COLORADO
Department of Health Care Policy & Financing

Fiscal Year 2017–2018 Site Review Report

for

Colorado Health Partnerships, LLC

March 2018

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

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

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

Summary of Results

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

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

Table 1-1—Summary of Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
V. Member Information	12	11	8	3	0	1	73%
VI. Grievance System	27	27	17	10	0	0	63%
VII. Provider Participation and Program Integrity	13	13	11	2	0	0	85%
IX. Subcontracts and Delegation	4	4	4	0	0	0	100%
Totals	**56**	**55**	**40**	**15**	**0**	**1**	**73%**

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

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

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

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Appeals	60	59	52	7	1	88%
Grievances	60	44	44	0	16	100%
Totals	**120**	**103**	**96**	**7**	**17**	**93%**

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

Standard V—Member Information

Summary of Strengths and Findings as Evidence of Compliance

CHP delegated all tasks noted in 42 CFR 438.10 to its administrative services partner, Beacon Health Options (Beacon). **CHP** and Beacon provided policies and procedures that described the processes for ensuring that all member materials are written at a sixth-grade reading level and use a 12-point font size; are readily available in Spanish and alternative formats, and through the provision of auxiliary aids; and include large print and Spanish taglines that describe how to request auxiliary aids, written translation, and oral translation. **CHP** made interpretation services available free of charge and educated staff, providers, and members about the availability of and how to access the services.

The **CHP** website was easy to navigate and included the member handbook, provider directories, rights and responsibilities, advocacy and community resources, and information about benefits and services (including the Child Mental Health Treatment Act [CMHTA] and Early and Periodic Screening, Diagnostic, and Treatment [EPSDT] program) in English and Spanish. Information complied with language requirements and could be downloaded and printed. **CHP** notified members on its website that all information provided on the website is available in paper form free of charge and how to request it.

Summary of Findings Resulting in Opportunities for Improvement

CHP delegated the execution of website content and monitoring to Beacon. Beacon had a policy that described the accessibility requirements (i.e., complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines) and submitted monthly reports to **CHP** that delineated identified issues. HSAG recommends that **CHP** develop a policy (or that Beacon updates its policy) to describe the process and expected time frames for addressing compliance issues regarding the website and content.

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

During the on-site interview, **CHP** staff members stated that while **CHP** primarily communicates with members by mailing printed information and posting it on the website, **CHP** is increasing its use of encrypted email to communicate grievance and appeal acknowledgement and resolution information to members. Staff members stated that they use email only in instances when a member requests it and described the process for encrypting email containing protected and/or sensitive information. While HSAG identified no issues with the process described by staff, **CHP** should develop a policy to address appropriate use of email communications with members.

Summary of Required Actions

HSAG tested the readability of several documents including the grievance and appeal guide and several template letters related to the grievance and appeal processes using the Flesch-Kinkaid readability test. Many of these documents scored well above the sixth-grade level. Additionally, HSAG found that many of the grievance and appeal resolution letters reviewed as part of the record reviews were difficult to understand. **CHP** must ensure that all member information is written using easy-to-understand language.

CHP's provider directory included the name, group affiliation, street address, telephone number, areas of specialty, and languages spoken for all providers accepting new patients. The directory included no information regarding a provider's website URL, cultural competency training, or accessibility for people with physical disabilities. **CHP** must update its provider directory to include a provider's website URL (if available) and to indicate which providers have completed cultural competency training and which locations are accessible for people with physical disabilities.

HSAG conducted an accessibility check on several **CHP** webpages using the Wave Web Accessibility Evaluation Tool. Using this tool, HSAG discovered several general accessibility errors and contrast errors on various webpages. These findings were consistent with those reported on the Website Compliance Report dated November 14, 2017. HSAG also ran an accessibility check on several PDF documents available for download from the **CHP** website (e.g., grievance and appeal guide and provider directory). Using the Adobe Acrobat Pro accessibility checker, HSAG discovered accessibility errors within these PDF documents. **CHP** must develop a process to ensure that all information on its website is readily accessible.

Standard VI—Grievance System

Summary of Strengths and Findings as Evidence of Compliance

CHP provided clear evidence that it offers members a grievance process and an appeal process, and has processes to assist members in requesting a State fair hearing. Most definitions and processes were clearly depicted in **CHP**'s policies and procedures, with exceptions described below as opportunities for improvement and required actions. **CHP** provided member and provider materials and staff training documents as evidence that **CHP** processed grievances and appeals in a timely manner and assisted members in resolving grievances and appeals. On-site record review provided evidence that members, providers, and authorized representatives voiced grievances and filed appeals, both orally and in writing, and that **CHP** met all timeliness requirements in the records reviewed.

Summary of Findings Resulting in Opportunities for Improvement

CHP's policies and procedures that addressed the Grievance and Appeal System described **CHP**'s processes and included most of the Medicaid managed care regulations; however, the policies included repetition of regulations between sections of the policies, and some concepts were presented as if the

organization did not have a clear understanding of the rule or process being described. HSAG recommends that **CHP** review documents for consistency and accuracy, and ensure that all required content is included in specific policies. HSAG recommends focusing particular attention on areas that address expedited resolution of appeals and continuation of benefits during the appeal and State fair hearing.

Certain documents that addressed grievances (policies, letter templates, etc.) included detailed information about appeals and/or the State fair hearing process. HSAG recommends that this information be removed from documents pertaining to grievances (particularly member communications) since the grievance process does not lead to an appeal process or a right to request a State fair hearing.

Summary of Required Actions

CHP's Grievance Process policy and Appeals Process policy both included a definition of "adverse benefit determination"; however, the two definitions were inconsistent and incomplete. In both policies, the denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other) was missing from the definition. Therefore, **CHP** must review its policies, procedures, and other applicable documents (e.g., member and provider communications) that address the Grievance and Appeal System to ensure they include an accurate definition of "adverse benefit determination."

While on-site, HSAG found that instructions provided to individuals responsible for processing and resolving grievances directed staff to ask members calling to express dissatisfaction whether they wished to file a grievance or wished to file a "formal grievance." **CHP**'s complaint form also asked members if they wished to file a "formal grievance." During the on-site interview, **CHP** staff also stated that if grievances were resolved at the initial point of contact, acknowledgement and/or resolution letters were not required. HSAG cautioned **CHP** staff members that once a member calls to express dissatisfaction, the call must be handled as a grievance (if not pertaining to an adverse benefit determination), and that leading members to believe that another action must take place or using the term "formal" may cause members to say no, thereby denying these members due process. Not considering issues that are resolved quickly as grievances also may prevent members from receiving due process and lead to inaccurate grievance reporting to the State. **CHP** must ensure that member materials, forms, training, job aids, informal direction, and other communications to staff who are responsible for processing grievances emphasize that all expressions of dissatisfaction about any matter other than an adverse benefit determination must be considered a grievance, and documented and treated as such, including due process procedures such as acknowledging, resolving, and notifying members of a resolution.

The requirement that **CHP**'s appeal process will inform members of the limited time available to them to provide evidence and testimony sufficiently in advance of the resolution time frame, in the case of expedited resolution, was not adequately addressed in policies, procedures, and other documents. Although the Appeal Process policy included this provision, it was located in the section of the policy that addressed standard appeals, not in the section that addressed requests for expedited appeal

resolution. In addition, the Expedited Appeal Process Flow Chart and Job Aid did not provide direction to staff to inform the member or representative requesting expedited resolution of an appeal about the limited time available to provide information or evidence, or for preparing testimony, legal, or factual arguments. **CHP**'s expedited appeal process must ensure that members or representatives requesting expedited resolution of an appeal are informed of the limited time available to present evidence or testimony and to make legal and factual arguments sufficiently in advance of the resolution time frame.

The Appeal Process policy included time frames for resolving appeals and providing written notice to members. The time frame for expedited resolution and notice was inaccurately depicted in the policy. The policy stated that the time frame for verbal notification for expedited resolution is 72 hours, with written notification to follow within two days. This policy language depicts a misunderstanding of the regulations. There is no two-day written time frame requirement related to expedited resolution of appeals. The two-day written notification requirement is related to extensions of resolution time frames, or denial of the expedited process. For expedited resolutions, written notification is due within 72 hours (see 42 CFR 438.408(b)(3) and 438.408(d)(2)(i) and (ii)). In addition, the BHO is required to make reasonable effort to provide oral notice of the expedited resolution. On-site record review demonstrated, however, that **CHP** did send written notification of expedited resolution within the required 72-hour time frame. In addition, on-site review of appeals records also revealed that resolution notices to members contained clinical and/or technical language causing the notices to score above a sixth-grade reading level, which made it difficult for members to understand them. **CHP** must revise the Appeal Process policy to reflect accurate time frames and processes for expedited resolution of appeals. In addition, **CHP** must also review other documents, job aids, and member and provider communications to ensure accuracy and consistency across documents. **CHP** must also develop a mechanism to ensure appeal resolution notices meet the format and language requirements of 42 CFR 438.10 to the extent possible.

CHP's appeal resolution letter did not include the required language that informs the member of the right to request continuation of benefits/services (within 10 calendar days of resolution) during the State fair hearing. None of the appeals reviewed during the on-site record review were related to the termination, suspension, or reduction of previously authorized services; therefore, this content missing from resolution notices reviewed was not considered for scoring the appeals records. **CHP** did not, however, provide evidence that it used a specific template which included the required language for applicable situations. **CHP** must develop a mechanism to ensure that members are informed, via the resolution notice, of their right to request continuation of services during the State fair hearing, if applicable. **CHP** could add language to its existing template (making it clear whether this applies to the current appeal). Alternatively, **CHP** could consider developing a specific template to be used when the appeal involves a 10-day advance notice to terminate, suspend, or reduce previously authorized services.

While **CHP**'s Appeal Process policy accurately included the provision that members may request a State fair hearing 120 days from the date of the appeal resolution notice adverse to the member, the appeal resolution notice template stated 120 days from the adverse benefit determination. Several records reviewed on-site used the flawed template; however, in some records HSAG found that **CHP**'s staff had discovered and corrected the error before sending the notice to the member. **CHP** must ensure that

policies, procedures, and other applicable documents accurately depict the member's right to request a State fair hearing within 120 days following the adverse appeal resolution notice.

The Appeals Process policy did not adequately address expedited resolution of appeals. The requirements associated with the denial of expedited resolution were not described in the policy, nor were they described in staff directional materials (e.g., job aids or workflows). **CHP** must revise its policy and other applicable documents to reflect the complete expedited appeal process which includes the following steps that must be taken if the BHO denies a request for expedited resolution of an appeal: transferring the appeal to the standard time frame, making reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution, and within two calendar days providing the member written notice of the reason for the decision that informs the member of the right to file a grievance if he or she disagrees with that decision.

CHP's Appeals Process policy and member and staff materials had not been revised to reflect the changes to requirements associated with continuation of services during an appeal or State fair hearing. The policy, the Notice of Adverse Benefit Determination, and the Grievance and Appeal Guide implied that **CHP** could terminate services without a 10-day advance notice, and stated that members requesting continuation of service must file the appeal within 10 days of the notice of benefit determination or before the proposed date of the termination or change in services. **CHP** must revise all applicable documents to accurately reflect that:

- Members receive a 10-day advance notice if **CHP** proposes to terminate, suspend, or reduce services.
- Timely filing requirements apply to the request for continuation of services during the appeal.
- Members have 60 days to file the appeal even if continuation of the services in dispute was requested within the required time frame for requesting the continuation (within the 10-day advance-notice period or before the effective date of the proposed termination or change in services).
- Although members have 120 days following the appeal resolution notice to request a State fair hearing, members may request continuation of services within 10 days following the appeal resolution notice.

In addition, the policy, the Notice of Adverse Benefit Determination, and the Grievance and Appeal Guide stated that the period of time benefits would continue may conclude at the end of the benefit limits or service authorization time frame. Changes in the federal regulation only allow for the benefits to continue until 10 days pass (if the member has not requested a State fair hearing with continuation of the disputed services within those 10 days), or until the State fair hearing officer issues a decision (in cases where the member has requested the State fair hearing with continuation of services). **CHP** must revise all applicable documents to remove the provision that continued services may cease at the end of the benefit limits or service authorization time frame.

Although **CHP**'s provider manual included information about the Medicaid member grievance system, inaccuracies and incomplete content contained in the policies and procedures, member communications, and staff materials were reflected in the provider manual. **CHP** must revise its provider manual and

review other provider-facing materials for accuracy and completeness, to ensure that providers are accurately informed of requirements and time frames regarding the Grievance and Appeal System at the time of contracting.

Standard VII—Provider Participation and Program Integrity

Summary of Strengths and Findings as Evidence of Compliance

CHP had several policies that described processes and procedures for selection and retention of the provider network. The Network Development Plan and the Network Density Report addressed adding independent providers to the network and stated that the decision whether to contract with additional providers was based on a variety factors such as analysis of member density; specific practice needs; and provider location, specialty, and license type.

CHP's policies and procedures, credentialing checklists, and on-site interviews provided evidence that **CHP** uses NCQA standards and guidelines to complete credentialing and recredentialing activities.

CHP provided its Compliance Oversight Plan and several related policies and procedures that effectively articulated both **CHP**'s and Beacon's commitment to comply with federal and State laws with regard to preventing, reporting, and responding to reports of fraud, waste, and abuse and noncompliance with BHO contract provisions. While **CHP**'s compliance officer was located in Colorado, many of the audit activities were performed at Beacon's corporate office, with frequent communications between the corporate and Colorado offices. **CHP** provided evidence of meeting all requirements of a corporate compliance program.

Summary of Findings Resulting in Opportunities for Improvement

All opportunities for improvement related to provider participation and program integrity resulted in required actions.

Summary of Required Actions

CHP was unable to provide adequate documentation of procedures to provide the Department written disclosure of ownership and control within 35 days after any change in ownership of the managed care entity, or to provide to the Department written disclosure of any prohibited affiliation within five business days of discovery. **CHP** must develop procedures to provide the Department written disclosure of ownership and control within 35 days after any change in ownership of the managed care entity, or to provide to the Department written disclosure of any prohibited affiliation within five business days of discovery.

CHP did not provide evidence of having a mechanism for requiring network providers to report to **CHP** when they have received an overpayment, to return the overpayment to **CHP** within 60 calendar days of

identifying the overpayment, and to notify **CHP** in writing of the reason for the overpayment. While the provider manual did address overpayments, it did not specifically state that providers are required to report (in writing) overpayments and the reason for the overpayment to **CHP**. **CHP** must develop a mechanism to ensure that network providers report any overpayments received to **CHP**, return the overpayment to **CHP** within 60 calendar days of identifying the overpayment, and notify **CHP** in writing of the reason for the overpayment.

Standard IX—Subcontracts and Delegation

Summary of Strengths and Findings as Evidence of Compliance

CHP delegated grievance processing to its partner community mental health centers (CMHCs) and numerous operational functions to Beacon. The written agreements described the delegated activities and obligations, reporting responsibilities, and specified remedies in instances of unsatisfactory performance. The written agreements required compliance with all applicable State, federal, and Medicaid laws and regulations, and they included the requirements related to the right for the State, CMS, the Department of Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees to conduct audits. **CHP**'s agreements with Beacon and the partner CMHCs pre-dated the requirements related to predelegation assessments; therefore, **CHP** performed no predelegation assessments.

CHP provided a variety of documents that demonstrated ongoing and formal monitoring of delegated activities including monthly reports and annual reviews. **CHP**'s Class B Board agendas and meeting minutes documented monthly review of delegation reports. **CHP** required no corrective actions of its delegates; however, staff members clearly described the process for implementing and monitoring corrective actions, as needed.

Summary of Findings Resulting in Opportunities for Improvement

HSAG recommends that **CHP** develop a delegation policy or procedure that delineates all requirements related to delegation including predelegation; ongoing and formal assessments; reporting responsibilities; and compliance with State, federal, and Medicaid-specific laws and regulations. Additionally, although HSAG found compliance with the requirements related to grievance processing by partner CMHCs, requirements were documented across several documents and written agreements. HSAG suggests that **CHP** consolidate requirements related to delegation to its partner CMHCs into one or two written agreements, similar to its delegation agreement with Beacon.

Summary of Required Actions

HSAG identified no required actions for this standard.

2. Overview and Background

Overview of FY 2017–2018 Compliance Monitoring Activities

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

Compliance Monitoring Site Review Methodology

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

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

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

Version 2.0, September 2012.[2-1] Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The four standards chosen for the FY 2017–2018 site reviews represent a portion of the Medicaid managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement.

Objective of the Site Review

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

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

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Sep 26, 2017.

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

FY 2016–2017 Corrective Action Methodology

As a follow-up to the FY 2016–2017 site review, each BHO that received one or more *Partially Met* or *Not Met* scores was required to submit a corrective action plan (CAP) to the Department addressing those requirements found not to be fully compliant. If applicable, the BHO was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the BHO and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **CHP** until it completed each of the required actions from the FY 2016–2017 compliance monitoring site review.

Summary of FY 2016–2017 Required Actions

For FY 2016–2017, HSAG reviewed Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. HSAG found **CHP** 100 percent compliant with the requirements in the access and availability standard. **CHP** was required to develop a plan to address two issues related to coverage and authorization of services:

- Clarify policies and procedures and ensure that **CHP** sends members and providers a notice of action for denial of claims payment at the time of the action affecting the claim.
- Remove language from policies and procedures that allows **CHP** to extend the authorization decision time frame "due to matters justifiably beyond the control of the BHO."

Summary of Corrective Action/Document Review

CHP submitted a proposed plan of corrective action in May 2017 and evidence of having implemented its plan in September 2017. HSAG and the Department carefully reviewed all materials and determined in September 2017 that **CHP** had addressed all required actions.

Summary of Continued Required Actions

No required actions were continued from the FY 2016–2017 site review activities.

Appendix A. Compliance Monitoring Tool

The completed compliance monitoring tool follows this cover page.

