COLORADO
Department of Health Care Policy & Financing

Fiscal Year 2017–2018 Site Review Report

for

Access Behavioral Care—Denver and Access Behavioral Care—Northeast

January 2018

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

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1. Executive Summary

The Code of Federal Regulations, Title 42—federal Medicaid managed care regulations, published May 6, 2016—requires that states conduct a periodic evaluation of their managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to determine compliance with federal healthcare regulations and managed care contract requirements. The Department of Health Care Policy and Financing (the Department) has elected to complete this requirement for Colorado's behavioral health organizations (BHOs) by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

In order to allow for implementation of new federal managed care regulations published May 2016, the Department determined that the review period for FY 2017–2018 was July 1, 2017, through December 31, 2017. This report documents results of the FY 2017–2018 site review activities for both **Access Behavioral Care—Denver** (**ABC-D**) and **Access Behavioral Care—Northeast** (**ABC-NE**). For each of the four standard areas reviewed this year, this section contains summaries of the findings as evidence of compliance, strengths, findings resulting in opportunities for improvement, and required actions. Section 2 describes the background and methodology used for the 2017–2018 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the 2016–2017 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 appeals and grievances record reviews. Appendix C lists HSAG, BHO, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process the BHO will be required to complete for FY 2017–2018 and the required template for doing so. Appendix E contains a detailed description of HSAG's site review activities consistent with the Centers for Medicare & Medicaid Services (CMS) final protocol.

Summary of Results

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

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

Table 1-1—Summary of ABC-D Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
V. Member Information	12	11	6	5	0	1	55%
VI. Grievance System	27	27	24	3	0	0	89%
VII. Provider Participation and Program Integrity	13	13	12	1	0	0	92%
IX. Subcontracts and Delegation	4	4	4	0	0	0	100%
Totals	**56**	**55**	**46**	**9**	**0**	**1**	**84%**

Note: While scoring related to individual, new federal requirements in the tool may indicate *Met* or *Not Scored*, all new requirements were scored *Not Applicable* in the total results; new federal requirements do not apply to CHP+ until July 1, 2018.

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

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

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

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Appeals	30	27	27	0	3	100%
Grievances	12	8	8	0	4	100%
Totals	**42**	**35**	**35**	**0**	**7**	**100%**

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

Table 1-3 presents the scores for **ABC-NE** for each of the standards. Findings for requirements receiving a score of *Met* are summarized in this section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* follow in Appendix A—Compliance Monitoring Tool.

Table 1-3—Summary of ABC-NE Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
V. Member Information	12	11	7	4	0	1	64%
VI. Grievance System	27	27	23	4	0	0	85%
VII. Provider Participation and Program Integrity	13	13	12	1	0	0	92%
IX. Subcontracts and Delegation	4	4	4	0	0	0	100%
Totals	**56**	**55**	**46**	**9**	**0**	**1**	**84%**

Note: While scoring related to individual, new federal requirements in the tool may indicate *Met* or *Not Scored*, all new requirements were scored *Not Applicable* in the total results; new federal requirements do not apply to CHP+ until July 1, 2018.

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

Table 1-4 presents the scores for **ABC-NE** for the record reviews. Details of the findings for the record reviews are in Appendix B—Record Review Tools.

Table 1-4—Summary of ABC-NE Scores for the Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Appeals	24	21	20	1	3	95%
Grievances	42	29	29	0	13	100%
Totals	**66**	**50**	**49**	**1**	**16**	**98%**

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

Standard V—Member Information

The following sections summarize findings applicable to both **ABC-D** and **ABC-NE**. Any notable differences in compliance between the two lines of business have been identified.

Summary of Strengths and Findings as Evidence of Compliance

HSAG reviewed **ABC** policies and procedure regarding member materials and found them appropriate to meet the requirements and ensure that member communications were accessible. **ABC-D** and **ABC-NE** used many of the same member materials across both lines of business and made all member materials available in English and in Spanish. In addition, the **ABC** website included a translation function which made the website viewable in over 50 languages. **ABC** is compliant in making member materials available in various, alternate formats and provided an example during the on-site interview where the BHO had converted the entire member handbook into Braille when it was requested. While this was an expensive endeavor, **ABC** ensured that this specific member had access to information regarding rights and processes for obtaining healthcare.

HSAG found that member materials, both printed and electronic, used simple, easy-to-understand language. **ABC** arranged its website in a user-friendly format that allows for intuitive use and member ease in finding important information. **ABC** provides a wealth of information to its members on the website, which serves as a valuable resource.

Summary of Findings Resulting in Opportunities for Improvement

ABC may wish to review all member documents to ensure that the general text of PDF versions of member materials is made available to members in at least a 12-point font. HSAG reviewed various member material available in PDF format; and while the font appeared to be in an acceptable range, HSAG was unable to directly confirm the font size due to the PDF format.

Summary of Required Actions

HSAG found that the taglines describing how to request auxiliary aids and services, including written translation and oral interpretation, while present, were not printed in 18-point font on both paper and in electronic member materials, as required. **ABC-D** and **ABC-NE** must ensure that all member materials include taglines describing how to request auxiliary aids and services including written translation and oral interpretation in 18-point font.

During the desk review, HSAG found that **ABC** provided two member handbooks to members, the Health First Colorado member handbook and **ABC**'s own member handbook available on its website at the webpage: http://coaccess.com/**ABC**-denver-plan-documents-and-forms. HSAG noted that the **ABC-D** handbook contained information which conflicts with the Health First Colorado member handbook, which could be confusing to members. For example, the information **ABC-D** provided to members in

the Member and Family Handbook had not been updated to reflect current time frames and procedures for grievance, appeals, and State fair hearings (SFHs) in accordance with 42 CFR §438.10 information requirements. During the on-site interview **ABC** noted that this was unintentional and that the **ABC** member handbook would be removed immediately. A week following the on-site review, HSAG confirmed that the webpage for **ABC-NE** contained a link to only the Health First Colorado member handbook; however, HSAG found that the **ABC-D** Member and Family Handbook had not been removed from the website. **ABC-D** must remove its Member and Family Handbook from its website to ensure that members are not receiving conflicting or inaccurate information on appeals, grievances, SFHs, or other member information.

During desk review, HSAG was unable to locate notification on the **ABC** website informing members that electronic information is available in paper form upon request without charge and is provided within five) business days. **ABC** must inform members on a prominent place of its website that information on the website is available in paper form upon request, without charge, and provided within five business days.

During the desk review process, HSAG conducted an accessibility check on several **ABC** webpages using the *Wave Web Accessibility Evaluation Tool*. Through use of the tool, HSAG discovered several general accessibility errors and contrast errors on various webpages. HSAG also ran an accessibility check on several PDF documents available for download from the **ABC** website. Through use of the Adobe Acrobat Pro accessibility checker, HSAG discovered accessibility errors within these PDF documents. HSAG repeated these accessibility checks during the on-site review for educational purposes and the same outcomes were discovered. **ABC** must develop a process to ensure that all information on its website is readily accessible (i.e., complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines).

HSAG found that the disability accommodation field in **ABC**'s "Find A Provider" provider search feature on its website did not define the specific accommodations available at each provider's location. **ABC** staff members confirmed that only one area of disability access, such as handicap parking or a nearby public transit line, could qualify a provider as having "disability access." The requirement, however, clarifies this to include accessible offices, exam rooms, and equipment. To comply with the requirement, **ABC** must update its provider directory or online "Find A Provider" feature to better clarify what it defines as "disability access."

Standard VI—Grievance System

The following sections summarize findings applicable to both **ABC-D** and **ABC-NE**. Any notable differences in compliance between the two lines of business have been identified.

Summary of Strengths and Findings as Evidence of Compliance

ABC had updated both its Member Grievance Process and Member Appeal Process policies to incorporate new federal and State regulations effective July 1, 2017. Although the written policies stated

an effectiveness date of late October 2017, staff members stated that new procedures were implemented July 1, 2017, which HSAG corroborated through appeal record reviews of processes applied and information provided to members in notices of adverse benefit determinations and appeal resolution letters. Staff stated that **ABC** would begin using the model letters provided by the Department on November 1, 2017. Staff members also stated that applicable changes in the federal regulations effective July 1, 2017, largely reflected processes already in place and operationally applied in processing of appeals and grievances by Colorado Access. Record reviews for both **ABC-D** and **ABC-NE** demonstrated 100 percent compliance with requirements for processing grievances. **ABC-D** also demonstrated 100 percent compliance with requirements for processing appeals, and **ABC-NE** demonstrated compliance in all but one record. Staff demonstrated that the appeal manager contacts all members orally (and in writing) to acknowledge receipt of appeals, offer assistance to members, share all available pre- and post-appeal information in the files, and ensure that each member understands his or her appeal resolution. **ABC** efficiently processes all grievances and appeals, rarely extending the time frame needed to issue a determination and rarely denying the request for an expedited decision. In addition, while **ABC** attempts to gain a signature from the member on any written appeal following an oral appeal, **ABC** routinely processes the appeal within the required time frame without a signature if necessary. (HSAG considers this "best practice" in these circumstances.) **ABC** maintains records of appeals and grievances, including all required information, in the Altruista Health care management system for a period of 10 or more years.

Summary of Findings Resulting in Opportunities for Improvement

HSAG made several on-site recommendations for improvement in **ABC** policies and procedures, which **ABC** modified at the time of on-site review. These recommendations included the following:

- Staff members confirmed that the processing of member quality of care concerns (QOCCs) was a component of the member grievance process; however, the Quality of Care Concern Investigations policy did not specify or refer the reader to the time frames for acknowledgement or grievance resolution letters to members. Staff members verbalized the process for handling QOC grievances and that each member would receive within 15 days a grievance resolution letter indicating that the grievance resolution was referred for further QOC review. HSAG recommended that the policy and procedures clearly state that QOC grievances will be processed according to time frames outlined in ADM203—Member Grievance Process and consider instructions for language to be included in the results of the resolution description when the grievance is a QOCC.
- HSAG noted that the Member Grievance process policy included a statement—decisions shall take into account all information submitted by a member "without regard to whether such information was submitted or considered in the initial *adverse benefit determination.*" As the quoted clause applies to appeals but not grievances, HSAG suggested it be deleted from the grievance policy.
- HSAG queried staff regarding the process for obtaining a member signature on a written appeal and the processing of an appeal when a signature cannot be obtained. Staff members described a very deliberate outreach process and stated that the BHO would not delay an appeal decision due to inability to obtain a member signature. HSAG suggested that written appeal procedures include a description of this process to ensure that it is followed by all staff.

