COLORADO

Department of Health Care Policy & Financing

Fiscal Year 2022–2023 Compliance Review Report

for

Colorado Community Health Alliance

Region 6

June 2023

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

In accordance with its authority under Colorado Revised Statute 25.5-1-101 et seq. and pursuant to Request for Proposal 2017000265, the Department of Healthcare Policy & Financing (the Department) executed contracts with the Regional Accountable Entities (RAEs) for the Accountable Care Collaborative (ACC) program, effective July 1, 2018. The RAEs are responsible for integrating the administration of physical and behavioral healthcare and managing networks of fee-for-service primary care providers and capitated behavioral health providers to ensure access to care for Medicaid members. Per the Code of Federal Regulations, Title 42 (42 CFR), RAEs qualify as both Primary Care Case Management (PCCM) entities and Prepaid Inpatient Health Plans (PIHPs). 42 CFR requires PCCM entities and PIHPs to comply with specified provisions of 42 CFR §438—managed care regulations—and requires that states conduct a periodic evaluation of their managed care entities (MCEs), including PCCM entities and PIHPs to determine compliance with Medicaid managed care regulations published May 6, 2016. Additional revisions were released in November 2020, with an effective date of December 2020. The Department has elected to complete this requirement for the RAEs by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This report documents results of the fiscal year (FY) 2022–2023 compliance review activities for **Colorado Community Health Alliance** (**CCHA**). For each of the four standard areas reviewed this year, this section contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 2 describes the background and methodology used for the FY 2022–2023 compliance monitoring review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2021–2022 compliance review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the denials of authorization of services (denials), grievances, and appeals record review tools. Appendix C lists HSAG, RAE, and Department personnel who participated in some way in the compliance review process. Appendix D describes the corrective action plan (CAP) process that the RAE will be required to complete for FY 2022–2023 and the required template for doing so. Appendix E contains a detailed description of HSAG's compliance review activities consistent with the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[1-1]

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Apr 26, 2023. At the start of FY 2022–2023 compliance review, CMS had not finalized the 2023 CMS EQR Protocol 3; therefore, the 2019 CMS EQR Protocol 3 was used for the period under review.

Summary of Compliance Results

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

Table 1-1 presents the scores for **CCHA RAE 6** for each of the standards. Findings for all requirements are summarized in this section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* follow in Appendix A—Compliance Monitoring Tool.

Table 1-1—Summary of Scores for Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
I. Coverage and Authorization of Services	32	32	30	2	0	0	94%
II. Adequate Capacity and Availability of Services	14	14	14	0	0	0	100%
VI. Grievance and Appeal Systems	35	35	26	9	0	0	74%
XII. Enrollment and Disenrollment	5	5	5	0	0	0	100%
Totals	**86**	**86**	**75**	**11**	**0**	**0**	**87%**

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

Table 1-2 presents the scores for **CCHA RAE 6** for the denials, grievances, and appeals record reviews. Details of the findings for the record reviews are in Appendix B—Record Review Tools.

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Denials	100	71	64	7	29	90%
Grievances	60	57	57	0	3	100%
Appeals	60	59	50	9	1	85%
Totals	**220**	**187**	**171**	**16**	**33**	**91%**

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

Standard I—Coverage and Authorization of Services

Evidence of Compliance and Strengths

Documentation submitted by **CCHA**'s utilization management (UM) program demonstrated clear overarching policies and procedures which have been strengthened during the review period by the addition of detailed desktop procedures and letter writing templates that laid a strong foundation for consistent communication and expanded monitoring. In particular, **CCHA**'s documentation expectations for utilization review of co-occurring and non-covered diagnosis had been expanded to include additional notes from internal staff members and requesting providers to show evidence of member-specific considerations. UM decision making was reviewed for consistent application of criteria through the use of the Elevance interrater reliability tests. While five staff members did not meet the 90 percent passing threshold during the review period for the Elevance interrater reliability assessment, **CCHA** followed up with trainings related to American Society of Addiction Medicine (ASAM) and Milliman Care Guidelines 26th edition criteria. For specialty reviews, **CCHA** had experts available to review denial decisions either through immediate staffing on the team or easily accessible through the larger Elevance organization.

Staff members were able to speak to increased and decreased utilization trends and presented forecasting of upcoming utilization due to expanded grants and changes after the upcoming end to the public health emergency.

Member notices of adverse benefit determination (NABDs) demonstrated an improvement in member-friendly language, particularly in the psychiatric inpatient letters.

Opportunities for Improvement and Recommendations

While staff members described how emergency services pass through the claims system and how poststabilization service requests are reviewed by the UM team, **CCHA** could benefit from more formalized documentation to detail the nuances of the claims system and instances where emergency services claims are allowed to pass through. The documentation could then serve as a basis for annual review to ensure coding and claims adjudication procedures are current.

Required Actions

Documentation such as the *Behavioral Health Provider Manual*, *P2P Desktop Process*, *UM Workflow*, *UM Program Description*, *UM Review Desktop Procedure*, and *Letter Desktop Procedure* outlined that, in some cases, peer-to-peer consultations occurred after the member was mailed the NABD. Documentation submitted by **CCHA** and interviews with staff members referenced "reconsideration" of denials and "overturning" denial procedures, which do not comply with managed care regulations. While most cases reviewed in the denial samples demonstrated that **CCHA** outreached the requesting providers when necessary, in some instances, **CCHA** would make the decision sooner than the required

72-hour and 10-day authorization decision timelines. Furthermore, staff members reported that **CCHA** did not use extensions for authorization decisions during the review period. Staff members stated that the Department was interested in denial decisions that were overturned during appeals; however, **CCHA** reported that the data were difficult to pinpoint. **CCHA** must update its *Behavioral Health Provider Manual*, *P2P Desktop Process*, *UM Workflow*, *UM Program Description*, *UM Review Desktop Procedure*, *Letter Desktop Procedure*, and any related policies and procedures to clarify that the peer-to-peer process must occur prior to issuing the member an NABD. **CCHA** should consider enhancing these same policies, procedures, and workflows to better define instances in which staff members could consider and use extensions.

A review of 10 sample denial records showed issues such as:

- Three out of 10 NABDs included an attachment that stated the member must sign the appeal form and that verbal appeals must be followed by a written appeal, which is no longer required. However, since **CCHA** removed this attachment early in the review period, no required action is needed; **CCHA** is currently in compliance regarding this finding.
- Three out of 10 NABDs regarding ASAM level of care requests did not include all dimensions, as required.
- One NABD included a diagnosis that was incorrect.