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. The Contractor provides all required member information to members in a manner and format that may be easily understood **and is readily accessible by members.** *(Note: Readily accessible means electronic information which complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines.)* *42 CFR 438.10(b)(1)* Contract Amendment 7: Exhibit A3—2.6.5.13.1	**Documents Submitted/Location Within Documents:** 1. IT302.2 508ComplianceofExternalWebSitesPolicy_2BHO- entire policy 2. 306LMemberMaterialsDevelopmentPolicy_2BHO Page 1, IA-B, page 2 IIB 3. ScreenshotofNoDiscriminationonWebsite_CHP-entire document 4. WebsiteComplianceCheck_CHP, page 2 **Description of Process:** CHP has delegated website management to Beacon Health Options. Beacon follows IT302.2 508 Compliance of External Websites policy for websites. This policy addresses our website being readily accessible. On page 1, I A, the policy states that Beacon's external websites must adhere and meet 508 compliance standards. On page 2, IIC, it states that under Section 508, agencies must CHP give disabled employees and members of the public access to information that is comparable to the access available to others. On page 2, IID, the policy addresses World Wide Web Consortium (W3C) that leads the website to its full potential. On page 2, III, the purpose of the policy is to publish procedures for the development of external web sites to ensure that 508 compliance is maintained. On page 2, IV A, the procedures have Priority 1 checklist items. Priority 1 items must be addressed and are required to make a site accessible. On page 4, the policy has Priority 2 Checklist items which should be addressed to make the site accessible, but these items are not required. On Page 6, the policy lists Priority 3 Checklist items These items could be addressed to improve the accessibility of a site. Our electronic information complies with 508 guidelines and W3C's Web Content Accessibility Guidelines. Beacon regularly runs 508/Web Content Accessibility Guidelines (WCAC) scans on their websites to resolve accessibility issues they can control (they cannot control PDF	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	content). Beacon sends the 508/WCAG reports monthly so that CHP is aware of what needs to be resolved to remediate any issues with accessing PDF documents. Please see Website Compliance Check_CHP to review our automated compliance report. On page 2, it is documented that there were 23 accessibility issues on 399 pages. Beacon National corrects the majority of these accessibility issues. CHP also follows 306L Member Materials Development Policy_2BHO which states in I A that Member materials will be easily understood, culturally relevant, and meaningful to Members and their families. In this same policy under IB, Member materials are written at an appropriate reading level so that they are clear, concise and understandable to the representative population. In IIB, CHP describes their use of the Flesch-Kinkaid software which ascertains the minimum education level required to understand materials. We have attached our website screenshot addressing discrimination to adhere to Section 504 of the Rehabilitation Act. See Screenshot of No Discrimination on Website_CHP.	
2. **For consistency in the information provided to members, the Contractor uses the following as developed by the State:** • **Definitions for managed care terminology, including appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice**	**Documents Submitted/Location Within Documents:** 1. ScreenshotManagedCareDefinitions_CHP- entire document 2. ManagedCareTerminology_2BHO-entire document 3. HealthFirstColoradoMemberHandbook_2BHO, page 63, 68 *Misc. 4. EvidenceofStateManagingMemberHandbook_2BHO -entire document 5. GrievanceandAppealGuide_CHP-entire document*Misc. 6. AppealDecisionLetter_CHP, page 2 7. EvidenceofMemberHandbookonCHPWebsite_CHP--entire document	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. • **Model member handbooks and member notices.** *42 CFR 438.10(c)(4)* Contract Amendment 7: Exhibit A3—2.2.6, 2.3.2, 3.1.7	**Description of Process:** CHP understands the need for consistency in the information that is provided to our Members between the state and our BHO. CHP has researched managed care definitions provided by Healthcare, Policy, and Financing in the Health First Colorado's (Colorado's Medicaid Program) Member Handbook and developed a Managed Care Terminology resource for our members (See Managed Care Terminology_2BHO). You can find this managed care terminology document by going to our website, www.coloradohealthpartnerships.com. It is located under the Resource tab under "Resources for All CHP Members." When you click on Managed Care Terminology, Members can access a PDF Document with all of these definitions. Please see Health First Colorado's Member Handbook_2BHO on page 63 for consistency in the "appeal" definition which aligns with one of our definitions in the Managed Care Terminology_2BHO document. Please note that the state officially took over the Member Handbook on July 1, 2017 (Evidence of State Managing Member Handbook_2BHO). CHP has adopted this handbook and loaded the Member handbook link on our website. See Evidence of Member Handbook on CHP Website_CHP. CHP sends out a Grievance and Appeal Guide_CHP with any Notice of Adverse Benefit Determination letter. CHP's Notice of Action letters were updated to Notice of Adverse Benefit Determination terminology to align with Amendment 7 changes to our contract. Please note the highlighted section on page one for the definition of "grievance." This definition is consistent with Health First Colorado's definition found in the Member Handbook on page 68.	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	To demonstrate that we have updated our terminology to align with Amendment 7 changes, please see our definition of "medically necessary" in our Appeal Decision Letter_CHP, page 2 (highlighted section). Medically necessary replaced "medical necessity." The definition is adopted from the Contract 7 amendment.	
Findings: HSAG is aware and the Department acknowledges that, for the FY 2017–2018 compliance review period, the State has not completed or communicated to health plan contractors a consensus list of managed care definitions to be used in information provided to members. HSAG has therefore scored this element as *Not Applicable.* HSAG recommends that all contractors maintain awareness of this requirement and, when received, incorporate State-defined managed care definitions into all applicable member communications, as directed by the Department.		
3. The Contractor makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • **Written materials that are critical to obtaining services include: provider directories, member handbooks, appeal and grievance notices, and denial and termination notices.** • **All written materials for members must:** – Use easily understood language and format. – **Use a font size no smaller than 12 point.** – Be available in alternative formats **and through provision of auxiliary aids and services** that take into consideration the special needs of	**Documents Submitted/Location Within Documents:** 1. DefinitionofPrevalentNonEnglishSpeakers_2BHO, page 8 2. DataUSAColorado_2BHO, page 28 3. EvidenceofMemberHandbookonCHPWebsite_CHP-entire document 4. HealthFirstColoradoMemberHandbookSpanish_2BHO- entire document*Misc. 5. ScreenShotofFindingaProvideronWebsite_CHP-entire document 6. ProviderDirectory_CHP, page 1 7. AppealAcknowledgementLetter_CHP, page 1 *Misc. 8. GrievanceAcknowledgementLetter_CHP, page 1 *Misc. 9. GrievanceandAppealGuide_CHP, page 1*Misc. 10. NoticeofAdverseBenefitDeterminationLetter_CHP, page 1 *Misc. 11. LettertoMemberofProviderTerminating_CHP, page 1 12. AppealDecisionLetter_CHP , page 1 13. GrievanceResolutionLetter_CHP-entire document*Misc. 14. 306LMemberMaterialsDevelopmentPolicy_2BHO, page 1, I C,D,E; page 2, II B	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
members **with disabilities** or limited English proficiency. – **Include taglines in large print (18 point) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service number, and availability of materials in alternative formats.** – Be available for immediate dissemination in that language. *42 CFR 438.10(d)(3) and (d)(6)* Contract Amendment 7: Exhibit A3—2.6.5.13.1–3, 2.6.5.13.6.1–3, 2.6.5.13.7, 2.6.5.13.10.1–4	15. 311LHandlingCallsWithLimitedEnglishSpeakingMembersPolicy_2BHO-entire policy *Misc. **Description of Process:** CHP researched the prevalent non-English language spoken in our region. According to Rule #MSB 17-01-18-A in the Revision to the Medical Assistance Rule Concerning Managed care, "prevalent" means a non-English language spoken by a significant number or percentage of members in the service area as identified by the state. According to Data USA, 17.2% of Colorado citizens are speakers of a non-English language which is lower than the national average of 21.5%. In 2015, the most common non-English language spoken in Colorado was Spanish. 10.7% of Colorado's overall population are native Spanish speakers, followed by German at .46% and Chinese at .42%. Based on this information, the most prevalent non-English language in Colorado is Spanish. CHP has taglines in large print and prevalent non-English language which describes how a Member can request auxiliary aids and services, written translation, or oral interpretation. We include our toll free and TTY/TDY customer service number and explain of the availability of materials in alternative formats at no charge to the member. We include this on our website under the Member Tab. See Evidence of Phone and TTY on Website_CHP. We have included several examples of materials that are critical for Members to obtain services including provider directories, a link to Health First Colorado Member Handbook Spanish_2BHO on our website, appeal, grievance, notice of adverse benefit determination, and letters to Member of provider terminating. See Appeal Acknowledgement Letter_CHP, Grievance Acknowledgement Letter_CHP, Notice of Adverse Benefit Determination Letter_CHP, Letter to Member of	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Provider Terminating_CHP, Appeal Decision Letter_CHP, Grievance Resolution Letter_CHP, and Grievance and Appeal Guide_CHP. CHP has uploaded a copy of Health First Colorado Member Handbook Spanish_2BHO on our website. This can be accessed under our Member tab on our website, www.ColoradoHealthPartnerships.com. See Evidence of Member Handbook on CHP website_CHP. CHP has a Member Material policy (306L Member Material Development_2BHO) which we follow to ensure that Member materials are accurate, easily understood, culturally relevant, clear, available in other languages at no charge to the member and available in alternative formats. CHP runs member materials through a Flesch-Kinkaid Score which is obtained through Microsoft Word. See 306L Member Materials Development Policy_2BHO on page 2 for readability testing guidelines. CHP also has a policy (311L Handing Calls for Limited English Speaking Members_2BHO) which guides our calls with limited English speaking members. We utilize Voiance® translation line which allows us to expediently connect Members with an interpreter in over 150 languages.	
Findings: CHP provided policies and procedures that described the processes for ensuring that all member materials are written at a sixth-grade reading level and use a 12-point font size; are readily available in Spanish and alternative formats, and through the provision of auxiliary aids; and include large print and Spanish taglines that describe how to request auxiliary aids, written translation, and oral translation.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
HSAG tested the readability of several documents including the grievance and appeal guide and several template letters related to the grievance and appeal processes using the Flesch-Kinkaid readability test. Many of these documents scored well above the sixth-grade level. Additionally, HSAG found that many of the grievance and appeal resolution letters reviewed as part of the record reviews were difficult to understand.		
Required Actions: CHP must ensure that all member information is written using easy-to-understand language.		
4. **If the Contractor makes information available electronically—Information provided electronically must meet the following requirements:** • **The format is readily accessible (see definition of readily accessible above).** • **The information is placed in a Web site location that is prominent and readily accessible.** • **The information can be electronically retained and printed.** • **The information complies with content and language requirements.** • **The member is informed that the information is available in paper form without charge upon request, and is provided within five (5) business days.** *42 CFR 438.10(c)(6)* Contract Amendment 7: Exhibit A3—2.6.5.3.6–8	**Documents Submitted/Location Within Documents:** 1. IT302.2 508ComplianceofExternalWebSites_Policy_2BHO-entire policy 2. WebsiteComplianceCheck_CHP, page 2 3. ScreenshotofSubmittingWebUpdates_CHP-entire document 4. 306LMemberMaterialsDevelopmentPolicy_Page 1, IA, B, D 5. ScreenshotofMemberInformationinProminentPlace_CHP-entire document 6. GuiltTipSheet6thgradereadinglevelcheck_CHP-entire document 7. HealthLiteracySigninSheet_CHP-entire document 8. HealthLiteracyTrainingPowerPoint_CHP-entire document 9. HealthLiteracyTrainingwithJeanineDraut_CHP-entire document 10. EvidenceofInfoAvailableforFree_CHP-entire document 11. EvidenceofDiscussingWebsiteatAdvocatesMeeting_CHP, page 2 12. ProviderDirectory_CHP-entire document 13. ScreenshotofFindingaProvider on Website_CHP-entire document **Description of Process:** CHP does make information available to our Members electronically on our website, http://www.coloradohealthpartnerships.com/. CHP has delegated the execution of website content and monitoring to Beacon. Beacon has a policy to guide the requirements of being readily accessible. See IT302.2 508 Compliance of External Websites. Beacon regularly runs 508/WCAG scans for their websites	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	to resolve accessibility issues they can control (they cannot control PDF content). The 508/WCAG reports are shared monthly so that everyone is aware of what needs to be resolved and so that accessible PDFs and content can be provided to remediate the issues. See Website Compliance Check_CHP. On Page 2 it is documented that there were 23 accessibility issues on 399 pages. Beacon National corrects the majority of these accessibility issues. CHP reviews content on a monthly basis to update relevant information for our Members. We inform Members that they can request any information at no charge upon request and that CHP will provide this information to them within five business days. See Evidence of Info Available for Free_CHP. We use Website Update tickets (WUTT) to keep the website current. See Screenshot of SubmittingWeb Updates_CHP. We use the "In the Spotlight" section to keep Members informed about Achieve Solutions. Achieve Solutions has practical, award-winning articles on both physical and behavioral health issues which Members can use as a resource and is updated monthly. Screenshot of Member Information in Prominent Place_CHP to see the latest articles. CHP updates Member benefit changes under "News and Events" section. Members can find out latest information about their benefits. See Screenshot of Member Information in a Prominent Place_CHP. CHP reviews website content with Advocates (note, some Advocates are also Members) during our b-annual monthly meetings. See Evidence of Discussing Website at Advocates Meeting_CHP. To demonstrate that that our information can be electronically retained and printed, we have attached Provider Directory_CHP. The provider directory is able to be printed and electronically retained as evidence of retaining this information from our website onto our	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	SharePoint site. Please see Screenshot of Finding a Provider on Website_CHP. CHP checks on the content and language requirements by running member materials through a Flesch-Kinkaid Score which is obtained through Microsoft Word. We use our Member Materials policy to guide the development of our Member Material. See 306L Member Materials Development Policy and Guilt Tip Sheet 6th grade reading level check_CHP for an example of using the 6th grade reading level check on member tip sheet information. CHP also understand the importance of training staff on Health Literacy. In January, we hosted a training with Jeanine Draut from InPraxis Communications for a one-hour seminar on health literacy. Jeanine has consulted with HCPF to ensure that Members understand the materials that they receive. Our staff benefitted greatly from the education that Jeanne provided. See Health Literacy Training Power Point, Health Literacy Training with Jeanine Draut_CHP and Health Literacy Sign In Sheet_CHP.	
Findings: HSAG conducted an accessibility check on several CHP webpages using the Wave Web Accessibility Evaluation Tool. Using this tool, HSAG discovered several general accessibility errors and contrast errors on various webpages. These findings were consistent with those reported on the Website Compliance Report dated November 14, 2017. HSAG also ran an accessibility check on several PDF documents available for download from the CHP website (e.g., grievance and appeal guide and provider directory). Using the Adobe Acrobat Pro accessibility checker, HSAG discovered accessibility errors within these PDF documents.		
Required Actions: CHP must develop a process to ensure that all information on its website is readily accessible (i.e., complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines).		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
5. The Contractor makes interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and how to access them. • **This includes oral interpretation and use of auxiliary aids such as TTY/TDY and American Sign Language.** • The Contractor notifies members that **auxiliary aids and services are available upon request and at no cost for members with disabilities**, and how to access them. *42 CFR 438.10(d)(4) and (d)(5)* Contract Amendment 7: Exhibit A3—2.6.5.13.7–9	**Documents Submitted/Location Within Documents:** 1. EvidenceofPhoneandTTYonwebsite_CHP-entire document 2. EvidenceofWrittenCommunicationFreeofCharge_CHP-entire document 3. 311LHandlingCallswithLimitedEnglishSpeakingMembers_2BHO – entire policy *Misc. 4. 306LMemberMaterialsPolicy_CHP - page 1, I, D, E 5. ProviderManual_2BHO, pages 120-121 *Misc. 6. NetworkAdequacyActionPlan_CHP, pages 5-6 7. EvidenceofUsingInterpretationServices_2BHO-entire document 8. EvidenceofTranslationServices_CHP-entire document 9. AppealAcknowledgementLetter_CHP, page 1 *Misc. 10. GrievanceAcknowledgementLetter_CHP, page 1 *Misc. 11. NoticeofAdverseBenefitDeterminationLetter_CHP, page 1 *Misc. 12. LettertoMemberofProviderTerminating_CHP, page 1 **Description of Process:** CHP makes interpretation services (for all non-English languages) available free of charge,notifies members that oral interpretation is available for any language, written translation is available in prevalent languages, and how to access them. This information is embedded in our correspondence which we send Members. See Appeal Acknowledgement Letter_CHP, Grievance Acknowledgement Letter_CHP, Notice of Adverse Benefit Determination Letter_CHP, and Letter to Member of Provider Terminating_CHP. CHP has policies and procedures which are followed to ensure that members have access to oral interpretation for any language free of	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	charge. CHP's phone numbers are in a prominent place on our website. Please see Evidence of Phone # and TTY on website_CHP. We inform Members that they have these services available to them at no charge on our websites in in our written communications. Please see Evidence of Written Communication Free of Charge_CHP informing members of the availability of these services. When a non-English speaking Member calls in, we follow our policy outlined in 311LHandlingCallswithLimitedEnglishSpeakingMembers_2BHO. This policy is provided as evidence for compliance with this standard because most requests for oral interpretation of Member materials are made telephonically. We have a guide attached to the policy, "Working with Interpreters," which guides staff members on how to use an interpreter. CHP does provide brief education about using interpreters prior to the interpreter appointment. We will send this guide to any provider upon request and also have this resource on our website for providers. Beacon Health Options contracts with Voiance® to provide interpreter services for our members in over 150 languages. Voiance is a leading provider of language interpreting services and their services are available 24/7. This service is used for members calling into our Access to Care Line, or members who request an oral interpretation of written materials into a language other than English or Spanish. This service allows us to provide interpreter services in "real time." See Evidence of Using Interpretation Services_2BHO for evidence of the number of times we used Voiance, our language line.	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	In our 306L_Member Materials_Development_Policy_2BHO, on page 1, Number I, point D, it states that Member materials are orally translated into other languages by request at no charge to the member. In point E, this policy states that Member Materials are available in alternative formats for Members who have communication disabilities. Alternative formats include large type and audio tape. Providers are made aware of their responsibility to offer interpreter services for Member in the Provider Manual_2BHO on pages 20-21. CHP has a Network Adequacy Action Plan where our strategy to recruit and retain providers who are fluent in alternative languages is outlined. See NetworkAdequacyActionPlan_CHP. CHP may use Voiance® initially to determine the extent of the need for further interpreter services when a Member needs to facilitate communication between two parties. If we ascertain that interpreter services will be needed beyond the initial call, the request is forwarded to the Office of Member and Family Affairs (OMFA). OMFA will request the Asian Pacific Development Center to provide interpreter services in other languages. They have interpreters available for face-to-face, telephonic, or Skype interpretation in approximately 70 languages. When a Member requires language interpretation for clinical services, the Provider can contact CHP and OMFA will find an interpreter and help set an appointment time. If interpreter services are needed for an administrative reason (grievances, etc.) the OMFA department will connect with the interpreter and set an appointment(s) to discuss the grievance or appeal.	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	CHP uses RelayColorado for members who are Deaf or hard of hearing. If interpreter services will be needed for clinical services, OMFA will find a provider in the network who is proficient in sign language, or contract with a sign language interpreter if no providers are available in the region. Please see Evidence of Translation Services_CHP.	
6. The Contractor makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice, to each member who received his or her primary care from or was seen on a regular basis by the terminated provider. *42 CFR 438.10(f)(1)* Contract Amendment 7: Exhibit A3—2.6.10.1	**Documents Submitted/Location Within Documents:** 1. BeaconProviderTerminationWorkflow_2BHO-entire document 2. PendingDisenrollmentReport_2BHO-entire document 3. LettertoMemberofProviderTerminating_CHP-entire document **Description of Process:** CHP has delegated Beacon Health Options' OMFA department to notify Members when Providers dis-enroll from the Network. Beacon makes a good faith effort to notify Members within 15 days upon receipt of the termination notice. Beacon's Knowledge Management and Reporting team (KMAR) developed an automatic Pending Disenrollment Report_2BHO outlining providers who are dis-enrolling or pending disenrollment from the network. This report is sent on a weekly basis via e-mail to OMFA, Provider Relations, and the Clinical team. The automated report includes the provider's name, date of disenrollment, and lists members who are currently seeing or have seen the provider in the last 6 months. Beacon's Provider Relations staff will verify if the provider is truly dis-enrolling prior to sending out notifications to Members. Providers may end up this report for several reasons such as: 1) Providers who have not returned re-credentialing paperwork; 2) Providers who have not re-validated with the State; 3) Providers who	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	have not filed a change of address; 4) Providers who have not met other administrative requirements; 5) Providers who have had a serious violation; or 6) Providers who have informed Beacon that they are voluntarily withdrawing from the Network. This report can be up to 90 days before a provider officially gets dis-enrolled. This time frame allows providers time to fulfill administrative requirements or to appeal a pending disenrollment decision. When a provider has exhausted all appeals, we receive a final report which contains Members who will need to have their care transitioned to a new provider. This is approximately 45 days before final disenrollment. However, there are times a provider moves, resigns from the network, or leaves the network in some other way. Provider Relations expediently informs OMFA when a provider is voluntarily dis-enrolling from the network. OMFA staff sends the Member a letter (see Letter to Member of Provider Terminating_CHP) to any Member who had been seeing the dis-enrolled provider during the previous six months. A letter is sent within 15 days of dis-enrollment when possible. Situations where we would not inform members within the 15-day window would be when the provider informs us after they have closed their practice, or upon the death of a provider. In these cases, we inform members as soon as possible after we receive the information.	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
7. The Contractor makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals**, pharmacies, and behavioral health providers, and long-term services and supports (LTSS) providers:** • The provider's name and **group affiliation**, street address(es), telephone number(s), **Web site URL, specialty (as appropriate),** and whether the providers will accept new members. • **The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training.** • **Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment.** *(Note: Information included in a paper provider directory must be updated at least monthly, and electronic provider directories must be updated no later than 30 calendar days after the Contractor receives updated provider information.)*	**Documents Submitted/Location Within Documents:** 1. ScreenShotofFindingaProviderforWebsite_CHP -entire document 2. ScreenshotofReferralConnect_2BHO-entire document 3. ScreenshotofProviderLanguageInformationfromProviderConnect_2BHO See Section B, C, E 4. EvidenceofProviderDirectoryUploadedMonthly_2BHO-Page 2 5. EvidenceofMonthlyDMATTupdate_CHP- entire document 6. ProviderDirectory_CHP- entire document 7. ExampleofProvideronHold_2BHO- entire document **Description of Process:** Colorado Health Partnerships' Provider Relations Department makes information available regarding our contracted in-network physicians (including specialists and hospitals) available to members in paper or electronic form. This information can be found in CHP's Provider Directory (See Provider Direcotry_CHP). Members are able to obtain a copy our contracted providers through our website, www.coloradohealthpartnerships.com. Once members select the Member tab, they will have three choices to find a provider. See Screenshot of Finding a Provider on Website_CHP. The first choice is the Provider Directory where Members will find a list of in-network behavioral health providers and hospitals. Providers/Facilities' street address, telephone number, linguistic capabilities, and specialties are listed. The second choice is Member Connect where Members can create an account to search for a provider. The third option is Referral Connect. Members are able to search by specialty, American Sign Language and if there are accommodations for Members with physical disabilities. See	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
42 CFR 438.10(h)(1-3) Contract Amendment 7: Exhibit A3—2.6.5.8.1–3	Screenshot of Referral Connect_2BHO. This website address is: https://www.valueoptions.com/referralconnect/providerDirectory.do. Many Members choose to call into CHP's call center to request Health First Colorado providers in their vicinity. A Customer Service Assistant (CSA) will use our Referral Connect system to find providers near the Member. A CSA can search several fields including specialties, language, gender preference, and access for disabilities. Providers can update their information on Provider Connect. Updated information can be phone numbers, addresses, specialties, whether they are currently accepting new patients, or linguistic capabilities, or access for physical disabilities. Screenshot of Provider Language Information from Provider Connect_2BHO, See Section B, C, E. Providers notify Beacon when they are unable to accept new Members. Provider Relations staff will list their practice as full and remove these providers from the next provider directory upload. See Example of Provider on Hold_2BHO. Beacon will use Providers' information to update the Provider Directory, including any of these changes on a monthly basis according to our Standard Operating Procedure. Information included in our paper provider directory is updated at least monthly, and electronic provider directories are updated no later than 30 calendar days after the Contractor receives updated provider information. See Evidence of Provider Directory Uploaded Monthly_2BHO.	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Provider Relations has an automated monthly Data Management & Analysis Task Tracker (DMATT) ticket to update the provider directory on a monthly basis. Once this directory is updated, it is uploaded to our website. See Evidence of Monthly DMATT Update_CHP.	
Findings: CHP's provider directory included the name, group affiliation, street address, telephone number, areas of specialty, and languages spoken for all providers accepting new patients. The directory included no information regarding a provider's website URL, cultural competency training, or accessibility for people with physical disabilities.		
Required Actions: CHP must update its provider directory to include a provider's website URL (if available) and to indicate which providers have completed cultural competency training and which locations are accessible for people with physical disabilities.		
8. **Provider directories are made available on the Contractor's Web site in a machine-readable file and format.** *42 CFR 438.10(h)(4)* Contract Amendment 7: Exhibit A3—2.6.5.8.4	**Documents Submitted/Location Within Documents:** 1. EvidenceofMonthlyDMATTupdate_CHP-entire document 2. ProviderDirectory_CHP- entire document 3. IT302.2 508ComplianceofExternalWebSitesPolicy_2BHO-Sections IA, III, IV 1-11 4. WebsiteComplianceCheck_CHP-entire document **Description of Process:** CHP has delegated to Beacon the responsibility to ensure that Provider Directories are available on our website. Provider Relations has an automated monthly Data Management & Analysis Task Tracker (DMATT) ticket to update the provider directory on a monthly basis. Once this directory is updated, it is uploaded to our website. See Evidence of Monthly DMATT Update_ For a copy of the provider directory, see Provider Directoy_CHP.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	According to Beacon's IT302.2 508 Compliance of ExternalWebsitesPolicy_2BHO, Beacon regularly runs 508/WCAG scans for their websites to resolve accessibility issues they can control (they cannot control PDF content). Beacon sends the 508/WCAG reports monthly so that CHP is aware of what needs to be resolved to remediate any issues with accessing PDF documents Beacon Colorado is notified if there are any machine readable file and format issues with the Provider Directory. See Website Compliance Check_CHP.	
9. The Contractor provides other necessary information to members, including: • The Child Mental Health Treatment Act (CMHTA). • Community resources. Contract Amendment 7: Exhibit A3—2.6.7.3.1 and 2.6.7.3.3	**Documents Submitted/Location Within Documents:** 1. CMHTAQandA_CHP-entire document 2. Health First Colorado's Members Handbook_2BHO-Page 62 3. ScreenshotofResourceSheetwithCMHTA_CHP-entire document 4. Notice of Adverse Benefit Determination Letter_CHP, page 7 5. CMHTALiaisonContactListfromState_2BHO-entire document 6. CMHCAdvocates_CHP-entire document 7. EvidenceofMemberHandbookonCHPWebsite_CHP-entire document 8. ProviderManual_2BHO, page 42 *Misc. **Description of Process:** CHP provides other necessary information to members including the Child Mental Health Treatment Act (CMHTA) and community resources. CHP has information about the Child Mental Health Treatment Act (CMHTA) located on our website at: http://www.coloradohealthpartnerships.com/members/pdf/Child-Mental-Health-Treatment-Act.pdf. See Screenshot of Resource Sheet with CMHTA_CHP. Information about CMHTA is in a "question/answer" format to help guide and answer question parents	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	may have of this treatment act relating to residential treatment. See CMHTA Q and A_CHP. There is a CMHTA "point person" at each community mental health center which is listed on the resource tab on our website. See CMHTA Liaison Contact List_2BHO. CHP relies on the expertise of this "point person" to assist our Members. When a Member contacts the mental health center, they are directed to the CMHTA point person. CHP also has Health First Colorado's Members Handbook link on our website where information about CMHTA can be found. See Health First Colorado Member Handbook_2BHO on page 62. When a child/adolescent has been denied residential treatment, we include information about CMHTA in the Notice of Adverse Benefit Determination letter (see Notice of Adverse Benefit Determination Letter_CHP, page 7. CHP has community resources located under our resource tab on our website, www.coloradohealthpartnerships.com where Members can obtain resources within their community. There are also Advocates and/or Case Managers at the community mental health centers that assist members in finding resources within their specific community. See CMHC Advocates_CHP which can be found on our website: http://www.coloradohealthpartnerships.com/members/pdf/CHP_advocates.pdf. Finally, information about CMHTA is found in Provider Manual_2BHO, page 42. Providers are made aware of the Child Mental Health Treatment Act and can use this to provide information for Members.	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
10. For any information provided to members by the Contractor, the Contractor ensures that information is consistent with federal requirements in 42 CFR 438.10. *42 CFR 438.10 (b)*	**Documents Submitted/Location Within Documents:** 1. 306LMemberMaterialsDevelopment_Policy_2BHO_ page 1, I A,B,C,D,E; page 2, II B, IV A iv, and IV D. 2. Evidence of Reading Level and Supervisor Proofing Materials_2BHO, page 18 and 19 3. EvidenceofReviewingMemberInformationwithState_2BHO-Entire document **Description of Process:** Colorado Health Partners has a process in place to make sure that any information provided to members is consistent with federal requirements in 42 CFR 438.10. CHP has a Member Material policy (See306L Member Materials Development Policy_2BHO) which we follow to ensure that Member materials are consistent with these requirements. Member materials are written at an appropriate reading level so that they are clear, concise and understandable. CHP runs member materials through a Flesch-Kinkaid Score which is obtained through Microsoft Word. CHP has a protocol to confirm that individual member letters are accurate, easily understood, and clear. Individual letters are reviewed by a supervisor prior to mailing to a member. As an example of this, we have loaded our Appeal Job Aid (see Evidence of Reading Level and Supervisor Proofing Materials_2BHO, page 18 and 19) to show our process of running appeal decision letters through Flesch-Kincaid and requiring supervisor approval. Member Materials are available in alternative formats for members who have communication disabilities. Alternative formats include large type and audio tape. Materials always have a tagline that	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	information is available in other languages at no charge to the member and available in alternative formats. CHP reviews materials that may go to multiple Members with Healthcare Policy and Financing's Contract Manager. For an example of this, please see Evidence of Reviewing Member Information with the State_2BHO. This email chain demonstrates that we asked for a Member material review by the state when we developed a new form that would go to multiple Members. This is consistent with following our 306L Member Materials Development_Policy_2BHO.	
11. **The Contractor provides member information by any of:** • **Mailing a printed copy of the information to the member's mailing address.** • **Providing the information by email after obtaining the member's agreement to receive the information by email.** • **Posting the information on the Contractor's Web site and advising the member in paper or electronic form that the information is available on the Internet and including the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost.**	**Documents Submitted/Location Within Documents:** 1. AppealAcknowledgementLetter_CHP-entire document*Misc. 2. GrievanceAcknowledgementLetter_CHP-entire document*Misc. 3. NoticeofAdverseBenefitDeterminationLetter_CHP-entire document*Misc. 4. LettertoMemberofProviderTerminating_CHP-entire document 5. AppealDecisionLetter_CHP-entire document 6. GrievanceResolutionLetter_CHP-entire document*Misc. 7. EvidenceofPostage_2BHO-entire document 8. ExampleofMemberAuthorizingEmail_CHP-entire document 9. ExampleofemailingMember_CHP-entire document 10. EvidenceofWrittenCommunicationFreeofCharge_CHP-entire document 11. NoticeofAdverseBenefitDeterminationLetter, page 3 *Misc. 12. LunchandLearnCourseEvaluation_CHP-entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
• **Providing the information by any other method that can reasonably be expected to result in the member receiving that information.** *42 CFR 438.10(g)(3)*	13. LunchandLearnMemberEmpowermentFlyer_CHP-entire document 14. ScreenShotofMemberInformationinProminentPlace_CHP-entire document 15. EvidenceofWrittenCommunicationFreeofCharge_CHP-entire document **Description of Process:** Colorado Health Partnerships provides member information through a variety of means. The predominant method is through mailings and our website. To demonstrate mailing a printed copy of information to a Member's mailing address, we have included copies of our grievance and appeal acknowledgement letters, notices of adverse benefit determination letters, grievance resolution letter and appeal decision letters. See Appeal Acknowledgement Letter_CHP, Grievance Acknowledgement Letter_CHP, Notice of Adverse Benefit Determination Letter_CHP, Letter to Member of Provider Terminating_CHP, Appeal Decision Letter_CHP, and Grievance Resolution Letter_CHP, We use the mailing address from our Service Connect/Care Connect system (SC/CC). Eligibility files are provided by HCPF and Members' addresses are downloaded into Beacon's SC/CC system. For evidence of sent letters, please see Evidence of Postage_2BHO. CHP will provide information via Email if we have the Member's consent to receive information by email. To demonstrate that we obtained Member's consent, please see Example of Member Authorizing Email_CHP. CHP has a designated email address for Member communication entitled BHO Member Mailing. For an	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	example of sending information via Email to a member, see Example of Emailing Member_CHP. CHP posts information on our website and informs members that they can access this information by going to the site. As an example of this, please see Notice of Adverse Benefit Determination_CHP on page 3. CHP informs Members that they can obtain Clinical Care Guidelines by going to the link provided in the letter. Members are made aware that they can obtain the information from our website in alternative formats at no charge. See Evidence of Written Communication Free of Charge_CHP. CHP keeps Members informed of benefit changes under "News and Events." For example, when Members' prescription benefits changed, we placed this information on our website. Please see Screen Shot of Member Information in Prominent Place_CHP. Lastly, CHP provides Member information through the method of Lunch and Learns. Lunch and Learns are a time when staff from the Office of Member and Family Affairs (OMFA) goes to the community to host a luncheon for Members. OMFA has been providing an overview of Member Rights at these luncheons. Members are encouraged to ask questions about their rights during these luncheons. OMFA coordinates with Advocates at the community mental health centers to advertise these Lunch and Learns. The Lunch and Learn fliers are also placed on our website. See Lunch and Learn Member Empowerment Flyer_CHP. This method of Lunch and Learns has been very effective in Members receiving information about their benefits. Members have been very positive about this format of receiving information. Please see Lunch and Learn Course Evaluation_CHP.	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the BHO**	**Score**
12. The Contractor must make available to members, upon request, any physician incentive plans in place. *42 CFR 438.10(f)(3)*	CHP does not have any physician incentive plans currently in place.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard V—Member Information							
Total	Met	=	8	X	1.00	=	8
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	11	**Total Score**		=	8
				Total Score ÷ Total Applicable		=	73%

