Colorado Medicaid
Managed Care Program

FY 2008–2009 Site Review Report

for

Colorado Access

March 2009

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

HSAG HEALTH SERVICES ADVISORY GROUP

1600 East Northern Avenue, Suite 100 • Phoenix, AZ 85020

Phone 602.264.6382 • Fax 602.241.0757

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Overview of FY 2008–2009 Compliance Monitoring Activities

The Balanced Budget Act of 1997, Public Law 105-33 (BBA), requires that states conduct an annual evaluation of their managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to determine compliance with regulations, contractual requirements, and the State's quality strategy. The Department of Health Care Policy & Financing (the Department) has elected to complete this requirement for the Colorado MCOs by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This is the first year that HSAG has performed compliance monitoring reviews of the MCOs. For the fiscal year (FY) 2008–2009 site review process, the Department requested a focused review of four areas of performance. For **Colorado Access**, a newly contracted MCO for FY 2008–2009, a fifth standard area was reviewed. HSAG developed a review strategy consisting of five standards for review for **Colorado Access**, which corresponded with the five areas identified by the Department. These were: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard III—Coordination and Continuity of Care, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation. Compliance with federal regulations and contract requirements was evaluated through review of the five standards. This report documents results of the FY 2008–2009 site review activities for the review period—June 1, 2008, through November 30, 2008. Section 2 contains summaries of the findings, strengths, opportunities for improvement, and required actions for each standard. Appendices A and B contain details of the findings.

Methodology

In developing the data collection tools and in reviewing the five standards, HSAG used the MCO's contract requirements and regulations specified by the BBA with revisions that were issued on June 14, 2002, and effective on August 13, 2002. HSAG conducted a desk review of materials submitted prior to the on-site review activities, a document review of materials provided on-site, interviews of key MCO personnel, and an on-site record review of medical and case management records to identify instances of care coordination. Documents submitted for the desk review and during the on-site document review consisted of policies and procedures, staff training materials, minutes of key committee meetings, and member and provider informational materials. Details of the review of the five standards follow in Appendix A.

For the record review, a random sample of 15 medical and case management records was selected and reviewed to document and describe instances of care coordination. Details of the findings for the coordination of care record review follow in Appendix B.

The five standards chosen for the FY 2008–2009 site review represent a portion of the requirements based on Medicaid managed care contract and BBA requirements. Standards IV—Member Rights and Protections, V—Member Information, VI—Grievance System, VIII—Credentialing and Recredentialing, and X—Quality Assessment and Performance Improvement will be reviewed in subsequent years.

The site review processes were consistent with the February 11, 2003, Centers for Medicare & Medicaid Services final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs).* A detailed description of HSAG's site review activities by activity outlined in the CMS final protocol is in Appendix E.

Objective of the Site Review

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

- The MCO's compliance with federal regulations and contract requirements in the five areas of review.
- The quality and timeliness of, and access to, health care furnished by the MCO, as assessed by the specific areas reviewed.
- Possible interventions to improve the quality the MCO's service related to the area reviewed.
- Activities to sustain and enhance performance processes.

Summary of Results

Based on the results from the Compliance Monitoring Tool, the record review tool, and conclusions drawn from the review activities, HSAG assigned each element within the standards in the Compliance Monitoring Tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. HSAG assigned required actions to any individual element within the Compliance Monitoring Tool receiving a score of *Partially Met* or *Not Met.*

Table 1-1 presents the score for **Colorado Access** for each of the standards. Details of the findings for each standard follow in Appendix A.

Table 1-1—Summary of Scores for the Standards								
Standard #	Description of Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
I	Coverage and Authorization of Services	25	25	24	1	0	0	96%
II	Access and Availability	14	14	13	1	0	0	93%
III	Coordination and Continuity of Care	9	9	9	0	0	0	100%
VII	Provider Participation and Program Integrity	16	15	15	0	0	1	100%
IX	Subcontracts and Delegation	8	8	7	0	1	0	88%
	Totals	**72**	**71**	**68**	**2**	**1**	**1**	**96%**

2. Summary of Performance Strengths and Required Actions for Colorado Access

Overall Summary of Performance

For four of the five standards HSAG reviewed (i.e., Coverage and Authorization of Services, Access and Availability, Coordination and Continuity of Care, and Provider Participation and Program Integrity) the MCO received overall percentage-of-compliance scores of 93 percent or more, with the Coordination and Continuity of Care and the Provider Participation and Program Integrity standards receiving a score of 100 percent, representing areas of clear strength for **Colorado Access**. **Colorado Access** achieved a score of 88 percent for one standard (Subcontracts and Delegation). The Subcontracts and Delegation standard, however, consisted of a total of eight scored requirements; therefore, the score of 88 percent was misleading and only represented one required corrective action.

Standard I—Coverage and Authorization of Services

Summary of Findings

Colorado Access had extensive policies and procedures, desktop procedures, and other resource documents that provided staff guidance in the area of coverage and authorization of services. The MCO also initiated several internal monitoring measures, including an analysis of service utilization data and a review of emergency room claims data soon after implementation of the Access Health Plan (AHP) line of business.

Summary of Strengths

Without exception, **Colorado Access**' policies and procedures related to coverage and authorization were consistent with requirements in the BBA and with its contract with the Department. The MCO also had a sophisticated utilization management program in place, including a strong training and mentoring program for frontline staff and an interface between the clinical management application and the claims adjudication application overseen by DST Health Solutions (DST).

Summary of Required Actions

While documentation in the MCO's clinical management application supported that providers were given notice of the 60-day benefit limitation for home health services, documentation did not support that the MCO ensured that home health services providers coordinated with the single entry point (SEP) agency as required by contract.

AHP must monitor its contracted home health services providers to ensure that providers coordinate prior authorization with the SEP agency for those members requiring home health services beyond the 60-day covered services limitation.

Standard II—Access and Availability

Summary of Findings

Colorado Access had adopted several policies to help ensure easy access to care for members. For example, the MCO allowed access without authorization to routine visits to an obstetrician/gynecologist (OB/GYN); required contracted providers to make telephone consultation services available to members 24 hours a day, 7 days a week; and demonstrated having provided covered services out of network and out of area as medically necessary. AHP also provided several examples of future monitoring to help ensure timely access to care, including use of a member survey and inclusion of providers from the AHP line of business in its after hours and secret shopper surveys.

Summary of Strengths

Colorado Access implemented several strategies aimed at providing culturally relevant care, including assessing each member's cultural and spiritual preferences upon enrollment and providing a comprehensive set of cultural competency trainings for internal staff and providers.

Summary of Required Actions

AHP must require its providers to meet standards for timely access to care and must initiate corrective action to address issues related to provider performance, as appropriate.

Standard III—Coordination and Continuity of Care

Summary of Findings

Colorado Access had mechanisms to ensure that members had a source of primary care, and to ensure continuity of care for members transitioning from other managed care organizations or from fee-for-service Medicaid. Assessment and treatment planning processes for AHP members included a continuum of case management provided based on the assessment. Risk stratification was used to determine the priority for initial contact and admission to the enhanced care management program. Providers and members were informed of both the enhanced care management program and privacy requirements through the Provider Manual and the Member Handbook, respectively.

HSAG reviewed 15 sets of clinical and case management records. Records consisted of case management documentation and medical records from primary care providers (PCPs) and specialty providers. Several members' cases contained only case management records or records from one medical provider. Nine of 15 cases appeared to include records from all providers involved. **Colorado Access** staff reported that several providers did not respond to the request for records despite an initial request letter sent December 1, 2008, and a second request letter sent December 15, 2008. While certain records were not available for review, reviewers found ample evidence in the records reviewed that **Colorado Access** implemented its policies and procedures for care management.

Three records included documentation that case management staff attempted multiple times (via calls, letters, contact with providers) to reach the member and were unsuccessful. Five cases contained evidence of coordination/communication between medical providers (it was clear in only eight cases that multiple medical providers were involved). Six cases contained documentation that the case manager linked the member with a PCP, specialty provider, or community services, as needed. Seven cases contained evidence that members had direct access to specialty providers. Seven cases contained documentation of authorization for nonformulary medications or services provided by out-of-network providers for continuity of care.

Summary of Strengths

Colorado Access case managers had a desktop manual that described details of the case management process, including timelines for specific coordination activities. **Colorado Access**' privacy practices included physical and electronic safeguards, access based on job needs, comprehensive Health Insurance Portability and Accountability Act (HIPAA) training at hiring and annually, and accountability for employees regarding HIPAA requirements through the annual employee performance evaluation process.

Summary of Required Actions

No corrective actions were required for this standard.

Standard VI—Provider Participation and Program Integrity

Summary of Findings

Colorado Access had mechanisms to ensure that it had a written agreement with each subcontracted provider. The provider agreements included the required content. **Colorado Access** had mechanisms to monitor covered services and the performance of providers both on an ongoing basis and through formal review. Those mechanisms included medical record reviews, performance improvement projects, HEDIS measures, and committee review of grievances and appeals, utilization data, and results of consumer satisfaction surveys. **Colorado Access** communicated with subcontracted providers regarding requirements primarily through the Provider Manual. **Colorado Access** provided evidence that provider selection and the credentialing process were not discriminatory.

Summary of Strengths

Credentialing processes were based on National Committee for Quality Assurance (NCQA) requirements and included systems to ensure nondiscrimination of providers based on licensure or populations served and that providers excluded from federal health care participation were not included in the provider network. **Colorado Access** had a comprehensive compliance program, which included policies and procedures, standards of conduct, and internal monitoring and auditing. The compliance officer and the compliance committee were accountable to senior management, as evidenced by compliance committee meeting minutes. The compliance officer provided annual compliance training and a variety of methods for employees to report instances of fraud or abuse.

Summary of Required Actions

No corrective actions were required for this standard.

Standard IX—Subcontracts and Delegation

Summary of Findings

Colorado Access had a written agreement with each delegate that specified the activities delegated, reporting responsibilities of the delegate, and responsibilities of both the delegate and **Colorado Access**. The delegation agreements also provided for remedies, including revocation of the agreement if a delegate's performance was inadequate. Predelegation audits were performed by **Colorado Access** prior to execution of delegation agreements.

Summary of Strengths

Ongoing monitoring of delegates' performance consisted of monthly and/or quarterly review of reports submitted by the delegate to **Colorado Access**. Formal annual audits were comprehensive and included evaluation of each activity required by the specific delegation agreement. There was evidence of **Colorado Access** requiring corrective action of its delegates as needed.

Summary of Required Actions

While **Colorado Access** provided ample evidence of monitoring its delegates, there was no evidence of having monitored the delegates specifically for compliance with the HIPAA regulation (45 CFR, Parts 160 and 164). **Colorado Access** must revise its process for monitoring delegates that encounter member information to include an evaluation of the subcontractors' compliance with HIPAA requirements.

The completed compliance monitoring tool follows this cover page.

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
42CFR438.210(a)(3) Contract: II.D.1.a Exhibit A	1. The Contractor provides or arranges for services and ensures that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Colorado Access Policy and Procedure CCS302, Medical Criteria for Utilization Review, included a definition of medically necessary services and referenced a Medical/Behavioral Quality Improvement Committee (MBQIC) that monitors quality standards and helps ensure the overall effectiveness of care provided to members. Colorado Access Policy and Procedure CCS305, Care Coordination, described the role of the care coordinator in advocating and helping to arrange for services as medically necessary. The MCO's Member Handbook and Provider Manual both included information regarding covered services and how to access care, including a reference to a Colorado Access Web site for additional information regarding services requiring authorization. At the time of the interview, staff reported that practice patterns of individual providers as well as monthly administrative reports regarding spending by service category were used to help ensure that services were being provided in sufficient amount, duration, and scope.	
	Required Actions: None	
42CFR438.210(a)(3) Contract: II.D.1.c	2. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Colorado Access Policy and Procedure ADM205, Nondiscrimination, stated that the MCO did not discriminate against members based on health status or disability and defined the role of the Office of Member and Family Affairs in disseminating information regarding nondiscrimination. Policy and Procedure CCS309, Emergency and Post-Stabilization Care, also clarified that the MCO did not limit emergency care on the basis of member diagnosis or presenting symptoms. Information about the Colorado Access policy regarding nondiscrimination was included in the MCO's Provider Manual. Staff reported that the MCO used additional strategies, including the use of standardized utilization review (UR) criteria, review of all UR denials by a physician, and monthly review of all denials for significant patterns to monitor that services were not being arbitrarily denied or reduced.	
	Required Actions: None	

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
42CFR438.210(a)(3) Contract: II.D.2.a	3. If the Contractor places limits on services, it is: ◆ On the basis of criteria applied under the State plan (medical necessity). ◆ For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Colorado Access provided two policies and procedures (CCS302, Medical Criteria for Utilization Review, and CCS307, Utilization Review Determinations) that included detailed descriptions of the MCO's utilization review process, including a definition of medically necessary services. The MCO's definition of medically necessary services included a provision that the service be reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the symptoms, pain, or suffering of a diagnosed medical condition. Policy and Procedure CCS302 also stated that utilization management determinations are made based on medical criteria or established guidelines, including InterQual criteria. The policy indicated that all criteria are reviewed by the vice president of clinical services and approved by the MBQIC annually.	
	Required Actions: None	
42CFR438.210(a)(4) Contract: Exhibit A	4. The Contractor specifies what constitutes "medically necessary services" in a manner that: ◆ Is no more restrictive than that used in the State Medicaid program. ◆ Addresses the extent to which the Contractor is responsible for covering services related to the following: ▪ The prevention, diagnosis, and treatment of health impairments ▪ The ability to achieve age-appropriate growth and development ▪ The ability to attain, maintain, or regain functional capacity	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Colorado Access Policy and Procedure CCS307, Utilization Review Determinations, included a definition of medically necessary services that is consistent with the Department's definition in Exhibit A of the contract. The MCO's Member Handbook and Provider Manual addressed the specific covered services related to the prevention, diagnosis, and treatment of medical conditions, illness, injury, or disability. The Colorado Access Web site included links for both members and providers to a set of preventive health guidelines that described practice standards for age-appropriate growth and development (Early and Periodic Screening, Diagnosis, and Treatment) as well as community standards and preventive health recommendations to attain, maintain, or regain functional capacity.	
	Required Actions: None	