Since **CCHA** removed the appeal form early in the review period, no required action is needed for that issue. However, **CCHA** must update its NABD templates and letter writing procedure for substance use disorder (SUD) requests to include information about all dimensions. Lastly, **CCHA** should enhance its oversight and monitoring to ensure accurate letters for members.

Standard II—Adequate Capacity and Availability of Services

Evidence of Compliance and Strengths

Policies, procedures, presentations, and staff member interviews demonstrated that **CCHA** monitors expected membership increases and decreases pending the end of the public health emergency in May 2023. In addition to enrollment monitoring, **CCHA** discussed expected utilization increases due to upcoming expanded benefits such as covered Autism Spectrum Disorder under the behavioral health benefit and other **CCHA** grants, including high intensity outpatient behavioral health services that could potentially impact utilization. During the review period, staff members reported the implementation of a new customer service software platform that includes functionality to better support the influx of calls and questions expected to occur during the public health emergency unwind.

According to the FY 2021–2022 Network Adequacy Plan, **CCHA** increased reimbursement rates for commonly billed behavioral health codes; engaged in workforce development efforts with partners at Jefferson Center for Mental Health and Diversus Health; implemented an access tracking mechanism for tracking open beds; and made efforts to expand access to 3.7 withdrawal management (WM) level of

care services at Cedar Springs and Centennial Peaks, as well as Valley Hope for Special Connections members, and engaged in ongoing efforts to contract with Universal Health Services for 3.7 WM level of care services.

The network management team, communication team, community liaisons, coaching, member support services, and quality staff members all collaborated to support the provider network, recruit and execute contracts, and support members in accessing services. Members were informed of their right to seek a second opinion, at no cost to the member. **CCHA** provided for direct access to women's healthcare specialists, which it communicated on its website on a dedicated webpage, the specialty provider page, and through the Department's member handbook.

Related to cultural competency, **CCHA** submitted multiple trainings and shared online resources available on its website, which addressed methods for providers to clarify communications with members of different backgrounds and beliefs in order to reduce potential barriers to accessing healthcare services. The provider newsletter examples included six months of various topics such as: exploring implicit bias; trauma-informed approaches to healthcare; lesbian, gay, bisexual, transgender, queer or questioning (LGBTQ) hotlines; and best practices regarding pronouns and other LGBTQ terminology. Additionally, **CCHA** staff members described turning to the experts in the accountable care network for ongoing workforce hiring to recruit and promote efforts to obtain diverse staffing in order to better support **CCHA**'s diverse membership. While member access to providers who speak languages other than English was lacking in some smaller counties, translation services were available through telephonic means. **CCHA** reported working with a Spanish-speaking equity consultant to review member materials written in Spanish. Lastly, **CCHA**'s website offered a means to search providers with specific accommodations such as high/low exam tables, wheelchair scales, scent/chemical-free facilities, etc.

Opportunities for Improvement and Recommendations

Broomfield County met all requirements other than SUD access to care for ASAM level 3.3, whereas all other counties fell slightly short of time and distance standards for one or more categories: psychiatric units in acute care hospitals, general and pediatric psychiatrists, and adult primary care and family practitioners. However, many of these categories were reported in the 90 to 99.9 percent access range. **CCHA** has an opportunity to continue working with the Department to identify ways to improve compliance with time and distance standards for SUD treatment practitioners (i.e., ASAM levels 3.1, 3.2 WM, 3.3, 3.5, 3.7, and 3.7 WM).

While **CCHA**'s Quality Management Committee minutes showed evidence of leadership reviewing any complaints related to access to care to monitor the member's experience of accessing care, the Region 6 Program Improvement Advisory Committee meeting minutes did not demonstrate a forum for oversight, monitoring, and feedback for network adequacy measures and outcomes. HSAG suggests **CCHA** ensure it reviews network adequacy validation quarterly reports and annual plans with leadership for oversight, monitoring, and feedback.

Although CCHA explicitly stated the expectation for primary care medical providers' (PCMPs') minimum hours of operation of 7:30 am to 5:30 pm, it did not provide the minimum hours of 8:00 am to 5:00 pm for behavioral health providers in documentation. HSAG recommends adding this information to a provider agreement, provider manual, or other similar documentation to clearly communicate the expectation with providers.

Monitoring of adherence to access to care standards, specifically timeliness of appointments, was well detailed for the PCMP network, which was monitored through a best practice approach called 3rd Next Appointment review. For the behavioral health provider network, response rates to the CCHA appointment surveys were low during the review period, around 10 percent. While staff members stated during the interview that rates had since improved, CCHA submitted no additional evidence to show how much of the behavioral health provider network participated in the survey or if appointment timeliness had improved. HSAG recommends increasing efforts to monitor the behavioral health provider network's adherence to timely appointment standards.

Required Actions

HSAG identified no required actions for this standard.

Standard VI—Grievance and Appeal Systems

Evidence of Compliance and Strengths

CCHA used a standard software system called NextGen, which allows staff to receive, document, and track grievances and appeals. Staff members reported that along with this system there are directors, managers, nurses, and other staff members who review grievances and appeals and send them through a process.

When discussing training opportunities for these staff members, CCHA reported it conducts detailed onboarding training as well as annual and monthly meetings for training opportunities to ensure it addresses all issues or questions. Related to oversight, CCHA reported the ability to access an array of medical professionals to review special clinical cases. Each reviewer's specialties are vetted through a detailed process to ensure the specialty reviewer has the relevant credentials within the scope of the specialty clinical case.

In regard to time frame requirements, CCHA accurately stated acknowledgement and resolution time frames in its appeals and grievance policies. For appeal requests, sample records showed that CCHA strictly adhered to the 60-day time frame for a member to request an appeal after the date of the NABD. However, staff members shared during the interview that CCHA has a process to review late appeal requests for emergent or important circumstances for the member in which case they would make an exception for the member. Related to State fair hearings, staff members reported receiving notification

of any overturned decisions and making efforts to authorize and provide services within the 72-hour time frame.

CCHA's grievance sample records were 100 percent compliant and appeal sample records were 85 percent compliant. HSAG removed and replaced one appeal sample file with an oversample since the case was a provider claim issue rather than a member appeal.