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. **The Contractor has established internal grievance procedures under which members, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance. The contractor must have a grievance and appeal system in place to handle appeals of an adverse benefit determination and grievances, as well as processes to collect and track information about them.** • **The Contractor may have only one level of appeal for members (or providers acting on their behalf).** • **A member may request a State fair hearing after receiving an appeal resolution notice from the Contractor that the adverse benefit determination has been upheld.** • **If the Contractor fails to adhere to required time frames for processing appeals, the member is deemed to have exhausted the Contractor's appeal process and the member may initiate a State fair hearing**. *42 CFR 438.400(a)(3)* *42 CFR 438.402(a-c)* *42 CFR 438.400(b)*	**Documents Submitted/Location Within Documents:** 1. 305LAppealsProcessPolicy_2BHO, Page 1 IA, B, Page 3, IIIE, Page 4, IV, A 3b 2. 303LGrievanceProcessPolicy_2BHO, Page 1, ID, Page 2, IIC 3. ExampleofDCRForm_CHP-entire document 4. ExampleofROIForm_CHP-entire document 5. ProviderManual_2BHO, page 45, 48, 121*Misc. 6. ScreenshotofGrievanceDatabase_CHP-entire document 7. ExampleofAppealLog_CHP-entire document 8. GrievanceJobAid_CHP-entire document 9. GrievanceJobAidforAdvocates_CHP-entire document 10. EvidenceofGrievanceAudit_CHP-entire document 11. AppealJobAid_2BHO-entire document 12. ExampleofCollectingAppealData_CHP-entire document 13. GrievanceandAppealGuide_CHP, page 1*Misc. 14. NoticeofAdverseBenefitDeterminationLetter_CHP, page 3, 6, 7 *Misc. 15. ScreenshotofGrievanceandAppealProcessonWebsite_CHP-entire document **Description of Process:** Colorado Health Partnerships (CHP) has delegated Beacon Health Options to oversee the grievance and appeal procedures. Beacon has established internal grievance procedures under which Members, Legal Guardians, or providers acting on Members' behalf, may challenge the denial of coverage of, or payment for, medical assistance. Beacon has an appeal system in place to handle appeals of an adverse benefit determination and grievance system to resolve grievances. Beacon also has a process to collect and track	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Contract Amendment 7: Exhibit A3—2.6.4.1, 2.6.4.9.1, 2.6.4.9.3 10 CCR 2505-10—8.209.3.A, 8.209.4.A.2.c, 8.208.4.N, and 8.209.4.O	information about appeals and grievances. Members can obtain information about the grievance and appeal process by following the link on our website. See Screenshot of Grievance and Appeal Process on Website_CHP. To demonstrate that CHP has established grievance and appeal guidelines in place, please see 305L Appeals Process Policy_2BHO and 303LGrievance Process Policy_2BHO. In these policies we state that either a Member, Legal Guardian, or a Designated Client Representative (DCR) can initiate an appeal or a grievance. A Member or their DCR may appeal an adverse benefit determination or file a grievance relating to any dissatisfaction about any matter other than an adverse determination. We send Members a Grievance and Appeal Guide_CHP when there is an adverse benefit determination. In the guide it states that Members and/or Legal Guardians may ask someone other than themselves, including their service provider to file a complaint or appeal on their behalf. We explain that Members and/or Legal Guardians will need to fill out a Designated Client Representative (DCR) form to represent the Member, as well as a Release of Information form (ROI). Members also are informed that a representative can act on their behalf in the Notice of Adverse Benefit Determination Letter (See Notice of Adverse Benefit Determination Letter_CHP). We have DCR and ROI forms located on our website under resources which can be downloaded (see Example of DCR Form_CHP and Example of ROI Form_CHP). Information about DCRs is also found in the Provider Manual_2BHO. Beacon has a process to collect and track appeals. See Appeal Job Aid_2BHO for a detailed explanation of the processes we use to collect appeal information. All of this information is stored on our	

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	shared drive. Please see Example of Collecting Appeal Data_CHP to demonstrate how all of the information is stored. Beacon's Knowledge Management and Reporting Team (KMART) generates a quarterly report tracking all the appeals for the previous quarter. See Example of Appeal Log_CHP for a copy of this report, Our 305L Appeals Process Policy_CHP, Grievance and Appeal Guide_CHP, and Notice of Adverse Benefit Determination letters (Notice of Adverse Benefit Determination_CHP) explain that there is only one level of appeal for a member. There is detail in these three resources that Members/Legal Guardians/DCRs must go through the appeal process prior to requesting a State Fair Hearing. We also explain that if CHP does not adhere to the required time frames for processing appeals, the Member is considered to have exhausted our appeal process and the Member may initiate a State Fair Hearing. CHP has a process to collect and track grievances. There is a designated Advocate to take grievances directly from Members at each of our eight community mental health centers. Our goal has always been to address grievances promptly and expediently with Members. Mental Health Center Advocates follow the Grievance Job Aid for Advocates_CHP guide to adhere to the process of collecting and tracking grievances. For an example of our grievance database where the information is collected, please see Screenshot of Grievance Database_CHP. Beacon does have a lead Grievance Coordinator who runs reports from the grievances which the Advocates enter. CHP also audits this work for consistency across mental health centers. See Evidence of Grievance Audit_CHP.	

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
2. The Contractor defines "adverse benefit determination" as: • The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. • The reduction, suspension, or termination of a previously authorized service. • The denial, in whole, or in part, of payment for a service. • The failure to provide services in a timely manner, as defined by the State. • The failure to act within the time frames defined by the State for standard resolution of grievances and appeals. • **The denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other).** • For a resident of a rural area with only one managed care plan, the denial of a Medicaid member's request to exercise his or her rights to obtain services outside of the network under the following circumstances:	**Documents Submitted/Location Within Documents:** 1. 305LAppealsProcessPolicy_2BHO, page 3, C 1-6 2. 303LGrievanceProcessPolicy_2BHO, pages 2-3, E1-6 3. 274LOutofNetworkPolicy_2BHO, page 2, IV B 2a, c, page 3 IV B 4 4. ProviderManual_2BHO_page50 *Misc. 5. AppealDecisionletter_CHP, page 2 6. 202LMedicalNecessity_2BHO, page 2, II, A1-4 7. HealthFirstColoradoMemberHandbook_2BHO, page 63 *Misc. 8. GrievanceandAppealGuide_CHP, page 2 *Misc. 9. GrievanceandAppealTraining_2BHO, Slide 4 & 5 10. EvidenceofGrievanceandAppealTraining_2BHO-entire document **Description of Process:** Colorado Health Partnerships has the definition of an adverse benefit determination located in several places. CHP has two policies that include this definition: See 305L Appeals Process Policy_2BHO, page 3 and 303L Grievance Process Policy_2BHO, page 2. We also send a Grievance and Appeal Guide_CHP to Members when there is a notice of adverse benefit determination, or Members can find this guide on our website. The guide addresses the definition of an Adverse Benefit Determination on page 2The specific definition of services which are medically necessary can be found in our policy, 202L Medical Necessity_2BHO on page 2 and in our Appeal Decision letter_CHP on page 2. The policies guide our handling and disposition of grievances & appeals. The definition of an adverse benefit determination is located in the Provider Manual_2BHO on page 50 to ensure that providers also	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
– The service or type of provider (in terms of training, expertise, and specialization) is not available within the network. – The provider is not part of the network but is the main source of a service to the member—provided that: o The provider is given the opportunity to become a participating provider. o If the provider does not choose to join the network or does not meet the Contractor's qualification requirements, the member will be given the opportunity to choose a participating provider and then will be transitioned to a participating provider within 60 days. *42 CFR 438.400(b)* *42 CFR 438.52(b)(2)(ii)* Contract Amendment 7: Exhibit A3—1.1.1.3 10 CCR 2505-10—8.209.2.A	know the correct terminology. CHP also relies on Health First Colorado's Member Handbook_2BHO on the definition of an Adverse Benefit determination which can be found on page 63. CHP's 274L Out of Network Policy_2BHO describes the single case agreement process. The policy describes the procedure we follow when Members request seeing an out-of-network provider and situations where a member may reside in a rural area and want to exercise their rights to obtain services outside of the network on pages 3 – 4. The policy addresses when Members need a provider with certain expertise or a rural provider who is not in network. Provider Relations staff will reach out to the provider and encourage them to become part of our network and approve single case agreements so the member can continue to see the provider. OMFA provided a training to Clinical staff to educate clinical staff members of the time frames to file grievances and appeals, review the definitions of grievances and appeals, and to discuss Members' rights to file grievances and appeals. See Grievance and Appeal Training_2BHO. OMFA had clinicians sign a training sign-in sheet for this training. Please see EvidenceofGrievanceandAppealTraining_2BHO-entire document	
Findings: CHP's Grievance Process policy and Appeals Process policy both included a definition of "adverse benefit determination"; however, the two definitions were inconsistent and incomplete. In both policies, the denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other) was missing from the definition.		
Required Actions: CHP must review its policies, procedures, and other applicable documents (e.g., member and provider communications) that address the Grievance and Appeal System to ensure they include an accurate definition of "adverse benefit determination."		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
3. The Contractor defines "Appeal" as "a review by the Contractor of an **adverse benefit determination**." *42 CFR 438.400(b)* Contract Amendment 7: Exhibit A3—1.1.1.4 10 CCR 2505-10—8.209.2.B	**Documents Submitted/Location Within Documents:** 1. 305LAppealsProcessPolicy_2BHO, page 2-3, B 2. 303LGrievanceProcessPolicy_2BHO, page 1, IIA 3. ManagedCareTerminology_2BHO, page 1 4. HealthFirstColoradoMemberHandbook_2BHO, page 63 *Misc. 5. GrievanceandAppealGuide_CHP, page 2 *Misc. 6. GrievanceandAppealTraining_2BHO, Slide 4 **Description of Process:** CHP defines "Appeal" as an adverse benefit determination made by the BHO. This definition is explained in the policies and procedures which we follow. Please see 305L Appeals Process Policy_2BHO on page 2-3 and 303L Grievance Process Policy_2BHO on page 1. CHP communicates this appeal definition to Members through our Managed Care Terminology_2BHO (located on our website, www.coloradohealthpartnerships.com) and in our Grievance and Appeal Guide_CHP on page 2. This definition is also located in Health First Colorado's Member Handbook_2BHO on page 63 which is located on our website as well. Whenever a Member/Legal Guardian/DCR disagrees with an adverse benefit determination, this generates the Member's appeal rights. OMFA provided a training to Clinical staff to educate clinical staff members of the time frames to file grievances and appeals, review the definitions of grievances and appeals, and to discuss Members' rights to file grievances and appeals. See Grievance and Appeal Training_2BHO. OMFA had clinicians sign a training sign-in sheet for this training. Please see EvidenceofGrievanceandAppealTraining_2BHO-entire document.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
4. The Contractor defines "grievance" as "an expression of dissatisfaction about any matter other than an **adverse benefit determination**." Grievances may include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the member's rights **regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision.** *42 CFR 438.400(b)* Contract Amendment 7: Exhibit A3—1.1.1.27, 2.6.4.5.8.1.2 10 CCR 2505-10—8.209.2.D, 8.209.4.A.3.c.i	**Documents Submitted/Location Within Documents:** 1. 303LGrievanceProcessPolicy_2BHO, page 2, IID 2. GrievanceandAppealTraining_2BHO - slide 16 3. GrievanceandAppealGuide_CHP, page 1, 5 *Misc. 4. EvidenceofGrievanceAppealTraining_2BHO-entire document 5. ExpeditedAppealRequestDenialLetter _CHP-entire document 6. AppealDelayLetter_CHP, page 2 7. HCPFGrievanceCategoriesDefinitions_2BHO-entire document **Description of Process:** CHP defines "grievance" as "an expression of dissatisfaction about any matter other than an adverse benefit determination. This definition can be found in our 303L Grievance Process Policy_2BHO on page 2 and in our 305L Appeals Process Policy_2BHO. Members can find the definition of a grievance in the Grievance and Appeal Guide_CHP on page 1. Members can find out that they can file a grievance if they disagree with CHP's decision to extend the time frame to review their appeal authorization decision. See page 2 in Appeal Delay Letter_CHP. We also notify Members that they can file a grievance if there request for an expedited appeal is denied (See Expedited Appeal Request Denial Letter_CHP) and Grievance and Appeal Guide_CHP on page 5. CHP also provides training to internal staff and community mental health center staff on the definition of a grievance. Please see our Grievance and AppealTraining_2BHO, slide 16 for the definition and Evidence of Grievance Appeal Training_2BHO for the clinical	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	staff who participated in this training. . HCPF provides definitions for grievance categories that we use as guides to record the grievance in the correct fields (see HCPF Grievance Categories Definitions_2BHO).	
Findings: Review of CHP's documents and on-site grievance record review provided evidence that CHP (and its delegates) accepted, processed, and documented grievances brought to the BHO's or delegates' attention. HSAG found, however, that instructions provided to individuals responsible for processing and resolving grievances directed staff to ask members calling to express dissatisfaction whether they wished to file a grievance or wished to file a "formal grievance." CHP's complaint form also asked members if they wished to file a "formal grievance." During the on-site interview, CHP staff also stated that if grievances were resolved at the initial point of contact, acknowledgement and/or resolution letters were not required. HSAG cautioned CHP staff members that once a member has called and expressed dissatisfaction, the call must be handled as a grievance (if not pertaining to an adverse benefit determination), and that leading members to believe that another action must take place or using the term "formal" may cause members to say no, thereby denying these members due process. Not considering issues that are resolved quickly as grievances also may prevent members from receiving due process and lead to inaccurate grievance reporting to the State.		
Required Actions: CHP must ensure that member materials, forms, training, job aids, informal direction, and other communications to staff who are responsible for processing grievances emphasize that all expressions of dissatisfaction about any matter other than an adverse benefit determination must be considered a grievance, and documented and treated as such, including due process procedures such as acknowledging, resolving, and notifying members of a resolution.		
5. The Contractor has provisions for who may file: • A member may file a grievance or a Contractor-level appeal and may request a State fair hearing. • With the member's written consent, a provider or authorized representative may file a grievance or a Contractor-level appeal and may request a State fair hearing on behalf of a member.	**Documents Submitted/Location Within Documents:** 1. 305LAppealsProcessPolicy_2BHO, Page 1 IA, B, Page 3 II E 2. 303LGrievanceProcessPolicy_2BHO, Page 1, ID, Page 2 IIC 3. ExampleofDCRForm_CHP-entire document 4. ProviderManual_2BHO, pages 45, 48, 125 *Misc. 5. GrievanceandAppealGuide_CHP, Page 1 *Misc. 6. HealthFirstColoradoMemberHandbook_2BHO, Pages 62, 65, 68 *Misc. 7. NoticeofAdverseBenefitDeterminationLetter_CHP, pages 3, 6 *Misc.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
42 CFR 438.402(c) Contract Amendment 7: Exhibit A3—2.6.4.4.1, 2.6.4.4.4, 2.6.4.6.3, 1.1.1.17 10 CCR 2505-10—8.209.3.B.1, 8.209.3.B.2, 8.209.2.C	**Description of Process:** Colorado Health Partnerships has provisions for who can file a grievance, appeal, and a State Fair Hearing. CHP allows anyone to act on a Member's behalf as long as the Member has authorized the individual to act as their Designated Client Representative (DCR) in writing. 303L Grievance Process Policy_2BHO states that anyone, including a health care professional, may act as a representative as long as the member names them in writing. In 305L Appeals Process Policy_2BHO we outline that Members/Guardians, or their DCR have the right to initiate an appeal or State Fair Hearing as long as Members have signed the DCR form. See Example of DCR Form_CHP. Members can sign this form designating an individual to act on their behalf in the grievance or appeal process. Members are made aware of this right in the Appeal and Grievance Guide_CHP, Health First Colorado Member Handbook _2BHO, and in the Notice of Adverse Benefit Determination Letter_CHP. Providers are made aware of who can file a grievance or appeal in the Provider Manual_2BHO.	
6. The Contractor accepts grievances orally or in writing. *42 CFR 438.402(c)(3)(i)* Contract Amendment 7: Exhibit A3—2.6.4.5.3 10 CCR 2505-10—8.209.5.D	**Documents Submitted/Location Within Documents:** 1. 303LGrievanceProcessPolicy_2BHO - page 1, IC 2. HealthFirstColoradoMemberHandbook_2BHO, Page 68 *Misc. 3. GrievanceTrainingPowerPoint_2BHO, Slide 7 4. ExampleofGrievanceinWriting_CHP, Page 1 5. ExampleofVerbalGrievance_CHP-entire document 6. GrievanceandAppealGuide_CHP, page 2 *Misc. 7. NoticeofAdverseBenefitDeterminationLetter_CHP, page 6 *Misc. 8. GrievanceFlowchart_2BHO-entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	9. ProviderManual_2BHO, Page 125 *Misc. **Description of Process:** Colorado Health Partnerships will accept a grievance orally or in writing. CHP follows our 303L Grievance Process Policy_2BHO which states that grievances can be filed orally or in writing. CHP also has a work flow in place since there are many avenues for Members to file grievances. See Grievance Flowchart_2BHO. For example, Members can file a grievance at their community mental health center as well as call CHP's Grievance Coordinator. Members are informed that they can file a grievance orally or in writing through Health First Colorado Member Handbook_2BHO on page 68, in the Grievance and Appeal Guide_CHP on page 2, or through Notice of Adverse Benefit Determination Letter_CHP on page 6 The Office of Member and Family Affairs (OMFA) provides training to our Engagement Center's Clinical staff who work in the call Center. See Grievance Training Power Point_2BHO, slide 16 reflecting that a grievance can be a written or oral expression of satisfaction. CHP's clinical department will identify if a Member wants to file a complaint and transfer them to the Grievance Coordinator in OMFA. Please see Example of Verbal Grievance_CHP and Example of Grievance in Writing_CHP to demonstrate that we take grievances both orally and in writing. Providers are made aware that Members can file a grievance either orally or in writing in the Provider Manual_2BHO on page 125	

