handling the denied expedited appeal and the member's right to file a grievance; however, it failed to demonstrate that the reason for the denial was included in the letter.		
Required Actions: DHMP must ensure that the written notice to the member regarding denial of an expedited appeal includes the reason for the denial.		

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
22. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)* *42 CFR 438.408(d)(2)* *42 CFR 438.10* R5 MCO Contract: Exhibit M-2—8.7.14.1, 7.2.7.3, 7.2.7.5 10 CCR 2505-10 8.209.4.J.1	• Medicaid Appeal Policy and Procedure- Pg. 4 under Timeframes • Attachment J - Appeal Resolution Adverse to Member • Attachment I - Appeal Resolution In Favor of Member	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: DHMP's procedures and on-site review of appeal records demonstrated compliance with the 10-day resolution time frame and, in most cases, that appeal resolution notices were written in language easy for the member to understand. However, HSAG identified in appeal record reviews one resolution letter in which the reason for the decision used medical acronyms that were not defined for the member.		
Required Actions: DHMP must ensure that the text description entered into the Appeal Resolution Letter to the member is written in language easy for the member to understand. HSAG recommends that DHMP consider having a non-clinical staff member review the letter prior to distribution to ensure that the information is easy for a member to understand.		

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
23. For expedited appeal, the Contractor must resolve the appeal and provide written notice of disposition to affected parties within 72 hours after the Contractor receives the appeal. • For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. *42 CFR 438.408(b)(3) and (d)(2)(ii)* R5 MCO Contract: Exhibit M-2— 8.7.14.2.3, 8.7.14.2.6 10 CCR 2505-10 8.209.4.J.2, 8.209.4.L	• Medicaid Appeal Policy and Procedure- Pg. 4 under Expedited.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
24. The Contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: • The member requests the extension; or • The Contractor shows (to the satisfaction of the Department, upon request) that there is need for additional information and how the delay is in the member's interest. *42 CFR 438.408(c)(1)* R5 MCO Contract: Exhibit M-2— 8.5.6, 8.7.14.2, 8.7.14.2.4 10 CCR 2505-10 8.209.4.K, 8.209.5.E	• Medicaid Appeal Policy and Procedure- Pg. 4 under Extension of Timeframes • Medicaid Grievance Policy and Procedure- Pg. 3 under Extension of Timeframes • Attachment D - Extension of Time Notification for an Appeal • Attachment D - Grievance Disposition Timeframe Extension	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
25. If the Contractor extends the time frames, it must—for any extension not requested by the member: • Make reasonable efforts to give the member prompt oral notice of the delay. • Within two (2) calendar days, give the member written notice of the reason for the delay and inform the member	• Medicaid Appeal Policy and Procedure- Pg. 4 under Extension of Timeframes • Medicaid Grievance Policy and Procedure- Pg. 3 under Extension of Timeframes • Attachment D - Extension of Time Notification for an Appeal	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
of the right to file a grievance if he or she disagrees with that decision. • Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. *42 CFR 438.408(c)(2)* R5 MCO Contract: Exhibit M-2—8.5.7, 8.7.14.1, 8.7.14.2.1, 8.7.14.2.5-6	• Attachment D - Grievance Disposition Timeframe Extension	
26. The written notice of appeal resolution must include: • The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. – The right to request that benefits/services continue* while the hearing is pending, and how to make the request. – That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's adverse benefit determination. **Continuation of benefits applies only to previously authorized services for which the Contractor provides 10-day advance notice to terminate, suspend, or reduce.* *42 CFR 438.408(e)* R5 MCO Contract: Exhibit M-2—8.7.14.3, 8.7.14.4 10 CCR 2505-10 8.209.4.M	• Attachment J - Appeal Resolution Adverse to Member • Attachment I - Appeal Resolution In Favor of Member • Attachment K - Appeal Rights and State Fair Hearing Rights	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: DHMP's Appeal Resolution Letter included all required information; however, the attachment to the letter describing the SFH process also referenced appeals and stated that the member "may file an appeal, a quick appeal, or a State fair hearing." At the point the member is receiving an Appeal Resolution Letter, the member's appeal rights are exhausted and the only option at that point is an SFH. The resolution letter inaccurately included reference to appeals, resulting in 7 of 10 record reviews being scored *Not Met* for "resolution letter includes required content."		
Required Actions: DHMP must revise the content of the attachment to the Appeal Resolution Letter to omit references to appeal processes.		
27. The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of resolution. • If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. *42 CFR 438.408(f)(1–2)* R5 MCO Contract: Exhibit M-2—8.7.15.1, 8.7.15.2 10 CCR 2505-10 8.209.4.N and O	• Attachment K - Appeal Rights and State Fair Hearing Rights	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
28. The parties to the State fair hearing include the Contractor as well as the member and his or her representative or the representative of a deceased member's estate. *42 CFR 438.408(f)(3)* R5 MCO Contract: Exhibit M-2—8.7.15.3	• Medicaid Appeal Policy and Procedure- Pg. 8 under State Fair Hearings	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