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
42CFR438.210(b)	5. The Contractor has written policies and procedures that address the processing of requests for initial and continuing authorization of services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Colorado Access Policy and Procedure CCS307, Utilization Review Determinations, described the handling of initial and continuing authorization of services for the AHP line of business. Colorado Access Policy and Procedure CCS302, Medical Criteria for Utilization Review, addressed the use of written standards to make utilization review decisions for initial and continued stay authorizations whenever written guidelines were available and described the role of intermediate-level reviewers or an associate medical director in processing these requests in the absence of written criteria.	
	Required Actions: None	
42CFR438.210(b) Contract: II.I.1.b	6. The Contractor's written policies and procedures include mechanisms to ensure consistent application of review criteria for authorization decisions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Colorado Access Policy and Procedure CCS302, Medical Criteria for Utilization Review, stated that utilization review determinations are made based on standardized criteria, including InterQual and internal criteria, which are based on professionally recognized standards of care. The MCO also provided documentation of a 2008 Inter-Rater Reliability Study conducted across several lines of business, including AHP. Findings from the study indicated that the aggregate score for staff exceeded 90 percent. At the time of the interview, staff confirmed that intake specialists making utilization review decisions had been trained in the use of scripted protocols and that all intermediate-level reviewers for the AHP line of business were licensed nurses.	
	Required Actions: None	

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
42CFR438.210(b)	7. The Contractor's written policies and procedures include the procedure to consult with the requesting provider when appropriate.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Colorado Access Policy and Procedure CCS307, Utilization Review Determinations, included a provision regarding consulting with the requesting provider as appropriate for any utilization review decision requiring physician review, including providing an opportunity for peer-to-peer consultation for any prospective review resulting in a utilization review denial. Staff members also reported that peer-to-peer consultation was available to treating providers as part of the retrospective review process.	
	Required Actions: None	
42CFR438.210(b)(3) Contract: II.I.1.e	8. The Contractor's written policies and procedures include the provision that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Colorado Access Policy and Procedure CCS301, Qualifications for Staff Engaged in Utilization Management Activities, stated that every determination to deny a service in an amount, duration, or scope that is less than requested is made by, and the notice signed by, a licensed physician familiar with standards of care in the State of Colorado. The MCO's Provider Manual also included language stating that decisions to deny service authorization requests are made by the Colorado Access medical director or a designated physician reviewer.	
	Required Actions: None	

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
42CFR438.210(c) Contract: II.I.1.a	9. The Contractor's written policies and procedures include processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested (notice to the provider need not be in writing).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Colorado Access Policy and Procedure CCS307, Utilization Review Determinations, included a provision regarding providing written notice of any decision to deny or limit authorization of a requested service to both the member and provider. Information regarding the handling of adverse service determinations was also included in the MCO's Member Handbook and Provider Manual.	
	Required Actions: None	
42CFR438.210(d) Contract: Exhibit H—8.209.4.A.3.c & 8.209.4.A.6	10. The Contractor's written policies and procedures include the time frames for making standard and expedited authorization decisions extending time frames, as specified in the Grievance System standard.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Colorado Access Policy and Procedure CCS307, Utilization Review Determinations, included time frames for making standard and expedited authorization decisions and for extending time frames that met all requirements in 42 CFR 438.210(d) and Exhibit H of the State contract. The policy stated that standard authorization decisions were to be made in a time frame appropriate to the member's condition but no later than 10 calendar days after receipt of the request for service, and that the time frame may be extended for up to 14 days under extenuating circumstances. The policy also stated that expedited authorization decisions are to be made in a time frame appropriate to the member's condition but no later than 3 calendar days after the request for service, and that the time frame may be extended for up to 3 calendar days, depending on the member's circumstances. Also, staff demonstrated that additional resource documents were available to frontline utilization review personnel to assist them in meeting required time frames across lines of business as part of CareSTEPP, the MCO's clinical management application.	
	Required Actions: None	

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
42CFR438.210(e) Contract: II.I.1.a	11. The Contractor's written policies and procedures provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Colorado Access Policy and Procedure CCS301, Qualifications for Staff Engaged in Utilization Management Activities, stated that the MCO does not provide financial or other incentives to staff making utilization review determinations that result in underutilization. Staff are also required to sign an Employee Affirmation Statement of Unencumbered Utilization Review Determinations at hire and annually thereafter. The statement affirms that each staff member understands that utilization review determinations are to be made based on eligibility, medical necessity, and appropriateness of care only.	
	Required Actions: None	
42CFR438.114(a) Contract: I.12 & II.D.4.c	12. The Contractor defines emergency medical condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: ◆ Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy ◆ Serious impairment to bodily functions ◆ Serious dysfunction of any bodily organ or part	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Both Colorado Access Policy and Procedure CCS307, Utilization Review Determinations, and CCS309, Emergency and Post-Stabilization Care, incorporated the definition for "emergency medical condition" from 42 CFR 438.114(a). In addition, the MCO's Member Handbook and Provider Manual included information regarding the prudent layperson definition for an emergency medical condition.	
	Required Actions: None	

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
42CFR438.114(a) Contract: I.13	13. The Contractor defines emergency services as follows: ◆ Services furnished by a provider who is qualified to furnish these services under this title ◆ Services needed to evaluate or stabilize an emergency medical condition	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Colorado Access Policies and Procedures CCS307, Utilization Review Determinations, and CCS309, Emergency and Post-Stabilization Care, defined the term "emergency services" as covered inpatient and outpatient services that are furnished by a qualified provider and are needed to evaluate or stabilize an emergency medical condition.	
	Required Actions: None	
42CFR438.114 Contract: II.D.4.c	14. The Contractor does not: ◆ Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms ◆ Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the Contractor, or the State agency of the member's screening and treatment within 10 days of presentation for emergency services	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Colorado Access Policy and Procedure CCS309, Emergency and Post-Stabilization Care, stated that the MCO may not limit what constitutes an emergency medical condition on the basis of the member's diagnosis or symptoms. The policy also stipulated that Colorado Access may not refuse to cover emergency services based on the emergency room provider, hospital, or agent not notifying the member's primary care provider, Colorado Access, or the applicable State entity of the member's screening and treatment within 10 calendar days of presentation for emergency services. In addition, the MCO provided an Access Health Plan/Enhanced Care Management Emergency Visit Claims Review Report that evaluated emergency room claims, including the reasons for all denied claims, with dates of service between June 1, 2008, and August 3, 2008. The report did not identify any claims denied on the basis of member diagnosis, presenting symptoms, or due to lack of timely notice regarding the emergency room visit. During the interview, staff indicated that all emergency providers were paid on a fee-for-service basis and, therefore, had no incentive to limit the provision of care based on diagnosis or presenting symptoms. Staff members also reported that emergency claims are automatically approved for payment, assuming that the claims passed other MCO system edits.	
	Required Actions: None	

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
42CFR438.114(a) Contract: Exhibit A	15. The Contractor defines poststabilization care as covered services, related to an emergency medical condition, that are provided after a member is stabilized in order to maintain the stabilized condition, or are provided to improve or resolve the member's condition.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Colorado Access Policy and Procedure CCS307, Utilization Review Determinations, and Policy and Procedure CCS309, Emergency and Post-Stabilization Care, included a definition for the term "poststabilization care services" taken verbatim from 42 CFR 438.114(a). The AHP Provider Manual also included information regarding the right of members to request poststabilization care and described various covered services, including skilled nursing and home health care, that were available as medically necessary to maintain, improve, or resolve the member's condition.	
	Required Actions: None	
42CFR438.114(c)(1) Contract: II.D.4.a.2 & 4	16. The Contractor covers and pays for emergency services regardless of whether the provider who furnishes the services has a contract with the Contractor. Members temporarily out of the service area may receive out-of-network emergency and urgently needed services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Colorado Access Policy and Procedure CCS309, Emergency and Post-Stabilization Care, stated that the MCO was responsible for payment of claims involving the provision of emergency and poststabilization care provided by nonparticipating providers and that urgently needed services were provided to members temporarily absent from the service area. The policy did not define the term "temporary." The MCO also provided a copy of the Authorization Processing protocol used by DST, the entity used by the MCO to adjudicate claims. The protocol provided instructions to staff regarding the approval of emergency room claims from nonparticipating providers. In addition, the MCO's Member Handbook included information about accessing emergency care both outside of the AHP network and out of state. Staff provided two examples of paid AHP claims at Exempla Lutheran Medical Center, an out-of-network provider.	
	Required Actions: None	

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
42CFR438.114(c)(1) Contract: II.D.4.a.4	17. The Contractor may not deny payment for treatment obtained under either of the following circumstances: ◆ A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the following outcomes: ▪ Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy ▪ Serious impairment to bodily functions ▪ Serious dysfunction of any bodily organ or part ◆ A representative of the Contractor's organization instructed the member to seek emergency services	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Colorado Access Policy and Procedure CCS309, Emergency and Post-Stabilization Care, identified that the MCO covered emergency services to stabilize members in all cases where a prudent layperson would have believed that an emergency medical condition existed or in cases where a Colorado Access staff member instructed the member to seek emergency services. The MCO also provided a copy of an Authorization Processing protocol used by DST, the entity responsible for adjudicating AHP claims. The protocol provided guidance to staff regarding approval of emergency services meeting the prudent layperson definition of "emergency medical condition." At the time of the interview, staff confirmed that DST automatically approved all emergency room claims for payment, assuming that the claims met other MCO system edits.	
	Required Actions: None	
42CFR438.114(c)(2) Contract: II.D.4.d	18. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Colorado Access Policy and Procedure CCS309, Emergency and Post-Stabilization Care, stated that a member with an emergency medical condition shall not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member. In addition, the AHP Member Handbook included information regarding members not having to pay for emergency room care or follow-up care provided in a hospital when that level of care was required to further stabilize the member's medical condition. Colorado Access staff members indicated that AHP members are not required to pay deductibles or co-pays for any covered service, including emergency care.	
	Required Actions: None	

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
42CFR438.10.f.6.viii.B Contract: II.D.4.a.3	19. The Contractor does not require prior authorization for emergency or urgently needed services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Colorado Access Policy and Procedure CCS309, Emergency and Post-Stabilization Care, affirmed that emergency and urgently needed services do not require prior authorization. This information is also clearly stated in the Authorization Processing protocol used by DST, the entity responsible for adjudicating AHP claims. Information regarding emergency care not requiring prior authorization is included in the AHP Member Handbook and Provider Manual. An Access Health Plan/Enhanced Care Management Emergency Visit Claims Review Report summarized reasons for denial of emergency room claims between June 1, 2008, and August 31, 2008, and did not identify any claims denied due to a lack of prior authorization.	
	Required Actions: None	
42CFR438.114(d)(3) Contract: II.D.4.a.5	20. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Colorado Access Policy and Procedure CCS309, Emergency and Post-Stabilization Care, included a provision regarding the delegation of responsibility for determining when a member is sufficiently stabilized for transfer or discharge to the attending emergency physician or provider actually treating the member. The policy also stated that the provider's determination is binding on Colorado Access being responsible for coverage and payment. Information included in the AHP Provider Manual defined the provider's role in determining when a member is sufficiently stabilized for transfer or discharge.	
	Required Actions: None	

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
Contract: II.I.1.f	21. Utilization management activities are conducted under the auspices of a qualified clinician.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Colorado Access 2008–2009 Utilization Management Program Description stated that the MCO's utilization management program is overseen by the chief medical officer, a board-certified physician, and that the vice president of clinical services, a registered nurse, is responsible for daily operations of all utilization management activities. Training requirements for frontline staff conducting utilization reviews and the fact that all adverse determinations are made by board-certified physicians from the appropriate specialty area were described in Colorado Access Policy and Procedure CCS301, Qualifications for Staff Engaged in Utilization Management Activities. During the interview, staff reported that newly hired utilization review staff members are paired with more experienced reviewers and that frontline staff members meet weekly with the medical director to discuss treatment strategies, new technologies, and any barriers to discharge for AHP members.	
	Required Actions: None	
Contract: II.D.4.f.2.a	22. If the Contractor establishes a drug formulary for all medically necessary covered drugs with its own prior authorization criteria, the Contractor includes each therapeutic drug category in the Medicaid program.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Access Health Plan—Enhanced Care Management Formulary included a listing of all covered formulary medications and stated that select medications required prior authorization. Policy and Procedure CCS314, Colorado Access Formulary Development and Maintenance, stated that prescription drug formularies for all lines of business included medications from each drug class and that the MCO had a drug benefit in accordance with State and federal regulations. The policy also stated that the MCO's formulary was submitted to and approved by the Centers for Medicare & Medicaid Services.	
	Required Actions: None	