Opportunities for Improvement and Recommendations

CCHA informed providers of grievance and appeal requirements through the use of two provider manuals, one for behavioral health and one for physical health providers. During the review, HSAG noted that the *Physical Health Provider Manual* did not have as much information regarding grievances and appeals as the *Behavioral Health Provider Manual*. Although both included accurate information, HSAG recommends expanding the *Physical Health Provider Manual* to include additional details, where relevant.

During the interview, **CCHA** described that when waiting to obtain member consent during appeal procedures, staff members wait as long as possible, up until the resolution deadline, before sending an appeal resolution letter. HSAG recommends **CCHA** use extensions in instances where more information is needed to give the member more time.

Required Actions

CCHA defined "grievance" as an expression of dissatisfaction about any matter other than an adverse benefit determination in its policy. However, staff members reported when grievances are received, the member is asked if they would like to file a formal grievance. If the member declines, **CCHA** does not document the complaint in the grievance software system, NextGen, but rather in the customer service software system; therefore, the grievance cannot be tracked and trended. **CCHA** must enhance its messaging to the members in a way that encourages members to grieve freely without the barrier of a perceived second "formal" step. Additionally, **CCHA** must update and conduct a refresher training that reiterates the enhanced messaging to members expressing dissatisfaction. For example, "I understand and hear your concern. I will take this information down, look into it, and follow up with you." The customer service staff members who receive complaints should receive updated training regarding how to ensure all complaints are logged in the grievance system and ensure members receive a grievance acknowledgement letter and resolution letter. Monitoring should include a mechanism for monitoring the customer service calls to ensure all complaints are being processed as grievances, tracked within the grievance system, and reported quarterly to the Department.

Policies and procedures included accurate information describing how **CCHA** would accept additional information from the member during a review of a filed grievance by the member. During the record review, HSAG identified one member grievance record had documentation that indicated the member called to give more information and was advised to file a new grievance on the website rather than the representative taking down the additional information. **CCHA** must develop a refresher training on how

to handle additional information received from the member during the grievance process. **CCHA** should enhance its monitoring of staff member documentation to ensure that representatives are accepting and reviewing additional information received from a member during an open case. Staff members should not direct members to file a new grievance unless that grievance indicates a different grievance that is not related to the current open case.

All grievance acknowledgement letters in the sample records were timely. However, the **CCHA** website included a downloadable portable document format (PDF) titled "What is the grievance and appeal process?" The PDF included inaccurate information, such as:

- A grievance acknowledgement letter will be sent in five days.
- A verbal appeal must be followed up with a written appeal.

The PDF must be updated to accurately state that a grievance acknowledgement letter will be sent to the member in two working days and to remove the statement that a verbal appeal must be followed up with a written appeal. Additionally, during the record review, HSAG identified three out of 10 appeal acknowledgement letters that stated a member must follow up a verbal appeal in writing. Appeal acknowledgement letters must be updated to remove any requirement that the member must follow up a verbal appeal in writing.

One out of 10 member appeal resolution letters were not timely. All appeal resolution letters must be sent to the member within 10 working days. **CCHA** must enhance its monitoring of timeliness to ensure all appeal resolution letters are following the time frame set forth by the State contract and federal regulations.

CCHA's *Member Appeals Policy* stated the accurate time frame to resolve expedited appeals and provide written notice of disposition to affected parties is within 72 hours after the appeal is received. However, the policy did not include that the member may file a grievance if the member disagrees with the decision. The *Member Appeals Policy* must be updated to include that the member may file a grievance.

Therefore, the *Member Appeals Policy* on page 6, section 7.a. must include:

- The member may file a grievance if they disagree with the decision (please see 5.b on page 6 for an example).

Although **CCHA** did not have any extension requests in the appeals sample list, there were extension requests for grievances. Three out of 10 grievance samples were extended; however, **CCHA** did not include extension letters or oral notice to the member. **CCHA** must enhance its policies, procedures, and training for staff members to ensure that when an extension is in the best interest of the member, an extension letter is sent to the member as well as prompt oral notice of the delay.

CCHA's appeal resolution letters included information on how to request a State fair hearing and continuation of benefits. However, the appeal resolution letters only included how to request

continuation of benefits by mail or fax. While State fair hearings must be submitted in writing, the request for continuation of benefits does not need to be in writing. The appeal resolution letters must be updated to include the contact phone number and remove "written" from its language under the "Who to contact" portion of the appeal resolution letter in regard to continuation of benefits.

Although **CCHA**'s provider manuals for behavioral health and physical health included two separate sections for grievances and appeals, on page 48 of the *Behavioral Health Provider Manual*, there was one section that combined the two processes with three bullet points that did not apply to appeals. The three bullet points should be located under the grievance section only on page 49. Additionally, page 49 under "Members: Filing a Grievance" stated that the member "must" attach documents to a grievance request as evidence for an investigation. Page 52 did not include "For notice of an expedited resolution, the Contractor must also *make reasonable efforts to provide oral notice of resolution*." **CCHA** must update its *Behavioral Health Provider Manual* with the following:

- Remove "appeal" from the last section on page 48 and relocate the three bullet points under grievances.
- Remove the word "must" on page 49 regarding requiring the member to attach documents. **CCHA** can enhance this sentence by clarifying that the member may submit additional information through any means such as through a call or in writing by fax, email, or mail.
- On page 52, include "For notice of an expedited resolution, the Contractor must also *make reasonable efforts to provide oral notice of resolution*."

Standard XII—Enrollment and Disenrollment

Evidence of Compliance and Strengths

CCHA submitted an *Enrollment Policy*, *Disenrollment Policy*, and *Non-Discrimination Notice* as evidence for review. During the review, **CCHA** described a thorough process in which members are enrolled in the order in which they apply. Electronic Data Interchange (EDI) 834 files were received daily by **CCHA** and, once received, the files were processed by conducting daily reconciliations. Staff members described the process of conducting a monthly audit on the 834 files to reconcile and terminate members from the system based on that monthly audit.

Policies, procedures, and trainings supported efforts and awareness around member nondiscrimination. If a member were to accuse **CCHA** of discrimination, the member's discrimination accusation would be handled through the grievance process and investigated. However, staff members reported not being aware of any type of discrimination accusations and confirmed that they work with the members to access healthcare services as soon as the members are enrolled in **CCHA**.