29. The Contractor provides for continuation of benefits/services (when requested by the member) while the Contractor-level appeal and the State fair hearing are pending if: • The member files in a timely manner* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the Contractor mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal in accordance with required time frames. ** This definition of timely filing only applies for this scenario—i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced. (Note: The provider may not request continuation of benefits on behalf of the member.)* *42 CFR 438.420(a) and (b)* R5 MCO Contract: Exhibit M-2—8.7.13.1 10 CCR 2505-10 8.209.4.T	• Attachment K - Appeal Rights and State Fair Hearing Rights • Medicaid Appeal Policy and Procedure- Pg. 8 under Continuation of Benefits Pending Appeal or State Fair Hearing Decision	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: DHMP's appeal policy and procedures accurately addressed all of the circumstances for the provision of continued benefits during an appeal or SFH and the *Appeal Rights and State Fair Hearing Rights* attachment to the Appeal Resolution Letter communicated to the member the required time frame for the member to request continued benefits of previously approved services during an SFH. However, the Medicaid Medical Necessity Determination Letter, used to communicate information regarding appeals, inaccurately informed the member of the time frame for requesting continued benefits during an appeal.		
Required Actions: DHMP must correct the information sent to the member regarding how to request continued benefits during an *appeal* to include the required time frame—on or before the latter of 10 days after the health plan mails the NABD or the intended effective date of the adverse benefit determination—for requesting continued benefits.		
30. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of the following occurs: • The member withdraws the appeal or request for a State fair hearing. • The member fails to request a State fair hearing and continuation of benefits within 10 calendar days after the Contractor sends the notice of an adverse resolution to the member's appeal. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR 438.420(c)* R5 MCO Contract: Exhibit M-2—8.7.13.2 10 CCR 2505-10 8.209.4.U	• Medicaid Appeal Policy and Procedure- Pg. 9 under Continuation of Benefits Pending Appeal or State Fair Hearing Decision • Attachment K - Appeal Rights and State Fair Hearing Rights	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
31. Member responsibility for continued services: • If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's adverse benefit determination, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. *42 CFR 438.420(d)* R5 MCO Contract: Exhibit M-2—8.7.13.3 10 CCR 2505-10 8.209.4.V	• Medicaid Appeal Policy and Procedure- Pg. 9 under Continuation of Benefits Pending Appeal or State Fair Hearing Decision • Attachment K - Appeal Rights and State Fair Hearing Rights	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
32. If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services as promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. *42 CFR 438.424(a)* R5 MCO Contract: Exhibit M-2—8.7.13.4 10 CCR 2505-10 8.209.4.W	• Medicaid Appeal Policy and Procedure- Pg. 9 under Continuation of Benefits Pending Appeal or State Fair Hearing Decision • Attachment K - Appeal Rights and State Fair Hearing Rights	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
33. If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the Contractor must pay for those services. *42 CFR 438.424(b)* R5 MCO Contract: Exhibit M-2—8.7.13.5	• Medicaid Appeal Policy and Procedure- Pg. 9 under Continuation of Benefits Pending Appeal or State Fair Hearing Decision	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10 CCR 2505-10 8.209.4.X	• Attachment K - Appeal Rights and State Fair Hearing Rights	
34. The Contractor maintains records of all grievances and appeals. The records must be accurately maintained in a manner accessible to the State and available on request to CMS. • The record of each grievance and appeal must contain, at a minimum, all of the following information: – A general description of the reason for the grievance or appeal. – The date received. – The date of each review or, if applicable, review meeting. – Resolution at each level of the appeal or grievance. – Date of resolution at each level, if applicable. – Name of the person for whom the appeal or grievance was filed. • The Contractor quarterly submits to the Department a Grievance and Appeals report including this information. *42 CFR 438.416* R5 MCO Contract: Exhibit M-2—8.9.1-8.9.1.6 10 CCR 2505-10 8.209.3.C	• DHMC Grievance and Appeal SFY19 Q3- the template used in the beginning of 2019 • Grievance and Appeal I_DHMP Q4SFY19- the updated template from HCPF for G&A reporting • Grievance and Appeal II_DHMP Q4SFY19- same as above	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
35. The Contractor provides the information about the grievance, appeal, and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals.	• Provider Manual 2019- Pg. 54 • Provider Contract Template	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. – The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member. *42 CFR 438.414* *42 CFR 438.10(g)(xi)* R5 MCO Contract: Exhibit M-2—8.4 10 CCR 2505-10 8.209.3.B		

Findings:
DHMP's provider manual, distributed to providers at the time of contracting, included extensive information regarding the grievance and appeals processes; however, the information in the provider manual inadequately addressed the following:

- The text description of how to file a grievance did not describe the time frame for filing (i.e., at any time).
- The description of how to file an appeal stated that if a Medicaid member verbally requests an appeal, it will not be processed until written receipt of the appeal and receipt of related documents. HSAG finds this information misleading in that "related documents" is not defined and receipt of related documents is not required for processing an appeal (in addition, per regulation, the date of an oral appeal request establishes the date of filing for meeting the time frames for resolving an appeal).

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The information regarding continuation of benefits incompletely described the circumstances for continuing benefits during an appeal, including that: continuation of benefits applies only to services previously approved and then denied or reduced, continuation of services must be requested by the member (not the provider), and continuation of benefits must be requested within 10 days of the NABD.		
Required Actions: DHMP must update the provider manual to adequately describe all requirements and time frames for filing grievances and appeals and circumstances applicable to the continuation of benefits during an appeal or SFH.		