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
7. Members may file a grievance at any time. *42 CFR 438.402(c)(2)(i)* Contract Amendment 7: Exhibit A3—2.6.4.5.3 10 CCR 2505-10—8.209.5.A	**Documents Submitted/Location Within Documents:** 1. 303L GrievanceProcessPolicy_2BHO, page 5, IV 1 2. GrievanceandAppealGuide_CHP, Page 2 3. HealthFirstColoradoMemberHandbook_2BHO, page 68 *Misc. 4. NoticeofAdverseBenefitDetermination_CHP, page 6 5. ProviderManual_2BHO, page 125 *Misc. 6. GrievanceandAppealTraining_2BHO, slide 18 7. EvidenceofGrievanceandAppealTraining_2BHO-entire document **Description of Process:** Colorado Health Partnerships allows Members to file a grievance at any time. This is noted in our 303L Grievance Process Policy_2BHO on page 5 stating that Members can file a grievance at any time. Members are made aware of this right through the Grievance and Appeal Guide_CHP on page 1 Health First Colorado Member Handbook_2BHO on page 68 (found on www.coloradohealthpartnerships.com), and in our Notice of Adverse Benefit Determination Letter_CHP on page 6 The Office of Member and Family Affairs provide training to our Engagement Center's Clinical staff who work in the call Center on Members' rights to file grievances at any time. Please see slide 18 in our Grievance and Appeal Training_2BHO. For a list of staff who attended this training, please see EvidenceofGrievanceandAppealTraining_2BHO-entire document Providers are made aware that Members can file a grievance at any time in the Provider Manual_2BHO on page 125	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
8. The Contractor sends the member written acknowledgement of each grievance within two (2) working days of receipt. *42 CFR 438.406(b)(1)* Contract Amendment 7: Exhibit A3—2.6.4.5.3 10 CCR 2505-10—8.209.5.B	**Documents Submitted/Location Within Documents:** 1. 303LGrievanceProcessPolicy2BHO- page 6, IV 5 2. HealthFirstColoradoMemberHandbook_2BHO, page 68 *Misc. 3. GrievanceContactRecord_2BHO-entire document 4. GrievanceAcknowledgementLetter_CHP-entire document *Misc. 5. EvidenceofGrievanceAudit_CHP-entire document 6. URACAuditSummary_CHP, Page 2 7. GrievanceFlowChart_2BHO-Entire document 8. GrievanceJobAid_CHP, page 1 **Description of Process:** Colorado Health Partnerships sends Members a written acknowledgement letter within two (2) working days of the receipt of the grievance. CHP follows our 303L Grievance Process Policy_2BHO which states that we will send out an acknowledgement letter within two working days on page 5 This two-day requirement to send out an acknowledgement letter is also in our Grievance Flow Chart_2BHO, and Grievance Job Aid_CHP. The date the grievance is received sets the clock for the two-day turnaround time to send an acknowledgment letter. This could be the date the phone call is received, the date the fax is received, the letter is opened, or in a few cases, the date the e-mail is opened. This date is logged in the Member's Grievance Contact Record_2BHO. If the grievance is filed with the Engagement Center, the date is entered into the CHP grievance data base. If the date is filed with a community mental health center Advocate or at a	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	local OMFA office, the date is also logged into the CHP grievance data base and the data-base of the center. CHP has an internal audit conducted by their Executive Assistant. This Assistant reviews a sample of grievances to ensure that CHP is meeting our 303L Grievance Process Policy_2BHO and the required time frames within that policy. Please see EvidenceofGrievanceAudit_CHP which demonstrates 100% compliance in this category. Beacon also had an independent URAC audit completed in 2017 which reflected 100% compliance in the acknowledgement letter being sent category. See URAC Audit Summary_CHP on Page 2.Please note, CHP follows Colorado's standards of an acknowledgment letter sent within two working days versus URAC's standards of sending an acknowledgment letter in five working days. Members are made aware that they will receive an acknowledgement letter within two business days from Health First Colorado Member Handbook_2BHO on page 68. CHP has attached the acknowledgement letter that we send to Members within this two day time frame. See Grievance Acknowledgment Letter_CHP.	

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
9. The Contractor must resolve each grievance and provide notice as expeditiously as the member's health condition requires, and **within 15 working days of when the member files the grievance.** • Notice to the member must be in writing in the format established by the Department. • **Notice to the member must be in a format and language that may be easily understood by the member.** *42 CFR 438.408(a) and (b)(1) and (d)(1)* Contract Amendment 7: Exhibit A3—2.6.4.5.5, 2.6.4.5.5.1, 2.6.5.13.1 10 CCR 2505-10—8.209.5.D.1, 8.209.5.F	**Documents Submitted/Location Within Documents:** 1. 303LGrievanceProcessPolicy_2BHO, page 6 IV 11 2. 306LMemberMaterialsPolicy_2BHO, page 1 I A,B,C,D,E, Page 2 II B 3. GrievanceFlowChart_2BHO-entire document 4. GrievanceJobAid_CHP, page 2 5. HealthFirstColoradoMemberHandbook_2BHO, page 68 *Misc. 6. GrievanceandAppealGuide_CHP, page 2 *Misc. 7. GrievanceAcknowledgementLetter_CHP-entire document*Misc. 8. NoticeofAdverseBenefitDeterminationLetter_CHP, page 6 *Misc. 9. GrievanceResolutionLetter_CHP-entire document *Misc. 10. EvidenceofGrievanceAudit_CHP-entire document 11. URACAuditSummary_CHP, Page 2 **Description of Process:** Colorado Health Partnerships aims to resolve each grievance and provides notice to the Member of the resolution of their grievance as expeditiously as possible. This resolution time frame is within 15 working days from the receipt of the grievance. There are times that this time frame may need to be extended either by Member request, or because more time is required to resolve the grievance. CHP follows 303 L Grievance Process Policy_2BHO which aligns with state and federal regulations for grievance resolution deadlines. CHP follows the time frames as indicated in Grievance Flow Chart_2BHO and Grievance Job Aid_CHP.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Members are made aware of the time frame to resolve their grievance through a variety of ways. The information that their grievance will be resolved within 15 working days is listed in Health First Colorado Member Handbook_2BHO on page 68 and in the Grievance and Appeal Guide_CHP on page 2. Both of these two resources are both found on our website (www.coloradohealthpartnerships.com). Members also receive this information in Notice of Adverse Benefit Determination Letters_CHP, and in the Grievance Acknowledgement Letter_CHP. In the Grievance Acknowledgement Letter_CHP, we insert the date that the grievance will be resolved which is 15 working days of receipt of the grievance. The date the grievance is received establishes the clock for investigating and resolving the grievance. This could be the date the phone call is received, the date the fax is received, the letter is opened, or in a few cases, the date the e-mail is opened. The 15 working days is used to gather facts, consult with others, review policies and make assessments about the Member's complaint. When a reasonable resolution is found, the person handling the grievance notifies the member by letter, using the state-approved template GrievanceResolutionLetter_CHP. CHP uses their 306L Member Materials Policy_2BHO to guide the content in the Grievance Resolution Letter_CHP. The Grievance Resolution Letter_CHP is written at an appropriate reading level and in a format to be easily understood by Members. According to our Grievance Job Aid_CHP, the resolution letter needs to be sent to the supervisor for approval prior to sending out the letter to the Member. This gets a "second set of eyes" on the resolution letter.	

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	CHP has an internal audit conducted by their Executive Assistant. This Assistant reviews a sample of grievances to ensure that CHP is meeting our 303L Grievance Process Policy_2BHO and the required time frames within that policy. Please see EvidenceofGrievanceAudit_CHP which demonstrates 100% compliance in this category. The policy does state that we will send a resolution letter within 15 working days of the receipt of the grievance. Beacon also had an independent URAC audit completed in 2017 which reflected 100% compliance in resolution letters being sent out within 15 working days. See URAC Audit Summary_CHP on page 2.	
10. The written notice of grievance resolution includes: • Results of the disposition/resolution process and the date it was completed. Contract Amendment 7: Exhibit A3—2.6.4.5.5.2 10 CCR 2505-10—8.209.5.G	**Documents Submitted/Location Within Documents:** 1. 303LGrievanceProcessPolicy_2BHO - pages 6-7, IV 12 A-I 2. GrievanceResolutionLetter_CHP-entire document *Misc. 3. GrievanceJobAidforAdvocates_CHP, Page 2 4. GrievanceJobAid_CHP, Page 2 5. ExampleofGrievanceResolutionLetter_CHP-entire document **Description of Process:** Colorado Health Partnership's Grievance Resolution Letter_CHP includes the results of the disposition, the solution process, and the date it was completed. We follow our 303L Grievance Process Policy_2BHO which has specific information that needs to be included in the resolution letter including the process of the resolution and the date it was completed. CHP has job aids for both CHP's Grievance Coordinator and the community mental health centers Advocates. See Grievance Job Aid_CHP and Grievance Job Aid for Advocates_CHP.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	CHP uses the State department approved Grievance Resolution Letter_CHP. The letter contains the date the investigation and resolution was completed and the disposition of the grievance. The facts of the resolution are described in the body of the letter in enough detail that the member understands the resolution and is written in lay person language at a low grade reading level. Please see one of CHP's resolution letter Example of Grievance Resolution Letter_CHP from one of the community mental health centers.	
11. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, **auxiliary aids and services upon request**, as well as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. *42 CFR 438.406(a)(1)* Contract Amendment 7: Exhibit A3—2.6.4.3 10 CCR 2505-10—8.209.4.C	**Documents Submitted/Location Within Documents:** 1. 305LAppealProcessPolicy_2BHO, Page 1 IC Page 2, IH, Page 4 IV 3a 2. 303LGrievanceProcessPolicy_2BHO, page 1 IE 3. 311LHandlingCallswithLimitedEnglishSpeakingMembersPolicy_2BHO, page 1 IA, *Misc. 4. NoticeofAdverseBenefitDeterminationLetter_CHP, page 3 *Misc. 5. GrievanceandAppealGuide_CHP, page 1 *Misc. 6. GrievanceAcknowledementLetter_CHP-entire document 7. AppealAcknowledgementLetter_CHP-entire document *Misc. 8. EvidenceofHelpingMemberswithGrievanceandAppeals_CHP-entire document **Description of Process:** Colorado Health Partnerships will assist Members in completing any forms and with the procedures related to a grievance and/or appeal. Information about assistance for members filing appeals is delivered in the Notice of Adverse Benefit Determination Letter_CHP, and the Grievance and Appeal Guide_CHP (located on our website at www.coloradohealthpartnerships.com). CHP also	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	informs Members that we can assist with their grievance and appeal on our website. In the Evidence of Helping Members with Grievance and Appeal_CHP, we took a screen shot where we explain that we will make arrangements to ensure that people will have accommodations to assist them if they have any disability... The Office of Member and Family Affairs has the primary responsibility to assist Members with the process of filing an appeal and/or grievance. The Grievance and Appeal Coordinator will obtain the necessary language assistance (if necessary) to guide Members through the appeal and/or grievance process. CHP informs member that they can obtain interpreter services and auxiliary aids and services upon request. CHP provides toll free numbers and TTY/TTD and interpreter capability in our Appeal Acknowledgement Letter_CHP and Grievance Acknowledgement Letter_CHP. In our 311L Handling Calls With Limited English Speaking Members Policy_2BHO, we indicate that we will serve all callers regardless of language barriers. This includes persons with Limited English Proficiency and callers who are deaf or hard-of-hearing. CHP follows 305L Appeal Process Policy_2BHO and 303L Grievance Process Policy_2BHO which state that CHP will help Members with appeals and grievances.	
12. The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who: • Were not involved in any previous level of review or decision-making, nor a subordinate of any such individual. • Have the appropriate clinical expertise, as determined by the State, in treating the	**Documents Submitted/Location Within Documents:** 1. 305LAppealProcessPolicy_2BHO, page 2 I F, page 3, II D1-4 page 5 IV C 2. 303LGrievanceProcessPolicy_2BHO, Page 6 IV 10, 3. ExpeditedAppealWorkflow_2BHO-entire document 4. HealthFirstColoradoMemberHandbook_2BHO, page 68 *Misc. 5. NoticeofAdverseBenefitDeterminationLetter_CHP, page 4 *Misc.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
member's condition or disease if deciding any of the following: – An appeal of a denial that is based on lack of medical necessity. – A grievance regarding the denial of expedited resolution of an appeal. – A grievance or appeal that involves clinical issues. • **Take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.** *42 CFR 438.406(b)(2)* Contract Amendment 7: Exhibit A3—2.6.4.5.4, 2.6.4.6.10, 2.6.4.6.6.1, 2.6.4.7.1.1, 2.6.4.7.1.2 10 CCR 2505-10—8.209.5.C, 8.209.4.E	6. AppealDecisionLetter_CHP, page 1 7. GrievanceandAppealGuide_CHP, page 2 *Misc. 8. ExpeditedAppealRequestDenialLetter_CHP, page 1 9. ExampleofCollectingAppealData_CHP-entire document 10. ExampleofAdditionalInfoforAppeal_CHP-entire document 11. Appeal Acknowledgement Letter_CHP-entire document 12. ExampleofTeamMeeting_CHP-entire document **Description of Process:** Colorado Health Partnerships ensures that the individuals who make decisions on grievances and appeals are people who were not involved in any previous level of review or decision-making, nor a subordinate of any such individual. CHP follows our 305L Appeal Process Policy_BHO which defines a Peer Advisor as a health professional employed or contracted with the BHO. The Peer Advisor has a current and active, unrestricted license to practice medicine or a health profession. The Peer Advisor is board certified and in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment and is not the individual who made the original non-certification nor the subordinate of one who made decision. Peer advisors are the individuals who review denial decisions. The way that we enforce this procedure is in our Appeal Decision Letter_CHP. There is a standard paragraph with an attestation that the Peer Advisor was not involved in CHP's origination determination and states the scope of the Peer Advisor's licensure.	

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	To demonstrate that CHP takes into account all comments, documents, records and other information submitted by the Member or their representative without regard if this information was submitted or considered in the initial adverse benefit determination, see Example of Collecting Appeal Data_CHP. CHP's Appeal Coordinator compiles all information received from Member/DCR into a secure shared drive. This information is sent to the Peer Advisor. See Example of Additional Info for Appeal_CHP. Also, in our Appeal Acknowledgement Letter_CHP, we have standard wording to show what information was used in making the appeal decision. CHP follows our 303L Grievance Process Policy_2BHO which states that the staff person investigating the grievance shall ensure that the individual who make decisions on grievances are individuals who were not involved in any previous level of review or decision-making and who have the appropriate clinical expertise in treating the client's condition if deciding a grievance that involves clinical issues. The OMFA director regularly reviews grievances in team meetings and in individual coaching sessions with the Grievance Coordinator. See Example of Team Meeting_CHP for an example of reviewing grievances. Our Expedited Appeal Workflow_2BHO demonstrates our process when we receive a request for an expedited appeal. CHP's Appeal Coordinator will review the request with the medical director to see if the request meets criteria for an expedited request. If the medical director does not believe that it meets requirements, the member will receive an Expedited Appeal Request Denial Letter_CHP. In	

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	this letter, the Member is informed of the qualifications for the person who reviewed the request for the expedited appeal and the Member's right to file a grievance about the denied request. Members are made aware that those who make decisions on grievances and appeals are people who were not involved in any previous level of review or decision-making for the Member. This can be found in Health First Colorado Member Handbook_2BHO, Grievance and Appeal Guide_CHP found on our website, (www.coloradohealthpartnerships.com), and Notice of Adverse Benefit Determination Letter_CHP.	
13. A member may file an appeal with the Contractor **within 60 calendar days** from the date on the adverse benefit determination notice. *42 CFR 438.402(c)(2)(ii)* Contract Amendment 7: Exhibit A3—2.6.4.6.3.1 10 CCR 2505-10—8.209.4.B	**Documents Submitted/Location Within Documents:** 1. 305LAppealProcessPolicy_2BHO, page 1 IA, page 4, IV 2 2. HealthFirstColoradoMemberHandbook_2BHO, page 63 *Misc. 3. GrievanceandAppealGuide_CHP, page 3 *Misc. 4. NoticeofAdverseBenefitDeterminationLetter_CHP, page 4 *Misc. **Description of Process:** Colorado Health Partnerships allows Members/Legal Guardians/DCRS to file an appeal with us within 60 calendar days from the date on the Adverse Benefit Determination Letter_CHP. Members are made aware of this in the Notice of Adverse Benefit Determination Letter_CHP, through our Grievance and Appeal Guide_CHP which is found on our website at www.coloradohealthpartnerships.com, or through Health First Colorado's Members Handbook_2BHO on page 63.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	CHP follows state regulations for appeal filing deadlines. The "appeal clock" starts on the date the Notice of Adverse Benefit Determination_CHP is mailed. Our appeal policy, 305L Appeal Process Policy_2BHO directs the process for handling appeals within the 60 calendar days.	
14. The member may file an appeal either orally or in writing and must follow the oral request with a written, signed appeal (unless the request is for expedited resolution). *42 CFR 438.402(c)(3)(ii)* *42 CFR 438.406(b)(3)* Contract Amendment 7: Exhibit A3—2.6.4.6.3.2 10 CCR 2505-10—8.209.4.F	**Documents Submitted/Location Within Documents:** 1. 305LAppealProcessPolicy_2BHO, Page 1, IA, Page 4 IV 2 2. GrievanceandAppealGuide_CHP, page 3 *Misc. 3. NoticeofAdverseBenefitDeterminationLetter_CHP, page 4 *Misc. 4. AppealRequestLetter_CHP-entire document 5. AppealChecklist_2BHO-entire document 6. ExpeditedAppealWorkflow_2BHO-entire document 7. AppealJobAid_2BHO, page 15 **Description of Process:** Colorado Health Partnerships allows Members to file an appeal either orally or in writing. CHP informs Members that any oral standard appeal request needs to be followed up with in writing. Members are notified of their ability to request an appeal orally or in writing in the Grievance and Appeal Guide_CHP which is located on our website, www.coloradohealthpartnerships.com. This information is also communicated in the Notice of Adverse Benefit Determination letter_CHP.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	CHP follows state regulations for accepting appeals from Members/Guardians/DCRs. In our appeal policy, 305L Appeal Process Policy_2BHO, we indicate that Members can request an appeal either verbally or in writing. It is our procedure to request that any appeal requested verbally be followed up in writing for a standard appeal. CHP has created an internal document, Appeal Checklist_2BHO to ensure that we have the necessary documentation to process an appeal. When a Member requests an appeal verbally, we make attempts to obtain their signed request by sending the Appeal Request Letter_CHP with the Appeal Acknowledgment Letter. If the member/ guardian / DCR request an expedited appeal, there is no requirement for the member to follow up in writing. OMFA staff follow our Expedited Appeal Workflow_2BHO where it is stated that no written letter is required for expedited appeal requests. Also, in our Appeal Job Aid_2BHO, on page 15, it is indicated that the appeal clock starts as soon as we have an expedited request and no written letter is required.	
15. The Contractor sends the member written acknowledgement of each appeal within two (2) working days of receipt, unless the member or designated client representative requests an expedited resolution. *42 CFR 438.406(b)(1)* Contract Amendment 7: Exhibit A3—2.6.4.1 10 CCR 2505-10—8.209.4.D	**Documents Submitted/Location Within Documents:** 1. 305LAppealProcessPolicy_2BHO, page 5, IV A 4 2. HealthFirstColoradoMemberHandbook_2BHO, page 65 *Misc. 3. GrievanceandAppealGuide_CHP, Page 4 *Misc. 4. AppealAcknowledgementLetter_CHP-entire document*Misc. 5. ExpeditedAppealAcknowledgmentLetter_CHP-Entire document 6. URACAuditSummary_CHP, page 2	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Description of Process: Colorado Health Partnerships sends the Member a written acknowledgement of an appeal within two (2) working days of receipt, unless the member or designated client representative requests an expedited resolution. CHP follows state and federal regulations for acknowledging appeals and keeping within deadlines for appeals. We follow 305L Appeal Process Policy_2BHO which states that we will send an acknowledgement letter within two (2) working days from the date that we received the requested appeal. The date the appeal is received sets the clock for the appeal. This could be the date the phone call is received, the date the fax is received, the letter is opened, or in a few cases, the date the e-mail is opened. For expedited appeals, the time is also noted. Since appeals can be filed orally, but must be followed with a written request for standard appeals, the date of first contact is the date that starts the "appeal clock." If an oral appeal is filed, the date is when the member/guardian/DCR orally filed. This date is logged in the appeals file for tracking purposes. Typically, the first point of contact for an appeal is to the service center, but sometimes, the first contact is with the CMHC Advocate. If the member or DCR contacts the CMHC Advocate, the "appeal clock" starts when the Advocate is notified. CHP sends an approved Appeal Acknowledgement Letter_CHP to Members. This template is used to provide written acknowledgement of the receipt of an appeal. We try to send the appeal acknowledgment letter by close of business on the day we receive the appeal. If a Member is requesting an expedited appeal, we will send Expedited Appeal Acknowledgment Letter_CHP.	