In regard to disenrollment, **CCHA** staff members reported never having to request disenrollment of any member. In rare cases, staff members would utilize the *Transitions of Care Policy* to transfer a member if the member would be better supported by a different RAE. However, **CCHA** staff members stated

they would only do that to benefit the members, and staff members would work with each member by meeting the member where they are so they can continue to receive uninterrupted services.

Opportunities for Improvement and Recommendations

HSAG identified no opportunities for improvement or recommendations for this standard.

Required Actions

HSAG identified no required actions for this standard.

2. Overview and Background

Overview of FY 2022–2023 Compliance Monitoring Activities

For the FY 2022–2023 compliance 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 I—Coverage and Authorization of Services, Standard II—Adequate Capacity and Availability of Services, Standard VI—Grievance and Appeal Systems, and Standard XII—Enrollment and Disenrollment. Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the RAE's contract requirements and regulations specified by the federal Medicaid managed care regulations published May 6, 2016. Additional revisions were released in November 2020, with an effective date of December 2020. HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. The Department determined that the review period was January 1, 2022, through December 31, 2022. HSAG conducted a desk review of materials submitted prior to the compliance review activities; a review of records, documents, and materials requested during the compliance review; and interviews of key RAE personnel to determine compliance with applicable federal managed care regulations and contract requirements. Documents submitted for the desk review and compliance 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 denials of authorization, grievances, and appeals.

HSAG reviewed a sample of the RAE's administrative records related to denials, grievances, and appeals to evaluate implementation of federal and State healthcare regulations. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records (to the extent that a sufficient number existed) for each of the denials, grievances, and appeals. Using a random sampling technique, HSAG selected the samples from all RAE denial, grievance, and appeal records that occurred between January 1, 2022, and December 31, 2022. For the record review, the RAE received a score of *Met (M)*, *Not Met (NM)*, or *Not Applicable (NA)* for each required element. Results of record reviews were considered in the review of applicable requirements in Standard I—Coverage and Authorization of Services and Standard VI—Grievance and Appeal Systems. HSAG separately calculated a record review score for each record review requirement and an overall record review score.

The compliance review processes were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Appendix E contains a detailed description of HSAG's compliance review activities consistent with those outlined in the CMS EQR protocol. The four standards chosen for the FY 2022–2023 compliance reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care; Standard IV—Member Rights, Protections, and Confidentiality; Standard V—Member Information Requirements; Standard VII—Provider Selection and Program Integrity; Standard VIII—Credentialing and Recredentialing; Standard IX—Subcontractual Relationships and Delegation; Standard X—Quality Assessment and Performance Improvement; and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT).

Objective of the Compliance Review

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

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

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

FY 2021–2022 Corrective Action Methodology

As a follow-up to the FY 2021–2022 compliance review, each RAE that received one or more *Partially Met* or *Not Met* scores was required to submit a CAP to the Department addressing those requirements found not to be fully compliant. If applicable, the RAE was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the RAE and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **CCHA** until it completed each of the required actions from the FY 2021–2022 compliance monitoring review.

Summary of FY 2021–2022 Required Actions

For FY 2021–2022, HSAG reviewed Standard III—Coordination and Continuity of Care; Standard IV—Member Rights, Protections, and Confidentiality; Standard V—Member Information Requirements; and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services.

Related to Standard III—Coordination and Continuity of Care, **CCHA** was required to complete one corrective action, which was to strengthen applicable documents and create a more detailed procedure that outlines referral procedures and timeliness expectations and ensure all member needs are addressed, regardless of auto-assignment into a particular PCMP tier or condition management.

Related to Standard V—Member Information Requirements, **CCHA** was required to complete two corrective actions, which were to revise critical member materials to include all required components of a tagline and develop a mechanism to ensure that, upon request, members are provided with printed materials within five business days, at no cost.

Related to Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services, **CCHA** was required to complete one corrective action, which was to develop a process to ensure access to foster data and outreach to newly eligible foster children are completed within 60 days of identification by the Department of Human Services or **CCHA**.

Summary of Corrective Action/Document Review

CCHA submitted a proposed CAP in August 2022. HSAG and the Department reviewed and approved the proposed plan and responded to **CCHA**. **CCHA** submitted final documents and completed the CAP in November 2022.