Results for Standard VI—Grievances and Appeals							
Total	Met	=	29	X	1.00	=	29
	Partially Met	=	6	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	35	**Total Score**		=	29
				Total Score ÷ Total Applicable		=	83%

Appendix G2. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Denials Record Review Tool
for Denver Health Medical Plan (COA Region 5 MCO)

Review Period:	January 1, 2019–December 31, 2019
Date of Review:	January 8, 2020
Reviewer:	Kathy Bartilotta
Participating Plan Staff Member(s):	Christina Porter, Corie Culter, Lisa Artale Bross, Josh Holte

Requirements	File 1	File 2	File 3	File 4	File 5
Member ID	****	****	****	****	****
Date of initial request	12/14/18	2/22/19	5/28/19	6/6/19	6/12/19
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	CL	NR	NR	NR	NR
(Standard [S], Expedited [E], or Retrospective [R])	R	R	E	R	R
Date notice of adverse benefit determination (NABD) sent	1/7/19	3/22/19	5/29/19	6/14/19	7/11/19
Notice sent to provider and member? (M or NM)*	M	M	M	M	M
Number of days for decision/notice	24	28	1	8	29
Notice sent within required time frame? (M or NM) (S = 10 Cal days after; E = 72 hours after; T = 10 Cal days before)*	M	M	M	M	M
Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
If extended, extension notification sent to member? (M, NM, or NA)*	NA	NA	NA	NA	NA
If extended, extension notification includes required content? (M, NM, or NA)*	NA	NA	NA	NA	NA
NABD includes required content? (M or NM)*	M	NM	NM	NM	NM
Authorization decision made by qualified clinician? (M, NM, or NA)*	NA	NA	M	NA	NA
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (M, NM, or NA)*	NA	NA	NA	NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (M or NM)*	M	M	M	M	M
Was correspondence with the member easy to understand? (M or NM)*	M	M	M	M	M
Total Applicable Elements	**5**	**5**	**6**	**5**	**5**
Total Met Elements	**5**	**4**	**5**	**4**	**4**
Score (Number Met / Number Applicable) = %	**100%**	**80%**	**83%**	**80%**	**80%**

***** = Reference Denial Record Review Instructions for Corresponding Requirement in Compliance Monitoring Tool

M = Met, **NM** = Not Met, **NA** = Not Applicable, **Cal** = Calendar, **Y** = Yes, **N** = No (Yes and No = not scored—informational only)

**** = Redacted Member ID

Comments:

File 1: Claim processed on December 14, 2018 and was denied and notice sent on January 7, 2019. Per DHMP policy, retrospective (post-service) review determinations require notice sent 30 days from request.

File 2: This was a partially retrospective request received during member's stay in a skilled nursing facility (SNF). Request for authorization was February 22, 2019, for services already being provided by SNF. Services rendered prior to receipt of request were administratively denied due to "no prior authorization and not a covered benefit" (durable medical equipment [DME] in SNF). Per DHMP policy, retrospective (post-service) review determinations require notice sent 30 days from request. The appeal information in the NABD included inaccurate information in required content.

File 3: The medical reviewer determined services could be provided in network. The case was denied for "OON services." The appeal information in the NABD included inaccurate information in required content.

File 4: This was a retrospective request. Request for authorization was June 6, 2019, for services provided May 24, 2019. Services were administratively denied due to "no prior authorization for OON services." Per DHMP policy, retrospective (post-service) review determinations require notice sent 30 days from request. The appeal information in the NABD included inaccurate information in required content.

File 5: This was a retrospective request. Request for authorization was June 12, 2019, for services provided February 28, 2019. Services were administratively denied due to "no prior authorization for OON services." Per DHMP policy, retrospective (post-service) review determinations require notice sent 30 days from request. The appeal information in the NABD included inaccurate information in required content.

Appendix G2. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Denials Record Review Tool
for Denver Health Medical Plan (COA Region 5 MCO)

Requirements	File 6	File 7	File 8	File 9	File 10
Member ID	****	****	****	****	****
Date of initial request	Omit	9/30/19	10/23/19	11/1/19	Omit
What type of denial? (Termination [T], New Request [NR], or Claim [CL])		NR	NR	CL	
(Standard [S], Expedited [E], or Retrospective [R])		R	S	R	
Date notice of adverse benefit determination (NABD) sent		10/4/19	10/31/19	11/8/19	
Notice sent to provider and member? (M or NM)*		M	M	M	
Number of days for decision/notice		4	8	7	
Notice sent within required time frame? (M or NM) (S = 10 Cal days after; E = 72 hours after; T = 10 Cal days before)*		M	M	M	
Was authorization decision timeline extended? (Y or N)		N	N	N	
If extended, extension notification sent to member? (M, NM, or NA)*		NA	NA	NA	
If extended, extension notification includes required content? (M, NM, or NA)*		NA	NA	NA	
NABD includes required content? (M or NM)*		NM	NM	M	
Authorization decision made by qualified clinician? (M, NM, or NA)*		NA	NA	NA	
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (M, NM, or NA)*		NA	NA	NA	
Was the decision based on established authorization criteria (i.e., not arbitrary)? (M or NM)*		M	M	M	
Was correspondence with the member easy to understand? (M or NM)*		M	M	M	
Total Applicable Elements		**5**	**5**	**5**	
Total Met Elements		**4**	**4**	**5**	
Score (Number Met / Number Applicable) = %		**80%**	**80%**	**100%**	

