Colorado Medicaid
Managed Care Program

FY 2009–2010 Site Review Report

for

Colorado Access

June 2010

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 2009–2010 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 each state's quality strategy. The Colorado 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 second year that HSAG has performed compliance monitoring reviews of the MCOs. For its review of **Colorado Access**' Colorado Regional Integrated Care Collaborative (CRICC) program, HSAG developed a review strategy consisting of two standards: Standard III—Coordination of Care and Standard X—Quality Assessment and Performance Improvement. Compliance with federal regulations and contract requirements was evaluated through review of the two standards. This report documents results of the FY 2009–2010 review activities for the review period—July 1, 2009, through February 28, 2010 (the date the contract ended). Section 2 contains summaries of the findings, opportunities for improvement, strengths, and required actions for each standard area. Appendix A contains details of the findings.

Methodology

In developing the data collection tools and in reviewing the standards, HSAG used the MCO contract requirements and regulations specified by the BBA, with revisions that were issued June 14, 2002, and were effective August 13, 2002. To determine compliance, HSAG conducted a desk review of documents and materials provided prior to the telephonic interview of key MCO personnel. Documents submitted for the desk review consisted of policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. Details of the review of the two standards are in Appendix A.

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

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 two areas of review.
- Strengths, opportunities for improvement, and actions required to bring the MCO into compliance with federal health care regulations in the standard areas reviewed.
- 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 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*. HSAG also identified opportunities for improvement with associated recommendations to enhance some elements, regardless of the score. While HSAG provided recommendations for enhancement of MCO processes based on these identified opportunities for improvement, for requirements that may have been scored *Met*, these recommendations do not represent noncompliance with contract or BBA regulations at this time.

Table 1-1 presents the score for **Colorado Access** for each of the standards. Details of the findings for each standard are 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)
III	Coordination and Continuity of Care	10	10	10	0	0	0	100%
X	Quality Assessment and Performance Improvement	14	14	14	0	0	0	100%
	Totals	**24**	**24**	**24**	**0**	**0**	**0**	**100%**

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

Overall Summary of Performance

For each of the two standards HSAG reviewed, **Colorado Access** received compliance scores of 100 percent, which indicates a comprehensive understanding and implementation of the contract requirements. **Colorado Access** staff members clearly articulated the procedures followed, which was corroborated by the assessment of written policies and procedures.

Standard III—Coordination and Continuity of Care

Summary of Findings and Opportunities for Improvement

Colorado Access had a mechanism to ensure that members had an ongoing source of primary health care and care coordination. Members selected or were assigned a primary care provider (PCP), and **Colorado Access** supported member PCP change requests. **Colorado Access** procedures ensured that member privacy would be protected consistent with confidentiality requirements. **Colorado Access** had the ability to assess individual needs through the Colorado Access Case Manager software, a tool used to facilitate identification of members with special health care needs (SHCN) and develop care plans. All care plans were reviewed with a care manager team lead, a registered nurse, for appropriate screening and planning. **Colorado Access** had a mechanism in place to allow members to access a specialist appropriate to their condition and identified needs. Care management staff members collaborated with PCPs to obtain standing referrals for members with SHCN as appropriate. If **Colorado Access** did not have the direct capacity to provide a medically necessary, covered service within its network, arrangements could be made via a single-case agreement with a nonnetwork provider.

Summary of Strengths

Colorado Access assessed members and provided care management services at a level and intensity designed to improve the quality of care and decrease the cost of care for the highest-risk members.

The Colorado Access Case Manager electronic assessment and care planning software provided a comprehensive set of assessments designed to identify members' special health care needs and the resources to meet those needs.

Summary of Required Actions

There were no required actions for this standard.

Standard X—Quality Assessment and Performance Improvement

Summary of Findings and Opportunities for Improvement

Colorado Access published a quality assessment and performance improvement (QAPI) program description that described its quality program, included a list of goals and objectives related to performance improvement, defined the QAPI program governance structure, and described the role and responsibilities of the various committees that were part of the program. The QAPI program included mechanisms to detect both underutilization and overutilization of services. **Colorado Access** also produced an annual work plan that detailed quality improvement activities to be addressed in the upcoming fiscal year. **Colorado Access** adopted clinical practice guidelines for prenatal through postpartum care and for conditions related to disabilities or SHCN. **Colorado Access** convened both a Quality Improvement Committee (QIC) and Medical/Behavioral Quality Improvement Committee (MBQIC) to address issues related to performance improvement. **Colorado Access** maintained a health information system that had the ability to collect, analyze, integrate, and report quality data.

Summary of Strengths

Colorado Access had a health information system that produced a wide variety of reports related to utilization of services, accessibility of care, coordination of care, member satisfaction, and other quality measures described in the QAPI program description and QAPI program work plan. **Colorado Access** published a QAPI program evaluation that included a summary of findings for each activity included in the QAPI program work plan, and intervention strategies to further improve performance in the upcoming fiscal year. **Colorado Access** also evaluated the QAPI program throughout the year through the sharing of quality data at QIC and MBQIC meetings.

Summary of Required Actions

There were no required actions for this standard.

3. Follow-up on FY 2008–2009 Corrective Action Plan

for Colorado Access

Methodology

As a follow-up to the FY 2008–2009 site review, each MCO was required to submit a corrective action plan (CAP) to the Department addressing all components for which the MCO received a score of *Partially Met* or *Not Met*. The plan was to include interventions to achieve compliance and the timeline associated with those activities. HSAG reviewed the CAP and associated documents submitted by the MCO and determined whether the MCO successfully completed each of the required actions. HSAG and the Department continued to work with the MCO until HSAG and the Department determined that the MCO completed each of the required actions from the FY 2008–2009 compliance monitoring site review, or until the time of the on-site portion of the MCO's FY 2009–2010 site review.

Summary of 2008–2009 Required Actions

As a result of the 2008–2009 compliance review, Colorado Access was required to submit a CAP explaining how it would address one element in each of three standards: Standard I—Coverage and Authorization Services, Standard II—Access and Availability, and Standard IX—Subcontracts and Delegation.

Summary of Corrective Action/Document Review

Colorado Access submitted a CAP to HSAG and the Department. HSAG and the Department determined that if implemented as written, Colorado Access' CAP would bring the health plan into compliance.