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
Contract: II.D.4.f.2.b	23. The Contractor provides a covered drug if there is a medical necessity that is unmet by the Contractor's formulary product.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Access Health Plan—Enhanced Care Management Formulary stated that nonformulary drugs must be requested by submitting the MCO's Drug Authorization Form. Colorado Policy and Procedure CCS312, Medication Utilization Review Procedure, stated that medications requiring prior authorization are approved as medically necessary and described the process for requesting approval of nonformulary drugs, including timelines for review by the MCO. To ensure member access to medications in emergency situations, the policy also stated that the dispensing pharmacy had the option of providing members with a 72-hour supply of any formulary or nonformulary drug requiring authorization. At the time of the interview, staff indicated that a clinical pharmacist or associate medical director reviewed requests for nonformulary medications that involved questions of medical necessity.	
	Required Actions: None	
Contract: II.D.4.f.3	24. If a member requests a brand name for a prescription that is included on the Contractor's drug formulary in generic form, the member may pay the cost difference between the generic and brand name. The Contractor has a process to ensure that the member signs the prescription stating that he/she is willing to pay the difference to the pharmacy.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Colorado Access Policy and Procedure CCS312, Medication Utilization Review Procedure, included a provision to allow members to receive a brand-name prescription that is included on the formulary in generic form in cases where the member agrees to sign a statement regarding paying the difference between the generic and brand-name medication. The option of prescription or pharmacy "buy-up" was clearly communicated to members in the AHP Member Handbook. Staff reported that Caremark, the MCO's pharmacy benefit management company, communicates the option of paying the difference between generic and brand-name medications to pharmacies in the AHP network.	
	Required Actions: None	

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
Contract: II.D.4.i.3	25. The Contractor informs its home health services providers and members that home health services after 60 consecutive calendar days are not covered services but are available to members under FFS and require prior authorization. If home health services after 60 consecutive calendar days are anticipated, the Contractor ensures that at least 30 days prior to the 60th day of home health services, its home health services providers coordinate prior authorization with the single-entry-point agency for adult members and with the Medicaid fiscal agent for adult members.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: Information regarding home health services was clearly communicated to members and providers in the AHP Member Handbook and Provider Manual, including the fact that services after 60 consecutive days are not covered through Colorado Access but are available under the Medicaid fee-for-service program and require prior authorization. Additional information regarding home health services was included in the Colorado Access CCS Desktop Procedure—AHP Home Health Services. The desktop procedure stated that Colorado Access should inform home health services providers that services after 60 calendar days are not covered by the MCO but may be available under Medicaid fee for service and require prior authorization through the SEP agency. A listing of SEP agencies was included in the Community Resources section of the AHP Provider Manual. Staff reported that AHP care managers should document that contracted home health services providers have coordinated prior authorization with the SEP agency in CareSTEPP, the MCO's clinical management application. A review of a report from CareSTEPP for an AHP member included documentation that the provider had been noticed regarding the 60-day benefit limitation but did not document that the home health services provider had coordinated with the SEP agency as required by contract.	
	Required Actions: The MCO must monitor its contracted home health services providers to ensure that providers coordinate prior authorization with the SEP agency as required by contract.	

Results for Coverage and Authorization of Services							
Total	Met	=	24	X	1.00	=	24.00
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	25	**Total Score**		=	24.00

Total Score ÷ Total Applicable	=	96%

Standard II—Access and Availability		
References	**Requirement**	**Score**
42CFR438.206(b)(1) Contract: II.E.1.a & b	1. The Contractor maintains and monitors a network of providers that is supported by written agreements and is sufficient to provide adequate access to covered services. The Contractor considers essential community providers and other providers when establishing the network. The Contractor ensures a provider-to-member caseload ratio as follows: ◆ 1:2000 primary care physician to member ratio. ◆ 1:2000 physician specialist to member ratio. ◆ OB/GYN, gerontologists, and internal medicine physicians may be counted as either PCP or specialists, but not both.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings Colorado Access compiled a listing of essential community providers from the Department's Web site, and the MCO considered the providers with whom it had contracts when establishing its provider network. Colorado Access Policy and Procedure PNS309, Primary Care Provider (PCP) Designation and Responsibilities, stated that an individual PCP may not have more than 2,000 assigned Colorado Access members without the consent of the MCO. Access and availability standards, including member-to-physician ratios for PCPs and specialists, were included in the Colorado Access Health Plan—Enhanced Care Management Network Adequacy Report State Fiscal Year 2008–2009, First Quarter, and were communicated to providers in the AHP Provider Manual. Findings regarding PCP and specialty physician ratios that indicated compliance with physician-to-member ratio requirements were included in the Colorado Access Health Plan—Enhanced Care Management Network Adequacy Report State Fiscal Year 2008–2009, First Quarter. The MCO also provided Quality Improvement Committee meeting minutes for September 9, 2008, indicating that findings related to access and availability standards had been discussed. During the interview, staff members confirmed that they considered physician specialties specific to the needs of AHP members in establishing the provider network for the new line of business and that no PCPs or specialty physicians had requested a waiver regarding the 2,000 member-to-physician ratio.	
	Required Actions: None	

Standard II—Access and Availability		
References	**Requirement**	**Score**
42CFR438.206(b)(1) Contract: II.E.1.c	2. In establishing and maintaining the network, the Contractor considers: ◆ The anticipated Medicaid enrollment. ◆ The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the Contractor's service area. ◆ The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services. ◆ The numbers of network providers who are not accepting new Medicaid patients. ◆ The geographic location of providers and Medicaid members, and whether the location provides physical access for Medicaid members with disabilities.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Colorado Access Policy and Procedure PNS202, Selection and Retention of Providers, included a statement that all of the above factors were considered in the development and maintenance of the MCO's provider network. The Colorado Access Health Plan—Enhanced Care Management Network Adequacy Report State Fiscal Year 2008–2009, First Quarter, provided an analysis of data regarding the geographic location of members and providers, including providers not accepting new Medicaid members. MCO staff stated that historical fee-for-service utilization data were considered in making decisions regarding development of the provider network at program start-up and that efforts were made to include providers with whom enrolling members had a prior relationship. At the time of the interview, staff also reported that providers were required to attest to the fact that their facilities were accessible to Medicaid members with physical disabilities as part of the initial credentialing process and every 90 days thereafter.	
	Required Actions: None	

Standard II—Access and Availability		
References	**Requirement**	**Score**
42CFR438.206(b)(2) Contract: II.E.1.d	3. The Contractor provides female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health care specialist.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The AHP Member Handbook noted that women may access an OB/GYN without a referral for well-woman exams, pregnancy care, and/or family planning with a Colorado Access plan physician. The AHP Provider Manual indicated that routine visits with an OB/GYN do not require authorization and directed providers to the Colorado Access Web site for additional information regarding facility-based gynecological services that require authorization. Colorado Access Policy and Procedure CCS310, Access to Primary and Specialty Care, also stated that the MCO provided access without referral to a women's health specialist within the provider network for women's routine and preventive health care services, including obstetrical and prenatal services.	
	Required Actions: None	
42CFR438.6(m) Contract: II.E.7.a	4. The Contractor allows, to the extent possible and appropriate, each member to choose his or her primary care physician.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Colorado Access Policy and Procedure CS311, Primary Care Provider (PCP) Assignment/Changes, indicated that members may choose their primary care physician prior to enrollment or after the Department determines their eligibility. The policy also stated that those members who do not choose a PCP are auto-assigned to a practitioner near their home or with whom they have an established relationship. The AHP Member Handbook described both the process for choosing a PCP as well as instructions to call Colorado Access Customer Service to request a change in PCP assignment as needed. The Colorado Access Customer Service Web PCP Change Guideline included detailed instructions for PCPs wishing to assist members in changing their assigned physician online during the member's office visit.	
	Required Actions: None	

Standard II—Access and Availability		
References	**Requirement**	**Score**
42CFR438.206(b)(3) Contract: II.E.1.e	5. The Contractor has a mechanism to allow members to obtain a second opinion from an appropriate qualified health care professional within the network, or arranges for the member to obtain one outside the network, at no cost to the member.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Colorado Access Policy and Procedure CCS310, Access to Primary and Specialty Care, stated that the MCO worked with the member's PCP to facilitate referrals for second opinions from qualified health care professionals as requested and that second opinions—including second opinions with providers outside the network, if necessary—were provided at no cost to the member. The AHP Member Handbook listed the right to ask for a second medical opinion in the "Your Rights and Responsibilities" section of the manual. The MCO also provided a report that displayed the percentage of second opinions provided per 1,000 members for June 1, 2008, through September 30, 2008.	
	Required Actions: None	
42CFR438.206(b)(4) Contract: II.E.2.a	6. If the Contractor is unable to provide necessary services to a member in-network, the Contractor must adequately and timely cover the services out-of-network for the member, for as long as the Contractor is unable to provide them.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Colorado Access Policy and Procedure CCS310, Access to Primary and Specialty Care, included a provision for arranging for timely specialty care outside the MCO's provider network when network providers were either unavailable or inadequate to meet the member's medical needs. At the time of the interview, staff reported that requests for out-of-network specialty services were historically initiated by the treating provider but that members may also request care outside the network by contacting Colorado Access Customer Service. Staff stated that the MCO had not yet received any requests for out-of-network care for the AHP line of business.	
	Required Actions: None	

Standard II—Access and Availability		
References	**Requirement**	**Score**
42CFR438.206(b)(5) Contract: II.E.2.b	7. The Contractor requires out-of-network providers to coordinate with the Contractor with respect to payment and ensures that the cost to the member is no greater than it would be if the services were furnished within the network.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Colorado Access Policy and Procedure CCS310, Access to Primary and Specialty Care, stated that in cases in which the MCO is unable to provide medically necessary, covered services to a member, Colorado Access would adequately and timely provide the covered service through an out-of-network provider at no cost to the member. During the interview, staff stated that the MCO used single-case agreements with out-of-network providers and that the MCO attempted to negotiate fees that were consistent with Colorado Medicaid fee-for-services rates. Staff reported that written agreements with providers outside the network included a provision prohibiting providers from billing members for the cost of medical care.	
	Required Actions: None	
42CFR438.206(c)(1) Contract: II.D.1.b	8. The Contractor and its providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if the provider serves only Medicaid members.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The AHP Member Handbook indicated that the MCO's hours of operation were Monday through Friday, 8 a.m. to 5 p.m. Colorado Access provider contracts required that providers make covered services available in their offices during normal business hours and that staff be available to members for consultation by telephone 24 hours a day, 7 days a week. Colorado Access staff members stated that the requirements regarding hours of operation for AHP contractors were consistent with those for their other lines of business.	
	Required Actions: None	

Standard II—Access and Availability		
References	**Requirement**	**Score**
42CFR438.206(c)(1) Contract: II.E.4	9. The Contractor makes services available 24 hours a day, 7 days a week, when medically necessary, and has written policies and procedures for how this will be achieved.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Colorado Access Policies and Procedures PNS 309, Primary Care Provider (PCP) Designation and Responsibilities, and PNS306, Availability of After Hours Coverage, included information regarding the requirement that providers ensure access 24 hours a day, 7 days a week, to a qualified health care practitioner either through on-site call sharing or an answering service. The policies also addressed expectations regarding a plan for after-hours triage as required in the MCO's contract with the Department. The AHP Provider Manual included a description of requirements related to 24-hour accessibility. At the interview, staff indicated that all AHP providers will be included in next year's annual After Hours Access Survey, a telephone survey used by Colorado Access to assess availability of provider phone coverage outside normal business hours.	
	Required Actions: None	
42CFR438.206(c)(1) Contract: II.E.4	10. The Contractor has mechanisms to ensure compliance by providers regarding timely access to services, and to take corrective action if there is failure to comply. The Contractor communicates the access standards to providers and has routine monitoring mechanisms to ensure that participating providers comply with access policies and procedures.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Colorado Access Policies and Procedures PNS306, Availability of After Hours Coverage, and PNS309, Primary Care Provider (PCP) Designation and Responsibilities, detailed the MCO's plan for triage of requests for services 24 hours a day, 7 days a week, including after-hours triage and access to a qualified health care practitioner via live telephone. The MCO included a description of emergency and routine appointment standards in an October 2008 Provider Bulletin that were more stringent than those described in the AHP contract with the Department. Colorado Access monitored provider compliance with appointment standards through the use of the FY09 Secret Shopper survey, which assessed the availability of adult urgent and nonurgent medical appointments.	
	Required Actions: None	

Standard II—Access and Availability		
References	**Requirement**	**Score**
42CFR438.206(c)(1) Contract: II.E.5	11. The Contractor must meet, and require its providers (including use of corrective action when needed) to meet, the following standards for timely access to care: ◆ The Contractor has a comprehensive plan for triage of requests for services on a 24-hours-a-day, 7-days-a-week basis, including: ▪ Immediate medical screening exam by the PCP or hospital emergency room. ▪ Access to a qualified health care practitioner via live telephone coverage either on-site, call-sharing, or answering service. ▪ Practitioner backups covering all specialties. ◆ Scheduling and waiting times: The Contractor has clinically appropriate scheduling guidelines for various types of appointments necessary for the provision of primary and specialty care, including, but not limited to, routine physicals, diagnosis and treatment of acute pain or injury, and follow-up appointments for chronic conditions. ◆ Non-urgent care is scheduled within 2 weeks. ◆ Adult, non-symptomatic well care physical examinations scheduled within 3 months ◆ Urgently needed services provided within 48 hours of notification of the physician or Contractor.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The MCO's Access to Care Plan FY 2008–2009 and Colorado Access Policy and Procedure PNS306, Availability of After Hours Coverage, described the MCO's comprehensive plan to triage requests for services 24 hours a day, 7 days a week, including the availability of emergency room services and access to a qualified health care professional via live telephone coverage. MCO appointment standards for pediatric and adult routine care, nonurgent care, urgent care, and emergency care were detailed in the AHP Provider Manual as well as in the October 2008 AHP Provider Bulletin. AHP monitored provider performance regarding service accessibility through the use of the FY09 Secret Shopper survey, which assessed the availability of adult urgent and nonurgent medical appointments. The survey found that 52 percent of providers included in the sample met the MCO standard for making a nonurgent appointment available within a week, and 68 percent of providers met the standard for making an urgent appointment available within 24 hours. The MCO did fax secret shopper survey results to providers not meeting appointment standards; however, the correspondence did not clarify that meeting appointment standards was a contractual requirement, nor did it request follow-up action by the provider to remediate substandard performance.	
	Required Actions: The MCO must require its providers to meet standards for timely access to care and must initiate corrective action to address issues related to provider performance as appropriate.	