***** = Reference Denial Record Review Instructions for Corresponding Requirement in Compliance Monitoring Tool

M = Met, **NM** = Not Met, **NA** = Not Applicable, **Cal** = Calendar, **Y** = Yes, **N** = No (Yes and No = not scored—informational only)

**** = Redacted Member ID

Comments:

File 6: Medicaid was the secondary payor; primary payor paid services in full. No services were required to be paid or reviewed by Medicaid. This record was erroneously included in the sample universe.

File 7: This was a retrospective request. Request for authorization was September 30, 2019, for services provided September 23, 2019. Services were administratively denied due to "no prior authorization for OON services." Per DHMP policy, retrospective (post-service) review determinations require notice sent 30 days from request. The appeal information in the NABD included inaccurate information in required content.

File 8: This was a standard authorization request for physical therapy services provided from October 17, 2019, through January 1, 2020. Although the initial request was submitted October 18, it included inaccurate member identifying information (birthday) and had to be corrected and resubmitted. A valid request was received October 23. Therefore, this was a partially retrospective request for services already being delivered. Services rendered October 17 through October 22 were administratively denied due to "no prior authorization"; services requested from October 23, 2019, through January 1, 2020 were approved. The appeal information in the NABD included inaccurate information in required content.

File 9: Claim processed on November 7 was denied due to "no authorization for OON services." Notice sent on November 8.

File 10: Medicaid was the secondary payor; primary payor paid services in full. No services were required to be paid or reviewed by Medicaid. This record was erroneously included in the sample universe.

Requirements	OS 1	OS 2	OS 3	OS 4	OS 5
Member ID	****	****			
Date of initial request	3/6/19	6/6/19			
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	NR			
(Standard [S], Expedited [E], or Retrospective [R])	R	S			
Date notice of adverse benefit determination (NABD) sent	4/5/19	6/14/19			
Notice sent to provider and member? (M or NM)*	M	M			
Number of days for decision/notice	30	8			
Notice sent within required time frame? (M or NM) (S = 10 Cal days after; E = 72 hours after; T = 10 Cal days before)*	M	M			
Was authorization decision timeline extended? (Y or N)	N	N			
If extended, extension notification sent to member? (M, NM, or NA)*	NA	NA			
If extended, extension notification includes required content? (M, NM, or NA)*	NA	NA			
NABD includes required content? (M or NM)*	NM	NM			
Authorization decision made by qualified clinician? (M, NM, or NA)*	NA	M			
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (M, NM, or NA)*	NA	NA			
Was the decision based on established authorization criteria (i.e., not arbitrary)? (M or NM)*	M	M			
Was correspondence with the member easy to understand? (M or NM)*	M	M			
Total Applicable Elements	**5**	**6**			
Total Met Elements	**4**	**5**			
Score (Number Met / Number Applicable) = %	**80%**	**83%**			

***** = Reference Denial Record Review Instructions for Corresponding Requirement in Compliance Monitoring Tool

M = Met, **NM** = Not Met, **NA** = Not Applicable, **Cal** = Calendar, **Y** = Yes, **N** = No (Yes and No = not scored—informational only)

**** = Redacted Member ID

Comments:

File OS1: This was a retrospective request. Request for authorization was March 6, 2019, for services provided January 30, 2019. Services were administratively denied due to "no prior authorization for OON services." Per DHMP policy, retrospective (post-service) review determinations require notice sent 30 days from request. The appeal information in the NABD included inaccurate information in required content.

File OS2: The medical reviewer determined services could be provided in network. The case was denied for "OON services." The appeal information in the NABD included inaccurate information in required content.

Appendix G2. Colorado Department of Health Care Policy and Financing FY 2019–2020 Denials Record Review Tool for Denver Health Medical Plan (COA Region 5 MCO)

Total Record Review Score*	Total Applicable Elements:	Total Met Elements:	Total Record Review Score:
	52	44	85%

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

Appendix G2. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Grievance Record Review Tool
for Denver Health Medical Plan (COA Region 5 MCO)

Review Period:	January 1, 2019–December 31, 2019
Date of Review:	January 8, 2020
Reviewer:	Dara Dameron
Participating Health Plan Staff Member(s):	Marques Haley

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame*	Decision Maker Not Previous Level	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
1	****	1/25/19	M ☒ N ☐ N/A ☐	1/29/19	2	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments:										
2	****	2/5/19	M ☒ N ☐ N/A ☐	2/22/19	13	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments:										
3	****	2/14/19	M ☒ N ☐ N/A ☐	2/27/19	9	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments:										
4	****	5/2/19	M ☒ N ☐ N/A ☐	5/14/19	8	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments:										
5	****	6/7/19	M ☒ N ☐ N/A ☐	6/25/19	12	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments:										
6	****	8/20/19	M ☒ N ☐ N/A ☐	9/6/19	13	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments:										
7	****	9/4/19	M ☒ N ☐ N/A ☐	9/20/19	12	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments:										
8	****	9/18/19	M ☒ N ☐ N/A ☐	10/4/19	12	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments:										
9	****	11/15/19	M ☐ N ☐ N/A ☒	11/15/19	0	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: The resolution notice and the acknowledgement letter were sent in one combined letter, on the same day as when the grievance was filed.										