Colorado Access submitted documents that demonstrated it had implemented its plan as written in August 2009. After careful review, HSAG and the Department determined that Colorado Access had successfully completed all required actions.

Summary of Continued Required Actions

There were no corrective actions continued from FY 2008–2009.

The completed compliance monitoring tool follows this cover page.

Standard III—Coordination and Continuity of Care			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**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.	**Documents Submitted/Location Within Documents:** 1.CCS306 - Delivering Continuity and Transition of Care for Members 2.CCS310 - Access to Primary and Specialty Care 3.CS311 – Primary Care Provider Assignment Changes	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: Colorado Access had a documented mechanism to ensure that each member had an ongoing source of primary care and health care coordination. The Access to Primary and Specialty Care policy stated that members who did not choose a PCP were assigned one and that the PCP was responsible for all care except inpatient, specialty, and emergency care. The policy also stated that members were informed of their PCP assignment in writing. The PCP Assignments/Changes policy described Colorado Access' processes for assigning a PCP and changing a PCP at a member's request. The Delivering Continuity and Transition of Care for Members policy described Colorado Access' procedures for ensuring primary care for members when transitioning from a nonnetwork PCP or when a PCP is terminated from the network. The Care Coordination policy described Colorado Access' processes for identifying members appropriate for enhanced care management. The Colorado Access Health Plan Member Handbook (member handbook) described the role of the PCP, how to obtain care, and the role of care management. Screen shots of a member's electronic health record in the Colorado Access Case Manager (CACM) system identified the assigned PCP and caseworker as well as the mental health provider, patient demographics, and assessment information.		
	Required Actions: None		

Standard III—Coordination and Continuity of Care			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
COA 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.	**Documents Submitted/Location Within Documents:** 1.CCS305 - Care Coordination 2.PRA Screen Shot (1) 3.PRA Screen Shot (2)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: Colorado Access used risk stratification (Kronick scoring) to assess known prior costs and predict risk. Following the Kronick scoring process, Colorado Access contacted and interviewed members using a scripted set of questions from the Patient Risk Assessment (PRA) to determine the level of support, the appropriate intensity of services, and the interventions needed. The Care Coordination policy defined enhanced care management as a clinical program for Medicaid members composed of care coordination, case management activities, health education, consumer advocacy and empowerment, and health promotion tailored for a high-cost, high-risk, chronically ill population. The policy stated that risk stratification is used to determine the appropriate intensity of services. Results of the client assessment inform the care managers in developing the care plan. Screen shots of the electronic PRA system included questions for the patient about his or her health history, symptoms, and community and family supports.		
	Required Actions: None		

Standard III—Coordination and Continuity of Care			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
COA 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.	**Documents Submitted/Location Within Documents:** 1.CCS302 - Medical Criteria for Utilization Review 2.CCS305 - Care Coordination 3.CCS306 - Delivering Continuity and Transition of Care for Members 4.CCS309 - Emergency and Post Stabilization Care 5.CCS310 - Access to Primary and Specialty Care	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Care Coordination policy listed the goals of care coordination, one of which included ensuring timely coordination of covered services and continuity of care. The policy also stated that an individualized care plan should be time-specific and updated periodically. Staff members stated during the interview that case managers reviewed cases weekly through supervisory meetings and that individualized care plans were monitored and updated through that process. The policy also included procedures for developing, monitoring, and coordinating individualized care plans, which could include referrals and assistance obtaining primary and specialty medical care, referrals to community resources, and assistance obtaining benefits of the plan. The Access to Primary and Specialty Care policy stated that the PCP was responsible for providing all primary care and referrals for specialty and ancillary care. The policy described the process for all members to be assigned to (or choose) a PCP. The Emergency and Post-Stabilization Care policy stated that prior authorization for emergency and urgently needed services was not required and that members were informed of this via the member handbook. The member handbook included information about how to access routine, urgent, and emergency care. The Utilization Review Determinations policy included the time frames for making service authorization decisions. Appointment standards were included in the Colorado Access Health Plan Enhanced Care Management Provider Manual. The Delivering Continuity and Transition of Care for Members policy described Colorado Access' procedures for ensuring primary care for members when transitioning from a nonnetwork PCP or when a PCP is terminated from the network.		
	Required Actions: None		

Standard III—Coordination and Continuity of Care			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.208(b)(2) COA Contract: II.E.8.c & d	4. The Contractor coordinates services furnished to the member by the Contractor with the services the member receives from any other medical or behavioral health care organization. (This element requires a policy/procedure.)	**Documents Submitted/Location Within Documents:** 1.CCS305 - Care Coordination	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Care Coordination policy stated that one of the goals of care coordination was to improve access to medical and/or mental health care, community resources, and social supports for members with complex physical, mental, and cultural health care needs. The policy also stated that individualized care plans may include referrals to providers; community agencies; home and community-based services (HCBS) or Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services; and other benefits of the plan. The home page of the Colorado Access Web site has a link for members, which includes a link to community resources such as food banks, charity organizations, the BHOs in Colorado, and a variety of topic-specific foundations and organizations. Screen shots of a member's electronic health record documented other entities providing services to the member, and there were fields to prompt compliance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations regarding records.		
	Required Actions: None		

Standard III—Coordination and Continuity of Care			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.208(b)(4) COA 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 (This element requires a policy/procedure.)	**Documents Submitted/Location Within Documents:** 1.CCS305 - Care Coordination 2.CMP204 – Corporate Compliance Program Education & Training 3.HIP201 – Protection of Health Information	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Care Coordination policy stated that one of the care coordination interventions was working to ensure that member confidentiality is maintained. The Protection of Health Information policy and the Security of Electronic Protected Health Information policy described Colorado Access' procedures for protecting the confidentiality of records and other materials containing personally identifying information (defined in the policies as PHI). The procedures included limiting access to records based on what is necessary to perform the particular job function, fax procedures, e-mail procedures, and use of an authorization of disclosure form if the disclosure is for a purpose other than treatment, payment and operations, transportation of PHI procedures, and physical security procedures. The Protection of Health Information policy stated that all Colorado Access employees and nonemployee committee members were required to sign a confidentiality agreement upon hire and annually thereafter, and that provider contracts must include confidentiality requirements. The Compliance Program Education and Training policy indicated that all staff members were trained regarding patient confidentiality and compliance with HIPAA. Employees were required to complete annual online refresher training on confidentiality requirements, and the results of tests were kept in personnel files. Colorado Access' professional provider agreements included requirements for access to and the confidentiality of records in accordance with HIPAA requirements.		
	Required Actions: None		