Standard II—Access and Availability		
References	**Requirement**	**Score**
42CFR438.206(c)(2) Contract: II.E.10.c	12. The Contractor participates in the Department's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. In addition to requirements for interpretation and written materials found at 42CFR438.10, the Contractor implements the following requirements: ◆ Establishes and maintains the following policies related to: ▪ Reaching out to specific cultural and ethnic members for prevention, health education, and treatment for diseases prevalent in those groups. ▪ Providing health care services that respect individual health care attitudes, beliefs, customs and practices of members related to cultural affiliation. ▪ How the Contractor shall respond to requests from participating providers for interpreter services by a qualified interpreter. ▪ How the Contractor shall respond to requests from members for interpretive services by a qualified interpreter or publications in alternative formats. ▪ Ensuring compliance with requirements of the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973. ◆ Makes a reasonable effort to identify members whose cultural norms and practices may affect their access to health care ◆ Develops and/or provides cultural competency training programs, as needed, to the network providers and Contractor staff regarding: ▪ Health care attitudes, values, customs, and beliefs that affect access to and benefit from health care services. ▪ The medical risks associated with the client population's racial, ethnic, and socioeconomic conditions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Colorado Access participated in the Department's efforts to promote the delivery of services in a competent manner and met the requirements for interpretation and making written information available in nonprevalent languages as mandated in 42 CFR 438.10. The MCO addressed its efforts to include targeted messages to specific cultural and ethnic high-risk groups in Policy and Procedure CCS308, Preventive Health Services. Colorado Access' procedures also included questions regarding the impact of culture and spiritual beliefs in seeking medical care as part of its member assessment and screening process, and providing copies of a member welcome letter and plan brochure in Spanish. Colorado Access Policies and Procedures ADM206, Culturally Sensitive Services for Diverse Populations, and PNS202, Selection and Retention of Providers, described the MCO's commitment to providing services	

Standard II—Access and Availability		
References	**Requirement**	**Score**
	that respect the perspectives, beliefs, customs, practices, and differences of members and staff. These policies and procedures also defined the role of the Colorado Access director of member and family affairs in arranging for cultural competency training for both providers and MCO staff. Colorado Access Policy and Procedure ADM307, Effective Communication with Limited English Proficient Persons and Sensory-Impaired/Speech-Impaired Persons, outlined the MCO's process for responding to provider and member requests for interpreter services. The MCO also published an internal protocol that detailed the process for accessing interpreter services through the AT&T Language Line and included instructions regarding how to use the MCO's TTY equipment. The AHP Member Handbook described the availability of written information in alternate formats, the availability of services in prevalent languages, and the availability of services for deaf and hearing-impaired members. In addition, the MCO employed bilingual customer service staff to better assist monolingual non-English-speaking members. The MCO's processes for complying with federal nondiscrimination laws, including the Americans with Disabilities Act of 1990 and the Rehabilitation Act of 1973, were described in Colorado Policy and Procedure ADM205, Nondiscrimination. Colorado Access also offered several training opportunities for providers and MCO staff members in providing culturally relevant services, including trainings on disability awareness, cultural competency, and the value of effective interpretation. Staff members stated that the threshold for prevalent languages was met whenever more than 7,500 members enrolled in the MCO spoke a language and that the current prevalent languages for the AHP line of business included English and Spanish only.	
	Required Actions: None	

Standard II—Access and Availability		
References	**Requirement**	**Score**
42CFR438.207(b) Contract: II.E.6.c & d	13. The Contactor submits a network adequacy report (assurances of adequate capacity) that uses geographic access standards, provider network standards (travel of 30 minutes or 30 miles), and population demographics, and that provides documentation that the Contractor: ◆ Has the capacity to serve the expected enrollment in its service area. ◆ Provides an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of members for the services area. ◆ Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The MCO provided a Colorado Access Health Plan—Enhanced Care Management Network Adequacy Report State Fiscal Year 2008–2009, First Quarter, that included an analysis of geographic access standards, provider network standards, and information regarding the number of members by county. The report indicated that physician-to-member ratios were significantly lower than levels allowed by the Department and that all enrolled members had access to a PCP within 30 miles or 30 minutes from their home. The report determined that a total of seven members living in rural communities (less than 1 percent of enrolled AHP members) did not have access to a specialist within 30 miles of their residence. Staff members indicated that although they attempted to contract with specialists in these rural communities, a small number of counties lacked any specialists with whom AHP could contract.	
	Required Actions: None	

Standard II—Access and Availability		
References	**Requirement**	**Score**
42CFR438.207(c) Contract: II.E.6.c	14. The network adequacy report was submitted as required: ◆ At the time the Contractor entered into a contract with the State ◆ At any time there has been a significant change in the Contractor's operations that would affect adequate capacity and services: ▪ Change in the services, benefits or geographic service area ▪ Enrollment of a new population ◆ Quarterly	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The MCO provided cover memos to support the timely submission of the Colorado Access Health Plan—Enhanced Care Management Annual Network Adequacy Report and a Colorado Access Health Plan—Enhanced Care Management Network Adequacy Report State Fiscal Year 2008–2009, First Quarter. At the time of the interview the AHP program director stated that due to a delay in program start-up, the annual report submitted on August 27, 2008, was approved by the Department to meet requirements for both the annual submission and the report required at the time Colorado Access entered into its contract with the State.	
	Required Actions: None	

Results for Access and Availability							
Total	Met	=	13	X	1.00	=	13.00
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	14	**Total Score**		=	13.00

Total Score ÷ Total Applicable	=	93%

Standard III—Coordination and Continuity of Care		
References	**Requirement**	**Score**
42CFR438.208(b)(1)	1. The Contractor has a mechanism to ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Primary Care Physician (PCP) Assignment/Changes policy (CS311) described the method for automatic enrollment with a PCP, how members may request a PCP, and how members may request a change in PCP. The Delivering Continuity and Transition of Care for Members policy (CCS306) described the processes for transitioning new members to an in-network PCP when the PCP providing care prior to enrollment is a out-of-network physician. The policy also described provisions for continuity of care by offering network participation or single-case agreements as appropriate and allowing members to stay with their current PCP for up to 60 days for continuity of care. The PCP Assignment/Changes policy indicated that PCPs are responsible for coordinating care through the process for referring members to specialty providers. The Provider Manual informed PCPs of how PCP assignments and changes are made and their responsibilities for coordinating health care services for members, including referring members to specialists. The on-site review of member clinical and case management records demonstrated that members were provided primary care services and that Colorado Access case managers assisted members in accessing primary care when necessary. During the interview, Colorado Access staff explained the Colorado Access system of coordinating care. Staff stated that PCPs are responsible for coordinating medical care and that Colorado Access case managers are responsible for coordinating other services members may need. Other services may include assistance accessing community resources, social supports, or accessing PCP or specialty care as needed.	
	Required Actions: None	

Standard III—Coordination and Continuity of Care		
References	**Requirement**	**Score**
Contract: II.E.8.a & b	2. The Contractor provides a continuum of enhanced care management designed to improve the quality of care and decrease the cost of care for the highest-risk members. The Contractor uses risk stratification to make this intervention available to all members and to determine the appropriate intensity of services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Care Coordination policy (CCS305) stated that Colorado Access uses a continuum of case management services and a risk stratification process. The electronic Pre-Risk Assessment (PRA) (screen shot) demonstrated that Colorado Access uses a risk stratification methodology. The Stratification and Case Finding section of the CCS Care Management Desktop Manual further described the processes used by Colorado Access case managers to provide a continuum of case management services. During the on-site interview, staff explained that Colorado Access uses the Kronick Risk Stratification system to determine which members are at the highest risk and likely to result in higher costs. Colorado Access uses the Kronick scores to determine priority cases for initial contact by case managers to perform the initial set of assessments. Staff also explained that the results of the initial set of assessments (PRA, PHQ-9, and SF12) determine which specific assessments are then conducted (i.e., diabetes, depression, medical co-morbidity, chronic pain, family resource, mobility, transportation, and others). The MCO uses the results of all assessments to determine the appropriate care plan and interventions, resulting in the continuum of care management. The Provider Manual described the enhanced care management program to providers. Colorado Access staff stated that Colorado Access' goal is to engage 70 percent of AHP members in enhanced care management. Staff explained that due to difficulty locating some members and current staffing, the MCO contacted an estimated 50 to 60 percent of AHP members, and the MCO has engaged approximately half of those contacted (about 30 percent of the AHP population) in enhanced care management services. Staff stated that seven new care managers are anticipated to begin in January 2009. The Stratification and Case Finding section of the CCS Case Management Desktop Manual described the required steps for case managers to locate members if initial efforts are unsuccessful. Colorado Access staff explained that case managers typically work across Colorado Access' lines of business; however, the additional seven case managers expected to begin in January would be dedicated to the AHP program. In addition, staff indicated that 50 to 60 percent of the other case management FTEs (full time equivalents) would work with AHP members.	
	Required Actions: None	

Standard III—Coordination and Continuity of Care		
References	**Requirement**	**Score**
Contract: II.E.8.c	3. The Contractor has written policies and procedures to ensure timely coordination of the provision of covered services to its members to promote and assure service accessibility, attention to individual needs, continuity of care, maintenance of health, and independent living.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Care Coordination, Delivering Continuity and Transition of Care for Members, and Access to Primary and Specialty Care policies generally described Colorado Access' policies regarding care management. The CCS Care Management Desktop Manual described specific procedures used by case managers to ensure timely coordination of services. The Desktop Manual also described timelines for case managers for each case management activity. The CCS Care Management Desktop Manual described specific procedures used by case managers to ensure service accessibility, attention to individual needs, continuity of care, maintenance of health, and independent living.	
	Required Actions: None	
42CFR438.208(b)(2) Contract: II.E.8.c	4. The Contractor coordinates services furnished to the member by the Contractor with the services the member receives from any other health care organization (addressed in policy).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Care Coordination policy indicated that Colorado Access conducted coordination activities with family, the designated representative, providers, and Colorado Access staff to share assessment findings and develop care plans. The Intensive Case Management Process section of the CCS Care Management Desktop Manual described the specific tasks and processes case managers perform to coordinate services. The on-site record review of member clinical and case management records demonstrated that case managers communicated with the member, family members, providers, and community agencies to provide care coordination services.	
	Required Actions: None	

Standard III—Coordination and Continuity of Care		
References	**Requirement**	**Score**
42CFR438.208(b)(4) Contract: II.E.8.c	5. The Contractor ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E (HIPAA), to the extent that they are applicable (addressed in policy).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Physical Security and the Protection of Health Information policies addressed physical safeguards, policies for minimum necessary use, limited access to records, use of informed consent releases, and enrollee access to information. The policies also stated that information systems include electronic security safeguards. The Protection of Health Information policy (HIP201) stated that all employees sign a confidentiality agreement and that violators are subject to disciplinary action up to and including termination. Colorado Access staff described privacy and security practices, which include initial and annual refresher HIPAA training for all employees, limited access to electronic systems based on passwords linked to job title and need for access, locked physical records, password-protected desktop and laptop computers, and portable data storage devices. Executive Compliance Committee (ECC) meeting minutes demonstrated that the HIPAA security officer is accountable to the ECC for ensuring compliance with HIPAA. The provider agreement templates and the Provider Manual described provider responsibilities regarding confidentiality and privacy of member records. The annual employee evaluation form demonstrated that employees were held accountable for compliance with confidentiality and HIPAA regulations. The employee HIPAA training (PowerPoint presentation) was comprehensive.	
	Required Actions: None	
42CFR438.208(c)(2) Contract: II.E.8.f & II.E.9.b	6. The Contractor implements mechanisms to assess each Medicaid member, identified by the State to the Contractor as having special health care needs, in order to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals. Policies and procedures include: ◆ Capacity to provide individual needs assessment to identify special health care needs. ◆ The coordination of benefits, services, and referrals provided to those members who may require services from multiple providers, facilities, or agencies. ◆ A strategy to ensure that all members and/or authorized family members or guardians are involved in treatment planning and consent to medical treatment. ◆ Procedures to provide continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services that include, but are not limited to, care coordination staff trained to evaluate and handle individual case transition, care planning, assessment of equipment, and evaluating adequacy of participating providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
References	**Requirement**	**Score**
	◆ Informing the member that he or she may continue to receive services from his or her provider for 60 calendar days from the date of enrollment. ◆ Informing the member that he or she may continue to receive ancillary services for 75 calendar days from the date of enrollment. ◆ Informing a member who is in her second or third trimester of pregnancy that she may continue to receive services from her provider until the completion of postpartum care.	
	Findings: Colorado Access staff reported that Colorado Access considers all AHP members as having special health care needs as defined by the Medicaid managed care contract and that nurse case managers perform all assessments of members. Screen shots of the electronic case management system indicated that the assessments were comprehensive. Processes for assessment, care coordination, and continuity of care were described in detail in the CCS Care Management Desktop Manual. Staff confirmed that members received a set of assessments determined by the results of an initial assessment performed for each member contacted. On-site review of member clinical and case management records indicated that case managers worked with members, their family members, and providers to accomplish case management. The record review also demonstrated that medical equipment, out-of-formulary drugs, and access to out-of-network providers were authorized for newly enrolled members to provide continuity of care. The Member Handbook informed members that they may continue to receive services from their current provider for 60 days following enrollment in Colorado Access AHP and that they may receive ancillary services from the current provider for 75 days following enrollment in Colorado Access AHP. The Member Handbook also informed members that they may continue receiving prenatal care from their current provider if enrolled during the second or third trimester of pregnancy.	
	Required Actions: None	
42CFR438.208(b)(3) Contract: II.E.9.a	7. The Contractor shares with other health care organizations serving the member with special health care needs the results of its identification and assessment of that member's needs, to prevent duplication of those activities.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Care Coordination Interventions section of the Care Coordination policy and the CCS Care Management Desktop Manual described the process of sharing assessment information with providers. The on-site record review demonstrated specific instances of communication with providers regarding assessments performed.	
	Required Actions: None	