Appendix G2. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Grievance Record Review Tool
for Denver Health Medical Plan (COA Region 5 MCO)

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame*	Decision Maker Not Previous Level	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
10	****	2/8/19	M ☒ N ☐ N/A ☐	3/14/19	24	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: An extension was requested by DHMP. The extension notification letter was sent to the member on February 13, 2019. The reason for the extension request was due to DH needing to request and obtain the member's medical records to review for quality of care. The resolution notice letter was provided to the member within 15 working days plus 11 extension (calendar) days.										
Do not score shaded columns below.										
Column Subtotal of Applicable Elements			**9**			**10**	**10**	**2**	**10**	**10**
Column Subtotal of Compliant (Met) Elements			**9**			**10**	**10**	**2**	**10**	**10**
Percent Compliant (Divide Met by Applicable)			**100%**			**100%**	**100%**	**100%**	**100%**	**100%**

Key: M = Met; N = Not Met; N/A = Not Applicable

* Grievance timeline for resolution and notice sent is 15 working days (unless extended).

**Grievance resolution letter required content includes (1) results of the disposition/resolution process and (2) the date the disposition/resolution process was completed.

**** = Redacted Member ID

Total Applicable Elements	**51**
Total Compliant (Met) Elements	**51**
Total Percent Compliant	**100%**

Appendix G2. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Appeals Record Review Tool
for Denver Health Medical Plan (COA Region 5 MCO)

Review Period:	January 1, 2019–December 31, 2019
Date of Review:	January 8, 2020
Reviewer:	Barbara McConnell
Participating Health Plan Staff Member(s):	Marques Haley

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame*	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
1	****	1/16/19	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☐ N ☐ N/A ☒	Yes ☐ No ☒	Yes ☐ No ☒	1/17/19	M ☒ N ☐	M ☐ N ☒	M ☒ N ☐
Comments: This was an administrative determination. No clinical expertise was required. The appeal was upheld due to the member being ineligible for Medicaid at the time the service was provided. This letter was sent in Spanish. The appeal resolution letter included an attachment that described appeal and SFH rights. The attachment inaccurately informed members that they may file an "appeal, a quick appeal, or a State fair hearing." At the point the member is receiving an appeal resolution letter, the member's appeal rights are exhausted and the only option at that point is an SFH.											
2	****	2/11/19	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☐ N ☐ N/A ☒	Yes ☐ No ☒	Yes ☐ No ☒	2/13/19	M ☒ N ☐	M ☐ N ☒	M ☒ N ☐
Comments: This was an administrative determination. No clinical expertise was required. The appeal was upheld due to the member being ineligible for Medicaid at the time the service was provided. The appeal resolution letter included an attachment that described appeal and SFH rights. The attachment inaccurately informed members that they may file an "appeal, a quick appeal, or a State fair hearing." At the point the member is receiving an appeal resolution letter, the member's appeal rights are exhausted and the only option at that point is an SFH.											
3	****	3/26/19	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☐ N ☐ N/A ☒	Yes ☐ No ☒	Yes ☐ No ☒	4/8/19	M ☒ N ☐	M ☐ N ☒	M ☒ N ☐
Comments: This was an administrative determination following a claims denial. The claim had actually been paid and the member had misunderstood the explanation of benefits. The resolution letter explained this to the member. The appeal resolution letter included an attachment that described appeal and SFH rights. The attachment inaccurately informed members that they may file an "appeal, a quick appeal, or a State fair hearing." At the point the member is receiving an appeal resolution letter, the member's appeal rights are exhausted and the only option at that point is an SFH.											
4	****	4/24/19	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	Yes ☐ No ☒	Yes ☐ No ☒	5/13/19	M ☒ N ☐	M ☐ N ☒	M ☒ N ☐
Comments: This was a clinical denial. The appeal decision was made by an external physician consultant. The original denial had been made by the DHMP medical director. An extension letter was sent to the member on May 7, 2019. The decision and notice was completed in 10 working days plus 6 calendar (extension) days. The appeal resolution letter included an attachment that described appeal and SFH rights. The attachment inaccurately informed members that they may file an "appeal, a quick appeal, or a State fair hearing." At the point the member is receiving an appeal resolution letter, the member's appeal rights are exhausted and the only option at that point is an SFH.											
5	****	7/2/19	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	Yes ☐ No ☒	Yes ☐ No ☒	7/10/19	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: Initial denial decision was made by an All-Med external physician reviewer. Appeal decision was made by the DHMP medical director. The denial was overturned.											
6	****	7/23/19	M ☐ N ☒ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	Yes ☐ No ☒	Yes ☒ No ☐	8/9/19	M ☒ N ☐	M ☐ N ☒	M ☐ N ☒
Comments: The appeal was filed by a designated client representative (DCR) on July 2, 2019. A DCR form was required to accept the appeal and was provided July 23, 2019, which initiated the appeal (July 23 used as the appeal filing date). The appeal specialist was out of the office and the case was not reassigned as is usual process, so the acknowledgement letter was late. An extension letter was sent on August 1, 2019. The decision and notice were completed in 10 working days plus 3 calendar days. The decision reason used medical acronyms that were not defined for the member.											