- HSAG observed that Colorado Access informs members of their right to and process for requesting an SFH through both the notice of adverse benefit determination and the appeal resolution notice (if not in favor of the member). The Member Appeal policy stated only that the member is informed about an SFH in the notice of action (NOA). HSAG recommended adding appeal resolution notice language to the policy.

Colorado Access described the language concerning appeals and grievances to be included in the revised provider manual (with an anticipated completion date of early 2018), which would include links to the updated grievance and appeal policies on the provider website. The information included in the provider manual is very general concerning the member's right to file grievances and appeals and the provider's participation in doing so. HSAG advises that **ABC** consider including the essential information to providers, as described in the requirements, directly in the member handbook. In addition, the current provider manual refers providers to a link for the member handbook for information on grievances and appeals. **ABC** no longer controls the content of the member handbook; therefore, HSAG cautions that directing providers to the member handbook may be an inadequate action to meet requirements for informing providers of grievance and appeal procedures.

Summary of Required Actions

While the Member Grievance Process policy had been updated to indicate that a member may file a grievance at any time, the related policy—Quality of Care Concern (QOCC) Investigations—stated that a member must file a QOCC within 30 days of the incident. **ABC** must ensure that the QOCC policy is updated to reflect that a quality of care grievance may be filed by a member at any time. Policy revisions must be approved by appropriate governing bodies and implemented, including any applicable staff training.

HSAG noted one **ABC-NE** appeal record in which the BHO failed to send an acknowledgement letter within two days of receipt of the appeal request. **ABC-NE** must have mechanisms to ensure that written acknowledgement of a standard appeal request is sent to the member or designated representative, consistent with **ABC** policies and procedures.

Member Appeal Processes policy accurately addressed all required criteria for the length of time that benefits would continue during an appeal or SFH, but also included an additional criterion—"until the time period or service limits of the previously authorized service has been met." This circumstance does not apply to the length of time that benefits may continue. **ABC** must remove this specific criterion in the member appeals policy as well as in any related member or provider communications (e.g., appeal resolution or adverse determination letters). Policy revisions must be approved by appropriate governing bodies and implemented, including any applicable staff training.

The **ABC** provider manual contained no detailed information to address the required components of the information about the grievance, appeal, and SFH system. The manual directed the provider to two different Colorado Access website locations to find detailed instructions or procedures related to grievances and appeals, but neither website link included detailed procedures for appeals and grievances. In addition, the provider manual included no information on the appeals process available

under the Child Mental Health Treatment Act (CMHTA). Whereas new requirements and time frames for processing grievances and appeals have been in effect since July 1, 2017, **ABC** must develop accessible and timely mechanisms to inform providers and subcontractors about the grievance, appeal, and SFH system in sufficient detail to address all federal and State requirements for provider information.

Standard VII—Provider Participation and Program Integrity

The following sections summarize findings applicable to both **ABC-D** and **ABC-NE**. Any notable differences in compliance between the two lines of business have been identified.

Summary of Strengths and Findings as Evidence of Compliance

ABC's policy, *Member Services Verification Plan*, included recently implemented processes for providing individual notices to a sample of members to verify and report whether services billed by providers had actually been received by members.

ABC's policies for the selection and retention of providers were well written and clearly described methods used to identify a specific area of need and then to recruit providers to fill the gap. HSAG reviewed the template letter related to declining a new provider from participation and found the content appropriate. **ABC** provided a description of its process, both prior to hiring and monthly ongoing, for ensuring that all providers, employees, board members, consultants, etc., are not excluded from participation in federal healthcare programs. **ABC** staff members clearly described what would happen in the event that an applicant or current provider, employee, or other relationship was found to be excluded from participation in federal programs. **ABC** supplied HSAG with reports evidencing that a process for reviewing the LEIE and SAM monthly for current providers, employees, board members, consultants, and the like is in place as described in policies. **ABC** clearly described that, in the event that an applicant, current provider, employee, or other relationship was found to be excluded from participation in federal programs, the provider contract would be terminated and the appropriate channels, including the Department, notified.

During the on-site review, HSAG and **ABC** staff members spent considerable time discussing the compliance program, specifically as it relates to **ABC**'s compliance organizational structure, chain of command, and processes. **ABC** staff members discussed the in-person compliance training that takes place within **ABC** upon hire and the e-learning training that occurs annually. The compliance officer also noted the educational programs and professional organizations with which she maintains membership to ensure that she is up-to-date on topics in corporate compliance and fraud, waste, and abuse. **ABC** thoroughly described its processes for monitoring and reporting fraud, waste, and abuse.

Summary of Findings Resulting in Opportunities for Improvement

During the on-site review, the compliance officer discussed a new edition of **ABC**'s provider manual anticipated to be released in the first half of 2018. **ABC** is redesigning its manual to be web-based and to link providers directly to policies and procedures as well as other resources. This process will allow **ABC** to incorporate updates in real time, including up-to-date information on compliance and fraud, waste, and abuse. This will transform the provider manual into a more dynamic tool for provider communication. HSAG recommends that **ABC** expedite developing the new version of its provider manual.

Summary of Required Actions

HSAG determined that **ABC**'s policies did include a process for ensuring that laboratory-testing sites have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a certificate of registration along with a CLIA registration number. During the on-site interview, **ABC** staff members confirmed that hospital laboratories were used by members but that checking for CLIA certification was not a part of the credentialing process. **ABC** must ensure that it develops and adheres to a documented process whereby all laboratory-testing sites providing services to **ABC** members have either a CLIA Certificate of Waiver or a certificate of registration along with a CLIA registration number.

Standard IX—Subcontracts and Delegation

The following sections summarize findings applicable to both **ABC-D** and **ABC-NE**. Any notable differences in compliance between the two lines of business have been identified.

Summary of Strengths and Findings as Evidence of Compliance

ABC subcontracts and delegation policies, procedures, and agreements reflect the corporatewide processes of Colorado Access, applicable to all lines of business. No notable differences in compliance existed between **ABC-D** and **ABC-NE**. Colorado Access subcontracted with entities for the following services: provider credentialing, claims systems, pharmacy management, after-hours crisis calls, fulfillment of member identification cards, fulfillment of member materials, review of clinical appeals, specialist clinical review, and after-hours utilization management. Policies described the delegation program, accountable to the compliance officer, and addressed Colorado Access' ultimate accountability for all delegated activities, pre-delegation assessment of the subcontractor, and ongoing oversight and monitoring of delegated functions—with corrective actions and potential revocation of the subcontract if necessary. The subcontractor agreement template and existing subcontractor agreements had been updated to include all information described in the requirements of this standard as well as a detailed description of delegated activities and related reporting requirements. All agreements had been previously executed several years prior to the on-site review. Colorado Access had designated internal "business owners" for oversight of each subcontractor, including ongoing monitoring and management

of corrective actions and provided sample documentation of monthly performance tracking and annual audit of delegate requirements. Monitoring reports were provided monthly to the Colorado Access Quality Assurance Committee. During on-site interviews, staff members indicated that one of Colorado Access' subcontracts had been revoked during the past year for inability of the subcontractor to adequately perform the delegated functions. The process included collecting and investigating issues brought forward from various sources for validation; termination of the provider when allegations are confirmed; collection and reimbursement of paid funds; and notification of appropriate entities, including the Department.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to subcontracts and delegation.

Summary of Required Actions

HSAG identified no required actions for this standard.

2. Overview and Background

Overview of FY 2017–2018 Compliance Monitoring Activities

For the fiscal year (FY) 2017–2018 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation. Compliance with applicable federal managed care regulations and managed care contract requirements was evaluated through review of all four standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the BHO's contract requirements and regulations specified by federal Medicaid managed care regulations published May 6, 2016. The Department determined that the Health First Colorado member handbook was the source of member handbook information and that BHOs were not accountable for compliance with member handbook federal requirements in 42 CFR 438.10(g). 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 BHO personnel to determine compliance with federal managed care regulations and contract requirements. Documents submitted for the desk review and on-site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to BHO appeals and grievances.

HSAG also reviewed a sample of the BHO's administrative records related to Medicaid appeals and grievances to evaluate implementation of federal healthcare regulations and managed care contract requirements as specified in 42 CFR 438 Subpart F and 10 CCR 2505-10, Section 8.209. 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 **ABC-D** and **ABC-NE**. Using a random sampling technique, HSAG selected the samples from all applicable BHO Medicaid appeals and grievances that occurred between July 1, 2017, and December 31, 2017. For the record review, the BHO received a score of *M* (met), *NM* (not met), or *NA* (not applicable) for each required element. Results of record reviews were considered in the review of applicable requirements in Standard VI—Grievance System. HSAG also separately calculated a grievances record review score, an appeals record review score, and an overall record review score.

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

Version 2.0, September 2012.[3-1] Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The four standards chosen for the FY 2017–2018 site reviews represent a portion of the Medicaid managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement.

Objective of the Site Review

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

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

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Sep 26, 2017

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

FY 2016–2017 Corrective Action Methodology

As a follow-up to the FY 2016–2017 site review, each BHO 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 BHO 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 BHO and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **ABC-D** and **ABC-NE** until each completed the required actions from the FY 2016–2017 compliance monitoring site review.

Summary of FY 2016–2017 Required Actions

For the FY 2016–2017, HSAG reviewed Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. HSAG found **ABC-D** and **ABC-NE** 100 percent compliant with the requirements in the access and availability standard. Both **ABC-D** and **ABC-NE** were required to develop plans to address the following issues related to coverage and authorization of services:

- Effective mechanisms to ensure that all information in NOAs to members is appropriate to the members and written in language that ensures ease of understanding and that NOAs are mailed in the required time frames, as outlined in the policies and procedures
- A process to ensure that both the UM procedures and claims payment decisions are linked to the requirements for the Contractor's financial responsibilities for post-stabilization care services not pre-approved, as outlined in the Emergency and Post-Stabilization Care policy.
- A process to ensure that the Contractor's financial responsibilities for post-stabilization care services not pre-approved, as outlined in the Emergency and Post-Stabilization Care policy, are integrated into claims payment decisions.