Summary of Continued Required Actions

CCHA successfully completed the FY 2021–2022 CAP, resulting in no continued corrective actions.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor ensures that all services are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished. *42 CFR 438.210(a)(3)(i)* Contract: Exhibit B-8—14.6.2	**Both RAEs:** This document outlines clinical criteria policies and procedures for CCHA. • I.CA.1_Clinical Criteria Policy, pg. 2 This document outlines how determinations are made. • I.CA.1_UM Program Description, pg. 11-17 This document outlines a generalized overview of how medical necessity reviews are completed. • I.CA.1_ UM Review Desktop Procedure **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42 CFR 438.210(a)(3)(ii)* Contract: Exhibit B-8—14.6.4	**Both RAEs:** This document outlines clinical criteria policies and procedures for CCHA. • I.CA.1_Clinical Criteria Policy, pg.4 This document outlines a generalized overview of how determinations are made and not arbitrarily denied. • I.CA.1_ UM Review Desktop Procedure **R6-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	R7-specific:	
3. The Contractor may place appropriate limits on services— • On the basis of criteria applied under the Medicaid State plan (such as medical necessity). • For the purpose of utilization control, provided that the services furnished can reasonably achieve their purpose. – For Utilization Management, provided family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used. *Note: The Contractor shall not deny or reduce the amount, duration, and scope of services provided under EPSDT as long as the service is supporting a member to maintain stability or level of functioning or making treatment progress.* *42 CFR 438.210(a)(4)* Contract: Exhibit B-8—14.6.2.1, 14.6.5, 14.6.5. 2, and 14.6.5.2.3	**Both RAEs:** This document outlines clinical criteria policies and procedures for CCHA. • I.CA.1_Clinical Criteria Policy, pg. 4 **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor may place appropriate limits on services for utilization control, provided that any financial requirement or treatment limitation applied to mental health or substance use disorder (SUD) benefits in any classification is no more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in	**Both RAEs:** This document outlines no utilization controls or coverage limits. • I.CA.1_Clinical Criteria Policy, pg. 4	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
the same classification furnished to members (whether or not the benefits are furnished by the same Contractor). • The Contractor may only apply a Non-Quantitative Treatment Limitation (NQTL) for mental health or substance use disorder benefits, in any classification, in a manner comparable to, and no more stringently than, the processes, strategies, evidentiary standards, or other factors applied to the same NQTL in the same benefit classification of the members' medical/surgical benefits. *42 CFR 438.905* *HB19-1269: Section 3–10-16-104(3)(B)* Contract: Exhibit B-8—14.6.5.2.1, 14.6.5.2.2	**R6-specific:** **R7-specific:**	
5. The Contractor covers all medically necessary covered treatments for covered behavioral health (BH) diagnoses, regardless of any co-occurring conditions. The Contractor must ensure that the diagnosis of an intellectual or developmental disability, a neurological or neurocognitive disorder, or a traumatic brain injury does not preclude an individual from receiving a covered BH service. *HB19-1269: Section 12—25.5-5-402(3)(h-i)*	**Both RAEs:** This document outlines coverage under the BH capitation. • I.CA.1_Clinical Criteria Policy, pg. 5 This document outlines a generalized overview on reviewing non-covered benefits. • I.CA.5_NonCovered Benefit Desktop Procedure **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor definition of "medically necessary": • Is no more restrictive than that used in Colorado's Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in Colorado statutes and regulations, the Health First Colorado plan, and other Colorado policies and procedures; and • Addresses the extent to which the RAE is responsible for covering services that address: – The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability. – The ability for a member to achieve age-appropriate growth and development. – The ability for a member to attain, maintain, or regain function capacity. – The opportunity for a member receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and to live and work in the setting of their choice. *Note: For the purposes of EPSDT, medical necessity includes a good or service that will, or is reasonably expected to, assist the client to achieve or maintain maximum functional capacity in performing one or more Activities of Daily Living; and meets the criteria set forth at Section 8.076.1.8.b–g.* *The Contractor shall determine medical necessity under EPSDT based on an individualized clinical review of a member's medical status and in consideration that the requested treatment can correct or ameliorate a*	**Both RAEs:** This document includes the medical necessity definition CCHA uses to make authorization decisions, including the updated EPSDT definition. • I.CA.1_Clinical Criteria Policy, pg. 2 This document outlines considerations and extent of clinical information needed when making UM decisions. • I.CA.1_UM Program Description, pg. 11-12 This document outlines a generalized overview of clinical criteria that can be taken into consideration during medical necessity reviews. • I.CA.1_ UM Review Desktop Procedure **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
diagnosed health condition. *Note: The Contractor shall utilize the American Society of Addiction Medicine (ASAM) criteria to determine medical necessity for residential and inpatient substance use disorder treatment services.* *42 CFR 438.210(a)(5)* Contract: Exhibit B-8—14.6.5.1.1 10 CCR 2505-10 8.280.4.E.2 10 CCR 2505-10 8.205.10.B.4.a		
7. The Contractor and its subcontractors have in place and follow written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42 CFR 438.210(b)(1)* Contract: Exhibit B-8—14.8.2	**Both RAEs:** This document outlines clinical criteria policies and procedures for CCHA. • I.CA.1_Clinical Criteria Policy, pg. 3-4 This document outlines CCHA's procedure for making pre-service and concurrent review decisions. • I.CA.1_UM Program Description, "Pre-Service (Prospective) Review Decisions, pg. 11-18, and "Concurrent Review Decisions, pg. 15 This document outlines a generalized overview of how determinations are made and not arbitrarily denied. • I.CA.1_ UM Review Desktop Procedure This document outlines the process for the review and authorization of service requests. • I.CA.7_UM Workflow	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	R6-specific: **R7-specific:**	
8. The Contractor and its subcontractors have mechanisms in place and to ensure consistent application of review criteria for authorization decisions. *42 CFR 438.210(b)(2)(i)* Contract: Exhibit B-8—14.8.2.6	**Both RAEs:** This document outlines clinical criteria policies and procedures for CCHA. • I.CA.1_Clinical Criteria Policy, pg. 3 This document outlines the process for the review and authorization of service requests. • I.CA.7_UM Workflow This document outlines the service authorization timeline for standard and expedited service requests. • I.CA.8_Member Appeals Policy, pg. 3 This document outlines CCHA's development and implementation of its criteria for authorization decisions. • I.CA.1_UM Program Description, "Medical Necessity Review,' pg. 11-22 This document outlines a generalized overview of how determinations are made and not arbitrarily denied. • I.CA.1_ UM Review Desktop Procedure	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	These documents outline internal quality measures to maintain consistency. • I.CA.8_TAT Report • I.CA.8_UM Internal Audit Tool **R6-specific:** **R7-specific:**	
9. The Contractor and its subcontractors have in place mechanisms to consult with the requesting provider for medical services when appropriate. *42 CFR 438.210(b)(2)(ii)* Contract: Exhibit B-8—14.8.2.5	**Both RAEs:** This document outlines CCHA's Utilization Management program in more detail, including how medical necessity reviews may require provider consultations. • I.CA.1_UM Program Description, pg.14 and pg. 20 peer-to-peer conversations This document outlines a generalized overview of how P2P's are offered and documented. • I.CA.9_P2P Desktop Procedure **R6-specific:** **R7-specific:**	**RAE 6:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: Documentation such as the *Behavioral Health Provider Manual*, *P2P Desktop Process*, *UM Workflow*, *UM Program Description*, *UM Review Desktop Procedure*, and *Letter Desktop Procedure* outlined that, in some cases, peer-to-peer consultations occurred after the member was mailed the NABD. Documentation submitted by CCHA and interviews with staff members referenced "reconsideration" of denials and "overturning" denial procedures, which do not comply with managed care regulations. While most cases reviewed in the denial samples demonstrated that CCHA outreached the requesting providers when necessary, in some instances, CCHA would make the decision sooner than the required 72-hour and 10-day authorization decision timelines. Furthermore, staff members reported that CCHA did not use extensions for authorization decisions during the review period. Staff members stated that the Department was interested in denial decisions that were overturned during appeals; however, CCHA reported that the data were difficult to pinpoint.		
Required Actions: CCHA must update its *Behavioral Health Provider Manual*, *P2P Desktop Process*, *UM Workflow*, *UM Program Description*, *UM Review Desktop Procedure*, *Letter Desktop Procedure*, and any related policies and procedures to clarify that the peer-to-peer process must occur prior to issuing the member an NABD. CCHA should consider enhancing these same policies, procedures, and workflows to better define instances in which staff members could consider and use extensions.		