Appendix G2. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Appeals Record Review Tool
for Denver Health Medical Plan (COA Region 5 MCO)

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame*	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
7	****	8/23/19	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	Yes ☐ No ☒	Yes ☐ No ☒	9/4/19	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: This was a clinical determination for DME. The original denial was made by an All-Med external physician reviewer. The appeal decision was made by the medial director. The denial was overturned.											
8	****	9/17/19	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	Yes ☐ No ☒	Yes ☐ No ☒	9/26/19	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: This was a pharmacy denial originally made by MedImpact (the pharmacy benefits manager). The appeal decision was made by the medical director. The denial was overturned.											
9	****	9/27/19	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☐ N ☐ N/A ☒	Yes ☐ No ☒	Yes ☐ No ☒	10/10/19	M ☒ N ☐	M ☐ N ☒	M ☒ N ☐
Comments: This letter was sent in Spanish. This was an administrative determination based on a claims denial for out-of-network provider. The appeal resolution letter included an attachment that described appeal and SFH rights. The attachment inaccurately informed members that they may file an "appeal, a quick appeal, or a State fair hearing." At the point the member is receiving an appeal resolution letter, the member's appeal rights are exhausted and the only option at that point is an SFH.											
10	****	11/12/19	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☐ N ☐ N/A ☒	Yes ☐ No ☒	Yes ☐ No ☒	11/13/19	M ☒ N ☐	M ☐ N ☒	M ☒ N ☐
Comments: This was an administrative determination based on a claims denial. The appeal was upheld due to the member being ineligible for Medicaid at the time the service was provided. The member had been retroactively deemed ineligible by Medicaid. The appeal resolution letter included an attachment that described appeal and SFH rights. The attachment inaccurately informed members that they may file an "appeal, a quick appeal, or a State fair hearing." At the point the member is receiving an appeal resolution letter, the member's appeal rights are exhausted and the only option at that point is an SFH.											
Do not score shaded columns below.											
Column Subtotal of Applicable Elements			**10**	**5**	**5**				**10**	**10**	**10**
Column Subtotal of Compliant (Met) Elements			**9**	**5**	**5**				**10**	**3**	**9**
Percent Compliant (Divide Met by Applicable)			**90%**	**100%**	**100%**				**100%**	**30%**	**90%**

Key: M = Met; N = Not Met; N/A = Not Applicable
Yes; No = Not scored—information only

***Appeal resolution letter time frame** does not exceed 10 working days from the day the health plan receives the appeal (unless expedited—three calendar days; or unless extended—+14 calendar days).

****Appeal resolution letter required content** includes (1) the result of the resolution process; (2) the date the resolution was completed; (3) if the appeal is not resolved wholly in favor of the member, the right to request a State fair hearing and how to do so; (4) if the appeal is not resolved wholly in favor of the member, the right to request that benefits/services continue while the hearing is pending, and how to make that request.

**** = Redacted Member ID

Total Applicable Elements	**50**
Total Compliant (Met) Elements	**41**
Total Percent Compliant	**82%**

Appendix G3. Site Review Participants

Table G3-1 lists the participants in the FY 2019–2020 site review of **DHMP**.

Table G3-1—HSAG Reviewers and DHMP and Department Participants

HSAG Review Team	Title
Barbara McConnell	Executive Director
Kathy Bartilotta	Associate Director
DHMP Participants	**Title**
Catharine Fortney	Chief Compliance and Audit Officer
Christina Porter	Utilization Management Quality Assurances and Training
Christine Seals	Medical Director
Corie Culter	Manager of Utilization Management
Dallen Waldenroth Gomez	Analyst for CHP+ and Medicaid Denver Health
Elizabeth Strammiello	Colorado Access Chief Compliance Officer
Gina Eisenach	Director, Compliance and Internal Auditor
Jeremy Sax	Government Manager
Josh Holte	Interim Director of Claims
Kaitlin Gaffney	Analyst, CHP+ and Medicaid
Keri Gottlieb	Provider Relations and Contracting Manager
Lisa Artale Bross	Compliance Manager
Marques Haley	Monitoring, Auditing, Training Manager
Mike Wagner	Chief Administrative Officer
Robert Lodge	Pharmacist
Shanique Horne	Director of Provider Relations and Contracting
Stacy Grein	Compliance Analyst
Shayna Garcia	Pharmacy Compliance Analyst
Department Observers	**Title**
Russell Kennedy	Quality Program Manager—HCPF
Teresa Craig	Contract Manager—HCPF

Appendix G4. Corrective Action Plan Template for FY 2019–2020

If applicable, the RAE MCO 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 MCO 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 MCO must submit documents based on the approved timeline.