Additionally, **ABC-NE** was required to implement a mechanism to ensure that it gives the member written notice of any decision to deny a service authorization request.

Summary of Corrective Action/Document Review

ABC-D and **ABC-NE** submitted a proposed plan of corrective actions in May 2017. After reviewing the proposed plan, HSAG and the Department required that **ABC-D** and **ABC-NE** revise two proposed interventions. **ABC-D** and **ABC-NE** were allowed until December 30, 2017, to submit evidence of having implemented corrective actions. HSAG completed this 2017–2018 compliance monitoring report

prior to receiving and processing **ABC-D**'s and **ABC-NE**'s 2016–2017 CAP submission and is unable to comment on the completeness of the corrective actions.

Summary of Continued Required Actions

HSAG will review **ABC-D**'s and **ABC-NE**'s CAP submission with the Department when received and work with the BHOs to ensure full implementation of all corrective actions.

Appendix A. Compliance Monitoring Tool

The completed compliance monitoring tool follows this cover page.

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. The Contractor provides all required member information to members in a manner and format that may be easily understood **and is readily accessible by members.** *(Note: Readily accessible means electronic information which complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines.)* *42 CFR 438.10(b)(1)* Contract Amendment 7: Exhibit A3—2.6.5.13.1	• ADM208 Member Materials • ADM 207 Effective Communication with LEP & SI/SI Persons • MKT203 Website Design, Maintenance and Oversight • MKT201 Printing/Marketing Information and Corporate Branding Materials • Language selection on Colorado Access Website http://www.coaccess.com/access-behavioral-care	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. **For consistency in the information provided to members, the Contractor uses the following as developed by the State:** • **Definitions for managed care terminology, including appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider,**		**ABC-D** ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A **ABC-NE** ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. • **Model member handbooks and member notices.** *42 CFR 438.10(c)(4)* Contract Amendment 7: Exhibit A3—2.2.6, 2.3.2, 3.1.7		
Findings: HSAG is aware and the Department acknowledges that, for the 2017–2018 compliance review period, the State has not completed nor communicated to health plan contractors a consensus list of managed care definitions to be used in information provided to members. HSAG has therefore scored this element *Not Applicable*. HSAG recommends that all Contractors maintain awareness of this requirement and, when received, incorporate State-defined managed care definitions into all applicable member communications, as directed by the Department.		
3. The Contractor makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • **Written materials that are critical to obtaining services include: provider directories, member handbooks, appeal and grievance notices, and denial and termination notices.** • **All written materials for members must:** – Use easily understood language and format. – **Use a font size no smaller than 12 point.** – Be available in alternative formats **and through provision of auxiliary aids and**	• ADM208 Member Material • MKT201 Printed Marketing/Informational and Corporate Branding Materials • ADM207 Effective Communication with Limited English Proficient Persons and SI/SI Persons • Language selection on Colorado Access Website http://www.coaccess.com/access-behavioral-care	**ABC-D** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
services that take into consideration the special needs of members **with disabilities** or limited English proficiency. – **Include taglines in large print (18 point) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service number, and availability of materials in alternative formats.** – Be available for immediate dissemination in that language. *42 CFR 438.10(d)(3) and (d)(6)* Contract Amendment 7: Exhibit A3—2.6.5.13.1–3, 2.6.5.13.6.1–3, 2.6.5.13.7, 2.6.5.13.10.1–4		
Findings: HSAG found that the taglines describing how to request auxiliary aids and services including written translation and oral interpretation, while present, were not in 18-point font on either paper or electronic member materials, as required.		
Required Actions: ABC-D and ABC-NE must ensure that all member materials include taglines describing how to request auxiliary aids and services including written translation and oral interpretation in 18-point font.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
4. **If the Contractor makes information available electronically—Information provided electronically must meet the following requirements:** • **The format is readily accessible (see definition of readily accessible above).** • **The information is placed in a Web site location that is prominent and readily accessible.** • **The information can be electronically retained and printed.** • **The information complies with content and language requirements.** • **The member is informed that the information is available in paper form without charge upon request, and is provided within five (5) business days.** *42 CFR 438.10(c)(6)* Contract Amendment 7: Exhibit A3—2.6.5.3.6–8	• MKT203 Website Design, Maintenance and Oversight • ADM207 Effective Communication with Limited English Proficient Persons and SI/SI Persons	**ABC-D** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: During the desk review process, HSAG conducted an accessibility check on a few ABC Web pages using the WAVE Web Accessibility Evaluation Tool. Through use of the tool, HSAG discovered several general accessibility errors and contrast errors on various Web pages. HSAG also ran an accessibility check on several PDF documents available for download from the ABC website. Through use of the Adobe Acrobat Pro accessibility checker, HSAG discovered accessibility errors. HSAG repeated these accessibility checks during the on-site review for educational purposes, and the same outcomes were discovered.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
HSAG was unable to locate notification on the ABC website informing members that electronic information is available in paper form upon request without charge and is provided within five business days. During the on-site interview, HSAG and ABC discussed possible placement on the website appropriate for displaying such messaging, especially considering that many members may not have state-of-the-art cell phones or access to sufficient bandwidth to search the website for this notice or to download the available PDF documents.		
Required Actions: ABC must develop a process to ensure that all information on its website is readily accessible (i.e., complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines). ABC must inform members in a prominent place of its website that information on the website is available in paper form upon request without charge, and provided within five business days.		
5. The Contractor makes interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and how to access them. • **This includes oral interpretation and use of auxiliary aids such as TTY/TDY and American Sign Language.** • The Contractor notifies members that **auxiliary aids and services are available upon request and at no cost for members with disabilities**, and how to access them. *42 CFR 438.10(d)(4) and (d)(5)* Contract Amendment 7: Exhibit A3—2.6.5.13.7–9	• ADM207 Effective Communication with Limited English Proficient Persons and SI/SI Persons • COA Provider Manual, Page 3-4, 9	**ABC-D** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: On its website, ABC included a function to decipher its webpages (not including PDF documents) into any one of over 50 languages. ABC did not, however, include directly on its website or within the associated PDF member materials notification to the member that oral interpretation in any language, as well as other auxiliary aids, are available free of charge or how members may access them.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Required Actions: While ABC does provide oral interpretation, and use of auxiliary aids to members free of charge as needed, ABC must notify members that these provisions are available and how to access them. During the on-site review, HSAG and ABC discussed prominent places for disseminating this information on the ABC website.		
6. The Contractor makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice, to each member who received his or her primary care from or was seen on a regular basis by the terminated provider. *42 CFR 438.10(f)(1)* Contract Amendment 7: Exhibit A3—2.6.10.1	• ADM300 Provider Terminations	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
7. The Contractor makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals**, pharmacies, and behavioral health providers, and long-term services and supports (LTSS) providers:** • The provider's name and **group affiliation**, street address(es), telephone number(s), **Web site URL, specialty (as appropriate),** and whether the providers will accept new members. • **The provider's cultural and linguistic capabilities, including languages (including**	• COA Website https://providers.coaccess.com/ProviderSearch/home.jsf	**ABC-D** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training. • **Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment.** *(Note: Information included in a paper provider directory must be updated at least monthly, and electronic provider directories must be updated no later than 30 calendar days after the Contractor receives updated provider information.)* *42 CFR 438.10(h)(1-3)* Contract Amendment 7: Exhibit A3—2.6.5.8.1–3		
Findings: HSAG reviewed both the provider directory and the "Find A Provider" feature on the ABC website. While the provider directory did not contain all required information, the "Find A Provider" was a valuable resource that contained comprehensive information in a searchable format. As discussed on-site, the disability accommodation field did not define the accommodations available at each provider's location. Further research performed by ABC during the on-site visit concluded that only one area of disability access, such as handicap parking or a nearby public transit line, could qualify a provider as having "disability access." The requirement, however, clarifies this to include accessible offices, exam rooms, and equipment.		
Required Actions: ABC must update its provider directory or online "Find A Provider" feature to better clarify what it defines as "disability access," in agreement with the requirement.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
8. **Provider directories are made available on the Contractor's Web site in a machine-readable file and format.** *42 CFR 438.10(h)(4)* Contract Amendment 7: Exhibit A3—2.6.5.8.4	• COA Website: https://providers.coaccess.com/ProviderSearch/home.jsf • MKT203 Website Design, Maintenance and Oversight	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor provides other necessary information to members, including: • The Child Mental Health Treatment Act (CMHTA). • Community resources. Contract Amendment 7: Exhibit A3—2.6.7.3.1 and 2.6.7.3.3	• Health First Colorado Member handbook https://www.healthfirstcolorado.com/benefits-services/ • Colorado Access Website http://www.coaccess.com/find-a-community-resource	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
10. For any information provided to members by the Contractor, the Contractor ensures that information is consistent with federal requirements in 42 CFR 438.10. *42 CFR 438.10 (b)*	• ADM208 Member Materials	**ABC-D** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: During the desk review, HSAG found that ABC had two member handbooks, the Health First Colorado member handbook and its own member handbook, on its website at the webpage coaccess.com/abc-denver-plan-documents-and-forms. During the on-site interview, ABC noted that this was unintentional and that it would be removed immediately. A week following the on-site review, the ABC-D Member and Family Handbook had not been removed. HSAG found that the ABC-D handbook contained information which conflicts with the Health First Colorado member handbook, which could be confusing to members. For example, the information ABC-D provided to members in the Member and Family Handbook had not been updated to reflect current time frames and procedures for grievances and appeals in accordance with 42 CFR §438.10 information requirements. HSAG viewed a similar webpage for ABC-NE, which contained only a link to the Health First Colorado member handbook.		
Required Actions: ABC-D must remove its Member and Family Handbook from its webpage to ensure that members are not receiving conflicting or inaccurate information about appeals and grievances.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
11. **The Contractor provides member information by any of:** • **Mailing a printed copy of the information to the member's mailing address.** • **Providing the information by email after obtaining the member's agreement to receive the information by email.** • **Posting the information on the Contractor's Web site and advising the member in paper or electronic form that the information is available on the Internet and including the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost.** • **Providing the information by any other method that can reasonably be expected to result in the member receiving that information.** *42 CFR 438.10(g)(3)*	• ADM207 Effective Communication with LEP & SI/SI Persons • ABCD_ABCNE FY17 Annual Communications Plan	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
12. The Contractor must make available to members, upon request, any physician incentive plans in place. 42. *FR 438.10(f)(3)*	• ABC309 Physician Incentive Plans • CS DP24 Physician Incentive Plans	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard V—Member Information for ABC-D							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	5	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	11	**Total Score**		=	6
				Total Score ÷ Total Applicable		=	55%