Standard III—Coordination and Continuity of Care			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.208(c)(2) COA Contract: 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.	**Documents Submitted/Location Within Documents:** 1.CCS305- Care Coordination 2.Intensive Case Management Desktop Manual 3.CACM Screenshots - Abuse 4.CACM Screenshots – Adult Asthma 5.CACM Screenshots – Anxiety 6.CACM Screenshots – Asthma Follow Up 7.CACM Screenshots – Bipolar 8.CACM Screenshots – Care Plan Knowledge Deficit 9.CACM Screenshots – Care Plan Lack of PCP 10.CACM Screenshots – Care Plan PHQ9 11.CACM Screenshots – Care Plan Self Management 12.CACM Screenshots – Care Plan Social Support 13.CACM Screenshots – Chronic Pain Management 14.CACM Screenshots – Diabetes 15.CACM Screenshots – Educational Services 16.CACM Screenshots – Employment 17.CACM Screenshots – Family Resource 18.CACM Screenshots – Lack of Mental Healthcare 19.CACM Screenshots – Medical Co morbidity 20.CACM Screenshots – Mobility Screening 21.CACM Screenshots – PHQ9 22.CACM Screenshots – Psychosis 23.CACM Screenshots – Self Efficacy 24.CACM Screenshots – SF12 25.CACM Screenshots – Special Equipment 26.CACM Screenshots – Substance Abuse	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
		27.CACM Screenshots – Transfer Screening 28.CACM Screenshots - Transportation	
	Findings: The Care Coordination policy described Colorado Access' goals for providing care coordination to members with SHCN and stated that methods of identifying members for the care coordination program included: ◆ The use of internal data sources such as condition-specific profiles, emergency room visit reports, inpatient census reports, readmission reports, and historical cost reports. ◆ Telephonic outreach and screening. ◆ Referrals from members, designated client representatives (DCRs), authorized representatives, or family members. ◆ Referrals from PCPs; specialty care providers, including mental health providers; schools; home health care or ancillary service providers; human service agencies; the State; and other community agencies. ◆ Referrals from institutional providers (e.g., hospitals or skilled nursing, rehabilitation, residential, and subacute facilities). ◆ Referrals from other Colorado Access departments. The Intensive Case Management Process desktop procedure stated the when cases were received by the care manager without the completion of an assessment, the initial assessment was completed, then specific assessments were completed as indicated by the initial assessment. The member handbook described the process of care coordination to members. Colorado Access provided screen shots of blank assessments and care plans for a variety of conditions and provided several examples of actual member records.		
	Required Actions: None		

Standard III—Coordination and Continuity of Care			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
COA Contract: II.E.8.f	7. The Contractor has an effective care coordination system that includes: ◆ Capacity to provide individual needs assessment to identify special health care needs ◆ Procedures designed to address those members who may require services from multiple providers, facilities, or agencies and require complex coordination of benefits and services, and members who require ancillary services, including social services and other community resources ◆ 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 and criteria for making referrals and coordinating care by specialists, subspecialists and community-based organizations that will promote continuity as well as cost-effectiveness of care. ◆ 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 ◆ Informing the member that he or she may continue to receive services from his or her	**Documents Submitted/Location Within Documents:** 1.CCS305 - Care Coordination 2.CCS306 - Delivering Continuity and Transition of Care for Members 3.Member Handbook Care Coordination (PG 12) 4.CACM Screenshots - Abuse 5.CACM Screenshots – Adult Asthma 6.CACM Screenshots – Anxiety 7.CACM Screenshots – Asthma Follow Up 8.CACM Screenshots – Bipolar 9.CACM Screenshots – Care Plan Knowledge Deficit 10.CACM Screenshots – Care Plan Lack of PCP 11.CACM Screenshots – Care Plan PHQ9 12.CACM Screenshots – Care Plan Self Management 13.CACM Screenshots – Care Plan Social Support 14.CACM Screenshots – Chronic Pain Management 15.CACM Screenshots – Diabetes 16.CACM Screenshots – Educational Services 17.CACM Screenshots – Employment 18.CACM Screenshots – Family Resource 19.CACM Screenshots – Lack of Mental Healthcare 20.CACM Screenshots – Medical Co morbidity 21.CACM Screenshots – Mobility Screening 22.CACM Screenshots – PHQ9 23.CACM Screenshots – Psychosis 24.CACM Screenshots – Self Efficacy 25.CACM Screenshots – SF12 26.CACM Screenshots – Special Equipment	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
	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 that is in her second or third trimester of pregnancy that she may continue to receive services from her provider until the completion of post-partum care	27.CACM Screenshots – Substance Abuse 28.CACM Screenshots – Transfer Screening 29.CACM Screenshots - Transportation	
	Findings: The CACM electronic assessment and care planning software is a comprehensive set of assessments designed to identify members' special health care needs and the resources to meet those needs. Several screen shots of the CACM system demonstrated that the assessments were designed to identify the need for medical practitioners, community programs, ancillary providers, and social services. Screen shots of the care plan portion of the program demonstrated that care plans were derived from the results of assessments. The medical comorbidity assessment screen demonstrated that Colorado Access assessed for comorbidities and complicating factors for each member. The Care Coordination policy described care coordination interventions to include conducting coordination with the member, family, DCR, authorized representative, provider, and involved Colorado Access physical and/or mental health staff members on an ongoing basis to share assessment findings and to develop an agreed-upon care plan. The Access to Primary and Specialty Care policy stated that the PCP was responsible for all care except inpatient, specialty, and emergency care, and was responsible for specialty care referrals. The Delivering Continuity and Transition of Care for Members policy described Colorado Access' procedures for ensuring primary care for members when transitioning from a nonnetwork PCP or when a PCP was terminated from the network. Members were notified via the member handbook that a new member with special needs could continue "seeing" their current doctor for up to 60 days and keep their current home health or durable medical equipment (DME) company for up to 75 days. The member handbook also stated that members who were more than three months pregnant could keep their current doctor until after their delivery. The member handbook also clearly stated that these providers must agree to work with Colorado Access and that members must let Colorado Access know that they wish to continue care with their current provider.		
	Required Actions: None		