Table G4-1—Corrective Action Plan Process

Step	Action
Step 1	**Corrective action plans are submitted**
	If applicable, the MCO 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 MCO 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 MCO is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.
Step 3	**Department approval**
	Following review of the CAP, the Department and HSAG will: • Approve the planned interventions and instruct the MCO to proceed with implementation, or • Instruct the MCO to revise specific planned interventions and/or documents to be submitted as evidence of completion and also to proceed with implementation.
Step 4	**Documentation substantiating implementation**
	Once the MCO has received Department approval of the CAP, the MCO will have a time frame of 90 days (three months) to complete proposed actions and submit documents. The MCO will submit documents as evidence of completion one time only on or before the three-month deadline for all required actions in the CAP. (If necessary, the MCO will describe in the CAP document any revisions to the planned interventions that were required in the initial CAP approval document or determined by the MCO within the intervening time frame.) If the MCO is unable to submit documents of completion for any required action on or before the three-month deadline, it must obtain approval in writing from the Department to extend the deadline.

Step	Action
Step 5	**Technical Assistance**
	At the MCO's request, HSAG will schedule an interactive, verbal consultation and technical assistance session during the three-month time frame. The session may be scheduled at the MCO's discretion at any time the MCO determines would be most beneficial. HSAG will not document results of the verbal consultation in the CAP document.
Step 6	**Review and completion**
	Following a review of the CAP and all supporting documentation, the Department or HSAG will inform the MCO as to whether or not the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements. Any documentation that is considered unsatisfactory to complete the CAP requirements at the three-month deadline will result in a continued corrective action with a new date for completion established by the Department. HSAG will continue to work with the MCO until all required actions are satisfactorily completed.

The CAP template follows.

Table G4-2—FY 2019–2020 Corrective Action Plan for DHMP MCO

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
13. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to and copies of all documents and records relevant to the adverse benefit determination (includes medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits). • The member's right to request one level of appeal with the Contractor and the procedures for doing so. • The date the appeal is due. • The member's right to request a State fair hearing after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State fair hearing.	The Utilization Determinations policy, as well as the two template NABD letters—one for claims and one for denials of medical necessity—addressed all required content areas. However, the Medicaid Medical Necessity Denial Letter included several inaccuracies in the content of the appeal, SFH, and continuation of benefits information, specifically: • Must file the appeal by **the date listed on the NABD letter** (the only date listed on the letter is the date the NABD was sent; the date for filing an appeal is 60 calendar days after the NABD). • **Will continue services** during your appeal if: you **file your appeal** by the **date listed on your NABD** letter (member must request *continued benefits* within 10 days of the NABD or intended effective date of the proposed adverse benefit determination; member still has 60 days from date on NABD to file the appeal). • Will keep giving you these services until: **the time period of a previously authorized service has been met** (this criterion has been removed from federal regulations and is no longer applicable). • May request an **SFH** within **120 days of the NABD letter** (may request an SFH	DHMP must correct the inaccuracies noted in the required content of the Medicaid Medical Necessity Denial Letter.