Results for Standard V—Member Information for ABC-NE							
Total	Met	=	7	X	1.00	=	7
	Partially Met	=	4	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	11	**Total Score**		=	7
				Total Score ÷ Total Applicable		=	64%

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. **The Contractor has established internal grievance procedures under which members, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance. The contractor must have a grievance and appeal system in place to handle appeals of an adverse benefit determination and grievances, as well as processes to collect and track information about them.** • **The Contractor may have only one level of appeal for members (or providers acting on their behalf).** • **A member may request a State fair hearing after receiving an appeal resolution notice from the Contractor that the adverse benefit determination has been upheld.** • **If the Contractor fails to adhere to required time frames for processing appeals, the member is deemed to have exhausted the Contractor's appeal process and the member may initiate a State fair hearing**. *42 CFR 438.400(a)(3)* *42 CFR 438.402(a-c)* *42 CFR 438.400(b)* Contract Amendment 7: Exhibit A3—2.6.4.1, 2.6.4.9.1, 2.6.4.9.3 10 CCR 2505-10—8.209.3.A, 8.209.4.A.2.c, 8.208.4.N, and 8.209.4.O	• ADM203 Member Grievance Process • ADM219 Member Appeal Process • QM201 Investigation of Potential Clinical Quality of Care Grievances and Referrals	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
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).** • For a resident of a rural area with only one managed care plan, the denial of a Medicaid member's request to exercise his or her rights to obtain services outside of the network under the following circumstances: – The service or type of provider (in terms of training, expertise, and specialization) is not available within the network. – The provider is not part of the network but is the main source of a service to the member—provided that: o The provider is given the opportunity to become a participating provider.	• CCS307 Utilization Review Determinations • ADM219 Member Appeal Process	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
o If the provider does not choose to join the network or does not meet the Contractor's qualification requirements, the member will be given the opportunity to choose a participating provider and then will be transitioned to a participating provider within 60 days. *42 CFR 438.400(b)* *42 CFR 438.52(b)(2)(ii)* Contract Amendment 7: Exhibit A3—1.1.1.3 10 CCR 2505-10—8.209.2.A		
3. The Contractor defines "Appeal" as "a review by the Contractor of an **adverse benefit determination**." *42 CFR 438.400(b)* Contract Amendment 7: Exhibit A3—1.1.1.4 10 CCR 2505-10—8.209.2.B	• ADM219 Member Appeal Process	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
4. The Contractor defines "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. 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 Amendment 7: Exhibit A3—1.1.1.27, 2.6.4.5.8.1.2 10 CCR 2505-10—8.209.2.D, 8.209.4.A.3.c.i	• ADM203 Member Grievance Process	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ 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 Contractor-level appeal and may request a State fair hearing on behalf of a member. *42 CFR 438.402(c)* Contract Amendment 7: Exhibit A3—2.6.4.4.1, 2.6.4.4.4, 2.6.4.6.3, 1.1.1.17 10 CCR 2505-10—8.209.3.B.1, 8.209.3.B.2, 8.209.2.C	• ADM203 Member Grievance Process • ADM219 Member Appeal Process	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
6. The Contractor accepts grievances orally or in writing. *42 CFR 438.402(c)(3)(i)* Contract Amendment 7: Exhibit A3—2.6.4.5.3 10 CCR 2505-10—8.209.5.D	• ADM203 Member Grievance Process	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
7. Members may file a grievance at any time. *42 CFR 438.402(c)(2)(i)* Contract Amendment 7: Exhibit A3—2.6.4.5.3 10 CCR 2505-10—8.209.5.A	• ADM203 Member Grievance Process	**ABC-D** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The policy ADM203—Member Grievance Process stated that a member may file a grievance at any time. However, the related policy, QM201—Quality of Care Concern (QOCC) Investigations stated that a member may file a quality of care grievance within 30 days of the incident. Staff members stated that the standard operating procedure has always been to accept a member grievance of any nature at any time. During on-site review, staff members corrected the QOCC policy to comply with requirements and correlate with the member grievance policy.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
However, the revised policy was not effective during the review period; and ABC cannot be credited with this revision pending approval, implementation, and any applicable staff training.		
Required Actions: ABC must ensure that the QOCC policy is updated to reflect that a quality of care grievance may be filed by a member at any time. Policy revisions must be approved by appropriate governing bodies and implemented, including any applicable staff training.		
8. The Contractor sends the member written acknowledgement of each grievance within two (2) working days of receipt. *42 CFR 438.406(b)(1)* Contract Amendment 7: Exhibit A3—2.6.4.5.3 10 CCR 2505-10—8.209.5.B	• ADM203 Member Grievance Process	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. 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 writing in the format established by the Department. • **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 Amendment 7: Exhibit A3—2.6.4.5.5, 2.6.4.5.5.1, 2.6.5.13.1 10 CCR 2505-10—8.209.5.D.1, 8.209.5.F	• ADM203 Member Grievance Process • ADM208 Member Materials	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
10. The written notice of grievance resolution includes: • Results of the disposition/resolution process and the date it was completed. Contract Amendment 7: Exhibit A3—2.6.4.5.5.2 10 CCR 2505-10—8.209.5.G	• ADM203- Member Grievance Process	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11. 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/TTD and interpreter capability. *42 CFR 438.406(a)(1)* Contract Amendment 7: Exhibit A3—2.6.4.3 10 CCR 2505-10—8.209.4.C	• ADM203 Member Grievance Process • ADM219 Member Appeal Process • ADM207 Effective Communication with limited English proficient persons and SI/SI Persons	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
12. 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. • **Take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.** *42 CFR 438.406(b)(2)* Contract Amendment 7: Exhibit A3—2.6.4.5.4, 2.6.4.6.10, 2.6.4.6.6.1, 2.6.4.7.1.1, 2.6.4.7.1.2 10 CCR 2505-10—8.209.5.C, 8.209.4.E	• ADM219 Member Appeal Process • ADM203 Member Grievance Process	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
13. 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 Amendment 7: Exhibit A3—2.6.4.6.3.1 10 CCR 2505-10—8.209.4.B	• ADM219 Member Appeal Process	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
14. 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)* *42 CFR 438.406(b)(3)* Contract Amendment 7: Exhibit A3—2.6.4.6.3.2 10 CCR 2505-10—8.209.4.F	• ADM219 Member Appeal Process	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
15. The Contractor sends the member 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 Amendment 7: Exhibit A3—2.6.4.1 10 CCR 2505-10—8.209.4.D	• ADM219 Member Appeal Process	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: Appeal policies and procedures accurately addressed written acknowledgement of appeals—unless expedited—within two working days. This was demonstrated in 100 percent of ABC-D record reviews. However, HSAG noted one ABC-NE appeal record which failed to send an acknowledgement letter within two days of receipt of the appeal request.		
Required Actions: ABC-NE must have mechanisms to ensure that written acknowledgement of a standard appeal request is sent to the member or designated representative, consistent with ABC policies and procedures.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
16. 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), and must be confirmed in writing unless the member or provider requests expedited resolution. • That if the member orally requests an expedited appeal, the Contractor shall not require a written, signed appeal following the oral request. • 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.** • That included, as parties to the appeal, are: – The member and his or her representative. – The legal representative of a deceased member's estate. *42 CFR 438.406(b)(3-5)*	• ADM219 Member Appeal Process	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Contract Amendment 7: Exhibit A3—2.6.4.6.4, 2.6.4.6.5, 2.6.4.6.7, 2.6.4.6.8, 2.6.4.6.9 10 CCR 2505-10—8.209.4.F, 8.209.4.G, 8.209.4.H, 8.209.4.I		
17. 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. *Note: If the written appeal is not signed by the member or designated client representative (DCR), the appeal resolution will remain pending until the appeal is signed. All attempts to gain a signature shall be included in the record of the appeal.* • For expedited resolution of an appeal and notice 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. • 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)&(3)&(d)(2)* *42 CFR 438.10* Contract Amendment 7: Exhibit A3—2.6.4.7.1, 2.6.4.7.3.2, 2.6.4.7.3.5, 2.6.5.13.1 10 CCR 2505-10—8.209.4.J, 8.209.4.L	• ADM219 Member Appeal Process	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
18. 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 • If 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. • 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 noice 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 that the extension expires. • **If the Contractor fails to adhere to the notice and timing requirements for extension of the appeal resoultion time frame, the member may initiate a State fair hearing**. *42 CFR 438.408(c)* Contract Amendment 7: Exhibit A3—2.6.4.7.2, 2.6.4.7.2.1, 2.6.4.7.8, 2.6.4.7.3.3, 2.6.4.5.8.1.2, 2.6.4.9.3, 2.6.4.6.2.5.2.3 10 CCR 2505-10—8.209.4.J, 8.209.4.O	• ADM203 Member Grievance Process • ADM219 Member Appeal Process	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
19. 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. o 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 Amendment 7: Exhibit A3—2.6.4.7.4, 2.6.4.7.5 10 CCR 2505-10—8.209.4.M	• ADM219 Member Appeal Process	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
20. **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. • 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. • The Contractor shall participate in all State fair hearings regarding appeals. *42 CFR 438.408(f)(1) and (2) and (3)* Contract Amendment 7: Exhibit A3—2.6.4.9.1, 2.6.4.9.3, 2.6.4.9.2, 2.6.4.9.5 10 CCR 2505-10—8.209.4.N, 8.209.4.O, 8.209.4.H	• ADM219 Member Appeal Process	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
21. The Contractor maintains an expedited review process for appeals for 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. • 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* Contract Amendment 7: Exhibit A3—2.6.4.7.3, 2.6.4.7.3.1, 2.10.17.2 10 CCR 2505-10—8.209.4.Q, 8.209.4.R, 8.29.4.S	• ADM219 Member Appeal Process	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
22. The Contractor provides for continuation of benefits/services while the Contractor-level appeal and the State fair hearing are pending if: • The member files timely* 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 within 60 calendar days of the notice of adverse benefit determination. **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 Amendment 7: Exhibit A3—2.6.4.8.1 10 CCR 2505-10—8.209.4.T	• ADM219 Member Appeal Process	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
23. 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 Amendment 7: Exhibit A3—2.6.4.8.2 10 CCR 2505-10—8.209.4.U	• ADM219 Member Appeal Process	**ABC-D** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The policy ADM 219—Member Appeal Processes addressed all bullets outlined in the requirement. However, the policy also included an additional criterion: until "the time period or service limits of the previously authorized service has been met." This criterion is not applicable to the length of time that benefits will be continued. During on-site review, staff members corrected the applicable language in the policy to comply with requirements. However, the revised policy was not effective during the review period; and ABC cannot be credited with this revision pending approval, implementation, and any applicable staff training.		
Required Actions: ABC must remove inaccurate statements as noted in the member appeals policy as well as any related member or provider communications (e.g., appeal resolution or adverse determination letters). Policy revisions must be approved by appropriate governing bodies and implemented, including any applicable staff training.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
24. 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 Amendment 7: Exhibit A3—2.6.4.8.3 10 CCR 2505-10—8.209.4.V	• ADM203- Member Grievance Process	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
25. Effectuation of reversed appeal resolutions: • 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. • 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, unless State policy and regulations provide for the State to cover the cost of such services. *42 CFR 438.424* Contract Amendment 7: Exhibit A3—2.6.4.8.4, 2.6.4.8.5 10 CCR 2505-10—8.209.4.V, 8.209.W	• ADM219 Member Appeal Process	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
26. 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.** *42 CFR 438.416* Contract Amendment 7: Exhibit A3—2.9.6.2 10 CCR 2505-10—8.209.3.C	• ADM203 Member Grievance Process • ADM219 Member Appeal Process	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
27. 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, including how members obtain a hearing, and the representation rules at a hearing. • The availability of assistance in the filing processes. • The toll-free number to file orally. • 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. • Appeals process available under the Child Mental Health Treatment Act (CMHTA), if residential services are denied. • Any State-determined provider's appeal rights to challenge the failure of the organization to cover a service.	• Provider Manual Page 2, 84-85 • PNS201 Provider Manual Directory and Communication Updates	**ABC-D** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
42 CFR 438.414 *42 CFR 438.10(g)(xi)* Contract Amendment 7: Exhibit A3—2.6.4.4 10 CCR 2505-10—8.209.3.B		
Findings: The Colorado Access Professional Provider Agreement incorporates the provider manual by reference. The ABC provider manual included a limited description regarding the member's right to file grievances and appeals, and included no detailed information to address the required components of the information about the grievance appeal and SFH system. The manual directed the provider to two different Colorado Access website locations to find detailed instructions or procedures related to grievances and appeals. HSAG found that no detailed procedures for appeals or grievances were located at either specified link. In addition, the provider manual included no information on appeals process available under the Child Mental Health Treatment Act (CMHTA). During on-site interviews, staff members stated that the entire provider manual was being rewritten and would be available for publication on or after December 1, 2017. The new provider manual will link the provider to the revised ADM203—Member Grievance Process and ADM219—Member Appeal Process policies on the provider website.		
Required Action: ABC must develop accessible and timely mechanisms to inform providers and subcontractors about the grievance, appeal, and SFH system in sufficient detail to address all federal and State requirements for provider information.		