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Members are informed about the two (2) day turnaround to receive an acknowledgment letter in Health First Colorado Member Handbook_2BHO on page 65 and in the Grievance and Appeal Guide_CHP on page 4. Both of these documents are located on our website at www.coloradohealthpartnerships.com. CHP had an internal URAC audit conducted by Beacon Health Options. We had 100% compliance with Appeal Acknowledgement time frames. See URAC Audit Summary_CHP.	
16. The Contractor's appeal process must provide: • That oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date), and must be confirmed in writing unless the member or provider requests expedited resolution. • That if the member orally requests an expedited appeal, the Contractor shall not require a written, signed appeal following the oral request. • The member a reasonable opportunity, in person and in writing, to present evidence **and testimony** and make legal and factual arguments. **(The Contractor must inform the member of the limited time available for this sufficiently in advance of the**	**Documents Submitted/Location Within Documents:** 1. 305LAppealProcessPolicy_2BHO i. Page 1, I, A and E ii. Page 2, I, F, G iii. Page 4, IV A2 iv. Pages 5 IV A 3c, d 2. HealthFirstColoradoMemberHandbook_2BHO, page 64, 65 *Misc. 3. GrievanceandAppealGuide_CHP, page 3 *Misc. 4. NoticeofAdverseBenefitDeterminationLetter_CHP, page 3 *Misc. 5. VerbalRequestforInfoandAppealRights_CHP-entire document 6. ExpeditedWorkFlow_2BHO-entire document 7. AppealJobAid_2BHO, page 15 8. RecordsRequest_2BHO-entire document **Description of Process:** Colorado Health Partnerships Appeal process provides for Members/Guardians/DCRs to request an appeal verbally once they	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
resolution time frame in the case of expedited resolution.) • The member and his or her representative the member's case file, including medical records, other documents and records, and **any new or additional documents considered, relied upon, or generated by the Contractor in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame.** • That included, as parties to the appeal, are: – The member and his or her representative. – The legal representative of a deceased member's estate. *42 CFR 438.406(b)(3-5)* Contract Amendment 7: Exhibit A3—2.6.4.6.4, 2.6.4.6.5, 2.6.4.6.7, 2.6.4.6.8, 2.6.4.6.9 10 CCR 2505-10—8.209.4.F, 8.209.4.G, 8.209.4.H, 8.209.4.I	have been notified of an Adverse Benefit Determination. CHP follows state and federal regulations to ensure that Members/ Guardians/DCR's can exercise all of their rights in the appeal process and that members have all access to appropriate files, can present evidence to substantiate their appeal, and that oral inquiries will be treated as an appeal to establish the earliest filing date. CHP's designated Appeal Coordinator explain all of the rights to the Member when they call to request an appeal. The Appeal Coordinator communicates to the Member/Guardian/DCR of the limited time frames in making an appeal decision. The Appeal Coordinator follows the Appeal Job Aid_2BHO. On page 15, we discuss our protocol to notify the Member/DCR of the time frames that they have if they want to include additional information for their appeal. This protocol is both for standard and expedited requests. The Office of Member and Family Affairs (OMFA) staff are guided by 305L Appeal Process Policy_2BHO. On page 1, I A and page 4 IV A2, the policy states that a Member/Guardian/DCR can verbally request an appeal. Once the verbal appeal request is made, the Appeal Coordinator starts the 'appeal clock." On page 1, IE states that Members/Guardians/DCRs have the right to be informed that they can request an expedited appeal in situations where the life, safety, or fullest recovery of the Member would be put at risk. On page 2, I F and page 5 3Ac, the policy states that Members/Guardians/DRS have to the right to submit any information in a timely manner that they would like considered in an appeal. On page 2 IG and page 5, 3Ad we state that Members/Guardians/DCRS have the right to request copies of the information used in making an appeal.	

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	CHP sends a Grievance and Appeal Guide_CHP to members with the Notice of Adverse Benefit Determination Letter_CHP and makes the guide available on our website at www.coloradohealthpartnerships.com. In the Grievance and Appeal Guide_CHP, on page 3, we inform Members that they can request an appeal verbally, however, this oral request needs to be followed up in writing if it is for a standard appeal. We inform members that they can provide any information they think would be helpful in making a decision about their appeal. When records are requested, we send a Records Request_2BHO to the facility to obtain the records at no charge to the Member. We also inform members that they can request to see any review any records that were used in making a decision, free of charge. In the Notice of Adverse Benefit Determination Letter_CHP, on page 3, Members are informed that they can ask CHP for a complete copy of their file, including medical records to use for their appeal and that they can receive this free of charge. In our Verbal Request for Info and Appeal Rights_CHP, we inform the Member or DCR that they can request an appeal orally or in writing. In our Expedited Work Flow_2BHO, we have a process in place to help members with their expedited appeals. We do not require a signed letter when the request is for an expedited appeal. Members can learn about their appeals rights through Health First Colorado Member Handbook_2BHO. On Page 64 the handbook	

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	explains that Members can ask their health plan for a complete copy of their medical records and that they can receive this free of charge. On page 65, Members are made aware of the ability to request an expedited appeal.	
Findings: The requirement that CHP's appeal process will inform members of the limited time available for them to provide evidence and testimony sufficiently in advance of the resolution time frame, in the case of expedited resolution, was not adequately addressed in policies and procedures and other documents. Although the Appeal Process policy included this provision, it was located in the section of the policy that addressed standard appeals, not in the section that addressed requests for expedited appeal resolution. In addition, the Expedited Appeal Process Flow Chart and Job Aid did not provide direction to staff to inform the member or representative requesting expedited resolution of an appeal about the limited time available to provide information or evidence, or for preparing testimony, legal, or factual arguments.		
Required Actions: CHP's expedited appeal process must ensure that members or representatives requesting expedited resolution of an appeal are informed of the limited time available to present evidence or testimony and to make legal and factual arguments sufficiently in advance of the resolution time frame.		
17. The Contractor must resolve each appeal and provide written notice of the disposition as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. *Note: If the written appeal is not signed by the member or designated client representative (DCR), the appeal resolution will remain pending until the appeal is signed. All attempts to gain a signature shall be included in the record of the appeal.*	**Documents Submitted/Location Within Documents:** 1. 305LAppealProcessPolicy_2BHO, page 1, ID, E, Page 7, VIC7, D1a,c 2. Time framesforAppealsandGrievances_2BHO-entire document 3. HealthFirstColoradoMemberHandbook_2BHO, page 65, 66 *Misc. 4. GrievanceandAppealGuide_2BHO, page 4 *Misc. 5. ProviderManual_2BHO, page 51*Misc. 6. AppealAcknowledgementLetter_CHP-entire document *Misc. 7. ExpeditedAppealAcknowledgementLetter_CHP-entire document 8. ExpeditedAppealWorkFlow_2BHO-entire document 9. StandardAppealWorkFlow__2BHO-entire document 10. AppealRequestLetter_CHP-entire document 11. AppealDecisionLetter_CHP-entire document	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
• For expedited resolution of an appeal and notice to affected parties, **within 72 hours** after the Contractor receives the appeal. • For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)&(3)&(d)(2)* *42 CFR 438.10* Contract Amendment 7: Exhibit A3—2.6.4.7.1, 2.6.4.7.3.2, 2.6.4.7.3.5, 2.6.5.13.1 10 CCR 2505-10—8.209.4.J, 8.209.4.L	12. ExpeditedAppealDecisionLetter_CHP-entire document 13. AppealJobAid_2BHO, page 19 14. URACAuditSummary_CHP, page 2 **Description of Process:** Colorado Health Partnerships resolves each appeal and provides written notice of the disposition as expeditiously as the Member's health condition requires. We follow state and federal regulations for resolving and making decisions about the appeal and informing the member/guardian/DCR. OMFA staff follows the 305 L Appeal Process Policy_2BHO to ensure that we are meeting regulations. On page 1 ID and E and page 7 we outline the policy that Members have a right to resolution of a standard appeal within ten (10) working days and for an Expedited Appeal within seventy-two (72) hours. On page 7, we state that verbal notification for inpatient services and expedited appeals will be given the same day as the decision. We also use Time frames for Appeals and Greivances_2BHO as a guide of timeliness standards. In our Appeal Job Aid_2BHO on page 19, we outline the process for the readability testing to ensure that the letter can be easily understood by the Member. All letters are reviewed by a supervisor to ensure that they are in a language and format that the Member could easily understand. CHP also follows the Expedited Appeal Work Flow_2BHO and Standard Appeal Work Flow_2BHO to follow timelines. Members can learn about the time frames that they can expect to receive a decision about their appeal. This information can be found on our website, www.coloradohealthpartnerships.com in Health First Colorado Member Handbook_2BHO and Grievance	

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	and Appeal Guide_CHP. Providers can learn about these time frames in the Provider Manual_2BHO on page 51. When a Member requests either a standard or expedited appeal, we send them an acknowledgement letter letting them know the time frame for making a decision. See Appeal Acknowledgement Letter_CHP and Expedited Appeal Acknowledgement Letter_CHP. Members will be sent an Appeal Decision Letter_CHP within 10 working days of filing the appeal. Members will receive an Expedited Appeal Decision Letter_CHP within 72 hours of an approved expedited appeal request. CHP developed the Appeal Request Letter_CHP to send to Members when they verbally request a standard appeal. This Appeal Request Letter_CHP is sent to the Member with the Appeal Acknowledgement Letter_CHP. We explain to the Member that they need to follow up their request for a standard appeal in writing and we provide a self-addressed stamped envelope for Members to use to return the form. CHP had an internal URAC audit in 2017. See URAC Audit Summary_CHP. We were 100% compliant of 17/17 appeal cases audited to meet timeliness standards for decisions and written notification.	
Findings: The Appeal Process policy included time frames for resolving appeals and providing written notice to members. The time frame for expedited resolution and notice was inaccurately depicted in the policy. The policy stated that the time frame for verbal notification for expedited resolution is 72 hours, with written notification to follow within two days. This policy language depicts a misunderstanding of the regulations. There is no two-day written time frame requirement related to expedited resolution of appeals. The two-day written notification requirement is related to extensions of resolution time frames, or denial of the expedited process. For expedited resolutions, written notification is due within 72 hours (see		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
42 CFR 438.408(b)(3) and 438.408(d)(2)(i) and (ii)). In addition, the BHO is required to make reasonable effort to provide oral notice of the expedited resolution. On-site record review demonstrated, however, that CHP did send written notification of expedited resolution within the required 72-hour time frame. On-site review of appeals records also revealed that resolution notices to members contained clinical and/or technical language causing the notices to score above a sixth-grade reading level, which made it difficult for members to understand them.		
Required Actions: CHP must revise the Appeal Process policy to reflect accurate time frames and processes for expedited resolution of appeals. In addition, CHP must review other documents, job aids, and member and provider communications to ensure accuracy and consistency across documents. CHP must also develop a mechanism to ensure appeal resolution notices meet the format and language requirements of 42 CFR 438.10 to the extent possible.		
18. The contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days: • If the member requests the extension; or • If the Contractor shows (to the satisfaction of the Department, upon request) that there is need for additional information and how the delay is in the member's interest. • If the Contractor extends the time frames, it must—for any extension not requested by the member: – Make reasonable efforts to give the member prompt oral noice of the delay. – **Within two (2) calendar days**, give the member written notice of the reason for the delay and inform the member of the	**Documents Submitted/Location Within Documents:** 1. 305LAppealProcessPolicy_2BHO page 1, I C,E, page 2 IE1, Page 6, IV5 a-b 2. 303L_GrievanceProcessPolicy_2BHO , page 7 IV 13 3. HealthFirstColoradoMemberHandbook_2BHO, page 65 *Misc. 4. GrievanceandAppealGuide_CHP, page 2, 4, 5 *Misc. 5. NoticeofAdverseBenefitDeterminationLetter_CHP, page 5, 6 *Misc. 6. GrievanceDelayLetter_CHP-entire document 7. AppealDelayLetter_CHP-entire document 8. ExampleofStandardDelayLetter_CHP-entire document **Description of Process:** Colorado Health Partnerships can extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days when a Member requests the extension or when CHP believes that there is a need for additional information	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by the BHO**	**Score**
right to file a grievance if he or she disagrees with that decision. – Resolve the appeal as expeditiously as the member's health condition requires and no later than the date that the extension expires. • **If the Contractor fails to adhere to the notice and timing requirements for extension of the appeal resoultion time frame, the member may initiate a State fair hearing**. *42 CFR 438.408(c)* Contract Amendment 7: Exhibit A3—2.6.4.7.2, 2.6.4.7.2.1, 2.6.4.7.8, 2.6.4.7.3.3, 2.6.4.5.8.1.2, 2.6.4.9.3, 2.6.4.6.2.5.2.3 10 CCR 2505-10—8.209.4.J, 8.209.4.O	and that the delay in making a decision would be in the Member's best interest. CHP follows all state and federal guidelines for extending time frames for resolution of grievances and appeals (both expedited and standard) by 14 calendar days. CHP's 303L Grievance Process Policy_2BHO shows on page 7 that we can extend the time frame for the resolution of a grievance by up to 14 calendar days if the Member requests the extension or if there is a need for additional information and that the delay is in the Member's best interest. CHP notifies the Member within 2 business days when there has been a request for an extension and attempt to contact the Member on the phone. We send out a letter to the member to notify them. See Grievance Delay Letter_CHP. In the body of the letter, we document why it is in the Member's best interest to delay the grievance. CHP's 305L Appeal Process Policy_2BHO_ provides the protocols we follow when either a Member requests an extension, or when we believe it would be in the Member's best interest to have additional time to make a decision. We send the Member written notification when the time frame is extended. The policy states on page 6 that we will include the reason for the extension, the date by which CHP will make a final determination, and the notification of Member's rights to file a grievance if the Member disagrees with the extension. We send this letter to Member within 2 business days. See Appeal Delay Letter_CHP. In the body of the letter, we document why it is in the Member's best interest to delay the appeal. Please see Example of Standard Delay Letter_CHP for	

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Requirement	**Evidence as Submitted by the BHO**	**Score**
	content that is embedded in the letter with the reason for filing extension as well as the right to file a grievance if there is a disagreement about the extension. Members are made aware of the ability to delay either a grievance or appeal by up to fourteen (14) calendar days by accessing the Grievance and Appeal Guide_CHP on our website, www.coloradohealthpartnerships.com. In our Grievance and Appeal Guide_CHP, on page 2, 4 and 5, we outline for Members this right to delay an appeal or grievance. Members are also alerted about this ability to delay a grievance or appeal decision in the Notice Of Adverse Benefit Determination Letter_CHP on page 5, 6. In Health First Colorado Member Handbook_2BHO, Members are alerted to the fact that they may request a State Fair Hearing if the BHO does not follow the timelines for appeals.	
19. The written notice of appeal resolution must include: • The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. – The right to request that benefits/services continue* while the hearing is pending, and how to make the request. o That the member may be held liable for the cost of these benefits if the hearing decision upholds the	**Documents Submitted/Location Within Documents:** 1. 305LAppealProcessPolicy_2BHO. Page 7, IV E1, 3b, 4a-b 2. GrievanceandAppealGuide_CHP, page 5, 19 *Misc. 3. HealthFirstColoradoMemberHandbook_2BHO, page 66, 67 *Misc. 4. AppealDecisionLetter_CHP-entire document 5. ExampleofAppealDecisionLetter_CHP-entire document 6. NoticeofAdverseBenefitDeterminationLetter_CHP, page 8 *Misc. **Description of Process:** Colorado Health Partnerships documents in the appeal decision letter the results of the resolution process and the date it was completed. CHP's OMFA staff follows 305L Appeal Process Policy_2BHO. On page 7, our policy states that the written notice	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by the BHO**	**Score**
Contractor's adverse benefit determination. **Continuation of benefits applies only to previously authorized services for which the Contractor provides 10-day advance notice to terminate, suspend, or reduce.* *42 CFR 438.408(e)* Contract Amendment 7: Exhibit A3—2.6.4.7.4, 2.6.4.7.5 10 CCR 2505-10—8.209.4.M	includes the results of the determination/resolution process and the date it was completed. The letter will specify the information that was reviewed in making the decision. This section also includes our policy that Members/Guardians/DCRs can request a State Fair Hearing in the determination was not wholly in favor of the Member. See Appeal Decision Letter_CHP and Example of Appeal Decision Letter_CHP. Members can find out about their right to request a State Fair Hearing if the appeal decision was not wholly in their favor. On page 5 of the Grievance and Appeals Guide_CHP, Members are instructed on how they can request a State Fair Hearing. Members are made aware on page 19 that they may be liable to pay for services if the appeal was not in their favor. In Health First Colorado Member Handbook_2BHO, Members are made aware on page 66 that they can request a State Fair Hearing. In Health First Colorado Member Handbook on page 67 and in the Notice of Adverse Benefit Determination Letter on page 8, Members are made aware that they can request to keep their services during an appeal. Members are also made aware that if they lose their appeal, they may be liable to pay back the cost of any services that they received during their appeal.	
Findings: CHP's appeal resolution letter did not include the required language that informs the member of the right to request continuation of benefits/services (within 10 calendar days of resolution) during the State fair hearing. None of the appeals reviewed during the on-site record review were related to the termination, suspension, or reduction of previously authorized services; therefore, this content missing from resolution notices reviewed was not considered for scoring the appeals records. CHP did not, however, provide evidence that it used a specific template which included the required language for applicable situations.		

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Requirement	**Evidence as Submitted by the BHO**	**Score**
Required Actions: CHP must develop a mechanism to ensure that members are informed, via the resolution notice, of their right to request continuation of services during the State fair hearing, if applicable. CHP could add language to its existing template (making it clear whether this applies to the current appeal). Alternatively, CHP could consider developing a specific template to be used when the appeal involves a 10-day advance notice to terminate, suspend, or reduce previously authorized services.		
20. **The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of resolution.** • If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. • The parties to the State fair hearing include the Contractor as well as the member and his or her representative or the representative of a deceased member's estate. • The Contractor shall participate in all State fair hearings regarding appeals. *42 CFR 438.408(f)(1) and (2) and (3)* Contract Amendment 7: Exhibit A3—2.6.4.9.1, 2.6.4.9.3, 2.6.4.9.2, 2.6.4.9.5 10 CCR 2505-10—8.209.4.N, 8.209.4.O, 8.209.4.H	**Documents Submitted/Location Within Documents:** 1. 305LAppealProcessPolicy_2BHO, page 1, I B, page 4, IV A 3b, page 7, 4b 2. GrievanceandAppealGuide_CHP, page 5 *Misc. 3. AppealDecisionLetter_CHP, page 2 4. NoticeofAdverseBenefitDeterminationLetter_CHP, page 6 *Misc. 5. ALJJobAid_2BHO, page 2, 3 **Description of Process:** Colorado Health Partnerships inform Members that they can request a State Fair Hearing after receiving notice that CHP is upholding the adverse benefit determination. We inform Members that they may request this within 120 calendar days from the date of the notice of resolution. In our 305LAppealProcessPolicy_2BHO, page 1, we have a procedure that Members can request a State Fair Hearing if we do not adhere to the notice and timing requirements. At this time, the Member is deemed to have exhausted the appeal process. In our Grievance and Appeal Guide_CHP, we inform members that they can request a State Fair Hearing within 120 days from the adverse appeal decision. We inform members that they may	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	represent themselves at the hearing, bring an Advocate, or have someone else represent them. In the Notice of Adverse Benefit Determination Letter_CHP on page 6 and I the Appeal Decision Letter page 2, Members are informed that they can request a State Fair Hearing within 120 days from the adverse appeal decision. In the Grievance and Appeals Guide on page 8, Members are informed that they have either have an Advocate, a representative, or they can represent themselves at the State Fair Hearing. CHP has an ALJJobAid_2BHO which we use to guide the process and ensure that we are represented in the State Fair Hearing. This process includes setting the hearing date and blocking out this time in the Medical Director's calendar to ensure that CHP participates.	
Findings: While CHP's Appeal Process policy accurately included the provision that members may request a State fair hearing 120 days from the date of the appeal resolution notice adverse to the member, the appeal resolution notice template stated 120 days from the adverse benefit determination. Several records reviewed on-site used the flawed template; however, in some records HSAG found that CHP's staff had discovered and corrected the error before sending the notice to the member. Because template issues are global, HSAG did not consider continued benefit language when scoring the content of letters in individual appeal record reviews.		
Required Actions: CHP must ensure that policies, procedures, and other applicable documents accurately depict the member's right to request a State fair hearing within 120 days following the adverse appeal resolution notice.		

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Requirement	**Evidence as Submitted by the BHO**	**Score**
21. The Contractor maintains an expedited review process for appeals for when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life; physical or mental health; or ability to attain, maintain, or regain maximum function. The Contractor's expedited review process includes that: • The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. • If the Contractor denies a request for expedited resolution of an appeal, it must: – Transfer the appeal to the time frame for standard resolution. – **Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and within two (2) calendar days provide the member written notice of the reason for the decision and inform the member of the right to file a grievance if he or she disagrees with that decision.** *42 CFR 438.410* Contract Amendment 7: Exhibit A3—2.6.4.7.3, 2.6.4.7.3.1, 2.10.17.2 10 CCR 2505-10—8.209.4.Q, 8.209.4.R, 8.29.4.S	**Documents Submitted/Location Within Documents:** 1. 305LAppealProcessPolicy_2BHO, page 1 IE, page 3 IIF, page 7 IV C6 2. HealthFirstColoradoMemberHandbook_2BHO, page 65, 66 *Misc. 3. GrievanceandAppealGuide_CHP, page 4 *Misc. 4. ExpeditedAppealRequestDenialLetter_CHP-entire document, 5. ExpeditedWorkflow_2BHO-entire document 6. NoticeofAdverseBenefitDeterminationLetter_2BHO, page 3, 5 *Misc. 7. ExampleofDeniedExpeditedRequest_CHP-entire document **Description of Process:** Colorado Health Partnerships maintains an expedited review process for appeals for when we determine or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life. In our 305L Appeal Process Policy_2BHO, we follow the procedure that Members/Guardians or their DCRs have the right to be informed that they may also request an Expedited Appeal in situations where the life, safety, or fullest recovery of the member would be put at risk by an appeal resolution that is within the standard time frames. On page 7, our policy states that no punitive action may be taken against a provider acting as a DCR who requests an expedited resolution or supports a Member's appeal. Our Expedited Workflow_2BHO reflects that the appeal will be transferred to the time frame of a standard resolution if an expedited request is denied	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Members are notified by letter when their request for an expedited appeal is denied. See Expedited Appeal Request Denial Letter_CHP. In this letter we explain that we will transfer the appeal to the time from for standard resolutions and that they can file a grievance if they are in disagreement with the denial to expedite their appeal. For an example of a sent letter in which we document the date the Member was contacted via phone, see Example of Expedited Appeal Request_CHP. In our Grievance and Appeal Guide_CHP, on page 4, we inform Members that they can request an expedited appeal if they believe that waiting for a decision will be harmful to their health. We explain that the Medical Director will decide if their request will be approved or denied and that we will attempt to call them on the phone to inform them of our decision. We also let member know if their request for an Expedited Review is denied, that we will send them a notice within two (2) calendar days. The notice will explain why the request was denied and that it will be transferred to standard time frames. In the Notice of Adverse Benefit Determination Letter_CHP, on page 3 it is explained that Members can request a quick appeal if they or their health care provider believe that waiting ten (10) business days for CHP to decide their appeal would put their health at risk. On page 5, we inform Members that if we do not agree with their request for a quick appeal, we will inform them within 10 business days of the appeal decision. We will also attempt to call the Member when the request is denied.	