Standard III—Coordination and Continuity of Care		
References	**Requirement**	**Score**
42CFR438.208(c)(3) Contract: II.E.8.f	8. The Contractor has procedures for developing treatment plans for members with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring. The treatment plan must: ◆ Be developed by the member's primary care provider with member participation, and in consultation with any specialists caring for the member. ◆ Be approved by the Contractor in a timely manner, (if required by the Contractor). ◆ Include: ▪ Treatment objectives, treatment follow-up. ▪ Monitoring of outcomes. ▪ The process for ensuring that treatment plans are revised as necessary.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Care Coordination policy indicated that care plans are developed with member and family participation and consultation from other providers. The policy also stated that monitoring occurs for progress toward goals and objectives, and is revised as necessary. Colorado Access staff reported that PCPs are expected to develop treatment plans specific to the medical care that the PCP provides and that Colorado Access does not require approval of physician-developed treatment plans (although it does monitor the appropriateness of the treatment plans during annual medical record reviews). Staff also reported that case managers work closely with PCPs to develop enhanced care management care plans. On-site review of member clinical and case management records demonstrated that care plans were developed and implemented. Screen shots of the electronic case management system demonstrated that care plans included treatment objectives, follow-up, and monitoring of outcomes. The CCS Care Management Desktop Manual included the method and frequency for revising care plans as needed.	
	Required Actions: None	

Standard III—Coordination and Continuity of Care		
References	**Requirement**	**Score**
42CFR438.208(c)(4) Contract: II.E.8.f	9. For members with special health care needs, the Contractor has a mechanism in place to allow members to directly access a specialist, as appropriate to the member's condition and identified needs.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Provider Handbook informed providers that members with special health care needs may obtain standing referrals to specialists so that they may directly access specialists as needed. The Access to Primary and Specialty Care policy (CCS310) indicated that Colorado Access staff will work with the PCP to obtain a standing referral for members so that direct access may be achieved. The Member Handbook informed members that a standing referral is available if they see a specialist often. The on-site record review demonstrated that members directly accessed specialty providers or obtained standing authorizations as needed.	
	Required Actions: None	

Results for Coordination and Continuity of Care							
Total	Met	=	9	X	1.00	=	9.0
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	9	**Total Score**		=	9.0

Total Score ÷ Total Applicable	=	100%

Standard VII—Provider Participation and Program Integrity		
References	**Requirement**	**Score**
42CFR438.230(b)(2) Contract: II.H.2	1. The Contractor has a written agreement with each subcontractor (subcontracted provider).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Colorado Access had an agreement template for each type of provider (PCP, professional provider, ancillary provider, facility, surgery center, and skilled nursing facility [SNF]). A screen print from the database used as a tracking system demonstrated that Colorado Access ensures that each provider has an executed contract.	
	Required Actions: None	
42CFR438.102(a) Contract: II.E.7.c	2. 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 ◆ The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Provider Manual included a statement that informed providers that "Colorado Access does not prohibit or restrict providers from advising members about any aspect of his or her health status or medical care, advocating on behalf of a member, or advising about alternative treatments regardless of whether such care is a covered benefit." The Provider Manual also included a listing of member rights, which included the right to receive information on available treatments and choices, and the right of members to participate in decisions about their health care, including the right to accept or refuse medical treatment.	
	Required Actions: None	

Standard VII—Provider Participation and Program Integrity		
References	**Requirement**	**Score**
42CFR438.12(a)(1) 42CFR438.214(c) Contract: II.G.1.f & II.G.11	3. The Contractor does not discriminate 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, and does not discriminate against particular providers who serve high-risk populations or specialize in conditions that require costly treatment. (A policy is required.)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Practitioner Credentialing and Recredentialing policy (CR301) stated that Colorado Access does not discriminate against providers based on licensure or populations served and that committee members sign a nondiscrimination statement. A blank nondiscrimination form was attached to the policy. The Selection and Retention of Providers policy (PNS202) and the Practitioner Credentialing and Recredentialing policy described recruitment and credentialing/recredentialing processes that were nondiscriminatory. During the interview, Colorado Access staff described the credentialing process as nondiscriminatory (i.e., a peer review process designed to build the network with a variety of provider types and decision making based on a predetermined set of criteria related to National Committee for Quality Assurance requirements).	
	Required Actions: None	
42CFR438.12(a)(1) Contract: II.G.11	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.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Selection and Retention of Providers policy indicated that the provider network services department sends written notice of the reason for the decision. Colorado Access provided template letters and one example of having declined participation in the network.	
	Required Actions: None	

Standard VII—Provider Participation and Program Integrity		
References	**Requirement**	**Score**
42CFR438.214(d) Contract: II.G.5.c	5. The Contractor does not employ or contract with providers excluded for participation in federal health care programs under either Section 1128 or 1128 A of the Social Security Act. A policy is required, and there must be a provision in provider subcontracts.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Practitioner Credentialing and Recredentialing policy stated that the National Practitioner Data Bank (NPBD) or the Federation of State Medical Boards (FSMB) is used to verify lack of Medicare/Medicaid and State sanctions during the credentialing and recredentialing processes. The Ongoing Monitoring of Sanctions (CR318) policy indicated that Colorado Access searches the Office of Inspector General (OIG) database monthly to ensure that none of its providers is on the list of excluded providers or entities. Colorado Access confirmed the process during the on-site interview. The credentialing checklist included a check for sanctions as part of the credentialing or recredentialing process.	
	Required Actions: None	
42CFR438.608 Contract: II.G.5.c	6. The Contractor may not knowingly have a director, partner officer, employee, subcontractor, or owner (owning 5 percent or more of the entity) who is debarred, suspended or otherwise excluded from participating in procurement or nonprocurement activities under federal acquisition regulation or Executive Order 12549.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Sanctions, Exclusions, Prohibited Affiliations, and Opt-Out Screening policy (CMP206) indicated that Colorado Access verifies monthly (using OIG) that none of its providers/practitioners is on the list of excluded providers or entities. The Selection and Retention of Providers policy and the Sanctions, Exclusions, Prohibited Affiliations, and Opt-Out Screening policy also indicated that directors, owners, partners, employees, and subcontractors are also checked initially upon hire and monthly against the OIG list of excluded individuals and entities.	
	Required Actions: None	

Standard VII—Provider Participation and Program Integrity		
References	**Requirement**	**Score**
42CFR438.106 Contract: VI.U	7. The Contractor provides that Medicaid members are not held liable for: ◆ The Contractor's debts in the event of the Contractor's or subcontractor'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 health care provider who provides 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.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: All contract templates had language informing providers that members may not be held liable for payment under the circumstances of contractor or subcontractor insolvency or nonpayment by the contractor or the State, or for payments in excess of what the member would pay if services were provided directly by the provider. Providers were also informed via the Provider Manual. Members were informed via the Member Handbook.	
	Required Actions: None	
42CFR438.102(b) Contract: II.F.1.d.8.g	8. 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. ◆ To the member before and during enrollment. ◆ To members within 90 days after adopting the policy with respect to any particular service (consistent with the format provisions in 42CFR438.10). (The Contractor need not furnish information on how and where to access the service.)	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
	Findings: Staff reported that there are no situations under which Colorado Access would object to providing services on moral or religious grounds.	
	Required Actions: None	

Standard VII—Provider Participation and Program Integrity		
References	**Requirement**	**Score**
42CFR438.608 Contract: II.G.5.a	9. The Contractor must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse and include: ◆ Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and State standards. ◆ The designation of a compliance officer and a compliance committee accountable to senior management. ◆ Effective training and education for the compliance officer and the Contractor's employees. ◆ Effective lines of communication between the compliance officer and the Contractor's employees. ◆ Enforcement of standards through well-publicized disciplinary guidelines. ◆ Provision for internal monitoring and auditing. ◆ Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the Medicaid managed care contract requirements.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Compliance Plan Description, The Compliance Program Standards of Business Conduct, and Colorado Access' compliance policies (Problem Reporting and Non-Retaliation; Corporate Compliance Hotline Operation; Standards of Business Conduct; Corporate Compliance Program Education and Training; Compliance Issue Resolution and Incident Records Management; Sanction and Exclusion Screening; Unannounced Visits, Subpoenas, Search Warrants, Records Retention and Destruction; Fraud and Abuse; and False Claims Act) included processes designed to guard against fraud and abuse and articulated Colorado Access' commitment to comply with federal and State standards related to fraud and abuse. The Fraud and Abuse policy described the roles of the corporate compliance officer (the director of human resources) and the Executive Compliance Committee (ECC). Minutes of the ECC meetings demonstrated implementation of the described roles of the corporate compliance officer and the ECC, and that Colorado Access' senior management staff members are members of the ECC. During the interview, Colorado Access' compliance officer described his initial compliance training (specific compliance training from an outside vendor) and described his ongoing training as attendance at compliance conferences when available. Annual training for employees included a comprehensive PowerPoint presentation describing the corporate compliance program and the standards of business conduct. Information from the compliance officer and compliance-related topics were communicated through flyers in employee areas, the compliance hotline, a compliance program e-mail address, confidential dedicated voice mail, and a compliance suggestion box. The ECC meeting minutes August 4, 2008, demonstrated that the compliance committee reviewed results of selected FY 2007–2008 compliance audits and developed the compliance audit plan for FY 2008–2009. The minutes also included a review and approval of a corrective action plan by the committee.	

Standard VII—Provider Participation and Program Integrity		
References	**Requirement**	**Score**
	Required Actions: None	
Contract: II.G.5.b	10. The Contractor reports possible instances of fraud to the Department within 10 business days of receipt of information. The referrals will include: ◆ Specific background information. ◆ The name of the provider. ◆ Description of how the Contractor became knowledgeable about the occurrence.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Fraud and Abuse policy (CMP211) stated that Colorado Access reports instances of suspected fraud to the Department within 10 business days of receiving the information. The policy included the required content of the report to the Department. Colorado Access staff stated that there had been no instances of suspected fraud within the last fiscal year.	
	Required Actions: None	
Contract: II.G 9.a	11. The Contractor notifies the Department, in writing, of its decision to terminate any existing participating provider agreement where such termination will cause the delivery of covered services to be inadequate in a given area. The written notice shall be provided to the Department at least 60 calendar days prior to termination of the services unless the termination is based upon quality or performance issues. The notice will include a description of how the Contractor will replace the provision of covered services at issue.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Communication of Changes to the Provider Network policy (PNS203) stated that the Department is notified in writing of significant changes to the provider network 90 days prior to the effective date of the change (unless the change is based on quality or performance issues). A 90-day notice exceeds the 60-day notice requirement. Colorado Access staff indicated that there had not been a change in the provider network within the previous fiscal year that caused the delivery of services to be inadequate in the Colorado Access service area**.**	
	Required Actions: None	

Standard VII—Provider Participation and Program Integrity		
References	**Requirement**	**Score**
42CFR438.240(b)(4) Contract: II.G.12	12. The Contractor monitors covered services rendered by subcontract providers for quality, appropriateness, and patient outcomes.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The AHP Enhanced Care Management Quality Assessment Performance Improvement (QAPI) Work Plan included aggregate measures of quality and patient outcomes, including analysis of grievance and appeal data, analysis of utilization data, the design and implementation of performance improvement projects, HEDIS measures, and analysis of member satisfaction surveys. The MBQIC meeting minutes demonstrated review of these measures and processes. The medical record review template included elements to evaluate quality and appropriateness of care. The Provider Manual informed providers of medical record standards and that medical record reviews will be performed annually. Colorado Access staff reported that the medical record reviews are performed annually in the spring across Colorado Access lines of business. Colorado Access provided an example of the most recent medical record review completed April–June 2008 for the Access Advantage (Medicare) line of business. Staff reported that the AHP population would be included in the spring 2009 review. Results of Colorado Access' most recent secret shopper survey (for the Access Advantage line of business) demonstrated monitoring of specific providers for compliance with access standards. Although the above examples of monitoring providers were not yet implemented for the AHP line of business due to not having been in operation for a full year, the above documentation provides evidence of Colorado Access' systems and mechanisms for monitoring covered services for quality, appropriateness, and patient outcomes.	
	Required Actions: None	