10. The Contractor ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the member's medical or BH needs. The Contractor's utilization management program includes identification of the type of personnel responsible for each level of utilization management decision-making. *42 CFR 438.210(b)(3)* Contract: Exhibit B-8—14.6.6, 14.8.2.4	**Both RAEs:** This document outlines the requirements for service review and medical necessity denial. • I.CA.1_Clinical Criteria Policy, pg. 1 This document outlines the requirements for service review by an appropriate clinician, including requirements for the Medical Director to issue medical necessity denials. • I.CA.8_Member Appeals Policy, pg. 4 This document outlines educational requirements for its Medical Directors and how the Medical Director has to issue a medical necessity denial.	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• I.CA.1_UM Program Description, pg. 6-8, 13-14 This document outlines the process for the review and authorization of service requests by the Medical Director. • I.CA.7_UM Workflow This document outlines the process for review for authorization and denial. • I.CA.1_ UM Review Desktop Procedure **R6-specific:** **R7-specific:**	
11. The Contractor notifies the requesting provider and gives the member written notice of any decision by the Contractor to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. *Note: Notice to the provider may be oral or in writing.* *42 CFR 438.210(c)* Contract: Exhibit B-8—8.6.1 10 CCR 2505-10 8.209.4.A.1	**Both RAEs:** This document outlines CCHA's responsibility for notifying providers and members when a service is denied or is authorized in an amount, scope, or duration that is less than requested. • I.CA.11_NoABD Policy, pg. 1 This document outlines CCHA's process to provide notice to members and provider when a service is denied or is authorized in an amount, scope or duration that is less than requested. • I.CA.1_UM Program Description, pg. 19-22	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This document outlines a generalized overview of the denial process. • I.CA.1_ UM Review Desktop Procedure **R6-specific:** **R7-specific:**	
12. The Contractor adheres to the following time frames for making standard and expedited authorization decisions: • For standard authorization decisions—as expeditiously as the member's condition requires and not to exceed 10 calendar days following the receipt of the request for service. • If the provider indicates, or the Contractor determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service. *42 CFR 438.210(d)(1–2)* *Memo: HCPF FFS UM Policy Requirements for SUD Benefit—August 4, 2020* Contract: Exhibit B-8—8.6.6, 8.6.8 10 CCR 2505-10 8.209.4.A.3(c)	**Both RAEs:** This document outlines the timelines for CCHA to make standard and expedited authorization decisions when issuing adverse benefit determinations. • I.CA.11_NoABD Policy pg. 2 This document outlines the authorization timelines for expedited and standard service requests. • I.CA.1_UM Program Description, pg. 17-18 This document outlines the timelines for CCHA to make standard and expedited authorization decision. • I.CA.8_Member Appeals Policy, pg. 5-6 This document outlines a generalized overview of turnaround times and extension timeframes. • I.CA.1_ UM Review Desktop Procedure	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	R6-specific: **R7-specific:**	
13. The Contractor may extend the time frame for making standard or expedited authorization decisions by up to 14 additional calendar days if: • The member or the provider requests an extension, or • The Contractor justifies (to the Department, upon request) a need for additional information and how the extension is in the member's interest. *42 CFR 438.210(d)(1)(i–ii) and (d)(2)(ii)* Contract: Exhibit B-8—8.6.6.1, 8.6.8.1	**Both RAEs:** This document outlines when CCHA can extend the timeline for authorization decisions when issuing an adverse benefit determination. • I.CA.11_NoABD Policy pg. 2 This document outlines when CCHA can extend the timeline for authorization decisions. • I.CA.8_Member Appeals Policy, pg. 6 This document describes the extension process. • I.CA.1_UM Program Description, pg. 17-18 This document outlines a generalized overview of turnaround times and extension timeframes. • I.CA.1_ UM Review Desktop Procedure **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The notice of adverse benefit determination must be written in language easy to understand, available in State-established prevalent non-English languages in the region, and available in alternative formats for persons with special needs. *42 CFR 438.404(a)* Contract: Exhibit B-8—8.6.1–8.6.1.4 10 CCR 2505-10 8.209.4.A.1	**Both RAEs:** This document outlines the requirement for the notice of adverse benefit determination, including requirements regarding language access and alternative formats. • I.CA.11_NoABD Policy, pg. 2 This document outlines requirements for appeal notices, including CCHA's responsibilities for providing notices in alternative formats and in the prevalent non-English languages in our regions. • I.CA.14_CCHA_Member and Provider Materials and Website Policy, pg. 1-5 This document outlines CCHA's process to provide notice to members and provider when a service is denied or is authorized in an amount, scope or duration that is less than requested. • I.CA.1_UM Program Description, pg. 19-21 This is a copy of the State's model Notice of Adverse Benefit Determination that CCHA uses to inform members of an adverse benefit determination. • I.CA.14_NoABD ENG This is a copy of the model Notice of Adverse Benefit Determination that CCHA uses to inform Spanish speaking members of an adverse benefit determination.	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• I.CA.14_NoABD SPA **R6-specific:** **R7-specific:**	
15. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to and copies of all documents and records relevant to the adverse benefit determination (includes medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits). • The member's right (or member's designated representative) to request one level of appeal with the Contractor and the procedures for doing so. • The date the appeal is due. • The member's right to request a State fair hearing after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State fair hearing. • The circumstances under which an appeal process can be expedited and how to make this request.	**Both RAEs:** This document outlines the requirements of the notice of adverse benefit determinations in order for members to understand their rights regarding the ability to appeal an adverse benefit determination. • I.CA.11_NoABD Policy, pg. 1-2 This is a copy of the State's model Notice of Adverse Benefit Determination that CCHA uses to inform members of an adverse benefit determination. • I.CA.14_NoABD ENG This is a copy of the model Notice of Adverse Benefit Determination that CCHA uses to inform Spanish speaking members of an adverse benefit determination. • I.CA.14_NoABD SPA This document outlines CCHA's process to provide notice to members and provider when a service is denied or is authorized in an amount, scope or duration that is less than requested.	**RAE 6:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The member's rights to have benefits/services continue (if applicable) pending the resolution of the appeal, how to request that benefits continue, and the circumstances (consistent with State policy) under which the member may be required to pay the cost of these services. • How each dimension of the most recent edition of ASAM criteria was considered when determining medical necessity for any adverse determination concerning residential or inpatient substance use disorder services. *42 CFR 438.404(b)* *SB21-137: Section 10-25.5-5-424(3)* Contract: Exhibit B-8—8.6.1.5–8.6.1.13 10 CCR 2505-10 8.209.4.A.2	• I.CA.1_UM Program Description, pg. 19-21 **R6-specific:** **R7-specific:**	
Findings: A review of 10 sample denial records showed issues such as: • Three out of 10 NABDs included an attachment that stated the member must sign the appeal form and that verbal appeals must be followed by a written appeal, which is no longer required. However, since CCHA removed this attachment early in the review period, no required action is needed; CCHA is currently in compliance regarding this finding. • Three out of 10 NABDs regarding ASAM level of care requests did not include all dimensions, as required. • One NABD included a diagnosis that was incorrect.		
Required Actions: Since CCHA removed the appeal form early in the review period, no required action is needed for that issue. However, CCHA must update its NABD templates and letter writing procedure for SUD requests to include information about all dimensions. Lastly, CCHA should enhance its oversight and monitoring to ensure accurate letters for members.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The Contractor mails the notice of adverse benefit determination within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, as defined in 42 CFR 431.211, 431.213 and 431.214 (see below). • For denial of payment, at the time of any denial affecting the claim. • For standard service authorization decisions that deny or limit services, within 10 calendar days following the receipt of the request for service. • For expedited service authorization decisions, within 72 hours after receipt of the request for service. • For extended service authorization decisions, no later than the date the extension expires. • For service authorization decisions not reached within the required time frames, on the date the time frames expire. *42 CFR 438.404(c)* *42 CFR 438.210(d)* Contract: Exhibit B-8—8.6.3.1, 8.6.5–8.6.8 10 CCR 2505-10 8.209.4.A.3	**Both RAEs:** This document outlines the mailing timelines for the notice of adverse benefit determination. • I.CA.11_NoABD Policy, pg. 2 This document outlines CCHA's process to provide notice to members and provider when a service is denied or is authorized in an amount, scope or duration that is less than requested. • I.CA.1_UM Program Description, pg. 19-21 This document outlines a generalized overview ensuring a NoABD letter is sent to the member and provider. • I.CA.17_Letter Desktop Procedure These documents outline internal quality measures to maintain consistency. • I.CA.8_TAT Report • I. CA.8_UM Internal Audit Tool **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. For reduction, suspension, or termination of a previously authorized Medicaid-covered service, the Contractor gives notice at least 10 days before the intended effective date of the proposed adverse benefit determination except: • The Contractor gives notice on or before the intended effective date of the proposed adverse benefit determination if: – The Contractor has factual information confirming the death of a member. – The Contractor receives a clear written statement signed by the member that the member no longer wishes services or gives information that requires termination or reduction of services and indicates that the member understands that this must be the result of supplying that information. – The member has been admitted to an institution where the member is ineligible under the plan for further services. – The member's whereabouts are unknown, and the post office returns Contractor mail directed to the member indicating no forwarding address. – The Contractor establishes that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth. – A change in the level of medical care is prescribed by the member's physician. – The notice involves an adverse benefit determination made with regard to the preadmission screening requirements.	