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Requirement	**Evidence as Submitted by the BHO**	**Score**
	Members can also learn about their right to request an expedited appeal in the Health First Colorado Member Handbook_2BHO on page 66-67.	
Findings: The Appeals Process policy did not adequately address expedited resolution of appeals. The requirements associated with the denial of expedited resolution were not described in the policy or in staff directional materials (e.g., job aids or workflows).		
Required Actions: CHP must revise its policy and other applicable documents to reflect the complete expedited appeal process which includes the following steps that must be taken if the BHO denies a request for expedited resolution of an appeal: transferring the appeal to the standard time frame, making reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution, and within two calendar days providing the member written notice of the reason for the decision that informs the member of the right to file a grievance if he or she disagrees with that decision.		
22. The Contractor provides for continuation of benefits/services while the Contractor-level appeal and the State fair hearing are pending if: • The member files timely* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the Contractor mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider.	**Documents Submitted/Location Within Documents:** 1. 305LAppealProcessPolicy_2BHO, page 5, IV B1, 2, 3 2. HealthFirstColoradoMemberHandbook_2BHO, page 67 *Misc. 3. ProviderManual_2BHO, page 49 *Misc. 4. GrievanceandAppealGuide_CHP, page 3 *Misc. **Description of Process:** Colorado Health Partnerships provides for continuation of benefits/services during an appeal or state fair hearing which may be pending. CHP follows our 305L Appeal Process Policy_2BHO in the administration of this requirement. On Page 5, our policy states that Continuation of Services during the Appeal Process occur only under certain circumstances. The Member files timely (within 10 days of CHP mailing the adverse benefit determination or the intended effective date of the proposed adverse benefit determination (2 a-b). The appeal is regarding a termination,	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by the BHO**	**Score**
• The original period covered by the original authorization has not expired. • The member requests an appeal within 60 calendar days of the notice of adverse benefit determination. **This definition of "timely filing" only applies for this scenario–i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced. (Note: The provider may not request continuation of benefits on behalf of the member.)* *42 CFR 438.420(a) and (b)* Contract Amendment 7: Exhibit A3—2.6.4.8.1 10 CCR 2505-10—8.209.4.T	suspension, or reduction of a previously authorized course of treatment (B 1); the services were ordered by an authorized provider (B3b); the original period covered by the original authorization has not expired (B3c); and the Member requests an appeal within 60 days of the notice of adverse benefit determination. Members are made aware of their right to request continuation of services through an appeal process through Health First Colorado Member Handbook_2BHO on page 67. CHP has a Grievance and Appeal Guide_CHP that explains to Members that if their authorization has not ended, they can ask for those services to continue during an appeal. We inform Members that they need to request that benefits continue within ten (10) days from the mailing date of the Notice of Adverse Benefit Determination or the date that the decision is effective. We will go be the latest date. We also inform them that the service must have been ordered by an authorized provider, the time period for the authorized service must not be over yet, and they must ask CHP to continue the service. CHP also sends out a Notice of Adverse Benefit Determination Letter_CHP. On page 8, we inform members that Members can request to continue to receive benefits during an appeal process. Both Health First Colorado Member Handbook_2BHO and Grievance and Appeal Guide_CHP can be found on our website at www.coloradohealthpartnerships.com.	

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Requirement	**Evidence as Submitted by the BHO**	**Score**
	Information about Members' rights to request continuation of services during an appeal can also be found in the Provider Manual_2BHO on page 49.	

Findings:
CHP's Appeals Process policy and member and staff materials had not been revised to reflect the changes to requirements associated with continuation of services during an appeal or State fair hearing. The policy, the Notice of Adverse Benefit Determination, and the Grievance and Appeal Guide implied that CHP could terminate services without a 10-day advance notice, and stated that members requesting continuation of service must file the appeal within 10 days of the notice of adverse benefit determination or before the proposed date of the termination or change in services.

Required Actions:
CHP must revise all applicable documents to accurately reflect that:

- Members receive a 10-day advance notice if CHP proposes to terminate, suspend, or reduce services.
- Timely filing requirements apply to the request for continuation of services during the appeal.
- Members have 60 days to file the appeal even if continuation of the services in dispute was requested within the required time frame for requesting the continuation (within the 10-day advance notice period or before the effective date of the proposed termination or change in services).
- Although members have 120 days following the appeal resolution notice to request a State fair hearing, members may request continuation of services within 10 days following the appeal resolution notice.

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Requirement	**Evidence as Submitted by the BHO**	**Score**
23. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of the following occurs: • The member withdraws the appeal or request for a State fair hearing. • The member fails to request a State fair hearing and continuation of benefits within 10 calendar days after the Contractor sends the notice of an adverse resolution to the member's appeal. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR 438.420(c)* Contract Amendment 7: Exhibit A3—2.6.4.8.2 10 CCR 2505-10—8.209.4.U	**Documents Submitted/Location Within Documents:** 1. 305L Appeal Process Policy_2BHO, page 5-6, 4 a,b,c,d 2. GrievanceandAppealGuide_CHP, page 4 *Misc. 3. ProviderManual_2BHO, page 49 *Misc. **Description of Process:** Colorado Health Partnerships will continue to reinstate benefits during the appeal unless certain conditions occur. In our 305L Appeal Process Policy_2BHO, on page 5-6, it states the requested service will continue unless member withdraws the appeal, ten (10) calendar days pass after the BHO mails the notice providing the resolution of the appeal upholding the original BHO termination, suspension, or reduction of services, unless the member, within a ten (10) calendar day time frame makes a request for a State Fair Hearing with continuation of services until a State Fair Hearing decision is reached; State Fair Hearing Office issues a hearing decision adverse to the member; or the time period of the previous authorization of the services expires. The 305L Appeal Process Policy_2BHO guides our adherence to this requirement. CHP's Grievance and Appeal Guide_CHP, states on page 4 that services will continue during an appeal unless a member withdraws the appeal, an appeal decision is made that is not in a Member's favor, or the time period or service limits of the original authorization have expired. Providers are made aware that services will continue unless certain conditions exist in the Provider Manual_2BHO on page 49.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: CHP's Appeals Process policy and member and staff materials had not been revised to reflect the changes to requirements associated with continuation of services during an appeal or State fair hearing. The policy, the Notice of Adverse Benefit Determination, and the Grievance and		

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Requirement	**Evidence as Submitted by the BHO**	**Score**
Appeal Guide stated that the period of time benefits would continue may conclude at the end of the benefit limits or service authorization time frame. Changes in the federal regulation only allow for benefits to continue until 10 days pass (if the member has not requested a State fair hearing with continuation of the disputed services within those 10 days), or until the State fair hearing officer issues a decision (in cases where the member has requested the State fair hearing with continuation of services).		
Required Actions: CHP must revise all applicable documents to remove the provision that continued services may cease at the end of the benefit limits or service authorization time frame.		
24. Member responsibility for continued services: • If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's adverse benefit determination, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. *42 CFR 438.420(d)* Contract Amendment 7: Exhibit A3—2.6.4.8.3 10 CCR 2505-10—8.209.4.V	**Documents Submitted/Location Within Documents:** 1. ProviderManual_2BHO, page 50 *Misc. Colorado Health Partnerships' Provider Manual_2BHO, on page 50 states If the BHO's decision on a member's appeal is adverse to the member, and the member has not filed for a State Fair Hearing, the BHO may recover the cost of the services furnished to the member while the appeal is pending, if the reason why the services were furnished was solely because of the requirements of this section.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
25. Effectuation of reversed appeal resolutions: • If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services as promptly and as expeditiously as the member's health condition requires but no	**Documents Submitted/Location Within Documents:** 1. 305LAppealProcessPolicy_2BHO, page 8 2. ProviderManual_2BHO, page 50 *Misc. 3. ALJJobAid_2BHO, page 4 4. ALJSettlement_CHP-entire document 5. ALJDismissalduetoSettlement_CHP-entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by the BHO**	**Score**
later than **72 hours** from the date it receives notice reversing the determination. • If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending, the Contractor must pay for those services, unless State policy and regulations provide for the State to cover the cost of such services. *42 CFR 438.424* Contract Amendment 7: Exhibit A3—2.6.4.8.4, 2.6.4.8.5 10 CCR 2505-10—8.209.4.V, 8.209.W	**Description of Process:** Colorado Health Partnerships follows our 305L Appeal Process Policy_2BHO which states on page 8, Section G: Implementation of Final Resolution Results states if the designated Reviewer or Administrative Law Judge upholds the appeal, the Grievance and Appeals Coordinator will ensure that disputed service or resolution is authorized or implemented expeditiously. The Provider Manual_2BHO, page 50 states if the BHO's decision on a member's appeal upholds the member's appeal and the member has not filed for a State Fair Hearing, the BHO must pay for the services that were furnished while the appeal is pending, if the reason why the services were furnished was solely because of the requirements listed above. Similarly, if the State Fair Hearing decision upholds the member's appeal and services were furnished while the Hearing was pending, the BHO must pay for the services that were furnished solely because of the requirements listed above. If the services were not provided, the BHO must provide the services as quickly as possible. CHP follows the ALJ Job Aid_2BHO. On page 4, we state that when we receive notification, the OMFA department will notify the clinical team to update the authorization when an appeal has been overturned. The process is to send the information to the Clinical Director. The clinical team will overturn the authorization and send to claims so that they can pay the authorization. In some circumstances the decision is made to settle out of court. We have submitted two documents, ALJ Settlement_CHP and ALJ Dismissal Due to Settlement_CHP as evidence that services overturned by appeal process were paid.	

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
26. The Contractor maintains records of all grievances and appeals. **The records must be accurately maintained in a manner accessible to the State and available on request to CMS. The record of each grievance and appeal must contain, at a minimum, all of the following information:** • **A general description of the reason for the grievance or appeal.** • **The date received.** • **The date of each review or, if applicable, review meeting.** • **Resolution at each level of the appeal or grievance.** • **Date of resolution at each level, if applicable.** • **Name of the person for whom the appeal or grievance was filed.** *42 CFR 438.416* Contract Amendment 7: Exhibit A3—2.9.6.2 10 CCR 2505-10—8.209.3.C	**Documents Submitted/Location Within Documents:** 1. 305LAppealProcessPolicy_2BHO, page 8, H1-5, I 2. 303LGrievanceProcessPolicy_2BHO, page 8, C 2, 3 3. FY18Q1AppealStateReport_CHP-entire document 4. FY18Q1GrievanceStateReport_CHP-entire document 5. GrievanceDatabase_CHP-entire document 6. ScreenshotofGrievanceDatabase_CHP-entire document 7. GrievanceandAppealReport_CHP-entire document 8. AppealandALJs_CHP-entire document **Description of Process:** Colorado Health Partnerships maintains records of all grievances and appeals. These records are accurately maintained in a manner accessible to the State and available upon request to CMS. In our 305L Appeal Process Policy_2BHO, on page 8, we have a section entitled Monitoring and Reporting by the Grievance and Appeals Coordinator. Each appeal is logged upon receipt and assigned expeditiously to an appropriate reviewer with notification to the reviewer of the timeline for a resolution. CHP's 303LGrievanceProcessPolicy_2BHO, page 8, #2 states that we will review our grievance tracking reports quarterly. In the same policy, #3 states that our Grievance and Appeals Coordinator will complete a report specifying the numbers and types of grievances reported and resolved quarterly and submit to the Department of Health Care Policy and Financing by the last day of the month following each quarter. An annual report of grievances will be submitted to the Department of Health Care Policy and Financing the month following the end of the fiscal year as required by contract.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by the BHO**	**Score**
	All documentation is maintained by the Grievance and Appeals Coordinator. CHP maintains a Grievance database where all relevant information regarding grievances are recorded. This security enabled database is accessible to the BHO, OMFA staff, including local mental health center Advocates, via log in and password. Data recorded includes, but is not limited to, the date the grievance is received, who filed the grievance and contact information, nature of the grievance, resolution, and date of grievance resolution. Please see Screenshot of Grievance Database_CHP. The CHP OMFA staff enters all of the data for each grievance as it arrives. For the reporting capabilities of our database, please see Grievance Database_CHP. At the end of the quarter, OMFA staff compiles the database information and submits the required quarterly reports to the Department within the required time frames. Please see: FY18Q1Grievance State Report_CHP and FY18Q1 Appeal State Report_CHP. For documentation about the general description of the grievance or appeal, please see Grievance and Appeal Report_CHP. These quarterly reports also include information required to report on appeals. CHP's Knowledge Management and Reporting Department compiles a report for all of the Appeals and ALJ's which come in during the quarter. See Appeals and ALJs_CHP. In this report is the members name id #, the date the appeal/alj was received, the contact source, the contact category, the date the acknowledgement letter was sent, the date the resolution letter was sent, and if it was upheld or overturned.	

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
27. The Contractor provides the information about the grievance appeal and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member, including how members obtain a hearing, and the representation rules at a hearing. • The availability of assistance in the filing processes. • The toll-free number to file orally. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. – The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member.	**Documents Submitted/Location Within Documents:** 1. ProviderManual_2BHO, page 45, 46, 48, 49, 121 *Misc. 2. NoticeofAdverseBenefitDeterminationLetter_CHP, page 3, 4, 5, 6, 7, 8 *Misc. **Description of Process:** Colorado Health Partnerships makes the following information know to Providers through the Provider Manual_2BHO and in the Notice of Adverse Benefit Determination Letter_CHP. When services to a provider are denied, the provider also receives a receipt of the Notice of Adverse Benefit Determination Letter_2BHO. • The Members' right to file grievances and appeals: Provider Manual_2BHO pages 45, 48, and 121 for appeals and page 121 for grievances. Notice of Adverse Benefit Determination Letter_CHP, Page 3 for appeals and page 5 for Grievances. • The requirements and time frames for filing grievances and appeals: Provider Manual, page 48 for appeal time frame, page 49 for state fair hearing time frame. Notice of Adverse Benefit Determination Letter_CHP, Page 4 for Appeals, page 6 for State Fair Hearing • The right to a State Fair Hearing after the BHO has made a decision on an appeal which is adverse to the Member, including how members obtain a hearing and the representation rules at a hearing. Provider Manual_2BHO, page 48. Notice of Adverse Benefit Determination Letter_CHP, page 3, 6 • The availability of assistance in the filing process. Provider Manual_2BHO on pages 46, 49, 121. Notice of Adverse Benefit Determination Letter_CHP, page 3	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the BHO**	**Score**
• Appeals process available under the Child Mental Health Treatment Act (CMHTA), if residential services are denied. • Any State-determined provider's appeal rights to challenge the failure of the organization to cover a service. *42 CFR 438.414* *42 CFR 438.10(g)(xi)* Contract Amendment 7: Exhibit A3—2.6.4.4 10 CCR 2505-10—8.209.3.B	• The toll free number to file orally: Provider Manual_2BHO on page 48. Notice of Adverse Benefit Determination Letter_CHP, page 4 and 5 • Continuation of Services: Provider Manual_2BHO on page 49 and Notice of Adverse Benefit Determination Letter_CHP, page 7-8 • Member may be required to pay: Notice of Adverse Benefit Determination Letter_CHP, page 8 • Appeals process under the CMHTA act, see Notice of Adverse Benefit Determination Letter_CHP, page 7 • State-determined provider's appeal rights to challenge the failure to cover a service, page 45	
Findings: Although CHP's provider manual included information about the Medicaid member grievance system, inaccuracies and incomplete content contained in the policies and procedures, member communications, and staff materials were reflected in the provider manual.		
Required Actions: CHP must revise its provider manual and review other provider-facing materials for accuracy and completeness, to ensure that providers are accurately informed of requirements and time frames regarding the Grievance and Appeal System at the time of contracting.		

Results for Standard VI—Grievance System							
Total	Met	=	17	X	1.00	=	17
	Partially Met	=	10	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	27	**Total Score**		=	17
				Total Score ÷ Total Applicable		=	63%

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. The Contractor implements written policies and procedures for selection and retention of providers. *42 CFR 438.214(a)* Contract Amendment 7: Exhibit A3—2.9.7.1.1	**Documents Submitted/Location Within Documents:** 1. Network Development Plan_FY2018_CHP-Page 1, 5 and 6 2. L604_LCC_CHP-section F and G 3. Annual Needs Assessment_2BHO – entire spreadsheet **Description of Process:** Beacon Health Options has policies in place to select providers (L604_LCC_CHP) and develops annual plan (Network Development Plan_FY2018_CHP) that outlines the strategies for selection and retention of providers. The plan is based on the Annual Needs Assessment_2BHO which has reports of providers and facilities based on counties (See Tabs "Network IPN Report" & "Facilities") and their specialties including language availability (See Tab "Specialty Information").	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor follows a documented process for credentialing and recredentialing that complies with the State's policies for credentialing. • The Contractor uses National Committee for Quality Assurance (NCQA) credentialing and recredentialing standards and guidelines as the uniform and required standards for all contracts. • The Contractor ensures that all laboratory-testing sites providing services under the Contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate	**Documents Submitted/Location Within Documents:** 1. N_CR202.03_Overview_2BHO-entire document 2. N_CR203.03_PracCredentialing_2BHO-entire document 3. N_CR217.02_FacCredentialing_2BHO-entire document 4. N_CR209.03_PracReCredentialing_2BHO-entire document 5. N_CR219.03_FacRecredentialing_2BHO-entire document 6. N_CR218.03_CredCriteria_Facility_2BHO – Page 3 **Description of Process:** Beacon Health Options reviews providers upon initial credentialing (N_CR203.03_PracCredentialing_2BHO and N_CR217.02_FacCredentialing_2BHO) and then again upon recredentialing in order to evaluate providers who participate in the Health First Colorado network. Policy	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
of Registration along with a CLIA registration number. *42 CFR 438.214(b) and (e)* Contract Amendment 7: Exhibit A3—2.9.7.1.1, 2.9.7.2.1.1–2, and 2.9.7.2.3.1	N_CR202.03_Overview_2BHO is an overview which establishes and maintains a functional area at the corporate level that develops and manages a national network of practitioners and organizational providers to meet the clinical needs of its members, based on objective, non-discriminatory criteria. Recredentialing per N_CR209.03_PracRecredentialing_ 2BHO and N_CR219.03_FacRecredentialing_2BHO occurs on a 3 year, or 36-month cycle. Beacon Health Options meets NCQA guidelines for meeting credentialing criteria. All policies are reviewed annually to ensure compliance. N_CR218.03_CredCriteria_Facility_2BHO evidences that Beacon Health Options, on behalf of BHO, ensures that all laboratory-testing sites providing services under the Contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration along with a CLIA registration number.	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
3. The Contractor's provider selection policies and procedures include provisions that the Contractor does not: • Discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. • Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42 CFR 438.12(a)(1) and (2)* *42 CFR 438.214(c)* Contract Amendment 7: Exhibit A3—2.5.14.1 and 2.9.7.1.3	**Documents Submitted/Location Within Documents:** 1. N_CR206.05_PrimSourceVerif_2BHO-entire document 2. N_CR202.03_Overview_2BHO- See Highlighted Section Pg. 1 3. PractitionerAgreement_2BHO-Page 8 and 30 **Description of Process:** Beacon Health Options does not discriminate as per PractitionerAgreement_2BHO against providers for acting within the scope of their license or providing services to members that require costly treatment. Policy N_CR202.03_Overview_2BHO states that non-discriminatory is defined as, "Non-Discriminatory – Not on the basis of attributes such as applicant's race, ethnic/national identity, gender, age, sexual orientation, or the type of procedure or patient in which the practitioner specializes." Policy N_CR206.05_PrimSourceVerif_2BHO indicates how non-discriminatory primary source data is used to make decisions about network participation.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This is not construed to: • Require the Contractor to contract with providers beyond the number necessary to meet the needs of its members. • Preclude the Contractor from using different reimbursement amounts for different	**Documents Submitted/Location Within Documents:** 1. CLCCDenialLetter_2017_CHP-entire document 2. Network Development Plan_FY2018_CHP – Page 2 **Description of Process:** CHP uses the Network Development Plan_FY2018_CHP to ensure that have the appropriate number of providers needed for its members and maintain a fair cost- based reimbursement practice. As demonstrated in CLCCDenialLetter_2017_CHP, Beacon Health Options notifies providers, in writing, of any decision to deny	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
specialties or for different practitioners in the same specialty. • Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members. *42 CFR 438.12(a-b)* Contract Amendment 7: Exhibit A3—2.5.14.1	inclusion of individual or groups of providers in the network and the reason for the denial. They are informed of their rights to appeal the decision.	
5. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, provider, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participation in federal healthcare programs. • The Contractor shall not employ or contract with any individual or entity who has been excluded from participation in Medicaid by the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG). • The Contractor has procedures to provide the Department written disclosure of ownership and control within 35 days after any change in ownership of the managed care entity.	**Documents Submitted/Location Within Documents:** 1. N_CR206.05_PrimSourceVerif_2BHO-entire document 2. MasterServiceAgreement_CHP-Page 3-4 and 8 3. Evidence of CHP Partner Screening_CHP – entire document 4. OIG_Check_CHP-entire document **Description of Process:** The Management Services Agreement (MasterServiceAgreement_CHP) state that CHP will not employ nor contract with persons who are debarred or excluded. An OIG check is done on a monthly (sees OIG_Check_CHP) basis to make sure that this requirement is met. Please see example on Evidence of CHP Partner Screening_CHP. Beacon Health Options does this through the PSV process for providers. Beacon Health Options does this for all employees and Beacon Health Options Colorado does this for employees and board members on a monthly basis.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
• The Contractor shall, prior to hire or contracting, and at least monthly thereafter, screen all of its employees and contractors against the HHS-OIG's List of Excluded Individuals (LEIE) to determine whether they have been excluded from participation in Medicaid. • The Contractor has procedures to provide to the Department written disclosure of any prohibited affiliation within five (5) business days of discovery. *42 CFR 438.214(d)* *42 CFR 438.610(a-c)* *42 CFR 438.608(c)(1-2)* Contract Amendment 7: Exhibit A3—2.9.7.3.3.2, 2.9.7.3.3.7, 2.9.10.9, 2.10.5.2, 2.10.5.3.7.2	Beacon policy requires exclusion screenings on all providers prior to contracting and monthly thereafter. It was recently discovered that our Network Operations Department has not been fully compliant with the policy with regards to out of network providers according to policy. The Department has been put on an internal corrective action plan as a result and is now being monitored by Beacon Compliance on a monthly basis.	
Findings: CHP provided adequate evidence that it checks the federal exclusion databases monthly, cross-checking them with all affiliations (staff, delegates, providers, and consultants) to ensure that CHP does not have any type of affiliation with individuals prohibited from federal healthcare or procurement participation. CHP was unable to provide adequate documentation of procedures to provide the Department written disclosure of ownership and control within 35 days after any change in ownership of the managed care entity, or to provide to the Department written disclosure of any prohibited affiliation within five business days of discovery.		
Required Actions: CHP must develop procedures to provide the Department written disclosure of ownership and control within 35 days after any change in ownership of the managed care entity, or to provide to the Department written disclosure of any prohibited affiliation within five business days of discovery.		