Standard III—Coordination and Continuity of Care			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.208(b)(3) COA Contract: II.E.9.a	8. 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.	**Documents Submitted/Location Within Documents:** 1.CCS305 - Care Coordination 2.CCS306 - Delivering Continuity and Transition of Care to Members	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Care Coordination policy stated that two of the goals of care coordination were to facilitate communication and coordination among providers, caregivers, and stakeholders, and to create efficiencies by decreasing duplication of services. CACM system screen shots of several members' electronic health records demonstrated that case managers identified other entities involved with the members. Colorado Access described that the methods used to share information varied by clinic site but included staffings with other care managers, secure e-mail communication, and faxed documentation. Additional activities could include appointment facilitation and direct communication with members' other providers.		
	Required Actions: None		
42CFR438.208(c)(3) COA Contract: II.E.8.f	9. 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 designed to accommodate the specific cultural and linguistic needs of the Contractor's member and include: ◆ Treatment objectives, treatment follow-up ◆ Monitoring of outcomes ◆ The process for ensuring that treatment plans are revised as necessary	**Documents Submitted/Location Within Documents:** 1.CCS305 - Care Coordination 2.CCS306 - Delivering Continuity and Transition of Care for Members 3.CACM Screenshots – Abuse 4.CACM Screenshots - Asthma 5.CACM Screenshots – Asthma Follow Up 6.CACM Screenshots - Anxiety 7.CACM Screenshots - Bipolar 8.CACM Screenshots – Care Plan Knowledge Deficit 9.CACM Screenshots – Care Plan Lack of PCP 10.CACM Screenshots – Care Plan PHQ9 11.CACM Screenshots – Care Plan Self Management 12.CACM Screenshots – Care Plan Social Support	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
		13.CACM Screenshots – Chronic Pain Management 14.CACM Screenshots – Diabetes 15.CACM Screenshots – Educational Services 16.CACM Screenshots - Employment 17.CACM Screenshots – Family Resource 18.CACM Screenshots – Lack of Mental Healthcare 19.CACM Screenshots – Medical Co morbidity 20.CACM Screenshots – Mobility Screening 21.CACM Screenshots –PHQ9 22.CACM Screenshots - Psychosis 23.CACM Screenshots – Self Efficacy 24.CACM Screenshots – SF12 25.CACM Screenshots – Special Equipment 26.CACM Screenshots – Substance Abuse 27.CACM Screenshots – Transfer Screening 28.CACM Screenshots – Transportation	
	Findings: Colorado Access had procedures for developing care plans for members with SHCN. The Care Coordination policy described Colorado Access' goals for providing care coordination to members with SHCN and described a variety of methods for identifying members for the care coordination program. Colorado Access' electronic care management program had the ability to design care plans for a variety of special health care needs. Care managers used the CACM program to assess members to determine needs and develop appropriate care plans. Colorado Access provided a variety of blank example screen shots from the program (see above) and provided several completed screen shots of member records. The care plans included treatment objectives, follow-up goals, and interventions. The Care Coordination policy stated that care plans were updated periodically. The member handbook described the process of care coordination to members. Treatment plans were created by PCPs and were required to have treatment objectives, treatment follow-up, and monitoring of outcomes. Colorado Access monitored medical records to ensure that treatment plans were consistent with diagnoses and possible risk factors for the patient.		
	Required Actions: None		

Standard III—Coordination and Continuity of Care			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.208©(4) COA Contract: II.E.8.f	10. 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.	**Documents Submitted/Location Within Documents:** 1.CCS305 – Care Coordination 2.CCS306 – Delivering Continuity and Transition of Care to Members 3.CCS310 – Access to Primary and Specialty Care	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: Colorado Access had a mechanism in place to allow a member to access a specialist appropriate to the member's condition and identified needs. The Access to Primary and Specialty Care policy stated that Colorado Access staff members would work with PCPs to obtain standing referrals for instances in which a member with SHCN had a demonstrated history of using a specialist for a particular condition. The member handbook stated, "If you need to see a specialist often, you can get a standing referral. This means you will not have to get a referral each time." The Delivering Continuity and Transition of Care for Members policy specified that Colorado Access allowed members with SHCN direct access to appropriate specialty care. Staff members clarified that the provider had to be in the Colorado Access network. If Colorado Access did not have the direct capacity to provide a medically necessary, covered service within its network, arrangements could be made via a single-case agreement with a nonnetwork provider.		
	Required Actions: None		

Results for Coordination and Continuity of Care							
Total	Met	=	10	X	1.00	=	10
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	10	**Total Score**		=	10

Total Score ÷ Total Applicable	=	100%

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.240(a) COA Contract: II.J.1 &II.J.2.i	1. The Contractor has an internal Quality Assessment and Performance Improvement (QAPI) Program. The Contractor has a QAPI plan that: ◆ Delineates current and future QAPI activities ◆ Integrates findings and opportunities for improvement indentified from focused studies, HEDIS measurements, enrollee satisfaction surveys, and other monitoring and quality activities	**Documents Submitted/Location Within Documents:** 1.2010 CoA QAPI Program Description 2.FY10 AHP ECM Work Plan 3.FY09 AHP ECM QAPI Annual Evaluation 4.MBQIC Agendas 01/06/09 – 01/05/10 5.MBQIC Minutes 01/06/09 – 01/05/10 6.QIC Agendas 01/13/09 – 12/08/09 7.QIC Minutes 01/13/08 – 12/08/09 8.FY09 Q2 QM BOD Report 9.FY09 Q3 QM BOD Report 10.FY09 Q4 QM BOD Report 11.FY10 Q1 QM BOD Report 12.FY10 Q1 QM BOD Report Graph	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: Colorado Access had a comprehensive QAPI Program Description, which described the QAPI program structure, goals, objectives, committees and subcommittees, activities, and responsible staff members. The QAPI Program Description included detailed information applicable to each of the Colorado Access lines of business, including the Access Health Plan (AHP) Enhanced Care Management (ECM) Program. Quality improvement activities and goals for FY 2009–2010 applicable to the AHP population were further described in the AHP ECM Work Plan. The FY 2008–2009 AHP ECM QAPI Annual Evaluation included findings from FY 2008–2009 quality improvement activities, including focus studies, disease management programs, Healthcare Effectiveness Data and Information Set (HEDIS) measures, member satisfaction surveys, monitoring of grievances and customer service activities, and access measures. The program evaluation also included goals for FY 2009–2010 quality improvement activities. QIC and MBQIC meeting minutes for FY 2009–2010 demonstrated that detailed AHP work plans, AHP focus studies, and AHP HEDIS measures were presented and discussed, as well as the AHP ECM QAPI Annual Evaluation.		
	Required Actions: None		