Results for Standard VI—Grievance System for ABC-D							
Total	Met	=	24	X	1.00	=	24
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	27	**Total Score**		=	24
				Total Score ÷ Total Applicable		=	89%

Results for Standard VI—Grievance System for ABC-NE							
Total	Met	=	23	X	1.00	=	23
	Partially Met	=	4	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	27	**Total Score**		=	23
				Total Score ÷ Total Applicable		=	85%

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. The Contractor implements written policies and procedures for selection and retention of providers. *42 CFR 438.214(a)* Contract Amendment 7: Exhibit A3—2.9.7.1.1	• PNS202 Selection and Retention of Providers	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor follows a documented process for credentialing and recredentialing that complies with the State's policies for credentialing. • The Contractor uses National Committee for Quality Assurance (NCQA) credentialing and recredentialing standards and guidelines as the uniform and required standards for all contracts. • The Contractor ensures that all laboratory-testing sites providing services under the Contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration along with a CLIA registration number. *42 CFR 438.214(b) and (e)* Contract Amendment 7: Exhibit A3—2.9.7.1.1, 2.9.7.2.1.1–2, and 2.9.7.2.3.1	• PNS202 Selection and Retention of Providers • CR301 Provider Credentialing and Recredentialing • CR305 Assessment of Organizational Providers	**ABC-D** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: Based on the desk review of policies and procedures, HSAG determined that ABC's policies did include a process for ensuring that laboratory-testing sites have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a certificate of registration along with a CLIA registration number. During the on-site review ABC staff members confirmed that this was not a part of ABC's credentialing process and that hospital laboratories were used by members. ABC staff corrected this oversight in the credentialing form immediately.		
Required Actions: ABC must ensure that it develops and adheres to a documented process whereby all laboratory-testing sites providing services to ABC members have either a CLIA Certificate of Waiver or a certificate of registration along with a CLIA registration number.		
3. The Contractor's provider selection policies and procedures include provisions that the Contractor does not: • Discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. • Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42 CFR 438.12(a)(1) and (2)* *42 CFR 438.214(c)* Contract Amendment 7: Exhibit A3—2.5.14.1 and 2.9.7.1.3	• PNS202 Selection and Retention of Providers • CR301 Provider Credentialing and Recredentialing • CR305 Assessment of Organizational Providers	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This is not construed to: • Require the Contractor to contract with providers beyond the number necessary to meet the needs of its members. • Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. • Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members. *42 CFR 438.12(a-b)* Contract Amendment 7: Exhibit A3—2.5.14.1	• CR301 Provider Credentialing & Recredentialing • CR305 Assessment of Organizational Providers	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, provider, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participation in federal healthcare programs. • The Contractor shall not employ or contract with any individual or entity who has been excluded from participation in Medicaid by the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG). • The Contractor has procedures to provide the Department written disclosure of ownership and control within 35	• CMP206 Sanction and Exclusion Screening • CR301 Provider Credentialing & Recredentialing • CR305 Assessment of Organizational Providers • CR DP04 Ongoing Monitoring of Providers • CMP DP08 Compliance Program Operations Manual • LGL DP02 Disclosure or Change in Ownership and Control	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
days after any change in ownership of the managed care entity. • The Contractor shall, prior to hire or contracting, and at least monthly thereafter, screen all of its employees and contractors against the HHS-OIG's List of Excluded Individuals (LEIE) to determine whether they have been excluded from participation in Medicaid. • The Contractor has procedures to provide to the Department written disclosure of any prohibited affiliation within five (5) business days of discovery. *42 CFR 438.214(d)* *42 CFR 438.610(a-c)* *42 CFR 438.608(c)(1-2)* Contract Amendment 7: Exhibit A3—2.9.7.3.3.2, 2.9.7.3.3.7, 2.9.10.9, 2.10.5.2, 2.10.5.3.7.2		
6. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: • The member's health status, medical care, or treatment options—including any alternative treatments that may be self-administered. • Any information the member needs in order to decide among all relevant treatment options. • The risks, benefits, and consequences of treatment or non-treatment.	• CS212 Member Rights & Responsibilities • Provider Manual Page 11	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
• The member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment and to express preferences about future treatment decisions. *42 CFR 438.102(a)(1)* Contract Amendment 7: Exhibit A3—2.10.17.1		
7. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: • To the State upon contracting or when adopting the policy during the term of the contract. • To members before and during enrollment. • To members within 90 days after adopting the policy with respect to any particular service. *42 CFR 438.102(b)* Contract Amendment 7: Exhibit A3—2.10.18.1 and 2.10.18.3	• Provider Manual Page 11	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
8. The Contractor has administrative and management arrangements or procedures, including a compliance program to detect and prevent fraud, waste, and abuse, and which includes: • Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal, State, and contract requirements. • The designation of a compliance officer who is responsible for developing and implementing policies, procedures, and practices to ensure compliance with requirements of the contract and who reports directly to the CEO and Board of Directors. • The establishment of a compliance committee of the Board of Directors and at the senior management level, charged with overseeing the organization's compliance program. • Training and education of the compliance officer, management, and organization's staff members for the federal and State standards and requirements under the contract. • Effective lines of communication between the compliance officer and the Contractor's employees. • Enforcement of standards through well-publicized disciplinary guidelines. • Implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks.	• Compliance Plan • Code of Conduct • CMP206 Sanctions Screening • CMP211 Fraud, Waste and Abuse • CMP212 False Claims Act • CMP213 Internal Compliance Reviews • Board of Directors Finance Audit and Compliance Committee Charter (available to review onsite) • CMP204 Compliance Training and Education • Compliance Acknowledgement Signed by Every Employee • CMP DP08 Compliance Operations Manual, specifically following sections: o Responding to Issues o Complaint and Hotline Reports o Reporting Suspected Provider or Member Fraud • QM302- Review of Provider Medical Records • QM DP06 ABC 411 and 137 Encounter Validation Audit	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
• Procedures for prompt response to compliance issues as they are raised, investigation of potential compliance problems identified in the course of self-evaluation and audits, correction of such problems quickly and thoroughly to reduce the potential for reoccurence, and ongoing compliance with the requirements under the contract. *42 CFR 438.608(a)(1)* Contract Amendment 7: Exhibit A3—2.9.3.1, 2.9.3.1.1.1–2, 2.9.3.1.3–7		
9. The Contractor's administrative and management procedures to detect and prevent fraud, waste, and abuse include: • Written policies for all employees, contractors or agents that provide detailed information about the False Claims Act, including the right of employees to be protected as whistleblowers. • Provisions for prompt referral of any potential fraud, waste, or abuse to the State Medicaid program integrity unit and any potential fraud to the State Medicaid Fraud Control Unit. Contractor provides to the Department: – Verbal report immediately. – Written report in three (3) business days. • Provisions for suspension of payments to a network provider for which the State determines there is credible allegation of fraud. *42 CFR 438.608(a)(6-8)* Contract Amendment 7: Exhibit A3—2.12.1, 2.9.3.2.1–2, 2.9.3.4.1, 2.9.3.4.4	• CMP 212 False Claims Act • CMP DP08 Compliance Program Operations Manual, Sections: o Reporting Suspected Provider or Member Fraud o HCPF Payment Suspension Requests	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