Standard VII—Provider Participation and Program Integrity		
References	**Requirement**	**Score**
Contract: II.G.12 & II.F.3.b	13. The Contractor monitors subcontracted providers for compliance with requirements for medical records, data reporting, and other applicable provisions of the Medicaid managed care contract. The Contractor also monitors for any requirements the Contractor imposes. Minimum medical record requirements include: ◆ Medical chart ◆ Prescription files ◆ Documentation sufficient to disclose the quality, quantity, appropriateness, and timeliness of services All records must be legible.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The medical record review template included elements to evaluate quality and appropriateness of care. The Provider Manual informed providers of medical record standards and that medical record reviews will be performed annually. Colorado Access staff reported that the medical record reviews are performed annually in the spring across Colorado Access lines of business. Colorado Access provided an example of the most recent medical record review completed April–June 2008 for the Access Advantage (Medicare) line of business. Staff reported that the AHP population would be included in the spring 2009 review.	
	Required Actions: None	
42CFR438.230(a)(3) Contract: II.H.3	14. The Contractor has implemented written procedures for monitoring subcontracted providers' performance on an ongoing basis. The Contractor subjects subcontracted providers to formal review on a schedule consistent with industry standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Colorado Access staff reported that ongoing monitoring consisted of reviewing data such as trend reports, creating provider profiles based on data, and reviewing grievance and appeal data to determine outliers and areas of focus for improvement. Review of MBQIC meeting minutes confirmed committee review of these reports. Formal review consisted of annual medical record reviews. Although the AHP member records had not yet been reviewed, Colorado Access staff reported that approximately 90 percent of the providers in the AHP panel were providers for another Colorado Access line of business (Access Advantage) and that the medical record review performed in 2008 did provide information about the quality of services provided by the majority of AHP providers. Staff reported that AHP records are scheduled to be reviewed in spring 2009.	
	Required Actions: None	

Standard VII—Provider Participation and Program Integrity		
References	**Requirement**	**Score**
42CFR438.230(a)(4) Contract: II.H.4	15. If the Contractor identifies deficiencies or areas for improvement, the Contractor and the subcontractor take corrective actions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Letters to specific Access Advantage providers requesting corrective action as a result of medical record reviews demonstrated Colorado Access' mechanism to comply with this requirement.	
	Required Actions: None	
Contract: II.I.1.c	16. At the time an agreement is executed with a participating provider, the Contractor provides information to the provider about how the Contractor's UM program functions and is used to determine medical necessary. The information includes: ◆ Appropriate points of contact with the program. ◆ Contact persons or numbers for information or questions. ◆ Information about how to initiate appeals related to UM decisions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Provider Manual addressed member appeals and how providers may assist members or file appeals on behalf of members. The front section of the provider manual included a quick reference section with phone numbers for faxing authorizations and for filing appeals. The Authorization and Referrals section of the Provider Manual described the authorization process and defined medical necessity. The welcome letter template demonstrated that providers are referred to the Colorado Access Web site to obtain the Provider Manual upon contracting with Colorado Access.	
	Required Actions: None	

Results for Provider Participation and Program Integrity							
Total	Met	=	15	X	1.00	=	15
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	0
Total Applicable		=	15	**Total Score**		=	15

Total Score ÷ Total Applicable	=	100%

Standard IX—Subcontracts and Delegation		
References	**Requirement**	**Score**
42CFR438.230(a)(1) Contract: II.H.1	1. The Contractor oversees, and is accountable for any functions and responsibilities that it delegates to any subcontractor.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Delegation policy (QM203) described auditing and monitoring procedures to ensure the quality of a delegate's performance and adherence to Medicaid contract requirements. Colorado Access delegated credentialing to the Boulder Valley Independent Provider Association (BVIPA), Denver Health and Hospital Authority (DHHA), University Physicians, Inc. (UPI), and National Jewish Medical Research Center (NJMRC). Colorado Access also delegated information technology tasks and data processing to DST. Colorado Access had performed annual audits of its delegates for all lines of business in February 2008. Although the AHP line of business did not become operational until June 2008, these audits, in addition to regular reporting from the delegates before and after June 2008, demonstrated Colorado Access' accountability and responsibility for the delegated tasks.	
	Required Actions: None	
42CFR438.230(b)(1) Contract: II.H.1	2. Before any delegation, the Contractor evaluates a prospective subcontractor's ability to perform the activities to be delegated.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Delegation policy described predelegation procedures to ensure the quality of a delegate's performance and adherence to Medicaid contract requirements. Colorado Access had performed predelegation audits using the annual delegation form for DST in October 2007 and NJMRC in February 2008. Although AHP did not begin operations until June 2008, Colorado Access accepted the annual audits of DHHA, BVIPA, and UPI that Colorado Access performed for all of its lines of business in February 2008 as fulfilling the predelegation audit requirement.	
	Required Actions: None	

Standard IX—Subcontracts and Delegation		
References	**Requirement**	**Score**
42CFR438.230(b)(2) Contract: II.H.2 NCQA CR 12— Element D	3. There is a written agreement with each delegate.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Delegation policy described the contracting process. Copies of each executed delegation contract demonstrated implementation of the policy.	
	Required Actions: None	
42CFR438.230(b)(2) Contract: II.H.2 NCQA CR12— Element A Element B Element C	4. The written delegation agreement: ◆ Specifies the activities and reporting responsibilities delegated to the subcontractor. ◆ Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. For delegation of credentialing only, the agreement: ◆ Is mutually agreed upon. ◆ Describes the responsibilities of the Contractor and the delegated entity. ◆ Describes the delegated activities. ◆ Requires at least semiannual reporting to the Contractor. ◆ Describes the process by which the Contractor evaluates the delegated entity's performance. ◆ Describes the remedies available to the Contractor if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement. ◆ Includes a list of allowed uses of PHI. ◆ Includes a description of delegate safeguards to protect the information (PHI) from inappropriate uses. ◆ Includes a stipulation that the delegate will ensure that subdelegates have similar safeguards. ◆ Includes a stipulation that the delegate will provide individuals with access to their PHI. ◆ Includes a stipulation that the delegate will inform the Contractor if inappropriate use of the information (PHI) occur. ◆ Includes a stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontracts and Delegation		
References	**Requirement**	**Score**
	◆ Includes a stipulation that the Contractor has the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision-making.	
	Findings: Copies of each executed delegation agreement included the specific activities delegated and the reporting responsibilities of the subcontractor. The agreements also included remedies available to Colorado Access if the delegate did not fulfill responsibilities, including provisions for imposing sanctions or revoking the contract. Signatures of both parties demonstrated mutual agreement to the provisions of the contracts. Evaluation of the delegates' performance was described in the contracts and included monthly reporting submitted by the delegate and annual audits to be performed by Colorado Access. Colorado Access had a separate business associate agreement with DST, which contained all required language related to member PHI. Colorado Access staff explained during the on-site interview that Colorado Access did not have a business associate agreement with BVIPA, UPI, DHHA, or NJMRC as these organizations did not encounter information identifying individual members related to the delegated task of credentialing.	
	Required Actions: None	
42CFR438.230(b)(3) Contract: II.H.3	5. The Contractor implements written procedures for monitoring the subcontractor's (delegates and providers) performance on an ongoing basis. The Contractor subjects subcontractors to a formal review according to a periodic schedule established by the State, consistent with industry standards or state MCO laws and regulations.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Delegation policy described ongoing monitoring (review of monthly reports submitted by the delegates) and formal review (annual audits of the delegates' performance). Monthly reports submitted by the delegates demonstrated ongoing monitoring of performance. Although the AHP line of business had not yet been in operation for a year, annual audits of these delegates for Colorado Access' other lines of business (e.g., the Access Advantage line of business) demonstrated Colorado Access' implementation of the Delegation policy. (See Standard VII for scoring related to this requirement for subcontracted providers.)	
	Required Actions: None	

Standard IX—Subcontracts and Delegation		
References	**Requirement**	**Score**
42CFR438.230(b)(4) Contract: II.H.4	6. If the Contractor identifies deficiencies or areas for improvement in the subcontractor's performance, the Contractor and the subcontractor take corrective action. (See Standard VII for scoring related to this requirement for subcontracted providers.)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Delegation policy described the process for requiring corrective action and follow-up. Colorado Access provided examples of corrective action plans and follow-up for NJMRC, BVIPA, DST, and UPI. The annual audit of DHHA indicated that there were no corrective actions required for DHHA.	
	Required Actions: None	
45CFR Part 164	7. The Contractor ensures that any subcontractors agree to implement reasonable and appropriate safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of protected health information (PHI), including electronic information. Those safeguards include: ◆ Not using or disclosing PHI except as required by the contract. ◆ Using appropriate safeguards (physical security, security of electronic records, appropriate use of releases of information) to protect PHI. ◆ Implementing reasonable and appropriate policies and procedures related to the use, disclosure, and protection of PHI. ◆ Making PHI available in accordance with 45CFR164.524. ◆ Using business associate agreements with business associates of the subcontractor. ◆ Not using or disclosing the information for employment-related actions or decisions. ◆ Reporting to the health plan any use or disclosure of PHI that it becomes aware of that is inconsistent with the uses or disclosures provided for by the contract. ◆ Restricting access to and use of PHI to employees or classes of employees for which the information is required related to payment of, or performance of, health care operations. ◆ Providing an effective mechanism for resolving any noncompliance by employees. ◆ If feasible, returning or destroying all PHI received from the health plan and retaining no copies when such information is no longer needed for the purpose for which disclosure was made.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The business associate agreement between DST and Colorado Access included the HIPAA-compliant PHI language. Colorado	

Standard IX—Subcontracts and Delegation		
References	**Requirement**	**Score**
	Access' other delegates (that performed credentialing) did not encounter information that identified individual members; therefore, a business associate agreement was not required for those delegates.	
	Required Actions: The term subcontractor refers to both subcontracted delegates as well as subcontracted providers. While the provider agreement templates contained general language regarding confidentiality of information identifying members, this language should more specifically require Colorado Access' subcontracted providers to comply with specific HIPAA requirements or, at a minimum, refer the subcontractor to the specific federal regulation (45 CFR, Parts 160 and 164).	
45CFR Part 164	8. The Contractor ensures that any subcontractors have implemented and complied with each requirement (see Requirement 7) with respect to use, disclosure, and protection of PHI.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
	Findings: Colorado had obtained DST's policies; however, the policies contained processes for performing specific job duties related to processing claims. The policies did not contain a description of processes in the context of protection of information identifying members, nor did the policies inform employees of the HIPAA requirements and/or possible consequences of HIPAA noncompliance. The DST audit performed by Colorado Access did not evaluate compliance with HIPAA regulations.	
	Required Actions: Colorado Access must revise its process for monitoring delegates to include an evaluation of the subcontractors' compliance with HIPAA requirements.	

Results for Delegation Subcontracts							
Total	Met	=	7	X	1.00	=	7
	Partially Met	=	0	X	.00	=	0
	Not Met	=	1	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	8	**Total Score**		=	7

Total Score ÷ Total Applicable	=	88%

Appendix B. Coordination of Care Record Review Tool for Colorado Access

The completed notice of coordination of care record review tool follows this cover page.

HSAG HEALTH SERVICES ADVISORY GROUP

Colorado Department of Health Care Policy & Financing
Record Review Worksheet
for Colorado Access

The goal of this record review is to identify and describe specific documentation that provides evidence of ongoing communication between the primary care physicians (or other primary care providers) and specialty providers (specialty physicians, ancillary services, durable medical equipment providers, etc.).

Documentation to be reviewed: health plan file (authorizations, case management) and primary care provider file (physician and other progress notes), specific forms used for documentation of care coordination, and other pertinent documentation regularly used by the health plan, case management, or providers to document ongoing communication between primary care and specialty services.

Sample #: 1	Diagnoses (list all): Asthma, obesity, hip
Reviewer: Tom Cummins	deformation, COPD, migraines, GERD, IBS,
Review Date: 12/16/08	HTN, carpal tunnel

Dates and Types of Authorization with Approval Dates (or Other Outcome of Authorization Requests):

7/16/08—Request for nonformulary medication, Singulair, approved for one month (approved).
8/5/08—Request for nonformulary medication, Singulair, authorized for one year (approved).
11/21/08—Nonformulary medication, Singulair, reauthorized (approved)
9/9/08—Nonformulary medications, Calirizine and Symbicort (denied—available OTC would cover written prescription).
8/28/08—Nonformulary medication, Zyrtec (approved).

Specialty or Ancillary Services Provided:

None noted.

Documentation of Coordination Activities:

Date of Documentation	Type of Documentation
Multiple	Progress notes—University of Colorado Hospital
Content of Documentation (Brief Description): None of the notes contained documentation of coordinating with other care providers.	
Date of Documentation	**Type of Documentation**
Multiple	Care management notes
Content of Documentation (Brief Description): Multiple attempts to contact the member between 7/28/08 and 12/10/08.	

Sample #: 2	Diagnoses (list all): COPD, pneumonia,
Reviewer: Barbara McConnell	emphysema, nicotine dependence, cocaine use,
Review Date: 12/16/08	hypertension

Dates and Types of Authorization with Approval Dates (or Other Outcome of Authorization Requests):
7/29/08—Request for oxygen rental (approved).
Inpatient admission—emergency admission 7/4/08.

Specialty or Ancillary Services Provided:
Durable medical equipment—oxygen rental.

Documentation of Coordination Activities:

Date of Documentation	Type of Documentation
7/31/08	Case management note
Content of Documentation (Brief Description): Case management note stated member indicated she has not seen a PCP in about one year. Recommended to do so, recommended smoking cessation classes. Note indicated member has been receiving medication for COPD and blood pressure (assume from specialists). No documentation of contact between case manager and specialist or between specialist and PCP.	
Date of Documentation	**Type of Documentation**
11/2/08	Case management note
Content of Documentation (Brief Description): Spoke with member regarding recent admission. Patient reported she has a PCP and reported a decrease in smoking.	

Sample #: 3	Diagnoses (list all): COPD, arthritis,
Reviewer: Tom Cummins	diabetes
Review Date: 12/16/08	

Dates and Types of Authorization with Approval Dates (or Other Outcome of Authorization Requests):
None noted.

Specialty or Ancillary Services Provided:
Referral for diagnostic imaging consult to rule out osteoporosis.
Orthopedic provider for follow up on surgery in October 2008 on left knee.