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References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.240(b)(3) COA Contract: II.J.2.e	2. The Contractor's QAPI program includes mechanisms to detect both underutilization and overutilization of services.	**Documents Submitted/Location Within Documents:** 1.CCS302 – Medical Criteria for Utilization Review 2.CCS307 – Utilization Review Determination 3..2010 QAPI Program Description (PGS 11-15) 4.FY10 AHP ECM Work Plan (PG 8) 5.FY09 AHP ECM QAPI Annual Evaluation (PGS 4, 14-15, 28 & 31-34) 6.FY10 UM Program Description 7.Avg Daily Census Jan 2010 8.Monthly ER Report Oct 2009 9.Monthly IP Report Nov 2009 10. ER Heavy Hitter Report FY10 Q2 (de identified) 11.Provider Manual (PGS 19-20,23& 50-61) 12. FY10 Access to Care Plan (PGS 8-14) 13. Provider Profiles Q4 CY09 14.AHP Fast Track Jan 2010 (de indentified) 15.Avoidable Admissions CY09 Q3 16. Kronick Report 17.FY09 Readmissions (de identified) 18.Rx Trends Q4 CY09	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: Activities described in the QAPI Program Description and the AHP ECM Work Plan included using data to monitor for potential over- and underutilization patterns. Colorado Access provided examples of utilization reports reviewed for over- or underutilization. Example reports included average daily census, emergency room (ER) utilization, inpatient utilization, avoidable admissions, readmissions, pharmacy utilization, and provider profiles. The QAPI Program Description detailed each of the measures for FY 2009–2010, which included monitoring utilization of services. The AHP ECM QAPI Annual Evaluation described disease management programs designed to educate members and encourage appropriate utilization. The AHP ECM Work Plan included measures and goals for increasing PCP visits and decreasing ER and inpatient utilization. The utilization management (UM) program description stated that the goals of the UM program were to: ◆ Review, monitor, and evaluate appropriateness of health care services from practitioners, hospitals, and other health care		

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References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
	professionals. ◆ Review professional services for appropriateness of and compatibility between diagnosis and treatment. ◆ Incorporate the provision of appropriate preventive and disease management services. ◆ Define the scope of care management services available to assist in managing the care needs of high-risk or high-utilization enrollees. ◆ Provide feedback to participating providers on their performance relative to their peers.		
	Required Actions: None		
42CFR438.240(e)(2) COA Contract: II.J.2.h	3. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program (at least annually). The process includes a review of: ◆ The techniques used by the Contractor to improve performance ◆ The outcome of each performance improvement project ◆ The overall impact and effectiveness of the QAPI program	**Documents Submitted/Location Within Documents:** 1.2010 CoA QAPI Program Description 2.FY10 AHP ECM Workplan 3.FY09 AHP ECM QAPI Annual Evaluation 4.MBQIC Agendas 01/06/09 – 01/05/10 5.MBQIC Minutes 01/06/09 – 01/05/10 6.QIC Agendas 01/13/09 – 12/08/09 7.QIC Minutes 01/13/08 – 12/08/09 8.FY09 Q2 QM BOD Report 9.FY09 Q3 QM BOD Report 10.FY09 Q4 QM BOD Report 11.FY10 Q1 QM BOD Report 12.FY10 Q1 QM BOD Report Graph	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: Colorado Access had an annual process in place for evaluating the impact and effectiveness of the QAPI program, as evidenced by the FY 2008–2009 AHP ECM QAPI Annual Evaluation. The evaluation included a summary of key metric trending, a review of study findings for each measure included in the AHP ECM Work Plan, and intervention strategies to further improve performance in FY 2009–2010. In addition, Colorado Access evaluated the QAPI program throughout the year through the sharing of quality data at QIC and MBQIC meetings, as evidenced by FY 2009–2010 QIC and MBQIC meeting minutes.		
	Required Actions: None		

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References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.236(b) COA Contract: II.J.2.a.2	4. The Contractor's QAPI program addresses practice guidelines. The Contractor adopts practice guidelines that meet the following requirements: ◆ Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field ◆ Consider the needs of the Contractor's members ◆ Are adopted in consultation with contracting health care professionals ◆ Are reviewed/updated annually	**Documents Submitted/Location Within Documents:** 1.CCS308 – Preventative Health Services (PG 2 IC) 2.CCS311 – Clinical Practice Guidelines 3.COA QAP1 Program Desc - Quality Assessment & Performance (PG 12) 4. FY10 AHP ECM Work Plan (PG 2) 5.FY09 AHP ECM QAPI Annual Evaluation (PGS 11-3 &16) 6.2009- 2010 Guideline Track 7. Prenatal Guideline 8. GERD Guideline 9. Asthma Guideline 10.Continuing Care of Adults with Diabetes 11. Depression Treatment Guideline 12. Influenza 13. Adult Preventive Care 14. Colorectal Cancer Screening 15. Tobacco Cessation 16. CAD and Stroke Prevention 17. Obesity Guideline 18. Acute Respiratory Infection 19. Bipolar Treatment Guideline 20. Metabolic Monitoring Guideline 21.MBQIC Agendas 01/06/09 – 01/05/10 22.MBQIC Minutes 01/06/09 – 01/05/10	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The QAPI Program Description stated that participating physicians adopt or adapt guidelines either for the health plan or in concurrence with the Colorado Clinical Guideline Collaborative. The FY 2009–2010 AHP ECM Work Plan included annual review and approval of practice guidelines applicable to the AHP population. Colorado Access' Clinical Practice Guidelines policy stated		