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
• The circumstances under which an appeal process can be expedited and how to make this request. • The member's rights to have benefits/services continue (if applicable) pending the resolution of the appeal, how to request that benefits continue, and the circumstances (consistent with State policy) under which the member may be required to pay the cost of these services. *42 CFR 438.404(b)(1–6)* R5 MCO Contract: Exhibit M-2—8.6.1.5-8.6.1.12 10 CCR 2505-10 8.209.4.A.2	within 120 days of the Appeal Resolution Letter). Due to the inaccuracies in content of the Medicaid Medical Necessity Denial Letter, HSAG scored 8 of 10 denial record reviews *Not Met* for required content of the NABD.	
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**
9. The Contractor must meet, and require its providers to meet, the State standards for timely access to care and services, taking into account the urgency of the need for services. The Contractor ensures that services are available as follows: • Urgent care within 24 hours from the initial identification of need. • Non-urgent symptomatic care visit within 7 days after member request. • Well-care visit within 1 month after member request. • Outpatient follow-up appointments within 7 days after discharge from hospitalization. *42 CFR 438.206(c)(1)(i)* R5 MCO Contract: Exhibit M-2—9.3.9.1	DHMP was unable to provide evidence of tracking to ensure compliance with the timeliness standards for non-urgent symptomatic care within seven days or an outpatient follow-up appointment within seven days.	DHMP must develop a mechanism to track compliance with timely access to appointments for non-urgent symptomatic care and follow-up care following an inpatient hospitalization.
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**
12. The Contractor ensures timely access by: • Establishing mechanisms to ensure compliance with access (e.g., appointment) standards by network providers. • Monitoring network providers regularly to determine compliance. • Taking corrective action if there is failure to comply. *42 CFR 438.206(c)(1)(iv)–(vi)* R5 MCO Contract: Exhibit M-2—9.4.1.8	The *Network Adequacy Report* accurately depicted the timely appointment standards. DHMP provided evidence of reviewing timeliness of primary and specialty care appointments made through the Denver Health Call Center; however, DHMP did not have a mechanism to monitor compliance with timely access standards for its contracted organizational providers (University Physicians, Inc. and The Children's Hospital of Colorado).	DHMP must develop a mechanism to monitor contracted providers regularly to ensure compliance with timely access standards and implement corrective action plans if the providers fail 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 VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
6. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, as well as providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability. *42 CFR 438.406(a)* R5 MCO Contract: Exhibit M-2—8.3 10 CCR 2505-10 8.209.4.C	DHMP's grievance and appeals policies and procedures addressed providing assistance to members with appeals and grievance forms and procedures. While the SFH attachment to the Appeal Resolution Letter offered the member assistance with the SFH, the appeal information in the Medicaid Medical Necessity Denial Letter did not offer the member assistance with completion of appeals forms and procedures.	DHMP must communicate in the NABD appeal information the offer to assist members with completing any forms or procedural steps related to an appeal.
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 VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
21. If the Contractor denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the time frame for standard resolution. • Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and within two (2) calendar days provide the member written notice of the reason for the decision and inform the member of the right to file a grievance if he or she disagrees with that decision. *42 CFR 438.410(c)* R5 MCO Contract: Exhibit M-2—8.7.14.2.2 10 CCR 2505-10 8.209.4.S	The template letter to members—Notice of Expedited Resolution Denial—communicated to the member the process for handling the denied expedited appeal and the member's right to file a grievance; however, it failed to demonstrate that the reason for the denial was included in the letter.	DHMP must ensure that the written notice to the member regarding denial of an expedited appeal includes the reason for the denial.
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 VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
22. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)* *42 CFR 438.408(d)(2)* *42 CFR 438.10* R5 MCO Contract: Exhibit M-2—8.7.14.1, 7.2.7.3, 7.2.7.5 10 CCR 2505-10 8.209.4.J.1	DHMP's procedures and on-site review of appeal records demonstrated compliance with the 10-day resolution time frame and, in most cases, that appeal resolution notices were written in language easy for the member to understand. However, HSAG identified in appeal record reviews one resolution letter in which the reason for the decision used medical acronyms that were not defined for the member.	DHMP must ensure that the text description entered into the Appeal Resolution Letter to the member is written in language easy for the member to understand.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
26. The written notice of appeal resolution must include: • The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. – The right to request that benefits/services continue* while the hearing is pending, and how to make the request. – That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's adverse benefit determination. **Continuation of benefits applies only to previously authorized services for which the Contractor provides 10-day advance notice to terminate, suspend, or reduce.* *42 CFR 438.408(e)* R5 MCO Contract: Exhibit M-2—8.7.14.3, 8.7.14.4 10 CCR 2505-10 8.209.4.M	DHMP's Appeal Resolution Letter included all required information; however, the attachment to the letter describing the SFH process also referenced appeals and stated that the member "may file an appeal, a quick appeal, or a State fair hearing." At the point the member is receiving an Appeal Resolution Letter, the member's appeal rights are exhausted and the only option at that point is an SFH. The resolution letter inaccurately included reference to appeals, resulting in 7 of 10 record reviews being scored *Not Met* for "resolution letter includes required content."	DHMP must revise the content of the attachment to the Appeal Resolution Letter to omit references to appeal processes.

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
29. The Contractor provides for continuation of benefits/services (when requested by the member) while the Contractor-level appeal and the State fair hearing are pending if: • The member files in a timely manner* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the Contractor mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal in accordance with required time frames. ** This definition of timely filing only applies for this scenario—i.e., when the member requests continuation of benefits for previously authorized services proposed to be*	The *Appeal Rights and State Fair Hearing Rights* attachment to the Appeal Resolution Letter communicated to the member the required time frame for the member to request continued benefits of previously approved services during an SFH. However, the Medicaid Medical Necessity Determination Letter, used to communicate information regarding appeals, inaccurately informed the member of the time frame for requesting continued benefits during an appeal.	DHMP must correct the information sent to the member regarding how to request continued benefits during an *appeal* to include the required time frame—on or before the latter of 10 days after the health plan mails the NABD or the intended effective date of the adverse benefit determination—for requesting continued benefits.

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
terminated, suspended, or reduced. (Note: The provider may not request continuation of benefits on behalf of the member.) *42 CFR 438.420(a) and (b)* R5 MCO Contract: Exhibit M-2—8.7.13.1 10 CCR 2505-10 8.209.4.T		
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 VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
35. The Contractor provides the information about the grievance, appeal, and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. – The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member.	DHMP's provider manual, distributed to providers at the time of contracting, included extensive information regarding the grievance and appeals processes; however, the information in the provider manual inadequately addressed the following: • The text description of how to file a grievance did not describe the time frame for filing (i.e., at any time). • The description of how to file an appeal stated that if a Medicaid member verbally requests an appeal, it will not be processed until written receipt of the appeal and receipt of related documents. HSAG finds this information misleading in that "related documents" is not defined and receipt of related documents is not required for processing an appeal (in addition, per regulation, the date of an oral appeal request establishes the date of filing for meeting the time frames for resolving an appeal). • The information regarding continuation of benefits incompletely described the circumstances for continuing benefits during an appeal, including that: continuation of benefits applies only to services previously approved and then denied or reduced, continuation of services must be requested by the member (not the provider), and continuation of	DHMP must update the provider manual to adequately describe all requirements and time frames for filing grievances and appeals and circumstances applicable to the continuation of benefits during an appeal or SFH.

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
42 CFR 438.414 *42 CFR 438.10(g)(xi)* R5 MCO Contract: Exhibit M-2—8.4 10 CCR 2505-10 8.209.3.B	benefits must be requested within 10 days of the NABD.	
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:		