**Both RAEs:** This document outlines when CCHA is able to provide less than ten days notice before the intended effective date of the adverse benefit determination. • I.CA.11_NoABD Policy, pg. 2-3 This document outlines reduction. suspension, or termination of a previously authorized Medicaid-covered service. • I.CA.1_UM Program Description, pg. 21 **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• If probable member fraud has been verified, the Contractor gives notice five calendar days before the intended effective date of the proposed adverse benefit determination. *42 CFR 438.404(c)* *42 CFR 431.211* *42 CFR 431.213* *42 CFR 431.214* Contract: Exhibit B-8—8.6.3.1–8.6.3.2, 8.6.4.1–8.6.4.8 10 CCR 2505-10 8.209.4.A.3(a)		
18. If the Contractor extends the time frame for standard authorization decisions, it must give the member written notice of the reason for the extension and inform the member of the right to file a grievance if the member disagrees with that decision. *42 CFR 438.404(c)(4)* Contract: Exhibit B-8—8.6.6.2 10 CCR 2505-10 8.209.4.A.3(c)(1)	**Both RAEs:** This document outlines CCHA's requirements when extending a standard authorization decision timeline. • I.CA.11_NoABD Policy, pg. 2- 3 This document outlines CCHA's process to provide an extension and the written notification. • I.CA.1_UM Program Description, pg. 18 **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
19. The Contractor provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42 CFR 438.210(e)* Contract: Exhibit B-8—14.8.7	**Both RAEs:** This publicly posted statement outlines CCHA's commitment to ensuring utilization management decisions are based only on the appropriateness of care and service and the existence of coverage. • BH UM Affirmative Statement: https://www.cchacares.com/Dal/M3d This document outlines CCHA's UM affirmative statement. • I.CA.1_UM Program Description, pg. 5 **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
20. The Contractor defines emergency medical condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part.	**Both RAEs:** This document outlines how CCHA defines an emergency medical condition. • I.CA.21_BH Emergency Services Policy, pg. 1 **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.114(a) Contract: Exhibit B-8—2.1.36; 7.3.8.1.6.1		
21. The Contractor defines emergency services as covered inpatient or outpatient services furnished by a provider that is qualified to deliver these services and are needed to evaluate or stabilize an emergency medical condition. *42 CFR 438.114(a)* Contract: Exhibit B-8—2.1.37	**Both RAEs:** This document outlines how CCHA defines emergency services. • I.CA.21_BH Emergency Services Policy, pg. 1 **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
22. The Contractor defines poststabilization care services as covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or provided to improve or resolve the member's condition. *42 CFR 438.114(a)* Contract: Exhibit B-8—2.1.82	**Both RAEs:** This document outlines how CCHA defines post-stabilization care services. • I.CA.23_BH Post-Stabilization Care Policy, pg. 1 **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
23. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. *42 CFR 438.114(c)(1)(i)* Contract: Exhibit B-8—14.5.6.2.2	**Both RAEs:** This document outlines CCHA's responsibility for coverage and payment of emergency services. • I.CA.21_BH Emergency Services Policy, pg. 2-3 **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
24. The Contractor may not deny payment for treatment obtained under either of the following circumstances: • A member had an emergency medical condition, including cases in which the absence of immediate medical attention would *not* have had the following outcomes: – Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; – Serious impairment to bodily functions; or – Serious dysfunction of any bodily organ or part. *(Note: The Contractor bases its coverage decisions for emergency services on the severity of the symptoms at the time of presentation and covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. 42 CFR 438.114—Preamble)* • A representative of the Contractor's organization instructed the member to seek emergency services.	**Both RAEs:** This document outlines CCHA's responsibility for coverage and payment of emergency services. • I.CA.21_BH Emergency Services Policy, pg. 2-3 **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.114(c)(1)(ii) Contract: Exhibit B-8—14.5.6.2.6		
25. The Contractor does not: • Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms. • Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent failing to notify the member's primary care provider or the Contractor of the member's screening and treatment within 10 calendar days of presentation for emergency services. *42 CFR 438.114(d)(1)* Contract: Exhibit B-8—14.5.6.2.8	**Both RAEs:** This document outlines CCHA's requirements to not deny an emergency service. • I.CA.21_BH Emergency Services Policy, pg. 2-3 **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
26. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42 CFR 438.114(d)(2)* Contract: Exhibit B-8—14.5.6.2.9	**Both RAEs:** This document outlines CCHA's requirement to not hold a member liable for receiving emergency services. • I.CA.21_BH Emergency Services Policy, pg. 2-3 **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
27. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment. *42 CFR 438.114(d)(3)* Contract: Exhibit B-8—14.5.6.2.10	**Both RAEs:** This document outlines CCHA's responsibility to ensure the treating provider makes the determination of member stability. • I.CA.21_BH Emergency Services Policy, pg. 2-3 **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
28. The Contractor is financially responsible for poststabilization care services that are prior authorized by an in-network provider or the Contractor's representative, regardless of whether they are provided within or outside the Contractor's network of providers. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(i)* Contract: Exhibit B-8—14.5.6.2.11	**Both RAEs:** This document outlines when CCHA is financially responsible for post-stabilization care services. • I.CA.23_BH Post-Stabilization Care Policy, pg. 1-2 **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
29. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition within one hour of a request to the organization for pre-approval of further poststabilization care services.	**Both RAEs:** This document outlines when CCHA is financially responsible for post-stabilization care services. • I.CA.23_BH Post-Stabilization Care Policy, pg. 1-2	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.114(e) *42 CFR 422.113(c)(2)(ii)* Contract: Exhibit B-8—14.5.6.2.12	This document outlines CCHA's timeline for pre-approval of post-stabilization care. • I.CA.1_UM Program Description, pg. 17 **R6-specific:** **R7-specific:**	
30. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the member's stabilized condition if: • The organization does not respond to a request for pre-approval within one hour. • The organization cannot be contacted. • The organization's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the organization must give the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with care of the patient until a plan provider is reached or one of the criteria in 422.113(c)(2)(iii) is met. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(iii)* Contract: Exhibit B-8—14.5.6.2.12	**Both RAEs:** This document outlines when CCHA is financially responsible for outpatient care when CCHA is unable to be contacted or CCHA and the treating physician cannot reach an agreement regarding a member's care. • I.CA.23_BH Post-Stabilization Care Policy, pg. 2 **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
31. The Contractor's financial responsibility for poststabilization care services it has not pre-approved ends when: • A plan physician with privileges at the treating hospital assumes responsibility for the member's care, • A plan physician assumes responsibility for the member's care through transfer, • A plan representative and the treating physician reach an agreement concerning the member's care, or • The member is discharged. *42 CFR 438.114(e)* *42 CFR 422.113(c)(3)* Contract: Exhibit B-8—14.5.6.2.14	**Both RAEs:** This document outlines when CCHA's financial responsible for post-stabilization care that was not pre-approved ends. • I.CA.23_BH Post-Stabilization Care Policy, pg. 2 **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
32. If the member receives poststabilization care services from a provider outside the Contractor's network, the Contractor does not charge the member more than they would be charged if the member had obtained the services through an in-network provider. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(iv)* Contract: Exhibit B-8—14.5.6.2.13	**Both RAEs:** This document outlines requirements regarding member charges for out of network post-stabilization care services. • I.CA.23_BH Post-Stabilization Care Policy, pg. 2 **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	30	X	1.00	=	30
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	32	**Total Score**		=	30
				Total Score ÷ Total Applicable		=	94%