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References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
	that all practice guidelines adopted by Colorado Access must: ◆ Be based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field that is addressed by the guidelines. ◆ Consider the needs of Colorado Access members. ◆ Be adopted in consultation with contracted health care professionals. ◆ Be reviewed and updated annually for physical health practice guidelines. Colorado Access submitted a schedule used for review and continued approval of Colorado Access' clinical practice guidelines. MBQIC meeting minutes for July 7, 2009, and September 1, 2009, demonstrated that clinical practice guidelines for asthma, gastroesophageal reflux disease (GERD), and influenza were reviewed and approved during the review period. Colorado Access submitted practice guidelines for a variety of conditions.		
	Required Actions: None		
COA Contract: II.J.2.a.1	5. The Contractor has practice guidelines for: ◆ Perinatal, prenatal, and postpartum care for women ◆ Conditions related to persons with a disability or special health care needs	**Documents Submitted/Location Within Documents:** 1. Prenatal Guideline 2. GERD Guideline 3. Asthma Guideline 4. Continuing Care of Adults with Diabetes 5. Depression Treatment Guideline 6. Influenza 7. Adult Preventive Care 8. Colorectal Cancer Screening 9. Tobacco Cessation 10. CAD and Stroke Prevention 11. Obesity Guideline 12. Acute Respiratory Infection 13. Bipolar Treatment Guideline 14. Metabolic Monitoring Guideline	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: Colorado Access had a prenatal practice guideline that included guidelines for care from the first prenatal visit through the postpartum visit six to eight weeks following delivery. Colorado Access also had practice guidelines related to individuals with a		

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References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
	disability or special health care needs, including GERD, asthma, diabetes, depression, coronary artery disease, and obesity (see above list).		
	Required Actions: None		
42CFR438.236(c) COA Contract: II.J.2.a.3	6. The Contractor disseminates the guidelines to all affected providers, and upon request, to members and potential members at no cost. The guidelines are available to non-members, including the public, at cost.	**Documents Submitted/Location Within Documents:** 1.CCS 308 – Preventative Health Services (PG 3V) 2. CCS 311 – Clinical Practice Guidelines (all) 3.2010 QAPI Program Description (PG 12) 4.FY10 AHP ECM Work Plan (PG 2) 5. FY09 AHP ECM Annual Evaluation (PGS 11 & 16) 7. Provider bulletin Feb 2009 8.Provider Manual (PG 14 & 24) 9.Member Handbook (PG 18) 10.MBQIC Agendas 01/06/09 – 01/05/10 11.MBQIC Minutes 01/06/09 – 01/05/10 Member AHP website http://www.coaccess.com/health-and-wellness Provider AHP website - http://www.coaccess.com/practice-guidelines	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The QAPI Program Description stated that approved practice guidelines were distributed to members and providers and were available on the Web site. Reviewers were able to locate guidelines under both the provider and member Web site tabs. The member handbook stated that members could request information about standard practice preventive guidelines, and the telephone number for the customer services department was printed at the bottom of the page. The Clinical Practice Guidelines policy stated that practice guidelines were distributed to providers via the Colorado Access Web site, as referenced in the provider manual. The policy also stated that practice guidelines were disseminated to members and potential members upon request. The Provider Bulletin February 2009 included a description of practice guidelines, a list of Colorado Access' guidelines, and the Web site address where Colorado Access' guidelines could be found.		
	Required Actions: None		

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References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.236(d) COA Contract: II.J.2.a.4	7. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the practice guidelines.	**Documents Submitted/Location Within Documents:** 1.CCS 308 – Preventative Health Services (PG 2 I C & PG 3 III & V) 2. CCS 311 – Clinical Practice Guidelines (PG 3) 3.2010 CoA QAPI Program Description (PG 12) 4. FY10 UM Program Description 5. Provider Manual (PG 29-30 Provider Responsibilities) 6. Provider Manual (PG 50-61 Authorizations & Referrals) 7. Provider Manual (PG 23-24 UM & QM) 8.Member Handbook (PG 12 & 13) 9.Member AHP website http://www.coaccess.com/health-and-wellness 10.Provider AHP website - http://www.coaccess.com/practice-guidelines	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Clinical Practice Guidelines policy stated that Colorado Access would ensure that decisions regarding UM, member education, covered services, and other areas to which the clinical practice guidelines applied were consistent with the guidelines. The Colorado Access 2009–2010 Utilization Management Program Description stated that the UM criteria used for authorization decisions were consistent with the clinical preventive and practice guidelines and the community standards used by Colorado Access. The provider manual informed providers that authorization decisions were based on nationally recognized utilization guidelines (InterQual) and consistent with clinical practice guidelines approved by Colorado Access. The MBQIC had oversight responsibility for the clinical components of the program, which included disease and care management, health promotions, and UM. This committee reviewed and approved UM criteria and behavioral, physical, and preventive clinical practice guidelines, which helped ensure that decisions regarding UM, member education, and coverage of services were consistent with the practice guidelines. The integration of clinical programs, care coordination, member education, and UM occurred via the Coordinated Clinical Services Department, which maintained interactive linkage with all aspects of Colorado Access operations.		
	Required Actions: None		