Documentation of Coordination Activities:

Date of Documentation	Type of Documentation
8/13/08	Diagnostic imaging report
Content of Documentation (Brief Description): Copy of diagnostic imaging report to rule out osteoporosis (it was not clear to whom this was sent).	

Date of Documentation	Type of Documentation
12/1/08	Care management note
Content of Documentation (Brief Description): Telephone call with member to provide assistance in locating a new PCP (her last contact with her PCP was more than one year ago and that physician wasn't in the AHP network.).	

Sample #: 4	Diagnoses (list all): Depression disorder,
Reviewer: Tom Cummins	IBS
Review Date: 12/16/08	

Dates and Types of Authorization with Approval Dates (or Other Outcome of Authorization Requests):
7/3/08—Request for nonformulary medication, Abilify (approved for one month).
8/22/08—Request for nonformulary medication, Abilify (approved for one month).

Specialty or Ancillary Services Provided:
None noted.

Documentation of Coordination Activities:

Date of Documentation	Type of Documentation
7/3/08	CareSTEPP note
Content of Documentation (Brief Description): Phone contact with Dr. Schivoni's (PCP) office regarding prescription for Abilify.	

Date of Documentation	Type of Documentation
12/11/08	Care management note
Content of Documentation (Brief Description): PCP office and pharmacy were contacted to verify member's telephone number. Also, care management notes between 6/16/08 and 12/11/08 of attempts to contact the member.	

Sample #: 5	Diagnoses (list all): Right foot pain, asthma
Reviewer: Barbara McConnell	
Review Date: 12/16/08	

Dates and Types of Authorization with Approval Dates (or Other Outcome of Authorization Requests):
None noted.

Specialty or Ancillary Services Provided:
None noted.

Documentation of Coordination Activities:

Date of Documentation	Type of Documentation

Content of Documentation (Brief Description):
File provided for review contained only documentation of three emergency room visits (6/14/08, 7/2/08, and 12/12/08) and case management notes that the member could not be located (no phone number and letters were returned).

Two of the three emergency room visits were for asthma or bronchospasm and one was for a foot injury.

Sample #: 6	Diagnoses (list all): Hypersomnia, lymphedema, lumbago, chronic pain, peripheral neuropathy, hyperlipidemia, sleep apnea, asthma, cataracts (both eyes), glaucoma, chronic interstitial lung disease, COPD, depression, diabetes, reflux
Reviewer: Barbara McConnell	
Review Date: 12/17/08	

Dates and Types of Authorization with Approval Dates (or Other Outcome of Authorization Requests):
Insert from other sections
8/4/08—Request for nonformulary drug (approved for one month).
9/3/08—Request for nonformulary drug (92 x one year approved).
9/16/08—Request for nonformulary drug (approved for one month for continuity).
9/19/08—Review detail report required for durable medical equipment (diabetic shoes with inserts) requested on 9/18/08, approved 9/18/08.
10/9/08—Review detail report required for diabetic test strips approved for one month for continuity.
10/23/08—Request for test strips approved for one month.

Specialty or Ancillary Services Provided:
Eye clinic
Pulmonology clinic
Sleep study
Electrocardiogram study
Podiatry clinic
Hanger prosthetics

Documentation of Coordination Activities:

Date of Documentation	Type of Documentation
7/14/08	Pulmonology note
Content of Documentation (Brief Description): Pulmonology note stated the member was referred by the PCP.	
Date of Documentation	**Type of Documentation**
8/8/08	Letter from pulmonologist to PCP
Content of Documentation (Brief Description): Letter from pulmonologist to PCP included medical history, current therapy, review of systems, and therapy plan.	
Date of Documentation	**Type of Documentation**
8/21/08	Letter from pulmonologist to PCP
Content of Documentation (Brief Description): Letter included symptom improvement, treatment received, exam results, and therapy plan.	
Date of Documentation	**Type of Documentation**
10/28/08	Case management note (staffing)
Content of Documentation (Brief Description): Reference to Dr. G and Dr. Pritt and says patient needs to see oncologist for lymphadema and may need compression stocking or physical therapy plan for case management to get with PCP to obtain therapy plan.	

Date of Documentation	Type of Documentation
10/29/08	Case management notes
Content of Documentation (Brief Description): Called patient with dental resource.	

Date of Documentation	Type of Documentation
12/10/08	Case management notes
Content of Documentation (Brief Description): Message left with member.	

Date of Documentation	Type of Documentation
12/15/08	Note from pulmonology clinic to patient
Content of Documentation (Brief Description): Durable medical equipment—Note from pulmonology clinic to patient to confirm working well with durable medical equipment company.	

Sample #: 7	Diagnoses (list all): COPD, HTN, GERD,
Reviewer: Tom Cummins	osteoarthritis of the knees, various
Review Date: 12/16/08	malalignment

Dates and Types of Authorization with Approval Dates (or Other Outcome of Authorization Requests):
7/28/08—Request nonformulary medication: Prevacid.
8/2/08—Request nonformulary medication: Oxycotin.
8/11/08—Precertification for knee surgery (approved).
8/13/08—Continued stay after knee surgery (approved).
8/14/08—Home care services with nonparticipating provider.
8/14/08—Home health services—follow-up, knee surgery.
8/26/08—Review to extend home health services (approved for two more weeks).

Specialty or Ancillary Services Provided:
Home care services referral from Avista Adventist Hospital
Home health services

Documentation of Coordination Activities:

Date of Documentation	Type of Documentation
6/23/08	Progress note from United Medical Center, Lyons, Colorado (PCP?)
Content of Documentation (Brief Description): Treatment for chronic pain. Also made referral to see a psychiatrist secondary to anger outbursts and ongoing depression. (Looks like this physician made the referral to orthopedic surgeon.) Also encouraged member to follow up with his cardiologist.	

Date of Documentation	Type of Documentation
7/17/08	Pulmonology report
Content of Documentation (Brief Description): Copy of Boulder Valley Pulmonology.	

Date of Documentation	Type of Documentation
8/6/08	Orthopedic surgeon note
Content of Documentation (Brief Description): Consult with physician (PCP) regarding an abdominal herniorrhaphy that had become infected. Concern regarding potential for problems related to upcoming knee surgery.	

Date of Documentation	Type of Documentation
8/8/08	Letter from cardiologist to orthopedic surgeon
Content of Documentation (Brief Description): Letter assessing member for orthopedic surgery secondary to his treatment of heart disease.	

Date of Documentation	Type of Documentation
8/13/08	Referral to Estes Park Home Care (Avista Adventist Hospital)
Content of Documentation (Brief Description): Referral packet sent by inpatient provider to home care provider following knee replacement surgery.	

Date of Documentation	Type of Documentation
8/15/08	CareSTEPP note
Content of Documentation (Brief Description): Care manager coordination with surgeon's office regarding discharge plans and home health services in place.	

Sample #: 8	Diagnoses (list all): COPD, bipolar, pain,
Reviewer: Barbara McConnell	dermatitis, chronic rhinitis, asthma, OCD,
Review Date: 12/17/08	paranoid schizophrenia

Dates and Types of Authorization with Approval Dates (or Other Outcome of Authorization Requests):
Review detail.
9/17/08—Request for oxygen durable medical equipment approved.
10/9/08—Review detail log.
10/13/08—Review detail log retroactive authorization for oxygen to 9/23/08.

Specialty or Ancillary Services Provided:
Durable medical equipment for home oxygen—concentrator and portable.

Documentation of Coordination Activities:

Date of Documentation	Type of Documentation
4/21/08	Case management notes
Content of Documentation (Brief Description): Case manager call to PCP to verify treatment plan.	

Sample #: 9	Diagnoses (list all): Respiratory failure,
Reviewer: Barbara McConnell	COPD, asthma, HTN, anxiety, cocaine use,
Review Date: 12/17/08	chronic pain, hepatitis C

Dates and Types of Authorization with Approval Dates (or Other Outcome of Authorization Requests):

7/22/08—Inpatient emergency room admission for respiratory failure.

8/19/08—Review detail log.

8/19/08—Request for inpatient rehabilitation (referred to additional stay 7/24–8/8 at different hospital [no notes provided].)

8/26/08—Rehabilitation stay approved retroactively.

Specialty or Ancillary Services Provided:

Rehabilitation inpatient stay included rehabilitation, nursing, respiratory therapy, physical therapy, occupational therapy, and patient and family education.

Documentation of Coordination Activities:

Date of Documentation	Type of Documentation
7/24/08	Discharge summary
Content of Documentation (Brief Description): University of Colorado Hospital discharge summary instructed patient to follow up with PCP.	

Sample #: 11	Diagnoses (list all): COPD, pulmonary
Reviewer: Barbara McConnell	nodules, tachycardia, GERD
Review Date: 12/16/08	

Dates and Types of Authorization with Approval Dates (or Other Outcome of Authorization Requests):

9/4/08—Prior authorization request for CT approved.

8/29/08—Pharmacy prior-authorization request approval.

9/11/08—Prior-authorization request approved for pulmonary rehabilitation (requested 7/25). Letter requesting additional information was sent on 7/25/08. No response from the pulmonologist, so the request was denied on 8/7/08 (per utilization management notes) and a denial letter was sent to member on 8/7/08 within the 14-day time frame). On July 25, "need more time" decision pended letter sent to member.

8/21/08—Case management note stated member has prescription for tub transfer bench. TED hose and physical therapy (didn't mention approval).

8/20/08—Inpatient authorization (admission date 8/15/08) approved for five days. Actual length of stay was six days.

8/20/08—Authorization and approval for a bilevel positive airway pressure device rental (requested 8/20/08).

8/29/08—Request for pulse oximetry machine (approved or denied?).

7/28/08—Authorization for home oxygen from LinCare (requested 7/28).

8/29/08—Authorization approval for medications (requested on 8/29/08).

Specialty or Ancillary Services Provided:

Durable medical equipment (home oxygen and bilevel positive airway pressure device)

Pulmonology clinic

Documentation of Coordination Activities:

Date of Documentation	Type of Documentation
6/3/08	Progress Note
Content of Documentation (Brief Description): PCP clinic (Potomac Street) placed call to daughter to discuss lab results and treatment options.	

Date of Documentation	Type of Documentation
6/3/08	Progress Note
Content of Documentation (Brief Description): Call from outpatient clinic to patient to discuss lab results and discussed with patient's daughter.	

Date of Documentation	Type of Documentation
7/3/08	Letter from pulmonologist to PCP
Content of Documentation (Brief Description): Letter from pulmonologist to PCP described improvement following recent treatment, medications list, most recent exam results and review of systems and treatment plan.	

Date of Documentation	Type of Documentation
7/15/08	Case management notes
Content of Documentation (Brief Description): Met with patient and PCP.	

Date of Documentation	Type of Documentation
7/18/08	Progress Note
Content of Documentation (Brief Description): PCP office called patient regarding changes to treatment plan.	

Date of Documentation	Type of Documentation
7/18/08	Case management note
Content of Documentation (Brief Description): Case management note documenting phone call from PCP office to case manager regarding prior-authorization request for medications (approved per case management notes).	

Date of Documentation	Type of Documentation
8/13/08	Progress Note
Content of Documentation (Brief Description): Call from radiology with results to PCP clinic (chest x ray).	

Date of Documentation	Type of Documentation
8/15/08	Progress Note
Content of Documentation (Brief Description): Call to University of Colorado Hospital to confirm inpatient hospitalization.	

Date of Documentation	Type of Documentation
8/16/08	CT scan report
Content of Documentation (Brief Description): CT scan report stated e-mail sent to Dr. D and Dr. L regarding suspicion of primary lung cancer (neither was PCP).	

Date of Documentation	Type of Documentation
8/19/08	University of Colorado Hospital
Content of Documentation (Brief Description): Discharge physician progress note instructed to follow up with PCP (included name and phone number) and pulmonary clinic.	

Date of Documentation	Type of Documentation
8/21/08	Discharge summary
Content of Documentation (Brief Description): Summary of inpatient treatment and discharge plan	

Date of Documentation	Type of Documentation
9/11/08	Case management note
Content of Documentation (Brief Description): Case management note stated pulmonologist letter was given to CG, RN with prior-authorization request approval for pulmonology rehabilitation.	

Sample #: 12	Diagnoses (list all): COPD, asthma, chronic
Reviewer: Tom Cummins	pain, anxiety, history seizure disorder, Arnold-
Review Date: 12/17/08	Chiari malformation, IBS, acid reflux

Dates and Types of Authorization with Approval Dates (or Other Outcome of Authorization Requests):
6/7/08—nonformulary medication: Lyrica (approved).
6/16/08—nonformulary medication: Lyrica (approved 1 additional month).
6/16/08—Inpatient hospital admit to St. Anthony.
6/24/08—nonformulary medication: Fentanyl patch (approved).
6/25/08—nonformulary medication: Fentanyl patch (approved 1 additional month).
7/10/08—nonformulary medication: Cymbalta (approved).
7/23/08—nonformulary medication: Cymbalta renewal.

Specialty or Ancillary Services Provided:
Pulmonology consult
Breast diagnostic mammography and left breast ultrasound
Pathology secondary to breast mass
Durable medical equipment assessment
Mobility assessment
Home health care

Documentation of Coordination Activities:

Date of Documentation	Type of Documentation
6/17/08	Letter from AHP to provider
Content of Documentation (Brief Description): Letter to provider regarding the approval for nonformulary medication (Lyrica).	

Date of Documentation	Type of Documentation
6/18/08	Inpatient discharge summary
Content of Documentation (Brief Description): Discharge summary from St. Anthony North Hospital. Recommended follow up with PCP in one week (faxed to AHP 6/19/08). Member visit by AHP care manager.	