10. The Contractor's compliance program includes: • Provision for prompt notification to the Department about member circumstances that may affect the member's eligibility, including change in residence and member death. • Provision for notification to the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including termination of the provider agreement with the Contractor. *42 CFR 438.608(a)(3-4)* Contract Amendment 7: Exhibit A3—2.9.3.2.1–2, 2.10.15.2	• CS DP25 Change in Member Status • ADM300 Provider Terminations	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11. The Contractor's compliance program includes provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potenial fraud. • The Contractor screens all provider claims, collectively and individually, for potential fraud, waste, or abuse—including mechanisms to identify overpayments to providers and to report suspected instances of up-coding, unbundling of services, services that were billed for but never rendered, and inflated bills for services and goods provided. • The Contractor has procedures for provision of a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members.	• ABC DP01 Member Services Verification Plan • CLM DP10 Claims Overpayments • CMP DP08 Compliance Program Operations Manual, Overpayment Section • QM302- Review of Provider Medical Records • QM DP06 ABC 411 and 137 Encounter Validation Audit • Current Provider Manual, pg 48. • New Provider Manual - not yet published (available for review onsite) • Colorado Access website "Non-Clinical Adjustment/Appeal Process Request" **Claims/Encounter processing audits and edits:** We use several mechanisms to verify that provider	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
- The Contractor provides individual notices to all or a sample of members who received services to verify and report whether services billed by providers were actually received by members. • The Contractor has a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days of identifying the overpayment, and to notify the Contractor in writing of the reason for the overpayment. • The Contractor has procedures to identify to the Department within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract. • The Contractor reports annually to the State on recoveries of overpayments. *42 CFR 438.608(a)(5), (c)(3), and (d)(2) and (3)* Contract Amendment 7: Exhibit A3—2.9.3.1.8, 2.9.3.1.1.3–9, 2.9.3.2.1–2, and 5.2.1.1,	billing and payment accurately reflect delivered services. Our claims system is configured to validate member eligibility, covered diagnosis, covered services, and also identifies duplicate payments and overpayments. We utilize the TriZetto QNXT claims/encounter processing system. Within this system, paper and electronic claims and encounters are electronically matched to the appropriate member and provider. Once a member and provider are established, the system runs through a series of automated adjudication rules that are administered within each member's eligibility and benefit package. The benefit package contains covered services and codes, benefit limitations, authorization rules, and member responsibility (i.e., copayments), if applicable. Then, we calculate the provider reimbursement amount from the fee schedule attached to that provider, under appropriate contract and line of business, and then the claim is ready for payment. In addition to payment rules within the provider and benefit setup, we also apply system-generated adjudication edits. These include validations of the service and diagnosis codes, as well as ensuring the claim was submitted within the timely filing requirements. The system also uses logic to check for duplicate claims submission to ensure that duplicate payments are not made. We routinely	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	audit system setup and reimbursement accuracy to ensure these payment rules are working correctly. We also utilize two McKesson tools: ClaimCheck and Policy Administration Module (PAM), which are integrated with the TriZetto QNXT transaction system. These tools are configured to edit claims against the requirements of the Uniform Services Coding Standards Manual by reviewing for coding utilization limits, invalid code combinations, correct modifiers, and place of service edits. With TriZetto, we have systems in place to flag and monitor outliers and unusual claim submissions for audit. A number of automated tools support this function. For example, controls are in place to identify high cost claims for review prior to payment. Colorado Access and Trizetto each employ operations/claims auditors who are specifically trained and experienced with reviewing claims/encounters against payment and processing policies and procedures. These claims auditors randomly audit at least three percent of claims processed daily. They audit for payment and processing accuracy for claims that were auto-adjudicated (i.e., without manual intervention), as well as claims we processed manually. We contract with external audit vendors to perform various post-payment audits, and these contractors are trained in recognizing potential fraud, waste, and abuse issues:	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	• SCIO – reviews facility claims for coding accuracy, up-coding, high-dollar claim reviews, and specialty audits, such as infusion/DME audits. • Optum – conducts reviews at hospitals to identify credit balances and overpayment. • First Recovery Group (FRG) – reviews claims paid for potential subrogation recovery opportunities. **Procedures to identify to the Department within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract:** The Department provides a list/files to Colorado Access of the members and the applicable capitation rate and payment. The Department also identifies errors and automatically adjusts error payments in following months.	
12. **The Contractor ensures that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure, screening, and enrollment requirements of the State.** *42 CFR 438.608(b)* Contract Amendment 7: Exhibit A3—2.5.9.12	• CR301 Provider Credentialing and Recredentialing • CR305 Organizational Providers Credentialing	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
13. The Contractor provides that Medicaid members are not held liable for: • The Contractor's debts in the event of the Contractor's insolvency. • Covered services provided to the member for which the State does not pay the Contractor. • Covered services provided to the member for which the State or the Contractor does not pay the healthcare provider that furnishes the services under a contractual, referral, or other arrangement. • Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. *42 CFR 438.106* Contract Amendment 7: Exhibit A3—2.2.3, 2.10.14.2	• Professional Provider Agreement Template o Section C.6, • Colorado Access Provider Manual, o Pg 47-48, Hold Harmless Clause	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard VII—Provider Participation and Program Integrity for ABC-D							
Total	Met	=	12	X	1.00	=	12
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	13	**Total Score**		=	12
			Total Score ÷ Total Applicable			=	92%

Results for Standard VII—Provider Participation and Program Integrity for ABC-NE							
Total	Met	=	12	X	1.00	=	12
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	13	**Total Score**		=	12
			Total Score ÷ Total Applicable			=	92%

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. **Notwithstanding any relationship(s) with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State.** The Contractor must: • Evaluate the prospective subcontractor's ability to perform the activities to be delegated. • Monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the State, consistent with industry standards or State laws and regulations. • Identify deficiencies or areas for improvement, and ensure that the subcontractor takes corrective action. *42 CFR 438.230(b)(1)* Contract Amendment 7: Exhibit A3—3.1.5, 3.1.5.1, 3.1.5.3–4	Note—This does not apply to provider agreements (unless provider contracted to perform responsibilities other than services to members). • ADM223 Delegation • Delegation agreement template, Article B.1. (pg 5) (will be available for review on site)	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. All contracts or written arrangements between the Contractor and any subcontractor specify: • The delegated activities **or obligations** and related reporting responsibilities. • **That the subcontractor agrees to perform the delegated activities and reporting responsibilities** • Provision for revocation of the delegation of activities or obligation or **specify other remedies in instances where the State or Contractor determines** that the subcontractor has not performed satisfactorily. *42 CFR 438.230(b)(2) and (c)(1)* Contract Amendment 7: Exhibit A3—3.1.5.1.2	• ADM223 Delegation • Delegation agreement template, Article B.1. (pg 5) (will be available for review on site)	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the BHO**	**Score**
3. The Contractor's written agreement with any subcontractor includes: • **The subcontractor's agreement to comply with all applicable Medicaid laws and regulations, including applicable sub-regulatory guidance and contract provisions.** *42 CFR 438.230 (c)(2)* Contract Amendment 7: Exhibit A—6.A	• ADM223 Delegation • Delegation agreement template, Article B.1. (pg 5) (will be available for review on site)	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. The written agreement with the subcontractor includes: • **The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State.** – **The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, and computer or other electronic systems related to Medicaid members.**	• ADM223 Delegation • Delegation agreement template, Article B.1. (pg 5) (will be available for review on site)	**ABC-D** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **ABC-NE** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the BHO**	**Score**
– **The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.** – **If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.** *42 CFR 438.230(c)(3)* Contract Amendment 7: Exhibit A3—2.9.9.5		

Results for Standard IX—Subcontracts and Delegation for ABC-D							
Total	Met	=	4	X	1.00	=	4
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	4	**Total Score**		=	4
				Total Score ÷ Total Applicable		=	100%

Results for Standard IX—Subcontracts and Delegation for ABC-NE							
Total	Met	=	4	X	1.00	=	4
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	4	**Total Score**		=	4
				Total Score ÷ Total Applicable		=	100%

Appendix B. Record Review Tools

The completed record review tools follow this cover page.