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References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.240(b) COA Contract: II.J.2.b-d & f	8. The QAPI Program includes the following basic elements: ◆ Performance improvement projects ◆ The submission of performance measurement data ◆ Member satisfaction ◆ Investigation of quality of care concerns	**Documents Submitted/Location Within Documents:** 1.QM201 - Investigation of Potential Clinical Quality of Care Grievances and Referrals 2.2010 QAPI Program Description (PG 11-15) 3.FY10 AHP ECM Work Plan (PGS 1, 4 & 6) 4.FY09 AHP ECM QAPI Annual Evaluation (PGS 9-10, 14-19, & 29) 5.Coordination of Care Behavioral & Physical 6. Member Survey Report	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The 2010 QAPI Program Description stated that at least two topics per year were chosen for a performance improvement project (PIP) or focus study for the AHP program. The QAPI Program Description included clinical care measures. The program description stated that the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and the Experience of Care and Health Outcomes (ECHO) surveys were used to evaluate member perception of service. The program description also stated that grievance and appeal data were monitored to identify trends in client satisfaction. Colorado Access provided the Quarterly Grievances and Appeals Report for the second quarter of FY 2009–2010. The report included analysis and trending for grievances and appeals for the current quarter and for the past four quarters. The QAPI Program Description stated that quality of care concerns were referred to the Quality Management Department for investigation. The FY 2009–2010 AHP ECM Work Plan indicated that the FY 2009–2010 PIP topic was coordination of care, and the focus study topic was transition of care. The work plan indicated that three HEDIS measures were collected: *Adults' Access to Preventive /Ambulatory Health Services*, *Annual Monitoring for Patients on Persistent Medications*, and *COPD Medication Management*. The work plan also indicated that member satisfaction was monitored via grievance/complaint trending and by conducting both an internal member satisfaction survey and the CAHPS member survey. The Investigation of Potential Clinical Quality of Care Grievances and Referrals policy stated that all grievances classified as potential quality of care concerns were investigated by the Quality Management Department with medical director supervision to ensure that each investigation outcome was given a score based on the severity of the concern and that, if warranted (based on the score), the provider was placed on a CAP. The policy stated that the credentials committee was notified, if warranted, and that the concern was tracked for possible trending. The FY 2008–2009 AHP ECM QAPI Annual Evaluation included the results of each of the quality activities for the fiscal year, including performance measures, PIPs, and member satisfaction findings.		
	Required Actions: None		

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References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
COA Contract: II.J.2.d.1	9. The Contractor's QAPI program includes mechanisms to monitor members' perceptions of accessibility and adequacy of services through the use of: ◆ Member satisfaction surveys ◆ Anecdotal information ◆ Grievance and appeal data ◆ Enrollment and disenrollment data	**Documents Submitted/Location Within Documents:** 1.2010 CoA QAPI Program Description (PGS 11-15) 2.FY10 AHP ECM Work Plan (PGS 6-7) 3.FY09 AHP ECM QAPI Annual Evaluation (PGS 17-21) 4. Appeals Reporting 5. Grievance Reporting 6.Monthly Membership Report 7.Network Adequacy Report Q2 8. Access to Care Plan 9. Adult Routine Care Secret Shopper 10.Adult Non Urgent Care Secret Shopper 11. Adult Urgent Secret Shopper 12. Provider Bulletin-Afterhours and Secret Shopper Announcement 13. After Hours Survey Results 14.Retention Study Results 15. Member Survey Results 16. Disenrollment Study	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Colorado Access QAPI program included mechanisms to monitor members' perceptions of accessibility and adequacy of services. The QAPI Program Description described the Colorado Access Consumer and Family Member Advisory boards and the process for the boards to identify concerns, make recommendations for improvement, and assist in the development of quality improvement initiatives and studies. The program description and the QAPI AHP ECM Work Plan also included a description of the Colorado Access internal consumer satisfaction survey and the CAHPS survey and how Colorado Access used the information obtained from these surveys. The FY 2008–2009 AHP ECM QAPI Annual Evaluation included the results of both member satisfaction surveys and the results and analysis of trending grievance data and disenrollment data. Anecdotal data were obtained using an open-ended question about how the member feels about Colorado Access for both the initial member survey conducted in January 2009 and the follow-up survey in November 2009. The Member Retention Report provided an analysis of member retention as an indicator of member satisfaction, given passive enrollment and members' right to opt out and disenroll. The After-Hours		

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References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
	Access Survey report provided information regarding specific providers offering access to after-hours care. Colorado Access acknowledged in the report the link between access to care and satisfaction.		
	Required Actions: None		
COA Contract: II.J.2.d.3	10. The Contractor develops a corrective action plan when members report statistically significant levels of dissatisfaction, when a pattern of complaint is detected, or when a serious complaint is reported.	**Documents Submitted/Location Within Documents:** 1.2010 QAPI Program Description (PGS 11-15) 2.FY10 AHP ECM Work Plan (PGS 6-7) 3.FY09 AHP ECM QAPI Annual Evaluation (PGS 17-21) 4.Appeals Reporting 5. Grievance Reporting 6. Access to Care Plan 7.Retention Study Results 8. Member Survey Results 9. Disenrollment Study	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: Colorado Access developed interventions as needed when members reported high levels of dissatisfaction, when a pattern of complaints was detected, or when a serious complaint was reported. Quarterly monitoring of grievances and appeals was performed by the QIC, and corrective actions were developed as needed. In the Quarterly Grievances and Appeals Report for the second quarter of FY 2010, trending over the past four quarters indicated that members were experiencing issues with obtaining prescriptions, which resulted in out-of-pocket expenses. A corrective action was developed pertaining to the pharmacy copayment issue. Also, corrective action was described relevant to provider education for substantiating medical necessity.		
	Required Actions: None		

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References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
COA Contract: II.J.2.d.4	11. The Contractor's QAPI program includes a mechanism to assess the quality and appropriateness of care for persons with special health care needs.	**Documents Submitted/Location Within Documents:** 1.2010 QAPI Program Description (PGS 12- 13, 16 & 19- 20) 2.FY10 AHP ECM Work Plan 3.FY09 AHP ECM QAPI Annual Evaluation 4.FY10 UM Program Description 5.Provider Bulletin Coordination of Care Between Providers & those with Special Needs 6. Member Newsletter Adams Arapahoe Denver for April 7.Member Newsletter Adams Arapahoe Denver for July 8.Member Newsletter Boulder Broomfield for January 9.Member Newsletter Boulder Broomfield for October 10.Provider Manual ECM/Special Needs (PGS 4, 13, 27 & 29-30)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The 2009–2010 QAPI Program Description and the 2009–2010 AHP ECM Work Plan described quality improvement activities such as performance measures, PIPs, focus studies, and member satisfaction surveys. The FY 2008–2009 AHP ECM QAPI Annual Evaluation included the results of Colorado Access' quality improvement activities. These activities assessed the quality and appropriateness of services provided to AHP members. AHP members are a specialized population with SHCN and, therefore, each of the Colorado Access quality improvement activities assessed the quality and appropriateness of services provided to members with SHCN.		
	Required Actions: None		