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
6. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: • The member's health status, medical care, or treatment options—including any alternative treatments that may be self-administered. • Any information the member needs in order to decide among all relevant treatment options. • The risks, benefits, and consequences of treatment or non-treatment. • The member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment and to express preferences about future treatment decisions. *42 CFR 438.102(a)(1)* Contract Amendment 7: Exhibit A3—2.10.17.1	**Documents Submitted/Location Within Documents:** 1. PractitionerAgreement_2BHO-Pages 8, 15 and 30 2. ProviderManual_2BHO Pages 124 and 129 *Misc. **Description of Process:** As stated in PractitionerAgreeement_2BHO and ProviderManual _2BHO, Beacon Health Options does not discriminate against providers who act within the scope of his/her license for advising or acting on the behalf of members. Providers are required to inform members of their rights, engage the member in the decision of treatment plan, and are able to appeal a decision on behalf of the member.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
7. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: • To the State upon contracting or when adopting the policy during the term of the contract.	**Documents Submitted/Location Within Documents:** 1. 310L_NonDiscrimination_OMFA_2BHO-entire document **Description of Process:** Beacon Health Options does not discriminate which makes the reporting to the State moot. The full policy, 310L_NonDiscrimination_OMFA_2BHO, affirms its position on	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
• To members before and during enrollment. • To members within 90 days after adopting the policy with respect to any particular service. *42 CFR 438.102(b)* Contract Amendment 7: Exhibit A3—2.10.18.1 and 2.10.18.3	non-discrimination with a clear statement on I.a. (page 1) that it does not "discriminate against members because of race, religion, gender, age, disability, health status or sexual orientation, in the context of receiving care and services from Beacon Health Options Colorado and its providers".	
8. The Contractor has administrative and management arrangements or procedures, including a compliance program to detect and prevent fraud, waste, and abuse, and which includes: • Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal, State, and contract requirements. • The designation of a compliance officer who is responsible for developing and implementing policies, procedures, and practices to ensure compliance with requirements of the contract and who reports directly to the CEO and Board of Directors. • The establishment of a compliance committee of the Board of Directors and at the senior management level, charged with overseeing the organization's compliance program.	**Documents Submitted/Location Within Documents:** 1. Compliance Oversight Plan _CHP-Pages 4, 5, 6 2. Compliance Committee Members_CHP-entire document 3. N_CO119A_COPSD_FWA_2BHO-entire document 4. N_CO101_ComplianceProgramActivities_2BHO -entire document 5. N_CO310Compliance with FWA Laws_2BHO -entire document 6. Beacon Code of Conduct_2BHO-entire document 7. N_CO119_Program Integrity Activities_2BHO -entire document 8. Certification of Training _CHP-entire document 9. Medicaid Contract Survey_CHP-entire document 10. Confidentiality Agreement_CHP-entire document 11. StateOfGrace_AudResultsLtr_CHP– entire document **Description of Process:** Beacon Health Options has written policies and procedures, as indicated above, that clearly describe compliance with federal and state standards; designated compliance officer and committee who	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
• Training and education of the compliance officer, management, and organization's staff members for the federal and State standards and requirements under the contract. • Effective lines of communication between the compliance officer and the Contractor's employees. • Enforcement of standards through well-publicized disciplinary guidelines. • Implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks. • Procedures for prompt response to compliance issues as they are raised, investigation of potential compliance problems identified in the course of self-evaluation and audits, correction of such problems quickly and thoroughly to reduce the potential for reoccurence, and ongoing compliance with the requirements under the contract. *42 CFR 438.608(a)(1)* Contract Amendment 7: Exhibit A3—2.9.3.1, 2.9.3.1.1.1–2, 2.9.3.1.3–7	are accountable to the senior management; and delineate training and education for the compliance officer and CHP's employees. Communication between the compliance officer and employees can occur through the hotline or by contacting the compliance officer directly. Procedures are in place for monitoring and auditing which includes audits of claims/encounters and clinical record reviews. Specific procedures are in place for investigating and reporting fraud and abuse. If fraud is suspected the Beacon Health Options Special Investigation Unit will investigate as well. Please see example of audit in StateOfGrace_AudResultsLtr_CHP. Per our Compliance Plan we are required to immediately reports indications or suspicions of fraud by giving a verbal report to our Contract manager. CHP then investigates its suspicions and submits its written findings to the contract manager within 3 business days of the verbal report. If the investigation is not complete within 3 business days, CHP continues to investigate and submit a final report within 15 business days of the initial notification. If CHP needs an extension, we contact our Contract Manager to ask for an extension. We also report the appropriate law enforcement agencies. Our Contract Manager reports indications or suspicions of fraud, waste or abuse to the Medicaid Fraud and Control Unit.	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
9. The Contractor's administrative and management procedures to detect and prevent fraud, waste, and abuse include: • Written policies for all employees, contractors or agents that provide detailed information about the False Claims Act, including the right of employees to be protected as whistleblowers. • Provisions for prompt referral of any potential fraud, waste, or abuse to the State Medicaid program integrity unit and any potential fraud to the State Medicaid Fraud Control Unit. Contractor provides to the Department: – Verbal report immediately. – Written report in three (3) business days. • Provisions for suspension of payments to a network provider for which the State determines there is credible allegation of fraud. *42 CFR 438.608(a)(6-8)* Contract Amendment 7: Exhibit A3—2.12.1, 2.9.3.2.1–2, 2.9.3.4.1, 2.9.3.4.4	**Documents Submitted/Location Within Documents:** 1. Code of Conduct_CHP-entire document 2. Compliance Oversight Plan _CHP-Pages 9-11 3. N_CO119A_COPSD_FWA_2BHO-entire document 4. N_CO310Compliance with FWA Laws_2BHO-entire document 5. N_CO101_Compliance Program Activities_2BHO-entire document 6. QM16D_ColoradoSpringECAddendum_2BHO-entire document **Description of Process:** Beacon Health Options has written policies and procedures QM16D_ColoradoSpringECAddendum_2BHO and N_CO10_Compliance Program Activities_2BHO that clearly describe compliance with federal and state standards including the Fraud Waste and Abuse Act. Communication between the compliance officer and employees can occur through the hotline or by contacting the compliance officer directly. Procedures are in place for monitoring and auditing which includes audits of claims/encounters and clinical record reviews. Specific procedures are in place for investigating and reporting fraud and abuse. If fraud is suspected the Beacon Health Options Special Investigation Unit will investigate as well. Per our Compliance Plan we are required to immediately reports indications or suspicions of fraud by giving a verbal report to our contract manager. As indicated in Page 14, CHP then investigates its suspicions and submit its written findings to the contract manager within 3 business days of the verbal report. If the	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	investigation is not complete within 3 business days, CHP continues to investigate and submit a final report to HCPF within 15 business days of the initial notification. If CHP needs an extension, we contact our Contract Manager to ask for an extension. We also report the appropriate law enforcement agencies. Our Contract Manager reports indications or suspicions of fraud, waste or abuse to the Medicaid Fraud and Control Unit.	
10. The Contractor's compliance program includes: • Provision for prompt notification to the Department about member circumstances that may affect the member's eligibility, including change in residence and member death. • Provision for notification to the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including termination of the provider agreement with the Contractor. *42 CFR 438.608(a)(3-4)* Contract Amendment 7: Exhibit A3—2.9.3.2.1–2, 2.10.15.2	**Documents Submitted/Location Within Documents:** 1. OMFA 101 Member Demographic Changes_2BHO 2. LCOA Reporting_CHP 3. N_CR208.03_Integrity Provider Data_2BHO-entire document 4. N_CR216.04_Provider Disenrollments_2BHO-entire document 5. PR_012 Provider Directory _2BHO-entire document 6. Quarterly Disenrollment Report_CHP – entire document **Description of Process:** Beacon Health Options, on behalf of the BHOs, facilitates communication between members or family members with the State on changes in member circumstances that may affect the member's eligibility. Additionally, Beacon notifies Contract Manager of the demographic change, as noted in the OMFA 101 Member Demographic Changes_2BHO and evidenced by LCOA Reporting_CHP. Beacon Health Options maintains and updates provider data and directories when changes in provider's circumstances change that affect their ability to participate in Medicaid as noted in N_CR208.03_Integrity Provider Data_2BHO and	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	N_CR216.04_Provider Disenrollments_2BHO. Beacon reports these changes to the State through quarterly as disenrollment report and updated monthly Provider Directory as noted in PR_012 Provider Directory_2BHO. This is evidenced by an example of Disenrollment Quarterly Report_CHP.	
11. The Contractor's compliance program includes provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potenial fraud. • The Contractor screens all provider claims, collectively and individually, for potential fraud, waste, or abuse— including mechanisms to identify overpayments to providers and to report suspected instances of up-coding, unbundling of services, services that were billed for but never rendered, and inflated bills for services and goods provided. • The Contractor has procedures for provision of a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. - The Contractor provides individual notices to all or a sample of members who received services to verify and report whether services billed by providers were actually received by members. • The Contractor has a mechanism for a network provider to report to the Contractor	**Documents Submitted/Location Within Documents:** 1. Code of Conduct_CHP-Page 3 2. Compliance Oversight Plan _CHP-entire document 3. N_CO119_COPSD_FWA_2BHO-entire document 4. N_CO310Compliance with FWA Laws_2BHO-entire document 5. N_CO101_Compliance Program Activities_2BHO-entire document 6. CHP_FY16_Year_Third Party Recovery Report-entire document 7. CHP FY18 Reconciliation Demand Letter-entire document 8. BHO Reconciliation Demand Letter-entire document **Description of Process:** Beacon Health Options has written policies and procedures that clearly describe compliance with federal and state standards of Fraud, Waste and Abuse Act. Requirement's bullet point 2 is evidenced by Section III of N_CO119_COPSD_FWA_2BHO. It outlines the procedures for identification, potential fraud and/or abusive billing practices, and review with time frames. Supplemental policies, N_CO310Compliance with FWA Laws_2BHO and N_CO101_Compliance Program Activities Section II C definition of Claims Billing Audits.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days of identifying the overpayment, and to notify the Contractor in writing of the reason for the overpayment. • The Contractor has procedures to identify to the Department within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract. • The Contractor reports annually to the State on recoveries of overpayments. *42 CFR 438.608(a)(5), (c)(3), and (d)(2) and (3)* Contract Amendment 7: Exhibit A3—2.9.3.1.8, 2.9.3.1.1.3–9, 2.9.3.2.1–2, and 5.2.1.1	Beacon Health Options has written policies on the reporting of overpayments as evidenced in N_CO119 Program Integrity Activities_2BHO. On page 2 and 3, Beacon staff, providers and all entities are required to report any suspicion of potential fraud, waste and abuse which includes overpayments. Furthermore, CHP_FY16_Year_Third Party Recovery Report demonstrates overpayments reported for third party pre-paid entities. The report does cover FY16 and due to the claims lag will not be available for FY17 until later in Q3FY18. Additionally, CHP FY18 Reconciliation Demand Letter and BHO Reconciliation Demand Letter demonstrate how CHP works with the department when an overpayment has been identified. The Code of Conduct_CHP requires all CHP staff or its affiliates to follow the federal and state requirements on billing, and report any potential or suspected cases of improper billing practices or overpayments.	
Findings: CHP did not provide evidence of having a mechanism for requiring network providers to report to CHP when they have received an overpayment, to return the overpayment to CHP within 60 calendar days of identifying the overpayment, and to notify CHP in writing of the reason for the overpayment. While the provider manual did address overpayments, it did not specifically state that providers are required to report (in writing) overpayments and the reason for the overpayment to CHP.		
Required Actions: CHP must develop a mechanism to ensure that network providers report any overpayments received to CHP, return the overpayment to the CHP within 60 calendar days of identifying the overpayment, and notify CHP in writing of the reason for the overpayment.		

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
12. **The Contractor ensures that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure, screening, and enrollment requirements of the State.** *42 CFR 438.608(b)* Contract Amendment 7: Exhibit A3—2.5.9.12	**Documents Submitted/Location Within Documents:** 1. N_CR206.05_PrimSourceVerif_2BHO-entire document 2. PR_011_Medicaid Enrollment Verfication_2BHO-Page 1 3. OIG_Check_CHP –entire document **Description of Process:** Beacon Health Options conducts a check of providers to make sure that they meet all requirements consistent with the provider disclosure, screen and enrollment requirements. An OIG check (see OIG_Check_CHP) is done on a monthly basis to make sure that this requirement is met. This is evidence by CHP Partner Screening_CHP. Beacon Health Options does this through the PSV process for providers as noted in the N_CR206.05_PrimSourcesVerif_2BHO. Starting March 1, 2017, Beacon Health Options, on behalf of the BHO, added process to ensure all providers are enrolled with the state as Medicaid provider. This includes providers already in the network, submitted claims or requested interest in joining the network (see PR_011_Medicaid Enrollment Verficiation_2BHO).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. The Contractor provides that Medicaid members are not held liable for: • The Contractor's debts in the event of the Contractor's insolvency. • Covered services provided to the member for which the State does not pay the Contractor. • Covered services provided to the member for which the State or the Contractor does not pay the healthcare provider that furnishes the	**Documents Submitted/Location Within Documents:** 1. ProviderManual_2BHO-Page 17 *Misc. 2. PractitionerAgreement_2BHO-Page 30 **Description of Process:** Beacon Health Options provider agreements and Provider Manual clearly state members cannot be held liable for payments for covered services or for the Contractor's debts.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the BHO**	**Score**
services under a contractual, referral, or other arrangement. • Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. *42 CFR 438.106* Contract Amendment 7: Exhibit A3—2.2.3, 2.10.14.2		

Results for Standard VII—Provider Participation and Program Integrity							
Total	Met	=	11	X	1.00	=	11
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	13	**Total Score**		=	11
				Total Score ÷ Total Applicable		=	85%

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. **Notwithstanding any relationship(s) with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State.** The Contractor must: • Evaluate the prospective subcontractor's ability to perform the activities to be delegated. • Monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the State, consistent with industry standards or State laws and regulations. • Identify deficiencies or areas for improvement, and ensure that the subcontractor takes corrective action. *42 CFR 438.230(b)(1)* Contract Amendment 7: Exhibit A3—3.1.5, 3.1.5.1, 3.1.5.3–4	Note—This does not apply to provider agreements (unless provider contracted to perform responsibilities other than services to members). This delegation between CHP and Beacon Health Options goes back to 2005; therefore, there was no pre-delegation assessment. It was assumed to be a continuation of our contract.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the BHO**	**Score**
2. All contracts or written arrangements between the Contractor and any subcontractor specify: • The delegated activities **or obligations** and related reporting responsibilities. • **That the subcontractor agrees to perform the delegated activities and reporting responsibilities** • Provision for revocation of the delegation of activities or obligation or **specify other remedies in instances where the State or Contractor determines** that the subcontractor has not performed satisfactorily. *42 CFR 438.230(b)(2) and (c)(1)* Contract Amendment 7: Exhibit A3—3.1.5.1.2	**Documents Submitted/Location Within Documents:** 1. Delegation Agreement Sep2016_CHP– entire document 2. Member Participation Agreement-final 11_CHP-Page 9 Section 6.2 3. Member Participation Agmt 8CMHC_CHP-entire document 4. Operational Agreement_CHP- Exhibit D, Page 48 5. StateAnalysis_SummaryQRT4_2017_CHP-entire document 6. CMHC Delegation Audit Grievances 2017 Summary-entire document 7. SEP2016 CHP Class B Minutes_CHP-entire document 8. DEC2016 CHP Class B Minutes_CHP-entire document **Description of Process:** CHP has a written agreement with each entity that is performing any delegated functions as referenced in Delegation Agreement SEP2016_CHP. This document specifies activities and reporting responsibilities which are delegated to the subcontractor. Please see highlighted section in the Member Participation Agreement – final CHP page 9 that demonstrates language for corrective action for breach. The Member Participation Agmt 8CMHC_CHP demonstrates that there is a signed agreement between each of the eight Colorado Mental Health Centers. In addition, Member Participation Agreement-final 11_CHP demonstrates the entire agreement was signed by each CMHC. As described in the Operational Agreement_CHP if there are performance issues the delegate will be subject to sanctions. StateAnalysis_SummaryQRT4_2017_CHP is a fourth quarter analysis of our grievances. Our grievances are then reviewed by our	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Board to demonstrate monitoring of delegation. The CMHC Delegation Audited Grievances 2017 Summary demonstrates that oversight took place. StateAnalysis_SummaryQRT4_2017_CHP is a fourth quarter analysis of our grievances. Our grievances are then reviewed by our Board to demonstrate monitoring of delegation. The CMHC Delegation Audited Grievances 2017 Summary demonstrates that oversight took place. The ultimate authority for oversight of CHP lies with the CHP Class B Board. The Class B Board consists of four representatives from the Class A Board, one each representing AspenPointe Health Services, SyCare LLC, West Slope Casa, and Beacon. Quality Management and Utilization Management functions have been delegated to Beacon by CHP. Documents titled DEC2016 CHP Class B Minutes_CHP and SEP2016 CHP Class B Minutes_CHP both demonstrate oversight which occurred at the CHP B board.	
3. The Contractor's written agreement with any subcontractor includes: • **The subcontractor's agreement to comply with all applicable Medicaid laws and regulations, including applicable sub-regulatory guidance and contract provisions.** *42 CFR 438.230 (c)(2)* Contract Amendment 7: Exhibit A—6.A	**Documents Submitted** 1. Delegation Agreement Amendment 1_CHP– entire document **Description of Process:** CHP and Beacon Health Options amended their delegation agreement to include the language from contract Amendment 7. The specific language can be found in the CHP Delegation Amendment 1_CHP. Specifically stated in numbers one and two is the language that was applied to the agreement which was taken directly from Amendment 7.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the BHO**	**Score**
4. The written agreement with the subcontractor includes: • **The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State.** – **The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, and computer or other electronic systems related to Medicaid members.** – **The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.** – **If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or**	**Documents Submitted** 1. Delegation Agreement Amendment 1_CHP– entire document plus number 2 **Description of Process:** CHP and Beacon Health Options amended their delegation agreement to include the language from contract Amendment 7. This language can be found in the CHP Delegation Agreement Amendment 1 under sections 1 and 2.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the BHO**	**Score**
similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. *42 CFR 438.230(c)(3)* Contract Amendment 7: Exhibit A3—2.9.9.5		

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

Appendix B. Record Review Tools

The completed record review tools follow this cover page.

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Appeals Record Review Tool
for Colorado Health Partnerships, LLC

Review Period:	July 1, 2017–December 31, 2017
Date of Review:	January 9, 2018
Reviewer:	Barbara McConnell and Rachel Henrichs
Participating Health Plan Staff Member:	Kelly Hann

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
1	****	09/11/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☒ No ☐	09/22/17	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: The member's mother called CHP to file an appeal on 09/11/17; however, she was not authorized to file on behalf of her son. CHP mailed the acknowledgement letter and designated client representative (DCR) form to the member on 09/11/17 and received written confirmation on 09/18/17. CHP mailed an extension letter with all required content on 09/21/17. The resolution letter, dated 09/22/17, was not easy to understand.											
2	****	11/16/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	11/29/17	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: The resolution letter was not easy to understand.											
3	****	11/22/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	12/06/17	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
4	****	11/13/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	11/27/17	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: The resolution letter was not easy to understand.											
5	****	10/17/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	10/23/17	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: The resolution letter was not easy to understand.											
6	****	11/01/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒		M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: The resolution letter was not easy to understand.											
7	****	10/30/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	11/01/17	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: The resolution letter was not easy to understand.											
8	****	10/17/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	11/14/17	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: The resolution letter incorrectly stated that the member had 120 days from the *adverse benefit determination* to file a State fair hearing.											
9	****	09/21/17	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	09/22/17	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Appeals Record Review Tool
for Colorado Health Partnerships, LLC

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
10	****	09/18/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	09/13/17	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
OS1			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS2			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS3			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS4			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS5			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
Do not score shaded columns below.											
Column Subtotal of Applicable Elements			**9**	**10**	**10**				**10**	**10**	**10**
Column Subtotal of Compliant (M) Elements			**9**	**10**	**10**				**10**	**10**	**3**
Percent Compliant (Divide Compliant by Applicable)			**100%**	**100%**	**100%**				**100%**	**100%**	**30%**

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

Total Applicable Elements	**59**
Total Compliant (M) Elements	**52**
Total Percent Compliant	**88%**

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Grievance Record Review Tool
for Colorado Health Partnerships, LLC

Review Period:	July 1, 2017–December 31, 2017
Date of Review:	January 9, 2018
Reviewer:	Barbara McConnell and Rachel Henrichs
Participating Health Plan Staff Member:	Lynne Bakalyan

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame	Decision Maker Not Previous Level (If Clinical)	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
1	****	11/08/17	Y ☒ N ☐ N/A ☐	11/09/17	1	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐
Comments:										
2	****	11/02/17	Y ☒ N ☐ N/A ☐	11/09/17	7	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐
Comments:										
3	****	10/17/17	Y ☒ N ☐ N/A ☐	10/20/17	3	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐
Comments:										
4	****	10/04/17	Y ☒ N ☐ N/A ☐	10/06/17	2	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐
Comments:										
5	****	09/28/17	Y ☒ N ☐ N/A ☐	10/12/17	14	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐
Comments:										
6	****	09/25/17	Y ☒ N ☐ N/A ☐	09/29/17	4	Y ☒ N ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
7	****	09/18/17	Y ☒ N ☐ N/A ☐	09/22/17	4	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐
Comments:										
8	****	09/7/17	Y ☒ N ☐ N/A ☐	09/07/17	1	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐
Comments:										
9	****	08/30/17	Y ☒ N ☐ N/A ☐	08/31/17	1	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐
Comments:										
10	****	08/23/17	Y ☒ N ☐ N/A ☐	08/24/17	1	Y ☒ N ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Grievance Record Review Tool
for Colorado Health Partnerships, LLC

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame	Decision Maker Not Previous Level (If Clinical)	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
OS 1			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
Comments:										
OS 2			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
Comments:										
OS 3			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
Comments:										
OS 4			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
Comments:										
OS 5			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
Comments:										
Do not score shaded columns below.										
Column Subtotal of Applicable Elements			**10**			**10**	**2**	**2**	**10**	**10**
Column Subtotal of Compliant (Yes) Elements			**10**			**10**	**2**	**2**	**10**	**10**
Percent Compliant (Divide Compliant by Applicable)			**100%**			**100%**	**100%**	**100%**	**100%**	**100%**

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

Total Applicable Elements	**44**
Total Compliant (Yes) Elements	**44**
Total Percent Compliant	**100%**

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2017–2018 site review of **CHP**.

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

HSAG Review Team	Title
Barbara McConnell	Executive Director
Rachel Henrichs	External Quality Review (EQR) Compliance Auditor
Jacqueline Luckey-Eaton	Project Manager
Amrit Kerr	Project Manager
CHP Participants	**Title**
Alma Mejorado	Director of Provider Relations
Erica Arnold Miller	Quality Improvement Director
Jeremy White	Quality Manager
Jim Bonk	Vice President of Operations
Kelly Hann	Grievance and Appeals Coordinator
Kristy Williams	Director of Corporate Compliance
Lisa Clements	Vice President of Transformation
Lynne Bakalyan	Director of Office of Member/Family Affairs
Scott Rambeck	Director of National Program Integrity
Tina McCrory	Chief Operating Officer

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

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

Table D-1—Corrective Action Plan Process

Step	Action
Step 1	**Corrective action plans are submitted**
	If applicable, the BHO will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final compliance site review report via email or through the file transfer protocol (FTP) site, with an email notification to HSAG and the Department. The BHO must submit the CAP using the template provided. For each element receiving a score of *Partially Met* or *Not Met*, the CAP must describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training and follow-up activities, and documents to be sent following the completion of the planned interventions.
Step 2	**Prior approval for timelines exceeding 30 days**
	If the BHO is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.
Step 3	**Department approval**
	Following review of the CAP, the Department and HSAG will: • Approve the planned interventions and instruct the BHO to proceed with implementation, or • Instruct the BHO to revise specific planned interventions and/or documents to be submitted as evidence of completion and also to proceed with implementation.
Step 4	**Documentation substantiating implementation**
	Once the BHO has received Department approval of the CAP, the BHO will have a time frame of six months to complete proposed actions and submit documents. The BHO will submit documents as evidence of completion one time only on or before the six-month deadline for all required actions in the CAP. (If necessary, the BHO will describe in the CAP document any revisions to the planned interventions that were required in the initial CAP approval document or determined by the health plan within the intervening time frame.)