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Appeals Record Review Tool
for Access Behavioral Care-Denver

Review Period:	July 1, 2017–December 31, 2017
Date of Review:	November 7, 2017
Reviewer:	Kathy Bartilotta
Participating Health Plan Staff Member:	Christine Gillespie

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	***	07/11/17	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	07/14/17	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: Expedited request; inpatient hospitalization; oral notice to provider as designated representative; appeal overturned denial.											
2	***	07/26/17	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	07/27/17	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: Expedited request; continued inpatient stay; provider was designated representative; appeal overturned denial.											
3	***	08/15/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	08/25/17	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: Inpatient hospitalization; retrospective review; provider was designated representative.											
4	***	08/15/17	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	08/18/17	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: Expedited request; residential treatment; appeal upheld; member notified orally.											
5	***	08/31/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	09/08/17	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: Member admitted to inpatient hospitalization despite authorization denial; provider appealed retrospectively as designated representative; appeal upheld.											
6			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
7			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
8			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
9			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
10			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Appeals Record Review Tool
for Access Behavioral Care-Denver

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
OS1			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS2			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS3			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS4			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS5			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
Do not score shaded columns below.											
Column Subtotal of Applicable Elements			**2**	**5**	**5**				**5**	**5**	**5**
Column Subtotal of Compliant (M) Elements			**2**	**5**	**5**				**5**	**5**	**5**
Percent Compliant (Divide Compliant by Applicable)			**100%**	**100%**	**100%**				**100%**	**100%**	**100%**

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

Total Applicable Elements	**27**
Total Compliant (M) Elements	**27**
Total Percent Compliant	**100%**

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Grievance Record Review Tool
for Access Behavioral Care-Denver

Review Period:	July 1, 2017–December 31, 2017
Date of Review:	November 7, 2017
Reviewer:	Gina Stepuncik
Participating Health Plan Staff Member:	Veronica Rodriguez

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 (If Clinical)	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
1	***	07/13/17	Y ☒ N ☐ N/A ☐	08/02/17	20	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
2	***	08/10/17	Y ☒ N ☐ N/A ☐	08/25/17	15	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
3			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
4			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
5			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
6			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
7			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
8			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
9			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
10			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Grievance Record Review Tool
for Access Behavioral Care-Denver

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 (If Clinical)	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
OS 1			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 2			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 3			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 4			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 5			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
Do not score shaded columns below.										
Column Subtotal of Applicable Elements			**2**			**2**	**0**	**0**	**2**	**2**
Column Subtotal of Compliant (Yes) Elements			**2**			**2**	**0**	**0**	**2**	**2**
Percent Compliant (Divide Compliant by Applicable)			**100%**			**100%**	**NA**	**NA**	**100%**	**100%**

Key: Y = Yes; N = No
N/A = Not Applicable

Total Applicable Elements	**8**
Total Compliant (Yes) Elements	**8**
Total Percent Compliant	**100%**

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Appeals Record Review Tool
for Access Behavioral Care-Northeast

Review Period:	July 1, 2017–December 31, 2017
Date of Review:	November 7, 2017
Reviewer:	Kathy Bartilotta
Participating Health Plan Staff Member:	Christine Gillespie

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	***	07/13/17	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	07/14/17	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: Residential treatment; no signature obtained; however, member verbal approval of appeal noted in record; denied on appeal; called member.											
2	***	08/16/17	M ☐ N ☒ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	08/18/17	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: Residential continued stay; provider request; appeal upheld denial decision.											
3	***	08/31/17	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	09/01/17	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: Member assigned CMHC as designated representative; appeal overturned denial.											
4	***	10/19/17	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒		M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: Expedited request; provider served as designated representative; non-covered diagnosis—appeal upheld; oral notice to provider.											
5			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
6			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
7			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
8			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
9			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
10			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Appeals Record Review Tool
for Access Behavioral Care-Northeast

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
OS1			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS2			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS3			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS4			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS5			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
Do not score shaded columns below.											
Column Subtotal of Applicable Elements			**1**	**4**	**4**				**4**	**4**	**4**
Column Subtotal of Compliant (M) Elements			**0**	**4**	**4**				**4**	**4**	**4**
Percent Compliant (Divide Compliant by Applicable)			**0%**	**100%**	**100%**				**100%**	**100%**	**100%**

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

Total Applicable Elements	**21**
Total Compliant (M) Elements	**20**
Total Percent Compliant	**95%**

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Grievance Record Review Tool
for Access Behavioral Care-Northeast

Review Period:	July 1, 2017–December 31, 2017
Date of Review:	November 7, 2017
Reviewer:	Gina Stepuncik
Participating Health Plan Staff Member:	Veronica Rodriguez

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 (If Clinical)	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
1	***	07/05/17	Y ☒ N ☐ N/A ☐	07/17/17	12	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
2	***	07/27/17	Y ☐ N ☐ N/A ☒	07/28/17	1	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments: Colorado Access sent the resolution letter the day after the grievance receipt date; therefore, the grievance was acknowledged through the resolution letter, and a separate acknowledgement letter was not necessary.										
3	***	08/10/17	Y ☒ N ☐ N/A ☐	08/30/17	20	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
4	***	08/23/17	Y ☒ N ☐ N/A ☐	09/12/17	20	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
5	***	08/31/17	Y ☒ N ☐ N/A ☐	09/20/17	20	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments: Colorado Access discussed this grievance with the member in the member's home, per the member's request. Colorado Access sent a written acknowledgement letter and a written resolution letter to the member following the home visit.										
6	***	08/24/17	Y ☒ N ☐ N/A ☐	09/12/17	19	Y ☒ N ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments: This grievance was clinical in nature as it involved the administering of medications to the member while the member was in residential care.										
7	***	10/02/17	Y ☒ N ☐ N/A ☐	10/20/17	18	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
8			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
9			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Grievance Record Review Tool
for Access Behavioral Care-Northeast

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 (If Clinical)	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
10			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 1			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 2			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 3			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 4			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 5			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
Do not score shaded columns below.										
Column Subtotal of Applicable Elements			**6**			**7**	**1**	**1**	**7**	**7**
Column Subtotal of Compliant (Yes) Elements			**6**			**7**	**1**	**1**	**7**	**7**
Percent Compliant (Divide Compliant by Applicable)			**100%**			**100%**	**100%**	**100%**	**100%**	**100%**

Key: Y = Yes; N = No
N/A = Not Applicablea

Total Applicable Elements	**29**
Total Compliant (Yes) Elements	**29**
Total Percent Compliant	**100%**

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2017–2018 site review of **ABC-D** and **ABC-NE**.

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

HSAG Review Team	Title
Kathy Bartilotta	Associate Director
Gina Stepuncik	Project Manager
ABC Participants	**Title**
Bethany Hines	Vice President, Program Services
Christine E. Gillespie	Manager, Clinical Appeals Manager
Claudine McDonald	Director, Member Engagement and Inclusion
Crystal Garrett	Compliance Specialist
David Rastatter	Director, Colorado Medicaid
Denise Brelsford	Configuration
Elizabeth Strammiello	Chief Compliance Officer
Heidi Warner	Marketing
Janet Milliman	Director CHP+, Pharmacy
Jason Smith	Provider Contracting
Jenny Nate	Department Director, Behavioral Health
Kristin Brown	Operations Manager, Behavioral Health
Marty Janssen	Deputy Director, Medicaid
Michelle Tomsche	Operations Director, Behavioral Health
Rebecca Lynn	Provider Contracting
Reyna Garcia	Sr. Director, Customer Service and Claim Appeals
Robert Bremer	Vice President, Integrated Care
Tanya Lilly	Grievance Manager
Travis Roth	Credentialing Manager
Veronica Rodriguez	Grievance
Department Observers	**Title**
Russ Kennedy	Quality/Compliance Specialist
Teresa Craig	Program and Contract Manager, CHP+

Appendix D. Corrective Action Plan Template for FY 2017–2018

If applicable, the BHO 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 BHO 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 BHO 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 BHO 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 BHO 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 BHO 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 BHO to proceed with implementation, or • Instruct the BHO 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 BHO has received Department approval of the CAP, the BHO will have a time frame of six months to complete proposed actions and submit documents. The BHO will submit documents as evidence of completion one time only on or before the six-month deadline for all required actions in the CAP. (If necessary, the BHO 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 health plan within the intervening time frame.)

Step	Action
Step 5	**Technical assistance**
	HSAG will schedule with the BHO a one-time, interactive, verbal consultation and technical assistance session during the six-month time frame. The session may be scheduled at the health plan's discretion at any time the health plan 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 BHO 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 six-month deadline will result in assignment as a delinquent corrective action that will be continued into the following compliance review year. (HSAG will list delinquent actions in the annual technical report and in the health plan's subsequent year's compliance site review report.)

The CAP template follows.

Table D-2—FY 2017–2018 Corrective Action Plan for ABC-D and ABC-NE

Standard V—Member Information—ABC-D and ABC-NE		
Requirement	**Findings**	**Required Action**
3. The Contractor makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • **Written materials that are critical to obtaining services include: provider directories, member handbooks, appeal and grievance notices, and denial and termination notices.** • **All written materials for members must:** – Use easily understood language and format. – **Use a font size no smaller than 12 point.** – Be available in alternative formats **and through provision of auxiliary aids and services** that take into consideration the special needs of members **with disabilities** or limited English proficiency. – **Include taglines in large print (18 point) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral**	HSAG found that the taglines describing how to request auxiliary aids and services including written translation and oral interpretation, while present, were not in 18-point font on either paper or electronic member materials, as required.	ABC-D and ABC-NE must ensure that all member materials include taglines describing how to request auxiliary aids and services including written translation and oral interpretation in 18-point font.

Standard V—Member Information—ABC-D and ABC-NE		
Requirement	**Findings**	**Required Action**
interpretation and the toll-free and TTY/TDY customer service number, and availability of materials in alternative formats. – Be available for immediate dissemination in that language. *42 CFR 438.10(d)(3) and (d)(6)* Contract Amendment 7: Exhibit A3—2.6.5.13.1–3, 2.6.5.13.6.1–3, 2.6.5.13.7, 2.6.5.13.10.1–4		
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 V—Member Information—ABC-D and ABC-NE		
Requirement	**Findings**	**Required Action**
4. If the Contractor makes information available electronically—Information provided electronically must meet the following requirements: • **The format is readily accessible (see definition of readily accessible above).** • **The information is placed in a Web site location that is prominent and readily accessible.** • **The information can be electronically retained and printed.** • **The information complies with content and language requirements.** • **The member is informed that the information is available in paper form without charge upon request, and is provided within five (5) business days.** *42 CFR 438.10(c)(6)* Contract Amendment 7: Exhibit A3—2.6.5.3.6–8	During the desk review process, HSAG conducted an accessibility check on a few ABC Web pages using the WAVE Web Accessibility Evaluation Tool. Through use of the tool, HSAG discovered several general accessibility errors and contrast errors on various Web pages. HSAG also ran an accessibility check on several PDF documents available for download from the ABC website. Through use of the Adobe Acrobat Pro accessibility checker, HSAG discovered accessibility errors. HSAG repeated these accessibility checks during the on-site review for educational purposes, and the same outcomes were discovered.	ABC must develop a process to ensure that all information on its website is readily accessible (i.e., complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines). ABC must inform members in a prominent place of its website that information on the website is available in paper form upon request without charge, and provided within five business days.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