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.242(a) COA Contract: II.J.2.k.1	12. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data that is used to support administration of the Contractor's Program.	**Documents Submitted/Location Within Documents:** 1.2010 CoA QAPI Program Description (PGS 11-12) 2.FY09 AHP ECM QAPI Annual Evaluation 3.Appeals Reporting 4.Grievance Reporting 5.Avg Daily Census Jan 2010 6.Monthly ER Report 7.Monthly IP Report 8.Monthly Membership Report 9.Provider Profiles Q4 CY09 10. Fast Track Report (de-identified) 11.Avoidable Admissions Q3 12.Kronick Report 13.FY09 Readmissions (de-identified) 14. Rx Trends Analysis Q4 CY09	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: Colorado Access had a comprehensive health information system in place to collect, analyze, and report data in support of its QAPI program. Colorado Access published a FY 2008–2009 AHP ECM QAPI Annual Evaluation that included comprehensive data regarding member demographics as well as an analysis of data related to a wide range of quality measures included in the health plan's AHP ECM Work Plan. Colorado Access provided several examples of periodic data reports produced by its information system, including a monthly ER report, a monthly inpatient report, admissions and readmissions reports, monthly membership reports, and grievances and appeals reports.		
	Required Actions: None		

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.242(a) COA Contract: II.J.2.k.1	13. The Contractor's health information system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.	**Documents Submitted/Location Within Documents:** 1.2010 QAPI Program Description (PGS 11-15) 2.FY10 AHP ECM Work Plan 3.FY09 AHP ECM QAPI Annual Evaluation 4. Appeals Reporting 5. Grievance Reporting 6.Avg Daily Census Jan 2010 7.Monthly ER Report 8.Monthly IP Report 9.Monthly Membership Report 10.Provider Profiles Q4 11.Fast Track Report (de-identified) 12.Avoidable Admissions Q3 13.Kronick Report 14.FY09 Readmissions (de-identified) 15.Rx Trend Analysis Q4 CY09	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: Colorado Access' FY 2009–2010 AHP ECM Work Plan included several metrics related to utilization and grievances and appeals. Colorado Access reports produced from the data system included average daily census, inpatient utilization, ER utilization, grievances, appeals, and monthly membership reports. The 2009 retention report demonstrated Colorado Access' ability to obtain disenrollment data from the system.		
	Required Actions: None		

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References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.242(b) COA Contract: II.J.2.k.2	14. The Contractor collects data on member and provider characteristics and on services furnished to members.	**Documents Submitted/Location Within Documents:** 1.2010QAPI Program Description (PGS 11-15) 2. FY10 AHP ECM Work Plan 3. FY09 AHP ECM QAPI Annual Evaluation 4.Monthly Membership Report 5. Network Adequacy Report Q2 6.Avg Daily Census Jan 2010 7.Monthly ER Report 8.Monthly IP Report 9.Provider Profile Report Q4 10. Fast Track Report (de-identified) 11. Avoidable Admissions Q3 12.Kronick Report 13.FY09 Readmissions (de-identified) 14.Rx Trend Analysis Q4 CY09	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: Colorado Access collected data on member and provider characteristics and on services furnished to members. The AHP ECM QAPI Annual Evaluation provided data on the average age of the population, gender ratio, top five chronic conditions of the population, average number of clinical conditions per member, average number of providers per member, and average number of prescriptions per member. The Provider Profile Report included statistics regarding utilization for AHP members for each provider. Numerous utilization reports demonstrated Colorado Access' ability to collect data on services furnished to members.		
	Required Actions: None		

Results for Quality Assessment and Performance Improvement							
Total	Met	=	14	X	1.00	=	14
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	14	**Total Score**		=	14

Total Score ÷ Total Applicable	=	100%

Appendix B. Site Review Participants for Colorado Access

Table B-1 lists the participants in the FY 2009–2010 site review of **Colorado Access**.

Table B-1—HSAG Reviewers and MCO Participants	
HSAG Review Team	**Title**
Diane Somerville	Director, State & Corporate Services
Rachel Henrichs	Project Coordinator
Colorado Access Participants	**Title**
April Abrahamson	Executive Director, Medicaid
Carrie Bandell	Director of Quality Management
Mary Burleigh	Supervisor, Care Management
Laura Coleman	Director, Coordinated Clinical Services
Reyna Garcia	Director of Customer Service, Executive Director, CHP+
Mike McKitterick	Vice President, Coordinated Clinical Services
Marie Steckbeck	Vice President, Operations
Department Observers	**Title**
Maggie Reyes	Quality/Compliance Specialist

Appendix C. Compliance Monitoring Review Activities for Colorado Access

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

Table C-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
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 for other review activities. ◆ HSAG staff members provided an orientation on October 1, 2009, for the MCO and the Department to preview the FY 2009–2010 compliance monitoring review process and to allow the MCO 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 members 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 BBA and MCO's current contract and addendums to develop HSAG's 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 review, HSAG notified the MCO in writing of the desk audit request and sent a documentation request form and an 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 two standards. ◆ Documents submitted for the desk review and during the interview consisted of policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. ◆ The HSAG review team reviewed all documentation submitted prior to the review.

Table C-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG completed the following activities:**
Activity 4:	**Conducted Interviews**
	◆ HSAG interviewed 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**
	◆ HSAG requested and reviewed additional documents it needed and had identified during its desk audit. ◆ HSAG requested and reviewed additional documents it needed and had identified during the interviews.
Activity 6:	**Analyzed and Compiled Findings**
	◆ HSAG used the FY 2009–2010 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. ◆ HSAG analyzed the findings and assigned scores. ◆ HSAG determined opportunities for improvement based on the review findings. ◆ HSAG determined actions to be required of the MCO to achieve full compliance with Medicaid managed care regulations.
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 2009–2010 Site Review Report. ◆ HSAG submitted the site review report to the Department and the MCO for review and comment. ◆ HSAG coordinated with the Department to incorporate comments and finalize the report. ◆ HSAG distributed the final report to the MCO and the Department.