Step	Action
Step 5	**Technical assistance**
	HSAG will schedule with the BHO a one-time, interactive, verbal consultation and technical assistance session during the six-month time frame. The session may be scheduled at the health plan's discretion at any time the health plan determines would be most beneficial. HSAG will not document results of the verbal consultation in the CAP document.
Step 6	**Review and completion**
	Following a review of the CAP and all supporting documentation, the Department or HSAG will inform the BHO as to whether or not the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements. Any documentation that is considered unsatisfactory to complete the CAP requirements at the six-month deadline will result in assignment as a delinquent corrective action that will be continued into the following compliance review year. (HSAG will list delinquent actions in the annual technical report and in the health plan's subsequent year's compliance site review report.)

The CAP template follows.

Table D-2—FY 2017–2018 Corrective Action Plan for CHP

Standard V—Member Information		
Requirement	**Findings**	**Required Action**
3. The Contractor makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • **Written materials that are critical to obtaining services include: provider directories, member handbooks, appeal and grievance notices, and denial and termination notices.** • **All written materials for members must:** – Use easily understood language and format. – **Use a font size no smaller than 12 point.** – Be available in alternative formats **and through provision of auxiliary aids and services** that take into consideration the special needs of members **with disabilities** or limited English proficiency. – **Include taglines in large print (18 point) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral**	CHP provided policies and procedures that described the processes for ensuring that all member materials are written at a sixth-grade reading level and use a 12-point font size; are readily available in Spanish and alternative formats, and through the provision of auxiliary aids; and include large print and Spanish taglines that describe how to request auxiliary aids, written translation, and oral translation. HSAG tested the readability of several documents including the grievance and appeal guide and several template letters related to the grievance and appeal processes using the Flesch-Kinkaid readability test. Many of these documents scored well above the sixth-grade level. Additionally, HSAG found that many of the grievance and appeal resolution letters reviewed as part of the record reviews were difficult to understand.	CHP must ensure that all member information is written using easy-to-understand language.

Standard V—Member Information		
Requirement	**Findings**	**Required Action**
interpretation and the toll-free and TTY/TDY customer service number, and availability of materials in alternative formats. – Be available for immediate dissemination in that language. *42 CFR 438.10(d)(3) and (d)(6)* Contract Amendment 7: Exhibit A3—2.6.5.13.1–3, 2.6.5.13.6.1–3, 2.6.5.13.7, 2.6.5.13.10.1–4		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard V—Member Information		
Requirement	**Findings**	**Required Action**
4. If the Contractor makes information available electronically—Information provided electronically must meet the following requirements: • **The format is readily accessible (see definition of readily accessible above).** • **The information is placed in a Web site location that is prominent and readily accessible.** • **The information can be electronically retained and printed.** • **The information complies with content and language requirements.** • **The member is informed that the information is available in paper form without charge upon request, and is provided within five (5) business days.** *42 CFR 438.10(c)(6)* Contract Amendment 7: Exhibit A3—2.6.5.3.6–8	HSAG conducted an accessibility check on several CHP webpages using the Wave Web Accessibility Evaluation Tool. Using this tool, HSAG discovered several general accessibility errors and contrast errors on various webpages. These findings were consistent with those reported on the Website Compliance Report dated November 14, 2017. HSAG also ran an accessibility check on several PDF documents available for download from the CHP website (e.g., grievance and appeal guide and provider directory). Using the Adobe Acrobat Pro accessibility checker, HSAG discovered accessibility errors within these PDF documents.	CHP must develop a process to ensure that all information on its website is readily accessible (i.e., complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines).
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

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

Standard V—Member Information		
Requirement	**Findings**	**Required Action**
7. The Contractor makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, **pharmacies, and behavioral health providers, and long-term services and supports (LTSS) providers:** • The provider's name and **group affiliation**, street address(es), telephone number(s), **Web site URL, specialty (as appropriate),** and whether the providers will accept new members. • **The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training.** • **Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment.** *(Note: Information included in a paper provider directory must be updated at least monthly, and electronic provider directories must be updated no later than*	CHP's provider directory included the name, group affiliation, street address, telephone number, areas of specialty, and languages spoken for all providers accepting new patients. The directory included no information regarding a provider's website URL, cultural competency training, or accessibility for people with physical disabilities.	CHP must update its provider directory to include a provider's website URL (if available) and to indicate which providers have completed cultural competency training and which locations are accessible for people with physical disabilities.

Standard V—Member Information		
Requirement	**Findings**	**Required Action**
30 calendar days after the Contractor receives updated provider information.) *42 CFR 438.10(h)(1-3)* Contract Amendment 7: Exhibit A3—2.6.5.8.1–3		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
2. The Contractor defines "adverse benefit determination" as: • The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. • The reduction, suspension, or termination of a previously authorized service. • The denial, in whole, or in part, of payment for a service. • The failure to provide services in a timely manner, as defined by the State. • The failure to act within the time frames defined by the State for standard resolution of grievances and appeals. • **The denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other).** • For a resident of a rural area with only one managed care plan, the denial of a Medicaid member's request to exercise his or her rights to obtain services	CHP's Grievance Process policy and Appeals Process policy both included a definition of "adverse benefit determination"; however, the two definitions were inconsistent and incomplete. In both policies, the denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other) was missing from the definition.	CHP must review its policies, procedures, and other applicable documents (e.g., member and provider communications) that address the Grievance and Appeal System to ensure they include an accurate definition of "adverse benefit determination."

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
outside of the network under the following circumstances: – The service or type of provider (in terms of training, expertise, and specialization) is not available within the network. – The provider is not part of the network but is the main source of a service to the member—provided that: o The provider is given the opportunity to become a participating provider. o If the provider does not choose to join the network or does not meet the Contractor's qualification requirements, the member will be given the opportunity to choose a participating provider and then will be transitioned to a participating provider within 60 days. *42 CFR 438.400(b)* *42 CFR 438.52(b)(2)(ii)* Contract Amendment 7: Exhibit A3—1.1.1.3 10 CCR 2505-10—8.209.2.A		

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

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
4. The Contractor defines "grievance" as "an expression of dissatisfaction about any matter other than an **adverse benefit determination**." Grievances may include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the member's rights **regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision.** *42 CFR 438.400(b)* Contract Amendment 7: Exhibit A3—1.1.1.27, 2.6.4.5.8.1.2 10 CCR 2505-10—8.209.2.D, 8.209.4.A.3.c.i	Review of CHP's documents and on-site grievance record review provided evidence that CHP (and its delegates) accepted, processed, and documented grievances brought to the BHO's or delegates' attention. HSAG found, however, that instructions provided to individuals responsible for processing and resolving grievances directed staff to ask members calling to express dissatisfaction whether they wished to file a grievance or wished to file a "formal grievance." CHP's complaint form also asked members if they wished to file a "formal grievance." During the on-site interview, CHP staff also stated that if grievances were resolved at the initial point of contact, acknowledgement and/or resolution letters were not required. HSAG cautioned CHP staff members that once a member has called and expressed dissatisfaction, the call must be handled as a grievance (if not pertaining to an adverse benefit determination), and that leading members to believe that another action must take place or using the term "formal" may cause members to say no, thereby denying these members due process. Not considering issues that are resolved quickly as grievances also may prevent members from receiving due process and lead to inaccurate grievance reporting to the State.	CHP must ensure that member materials, forms, training, job aids, informal direction, and other communications to staff who are responsible for processing grievances emphasize that all expressions of dissatisfaction about any matter other than an adverse benefit determination must be considered a grievance, and documented and treated as such, including due process procedures such as acknowledging, resolving, and notifying members of a resolution.

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

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
16. The Contractor's appeal process must provide: • That oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date), and must be confirmed in writing unless the member or provider requests expedited resolution. • That if the member orally requests an expedited appeal, the Contractor shall not require a written, signed appeal following the oral request. • The member a reasonable opportunity, in person and in writing, to present evidence **and testimony** and make legal and factual arguments. **(The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution time frame in the case of expedited resolution.)** • The member and his or her representative the member's case file, including medical records, other documents and records, and **any new or additional documents considered, relied upon, or generated by the Contractor in connection with the appeal. This information must be**	The requirement that CHP's appeal process will inform members of the limited time available for them to provide evidence and testimony sufficiently in advance of the resolution time frame, in the case of expedited resolution, was not adequately addressed in policies and procedures and other documents. Although the Appeal Process policy included this provision, it was located in the section of the policy that addressed standard appeals, not in the section that addressed requests for expedited appeal resolution. In addition, the Expedited Appeal Process Flow Chart and Job Aid did not provide direction to staff to inform the member or representative requesting expedited resolution of an appeal about the limited time available to provide information or evidence, or for preparing testimony, legal, or factual arguments.	CHP's expedited appeal process must ensure that members or representatives requesting expedited resolution of an appeal are informed of the limited time available to present evidence or testimony and to make legal and factual arguments sufficiently in advance of the resolution time frame.

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
provided free of charge and sufficiently in advance of the appeal resolution time frame. • That included, as parties to the appeal, are: – The member and his or her representative. – The legal representative of a deceased member's estate. *42 CFR 438.406(b)(3-5)* Contract Amendment 7: Exhibit A3—2.6.4.6.4, 2.6.4.6.5, 2.6.4.6.7, 2.6.4.6.8, 2.6.4.6.9 10 CCR 2505-10—8.209.4.F, 8.209.4.G, 8.209.4.H, 8.209.4.I		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
17. The Contractor must resolve each appeal and provide written notice of the disposition as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. *Note: If the written appeal is not signed by the member or designated client representative (DCR), the appeal resolution will remain pending until the appeal is signed. All attempts to gain a signature shall be included in the record of the appeal.* • For expedited resolution of an appeal and notice to affected parties, **within 72 hours** after the Contractor receives the appeal. • For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. • Written notice of appeal resolution must be in a format and language that	The Appeal Process policy included time frames for resolving appeals and providing written notice to members. The time frame for expedited resolution and notice was inaccurately depicted in the policy. The policy stated that the time frame for verbal notification for expedited resolution is 72 hours, with written notification to follow within two days. This policy language depicts a misunderstanding of the regulations. There is no two-day written time frame requirement related to expedited resolution of appeals. The two-day written notification requirement is related to extensions of resolution time frames, or denial of the expedited process. For expedited resolutions, written notification is due within 72 hours (see 42 CFR 438.408(b)(3) and 438.408(d)(2)(i) and (ii)). In addition, the BHO is required to make reasonable effort to provide oral notice of the expedited resolution. On-site record review demonstrated, however, that CHP did send written notification of expedited resolution within the required 72-hour time frame. On-site review of appeals records also revealed that resolution notices to members contained	CHP must revise the Appeal Process policy to reflect accurate time frames and processes for expedited resolution of appeals. In addition, CHP must review other documents, job aids, and member and provider communications to ensure accuracy and consistency across documents. CHP must also develop a mechanism to ensure appeal resolution notices meet the format and language requirements of 42 CFR 438.10 to the extent possible.

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
may be easily understood by the member. *42 CFR 438.408(b)(2)&(3)&(d)(2)* *42 CFR 438.10* Contract Amendment 7: Exhibit A3—2.6.4.7.1, 2.6.4.7.3.2, 2.6.4.7.3.5, 2.6.5.13.1 10 CCR 2505-10—8.209.4.J, 8.209.4.L	clinical and/or technical language causing the notices to score above a sixth-grade reading level, which made it difficult for members to understand them.	
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
19. The written notice of appeal resolution must include: • The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. – The right to request that benefits/services continue* while the hearing is pending, and how to make the request. o That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's adverse benefit determination. **Continuation of benefits applies only to previously authorized services for which the Contractor provides 10-day advance notice to terminate, suspend, or reduce.* *42 CFR 438.408(e)* Contract Amendment 7: Exhibit A3—2.6.4.7.4, 2.6.4.7.5 10 CCR 2505-10—8.209.4.M	CHP's appeal resolution letter did not include the required language that informs the member of the right to request continuation of benefits/services (within 10 calendar days of resolution) during the State fair hearing. None of the appeals reviewed during the on-site record review were related to the termination, suspension, or reduction of previously authorized services; therefore, this content missing from resolution notices reviewed was not considered for scoring the appeals records. CHP did not, however, provide evidence that it used a specific template which included the required language for applicable situations.	CHP must develop a mechanism to ensure that members are informed, via the resolution notice, of their right to request continuation of services during the State fair hearing, if applicable. CHP could add language to its existing template (making it clear whether this applies to the current appeal). Alternatively, CHP could consider developing a specific template to be used when the appeal involves a 10-day advance notice to terminate, suspend, or reduce previously authorized services.

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

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
20. **The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of resolution.** • If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. • The parties to the State fair hearing include the Contractor as well as the member and his or her representative or the representative of a deceased member's estate. • The Contractor shall participate in all State fair hearings regarding appeals. *42 CFR 438.408(f)(1) and (2) and (3)* Contract Amendment 7: Exhibit A3—2.6.4.9.1, 2.6.4.9.3, 2.6.4.9.2, 2.6.4.9.5 10 CCR 2505-10—8.209.4.N, 8.209.4.O, 8.209.4.H	While CHP's Appeal Process policy accurately included the provision that members may request a State fair hearing 120 days from the date of the appeal resolution notice adverse to the member, the appeal resolution notice template stated 120 days from the adverse benefit determination. Several records reviewed on-site used the flawed template; however, in some records HSAG found that CHP's staff had discovered and corrected the error before sending the notice to the member. Because template issues are global, HSAG did not consider continued benefit language when scoring the content of letters in individual appeal record reviews.	CHP must ensure that policies, procedures, and other applicable documents accurately depict the member's right to request a State fair hearing within 120 days following the adverse appeal resolution notice.

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

Standard VI—Grievance System		
Requirment	**Findings**	**Required Action**
21. The Contractor maintains an expedited review process for appeals for when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life; physical or mental health; or ability to attain, maintain, or regain maximum function. The Contractor's expedited review process includes that: • The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. • If the Contractor denies a request for expedited resolution of an appeal, it must: – Transfer the appeal to the time frame for standard resolution. – **Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and within two (2) calendar days provide the member written notice of the reason for the decision and inform the member of the right to file a grievance if he or she disagrees with that decision.** *42 CFR 438.410*	The Appeals Process policy did not adequately address expedited resolution of appeals. The requirements associated with the denial of expedited resolution were not described in the policy or in staff directional materials (e.g., job aids or workflows).	CHP must revise its policy and other applicable documents to reflect the complete expedited appeal process which includes the following steps that must be taken if the BHO denies a request for expedited resolution of an appeal: transferring the appeal to the standard time frame, making reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution, and within two calendar days providing the member written notice of the reason for the decision that informs the member of the right to file a grievance if he or she disagrees with that decision.

Standard VI—Grievance System		
Requirment	**Findings**	**Required Action**
Contract Amendment 7: Exhibit A3—2.6.4.7.3, 2.6.4.7.3.1, 2.10.17.2 10 CCR 2505-10—8.209.4.Q, 8.209.4.R, 8.29.4.S		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
22. The Contractor provides for continuation of benefits/services while the Contractor-level appeal and the State fair hearing are pending if: • The member files timely* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the Contractor mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal within 60 calendar days of the notice of adverse benefit determination. **This definition of "timely filing" only applies for this scenario–i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced. (Note: The*	CHP's Appeals Process policy and member and staff materials had not been revised to reflect the changes to requirements associated with continuation of services during an appeal or State fair hearing. The policy, the Notice of Adverse Benefit Determination, and the Grievance and Appeal Guide implied that CHP could terminate services without a 10-day advance notice, and stated that members requesting continuation of service must file the appeal within 10 days of the notice of adverse benefit determination or before the proposed date of the termination or change in services.	CHP must revise all applicable documents to accurately reflect that: • Members receive a 10-day advance notice if CHP proposes to terminate, suspend, or reduce services. • Timely filing requirements apply to the request for continuation of services during the appeal. • Members have 60 days to file the appeal even if continuation of the services in dispute was requested within the required time frame for requesting the continuation (within the 10-day advance notice period or before the effective date of the proposed termination or change in services). • Although members have 120 days following the appeal resolution notice to request a State fair hearing, members may request continuation of services within 10 days following the appeal resolution notice.

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
provider may not request continuation of benefits on behalf of the member.) *42 CFR 438.420(a) and (b)* Contract Amendment 7: Exhibit A3—2.6.4.8.1 10 CCR 2505-10—8.209.4.T		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
23. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of the following occurs: • The member withdraws the appeal or request for a State fair hearing. • The member fails to request a State fair hearing and continuation of benefits within 10 calendar days after the Contractor sends the notice of an adverse resolution to the member's appeal. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR 438.420(c)* Contract Amendment 7: Exhibit A3—2.6.4.8.2 10 CCR 2505-10—8.209.4.U	CHP's Appeals Process policy and member and staff materials had not been revised to reflect the changes to requirements associated with continuation of services during an appeal or State fair hearing. The policy, the Notice of Adverse Benefit Determination, and the Grievance and Appeal Guide stated that the period of time benefits would continue may conclude at the end of the benefit limits or service authorization time frame. Changes in the federal regulation only allow for benefits to continue until 10 days pass (if the member has not requested a State fair hearing with continuation of the disputed services within those 10 days), or until the State fair hearing officer issues a decision (in cases where the member has requested the State fair hearing with continuation of services).	CHP must revise all applicable documents to remove the provision that continued services may cease at the end of the benefit limits or service authorization time frame.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
27. The Contractor provides the information about the grievance appeal and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member, including how members obtain a hearing, and the representation rules at a hearing. • The availability of assistance in the filing processes. • The toll-free number to file orally. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. – The member may be required to pay the cost of services furnished while the appeal or State fair	Although CHP's provider manual included information about the Medicaid member grievance system, inaccuracies and incomplete content contained in the policies and procedures, member communications, and staff materials were reflected in the provider manual.	CHP must revise its provider manual and review other provider-facing materials for accuracy and completeness, to ensure that providers are accurately informed of requirements and time frames regarding the Grievance and Appeal System at the time of contracting.

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
hearing is pending, if the final decision is adverse to the member. • Appeals process available under the Child Mental Health Treatment Act (CMHTA), if residential services are denied. • Any State-determined provider's appeal rights to challenge the failure of the organization to cover a service. *42 CFR 438.414* *42 CFR 438.10(g)(xi)* Contract Amendment 7: Exhibit A3—2.6.4.4 10 CCR 2505-10—8.209.3.B		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VII—Provider Participation and Program Integrity		
Requirement	**Findings**	**Required Action**
5. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, provider, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participation in federal healthcare programs. • The Contractor shall not employ or contract with any individual or entity who has been excluded from participation in Medicaid by the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG). • The Contractor has procedures to provide the Department written disclosure of ownership and control within 35 days after any change in ownership of the managed care entity. • The Contractor shall, prior to hire or contracting, and at least monthly thereafter, screen all of its employees and contractors against the HHS-OIG's List of Excluded Individuals (LEIE) to determine whether they have been excluded from participation in Medicaid.	CHP provided adequate evidence that it checks the federal exclusion databases monthly, cross-checking them with all affiliations (staff, delegates, providers, and consultants) to ensure that CHP does not have any type of affiliation with individuals prohibited from federal healthcare or procurement participation. CHP was unable to provide adequate documentation of procedures to provide the Department written disclosure of ownership and control within 35 days after any change in ownership of the managed care entity, or to provide to the Department written disclosure of any prohibited affiliation within five business days of discovery.	CHP must develop procedures to provide the Department written disclosure of ownership and control within 35 days after any change in ownership of the managed care entity, or to provide to the Department written disclosure of any prohibited affiliation within five business days of discovery.

Standard VII—Provider Participation and Program Integrity		
Requirement	**Findings**	**Required Action**
• The Contractor has procedures to provide to the Department written disclosure of any prohibited affiliation within five (5) business days of discovery. *42 CFR 438.214(d)* *42 CFR 438.610(a-c)* *42 CFR 438.608(c)(1-2)* Contract Amendment 7: Exhibit A3—2.9.7.3.3.2, 2.9.7.3.3.7, 2.9.10.9, 2.10.5.2, 2.10.5.3.7.2		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VII—Provider Participation and Program Integrity		
Requirement	**Findings**	**Required Action**
11. The Contractor's compliance program includes provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potenial fraud. • The Contractor screens all provider claims, collectively and individually, for potential fraud, waste, or abuse—including mechanisms to identify overpayments to providers and to report suspected instances of up-coding, unbundling of services, services that were billed for but never rendered, and inflated bills for services and goods provided. • The Contractor has procedures for provision of a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. - The Contractor provides individual notices to all or a sample of members who received services to verify and report whether services billed by providers were actually received by members. • The Contractor has a mechanism for a network provider to report to the Contractor when it has received an	CHP did not provide evidence of having a mechanism for requiring network providers to report to CHP when they have received an overpayment, to return the overpayment to CHP within 60 calendar days of identifying the overpayment, and to notify CHP in writing of the reason for the overpayment. While the provider manual did address overpayments, it did not specifically state that providers are required to report (in writing) overpayments and the reason for the overpayment to CHP.	CHP must develop a mechanism to ensure that network providers report any overpayments received to CHP, return the overpayment to the CHP within 60 calendar days of identifying the overpayment, and notify CHP in writing of the reason for the overpayment.

Standard VII—Provider Participation and Program Integrity		
Requirement	**Findings**	**Required Action**
overpayment, to return the overpayment to the Contractor within 60 calendar days of identifying the overpayment, and to notify the Contractor in writing of the reason for the overpayment. • The Contractor has procedures to identify to the Department within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract. • The Contractor reports annually to the State on recoveries of overpayments. *42 CFR 438.608(a)(5), (c)(3), and (d)(2) and (3)* Contract Amendment 7: Exhibit A3—2.9.3.1.8, 2.9.3.1.1.3–9, 2.9.3.2.1–2, and 5.2.1.1		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review Protocol Activities

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

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal Medicaid managed care regulations and contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, on-site agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all site reviewers to ensure consistency in scoring across plans.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Behavioral Health Quality Improvement Committee (BQuIC) meetings and provided group technical assistance and training, as needed. • Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the BHO in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the three standards and on-site activities. Thirty days prior to the review, the BHO provided documentation for the desk review, as requested. • Documents submitted for the desk review and on-site review consisted of the completed desk review form, the compliance monitoring tool with the BHO's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The BHOs also submitted a list of all Medicaid appeals and grievances that occurred between July 1, 2017, and December 31, 2017. HSAG used a random sampling technique to select records for review during the site visit. • The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct Site Visit**
	• During the on-site portion of the review, HSAG met with the BHO's key staff members to obtain a complete picture of the BHO's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the BHO's performance. • HSAG reviewed a sample of administrative records to evaluate implementation of Medicaid managed care regulations related to BHO appeals and grievances. • Also while on-site, HSAG collected and reviewed additional documents as needed. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were confidential or proprietary, or were requested as a result of the pre-on-site document review.) • At the close of the on-site portion of the site review, HSAG met with BHO staff and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2017–2018 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. • HSAG analyzed the findings. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the State**
	• HSAG populated the report template. • HSAG submitted the draft site review report to the BHO and the Department for review and comment. • HSAG incorporated the BHO's and Department's comments, as applicable, and finalized the report. • HSAG distributed the final report to the BHO and the Department.