Standard V—Member Information—ABC-D and ABC-NE		
Requirement	**Findings**	**Required Action**
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard V—Member Information—ABC-D and ABC-NE		
Requirement	**Findings**	**Required Action**
5. The Contractor makes interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and how to access them. • **This includes oral interpretation and use of auxiliary aids such as TTY/TDY and American Sign Language.** • The Contractor notifies members that **auxiliary aids and services are available upon request and at no cost for members with disabilities**, and how to access them. *42 CFR 438.10(d)(4) and (d)(5)* Contract Amendment 7: Exhibit A3—2.6.5.13.7–9	On its website, ABC included a function to decipher its webpages (not including PDF documents) into any one of over 50 languages. ABC did not, however, include directly on its website or within the associated PDF member materials notification to the member that oral interpretation in any language, as well as other auxiliary aids, are available free of charge or how members may access them.	While ABC does provide oral interpretation, and use of auxiliary aids to members free of charge as needed, ABC must notify members that these provisions are available and how to access them. During the on-site review, HSAG and ABC discussed prominent places for disseminating this information on the ABC website.
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 V—Member Information—ABC-D and ABC-NE		
Requirement	**Findings**	**Required Action**
7. The Contractor makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals**, pharmacies, and behavioral health providers, and long-term services and supports (LTSS) providers:** • The provider's name and **group affiliation**, street address(es), telephone number(s), **Web site URL, specialty (as appropriate),** and whether the providers will accept new members. • **The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training.** • **Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment.** *(Note: Information included in a paper provider directory must be updated at least monthly, and electronic provider*	HSAG reviewed both the provider directory and the "Find A Provider" feature on the ABC website. While the provider directory did not contain all required information, the "Find A Provider" was a valuable resource that contained comprehensive information in a searchable format. As discussed on-site, the disability accommodation field did not define the accommodations available at each provider's location. Further research performed by ABC during the on-site visit concluded that only one area of disability access, such as handicap parking or a nearby public transit line, could qualify a provider as having "disability access." The requirement, however, clarifies this to include accessible offices, exam rooms, and equipment.	ABC must update its provider directory or online "Find A Provider" feature to better clarify what it defines as "disability access," in agreement with the requirement.

Standard V—Member Information—ABC-D and ABC-NE		
Requirement	**Findings**	**Required Action**
directories must be updated no later than 30 calendar days after the Contractor receives updated provider information.) *42 CFR 438.10(h)(1-3)* Contract Amendment 7: Exhibit A3—2.6.5.8.1–3		
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 V—Member Information—ABC-D Only		
Requirement	**Findings**	**Required Action**
10. For any information provided to members by the Contractor, the Contractor ensures that information is consistent with federal requirements in 42 CFR 438.10. *42 CFR 438.10 (b)*	During the desk review, HSAG found that ABC had two member handbooks, the Health First Colorado member handbook and its own member handbook, on its website at the webpage coaccess.com/abc-denver-plan-documents-and-forms. During the on-site interview, ABC noted that this was unintentional and that it would be removed immediately. A week following the on-site review, the ABC-D Member and Family Handbook had not been removed. HSAG found that the ABC-D handbook contained information which conflicts with the Health First Colorado member handbook, which could be confusing to members. For example, the information ABC-D provided to members in the Member and Family Handbook had not been updated to reflect current time frames and procedures for grievances and appeals in accordance with 42 CFR §438.10 information requirements. HSAG viewed a similar webpage for ABC-NE, which contained only a link to the Health First Colorado member handbook.	ABC-D must remove its Member and Family Handbook from its webpage to ensure that members are not receiving conflicting or inaccurate information about appeals and grievances.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

Standard V—Member Information—ABC-D Only		
Requirement	**Findings**	**Required Action**
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance System—ABC-D and ABC-NE		
Requirement	**Findings**	**Required Action**
7. Members may file a grievance at any time. *42 CFR 438.402(c)(2)(i)* Contract Amendment 7: Exhibit A3—2.6.4.5.3 10 CCR 2505-10—8.209.5.A	The policy ADM203—Member Grievance Process stated that a member may file a grievance at any time. However, the related policy, QM201—Quality of Care Concern (QOCC) Investigations stated that a member may file a quality of care grievance within 30 days of the incident. Staff members stated that the standard operating procedure has always been to accept a member grievance of any nature at any time. During on-site review, staff members corrected the QOCC policy to comply with requirements and correlate with the member grievance policy.	ABC must ensure that the QOCC policy is updated to reflect that a quality of care grievance may be filed by a member at any time. Policy revisions must be approved by appropriate governing bodies and implemented, including any applicable staff training.
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—Grievance System—ABC-NE Only		
Requirement	**Findings**	**Required Action**
15. The Contractor sends the member 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 Amendment 7: Exhibit A3—2.6.4.1 10 CCR 2505-10—8.209.4.D	Appeal policies and procedures accurately addressed written acknowledgement of appeals—unless expedited—within two working days. This was demonstrated in 100 percent of ABC-D record reviews. However, HSAG noted one ABC-NE appeal record which failed to send an acknowledgement letter within two days of receipt of the appeal request.	ABC-NE must have mechanisms to ensure that written acknowledgement of a standard appeal request is sent to the member or designated representative, consistent with ABC policies and procedures.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance System—ABC-D and ABC-NE		
Requirement	**Findings**	**Required Action**
23. 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 Amendment 7: Exhibit A3—2.6.4.8.2 10 CCR 2505-10—8.209.4.U	The policy ADM 219—Member Appeal Processes addressed all bullets outlined in the requirement. However, the policy also included an additional criterion: until "the time period or service limits of the previously authorized service has been met." This criterion is not applicable to the length of time that benefits will be continued. During on-site review, staff members corrected the applicable language in the policy to comply with requirements. However, the revised policy was not effective during the review period; and ABC cannot be credited with this revision pending approval, implementation, and any applicable staff training.	ABC must remove inaccurate statements as noted in the member appeals policy as well as any related member or provider communications (e.g., appeal resolution or adverse determination letters). Policy revisions must be approved by appropriate governing bodies and implemented, including any applicable staff training.
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—Grievance System—ABC-D and ABC-NE		
Requirement	**Findings**	**Required Action**
27. 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, including how members obtain a hearing, and the representation rules at a hearing. • The availability of assistance in the filing processes. • The toll-free number to file orally. • 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	The Colorado Access Professional Provider Agreement incorporates the provider manual by reference. The ABC provider manual included a limited description regarding the member's right to file grievances and appeals, and included no detailed information to address the required components of the information about the grievance appeal and SFH system. The manual directed the provider to two different Colorado Access website locations to find detailed instructions or procedures related to grievances and appeals. HSAG found that no detailed procedures for appeals or grievances were located at either specified link. In addition, the provider manual included no information on appeals process available under the Child Mental Health Treatment Act (CMHTA). During on-site interviews, staff members stated that the entire provider manual was being rewritten and would be available for publication on or after December 1, 2017. The new provider manual will link the provider to the revised ADM203—Member Grievance Process and ADM219—Member Appeal Process policies on the provider website.	ABC must develop accessible and timely mechanisms to inform providers and subcontractors about the grievance, appeal, and SFH system in sufficient detail to address all federal and State requirements for provider information.

Standard VI—Grievance System—ABC-D and ABC-NE		
Requirement	**Findings**	**Required Action**
while the appeal or State fair hearing is pending, if the final decision is adverse to the member. • Appeals process available under the Child Mental Health Treatment Act (CMHTA), if residential services are denied. • Any State-determined provider's appeal rights to challenge the failure of the organization to cover a service. *42 CFR 438.414* *42 CFR 438.10(g)(xi)* Contract Amendment 7: Exhibit A3—2.6.4.4 10 CCR 2505-10—8.209.3.B		
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 VII—Provider Participation and Program Integrity—ABC-D and ABC-NE		
Requirement	**Findings**	**Required Action**
2. The Contractor follows a documented process for credentialing and recredentialing that complies with the State's policies for credentialing. • The Contractor uses National Committee for Quality Assurance (NCQA) credentialing and recredentialing standards and guidelines as the uniform and required standards for all contracts. • The Contractor ensures that all laboratory-testing sites providing services under the Contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration along with a CLIA registration number. *42 CFR 438.214(b) and (e)* Contract Amendment 7: Exhibit A3—2.9.7.1.1, 2.9.7.2.1.1–2, and 2.9.7.2.3.1	Based on the desk review of policies and procedures, HSAG determined that ABC's policies did include a process for ensuring that laboratory-testing sites have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a certificate of registration along with a CLIA registration number. During the on-site review ABC staff members confirmed that this was not a part of ABC's credentialing process and that hospital laboratories were used by members. ABC staff corrected this oversight in the credentialing form immediately.	ABC must ensure that it develops and adheres to a documented process whereby all laboratory-testing sites providing services to ABC members have either a CLIA Certificate of Waiver or a certificate of registration along with a CLIA registration number.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		

Standard VII—Provider Participation and Program Integrity—ABC-D and ABC-NE		
Requirement	**Findings**	**Required Action**
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review Protocol Activities

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

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal Medicaid managed care regulations and contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, on-site agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all site reviewers to ensure consistency in scoring across plans.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Behavioral Health Quality Improvement Committee (BQuIC) 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 BHO 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 BHO 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 BHO's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The BHOs also submitted a list of all Medicaid appeals and grievances that occurred between July 1, 2017, and December 31, 2017. 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 BHO's key staff members to obtain a complete picture of the BHO's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the BHO's performance. • HSAG reviewed a sample of administrative records to evaluate implementation of Medicaid managed care regulations related to BHO appeals and grievances. • Also while on-site, HSAG collected and reviewed additional documents as needed. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were confidential or proprietary, or were requested as a result of the pre-on-site document review.) • At the close of the on-site portion of the site review, HSAG met with BHO staff and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2017–2018 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. • HSAG analyzed the findings. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the State**
	• HSAG populated the report template. • HSAG submitted the draft site review report to the BHO and the Department for review and comment. • HSAG incorporated the BHO's and Department's comments, as applicable, and finalized the report. • HSAG distributed the final report to the BHO and the Department.