Date of Documentation	Type of Documentation
6/25/08	Referral form
Content of Documentation (Brief Description): Referral from physician at St. Anthony Family Medicine Center (PCP "Medical Home") to pulmonologist.	

Date of Documentation	Type of Documentation
12/15/08	Copy of pulmonology consult
Content of Documentation (Brief Description): Consult (pulmonology) conducted by Dr. Good.	

Sample #: 13	Diagnoses (list all): Right leg wound, asthma
Reviewer: Tom Cummins	cellulotus, knee and back pain, total knee
Review Date: 12/17/08	reconstruction, GERD

Dates and Types of Authorization with Approval Dates (or Other Outcome of Authorization Requests):
None noted.

Specialty or Ancillary Services Provided:
Cardiac consult, pulmonary consult, mobility assessment

Documentation of Coordination Activities:

Date of Documentation	Type of Documentation
8/14/08	Progress notes—UM Denver Medical Clinic
Content of Documentation (Brief Description): Notes 8/14/08 through 8/22/08: Treatment for right leg wound after falling off a bike.	

Date of Documentation	Type of Documentation
12/12/08	Pulmonary report
Content of Documentation (Brief Description): Pulmonary report from National Jewish Medical Research Center (looks like she also saw a pulmonologist on 7/28/08 and 9/15/08).	

Sample #: 14	Diagnoses (list all): Seizure disorder, PTSD, depression, asthma, polycystic kidney disease, back surgery, blind in one eye secondary to gunshot wound, history of stroke
Reviewer: Tom Cummins	
Review Date: 12/17/08	

Dates and Types of Authorization with Approval Dates (or Other Outcome of Authorization Requests):
7/25/08–8/24/08—Durable medical equipment secondary to asthma (approved).
10/13/08—Reauthorization for durable medical equipment.

Specialty or Ancillary Services Provided:
Neurology consult
Durable medical equipment

Documentation of Coordination Activities:

Date of Documentation	Type of Documentation
7/16/08	Emergency room discharge summary
Content of Documentation (Brief Description): Emergency department summary from Medical Center of Aurora South (treatment of a headache). Returned to PCP for follow up on back pain, chest pain.	

Date of Documentation	Type of Documentation
8/14/08	History and physical by neurologist
Content of Documentation (Brief Description): Neurology consult by Advanced Neurological Evaluation and Treatment Center.	

Date of Documentation	Type of Documentation
Multiple	Case management note
Content of Documentation (Brief Description): Multiple attempts to contact member by care management.	

Sample #: 15	Diagnoses (list all): Mitochurdial myopathy,
Reviewer: Tom Cummins	diabetes, hypertension, morbid obesity,
Review Date: 12/16/08	hypothyroidism, migraines, muscular dystrophy

Dates and Types of Authorization with Approval Dates (or Other Outcome of Authorization Requests):
6/25/08—Nonformulary medication, Lantus insulin (approved).
6/27/08—Nonformulary medication, Lantus (approved).
6/30/08—Hospital admission: St. Anthony.
8/13/08—Admission to Highline Rehabilitation (skilled nursing home—approved).
8/20/08—Renewal-Highline Rehabilitation, seven days (approved).
8/22/08—Renewal-Highline Rehabilitation, 14 days (approved).
8/28/08—Renewal-Highline Rehabilitation, seven days (approved).
9/5/08—Renewal-Highline Rehabilitation, nine days (approved).

Specialty or Ancillary Services Provided:
Pulmonologist
Home health
Rehabilitation (skilled nursing home) posthospital discharge

Documentation of Coordination Activities:

Date of Documentation	Type of Documentation
6/29/08	Emergency room report (St. Anthony hospital)
Content of Documentation (Brief Description): Emergency room report: Treatment due to shortness of breath.	

Date of Documentation	Type of Documentation
7/5/08	Pulmonologist notes
Content of Documentation (Brief Description): Progress notes from pulmonologist, pulmonary and clinical care.	

Sample #: 17	Diagnoses (list all): COPD, pneumonia,
Reviewer: Tom Cummins	bipolar disorder
Review Date: 12/17/08	

Dates and Types of Authorization with Approval Dates (or Other Outcome of Authorization Requests):
6/7/08—Hospital admission
6/28/08—Hospital admission
7/15/08—Hospital admission
7/17/08—Continued stay authorized hospital

Specialty or Ancillary Services Provided:
Respiratory therapy
Speech therapy

Documentation of Coordination Activities:

Date of Documentation	Type of Documentation
6/7/08	Emergency room report
Content of Documentation (Brief Description): Admission summary from St. Anthony hospital emergency room faxed to AHP on 6/11/08.	

Date of Documentation	Type of Documentation
6/9/08	Fax from St. Anthony hospital
Content of Documentation (Brief Description): Fax from hospital to AHP with clinical information regarding the member's admission.	

Date of Documentation	Type of Documentation
6/9/08	Care management note
Content of Documentation (Brief Description): Progress note regarding face-to-face visit with member while hospitalized at St. Anthony.	

Date of Documentation	Type of Documentation
6/11/08	Referral to speech therapy by St. Anthony hospital
Content of Documentation (Brief Description): Fax to AHP notifying that the member had been referred to speech therapy.	

Date of Documentation	Type of Documentation
12/11/08	Psychiatric hospital admission note
Content of Documentation (Brief Description): Psychiatric hospital admission summary (West Pines).	

Date of Documentation	Type of Documentation
12/16/08	Evidence of physical exam
Content of Documentation (Brief Description): Note regarding physical exam including GYN at Clinica Campesina.	

Appendix C. Site Review Participants for Colorado Access

Table C-1 lists the participants in the FY 2008–2009 site review of **Colorado Access**.

Table C-1—HSAG Reviewers and MCO Participants	
HSAG Review Team	**Title**
Barbara McConnell, MBA, OTR	Project Director
Tom Cummins	Compliance Auditor
Colorado Access Participants	**Title**
April Abrahamson	Director, AHP—ECM
Carrie Bandell	Director, Quality Management
Reyna Garcia	Director, Customer Service
Christine E. Gillaspie	Utilization Manager
Irene Girgis	Director, Pharmacy Services
Alice Jordan	Director, Provider Contracts
Gary Marx	Director, Human Resources/Compliance Officer
Claudine McDonald	Director, Office of Member and Family Affairs
Gretchen McGinnis	Director, Strategic Planning and Business Development
Mike McKitterick	Vice President, Clinical Services
Julie McNamara	Director, Business Process and Systems Operations
Kelly Muenster	Director, Information Technology
Cynthia Pechon	Staff Attorney
Kay Pendergraft	Senior Project Coordinator, Provider Contracting
Travis Perez	Quality Program Manager
Phil Reed	Chief Financial Officer
Tami Snowden	Manager of Care Management
Marie Steckbeck	Vice President of Operations
Marshall Thomas	President/Chief Executive Officer/Chief Medical Officer
Michelle Tomsche	Operations Project Coordinator

Appendix D. Corrective Action Plan Process for FY 2008–2009 for Colorado Access

Colorado Access is required to submit to the Department a corrective action plan (CAP) 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 element that requires correction, the health plan should identify the planned interventions to achieve compliance with the requirement(s) and the timeline for completion. Supporting documents should not be submitted and will not be considered until the plan has been approved by the Department. Following Department approval, the MCO must submit documents per the timeline that was approved.

Table D-1—Corrective Action Plan Process

Step 1	**Corrective action plans are submitted**
	Each MCO will submit a CAP to the Department within 30 calendar days of receipt of the final external quality review site review report via e-mail or the file transfer protocol (FTP) site with an e-mail notification regarding the posting. The Department should be copied on any communication regarding CAPs. For each of the elements receiving a score of *Partially Met* or *Not Met*, the CAP must address the planned intervention(s) to complete the required actions and the timeline(s) for the intervention(s).
Step 2	**Prior approval for timelines exceeding 30 days**
	If the MCO is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.
Step 3	**Department approval**
	The Department will notify the MCO via e-mail whether: ◆ The plan has been approved and the MCO should proceed with the interventions as outlined in the plan, or ◆ Some or all of the elements of the plan must be revised and resubmitted.
Step 4	**Documentation substantiating implementation**
	Once the MCO has received Department approval of the plan, the MCO should implement all the planned interventions and submit evidence of such intervention to HSAG via e-mail or the FTP site with an e-mail notification regarding the posting. The Department should be copied on any communication regarding CAPs.
Step 5	**Progress reports may be required**
	For any planned interventions requiring an extended implementation date, the Department may, based on the nature and seriousness of the noncompliance, require the MCO to submit regular reports to the Department detailing progress made on one or more open elements in the CAP.

Table D-1—Corrective Action Plan Process	
Step 6	**Documentation substantiating implementation of the plans is reviewed and approved**
	Following a review of the CAP and all supporting documentation, the Department will inform the MCO as to whether: (1) the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements or (2) the MCO must submit additional documentation. The Department will inform each MCO in writing when the documentation substantiating implementation of all Department-approved corrective actions is deemed sufficient to bring the MCO into full compliance with all the applicable contract requirements.

The template for the CAP follows.

Table D-2—FY 2008–2009 Corrective Action Plan *for* Colorado Access				
Standard	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents to be Submitted as Evidence of Completion**
I. Coverage and Authorization of Services 25. A review of a report from CareSTEPP for an AHP member included documentation that the provider had been noticed regarding the 60-day benefit limitation but did not document that the home health services provider had coordinated with the SEP agency as required by contract.	CO Access must monitor its contracted home health services providers to ensure that providers coordinate prior authorization with the SEP agency as required by contract.			
II. Access and Availability 11. CO Access faxed secret shopper survey results to providers not meeting appointment standards; however, the correspondence did not clarify that meeting appointment standards was a contractual requirement, nor did it request follow-up action by the provider to remediate substandard performance.	CO Access must require its providers to meet standards for timely access to care and must initiate corrective action to address issues related to provider performance as appropriate.			

Table D-2—FY 2008–2009 Corrective Action Plan *for* Colorado Access				
Standard	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents to be Submitted as Evidence of Completion**
IX. Subcontracts and Delegation 8. The delegate's policies did not contain a description of processes in the context of protection of information identifying members, nor did the policies inform employees of the HIPAA requirements and/or possible consequences of HIPAA noncompliance. The DST audit performed by Colorado Access did not evaluate compliance with HIPAA regulations.	Colorado Access must revise its process for monitoring delegates to include an evaluation of the subcontractors' compliance with HIPAA requirements.			

Appendix E. Compliance Monitoring Review Activities for Colorado Access

The following table describes the activities performed throughout the compliance monitoring process. The activities listed below are consistent with CMS' final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)*, February 11, 2003.

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG…
Activity 1:	**Planned for Monitoring Activities**
	Before the compliance monitoring review: ◆ HSAG and the Department held teleconferences to determine the content of the review. ◆ HSAG coordinated with the Department and the MCO to set the date of the review. ◆ HSAG coordinated with the Department to determine timelines for the Department's review and approval of the tool and report template and other review activities. ◆ HSAG staff provided an orientation on October 3, 2008, for the MCO and the Department to preview the FY 2008–2009 compliance monitoring review process and to allow the MCOs to ask questions about the process. HSAG reviewed the processes related to the request for information, CMS' protocol for monitoring compliance, the components of the review, and the schedule of review activities. ◆ HSAG assigned staff to the review team. ◆ Prior to the review, HSAG representatives responded to questions from the MCO related to the process and federal managed care regulations to ensure that the MCO was prepared for the compliance monitoring review. HSAG maintained contact with the MCO as needed throughout the process and provided information to the MCO's key management staff members about review activities. Through this telephone and/or e-mail contact, HSAG responded to the MCO's questions about the request for documentation for the desk audit and about the on-site review process.
Activity 2:	**Obtained Background Information From the Department**
	◆ HSAG used the MCO's contract, dated April 1, 2008, to develop the monitoring tool, desk audit request, on-site agenda, and report template. ◆ HSAG submitted each of the above documents to the Department for its review and approval.
Activity 3:	**Reviewed Documents**
	◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the MCO in writing of the desk audit request and sent a documentation request form and an on-site agenda. The MCO had 30 days to provide all documentation for the desk audit. The desk audit request included instructions for organizing and preparing the documents related to the review of the five standards. ◆ Documents requested included applicable policies and procedures, minutes of key MCO committee or other group meetings, reports, logs, and other documentation. ◆ 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.

Table E-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG…**
Activity 4:	**Conducted Interviews**
	◆ During the on-site portion of the review, HSAG met with the MCO's key staff members to obtain a complete picture of the MCO's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the MCO's performance.
Activity 5:	**Collected Accessory Information**
	◆ During the on-site portion of the review, HSAG collected additional documents. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were of a confidential or proprietary nature.) ◆ HSAG requested and reviewed additional documents needed that HSAG identified during its desk audit. ◆ HSAG requested and reviewed additional documents needed that HSAG identified during the on-site interviews.
Activity 6:	**Analyzed and Compiled Findings**
	◆ Following the on-site portion of the review, HSAG met with MCO staff to provide an overview of preliminary findings of the review. ◆ HSAG used the FY 2008–2009 Site Review Report to compile the findings and incorporate information from the pre-on-site and on-site review activities. ◆ HSAG analyzed the findings and assigned scores. ◆ HSAG determined opportunities for improvement based on the review findings. ◆ HSAG determined actions required of the MCO to achieve full compliance with Medicaid managed care regulations.
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 2008–2009 Site Review Report. ◆ HSAG submitted the site review report to the Department for review and comment. ◆ HSAG coordinated with the Department to incorporate the Department's comments. ◆ HSAG distributed a second draft report to the MCO for review and comment. ◆ HSAG coordinated with the Department to incorporate the MCO's comments and finalize the report. ◆ HSAG distributed the final report to the MCO and the Department.