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor maintains and monitors a PCMP and BH network of providers that is supported by written agreements and is sufficient to provide adequate access to all covered services to all members, including those with limited English proficiency or physical or mental disabilities. The provider networks include the following provider types and areas of expertise: primary care (adult and pediatric), OB/GYN providers, mental health providers (adult and pediatric), SUD providers, psychiatrists (adult, child, and prescribers), and family planning providers. *42 CFR 438.206(b)(1)* Contract: Exhibit B-8—9.3.1, 9.5.1.1, 9.5.1.3	**Both RAEs:** The Provider Network Adequacy and Access Standards Policy outlines CCHA's requirements to establish an adequate network to provide access to covered services for all members, including members with limited English proficiency, members with physical or mental disabilities, and other special populations. • II.AA.1_Provider Network Adequacy and Access Standards Policy, pg. 3 The following document outlines CCHA's policy for ensuring its provider network is sufficient to meet the needs of all members, including those with disabilities and/or limited English proficiency. • II.AA.1_Americans with Disabilities Act Compliance for Participating Providers Policy, pg. 1 The following provider recruitment strategies demonstrate how CCHA acts upon the analysis of network monitoring activities to recruit new providers to ensure network adequacy. • II.AA.1_Annual BH Recruitment Strategy, entire document • II.AA.1_Annual PCMP Recruitment Strategy, entire document	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following documents demonstrate how CCHA collects information from primary care medical providers (PCMPs), including details on provider specialties, telehealth services, accessibility/disability accommodations, etc. • II.AA.1_New Practice Application Form, pgs. 1, 3 • II.AA.1_New Provider Application Form, pg. 2 • II.AA.1_Add-Change-Terminations Provider Roster Updates, entire document The following documents are completed by behavioral health practitioners and facilities during the CCHA provider enrollment process, which include disability accommodation and language information. • II.AA.1_BH Practice Information Form (Facility), pgs. 1-2 • II.AA.1_BH Provider Information Form (Facility), entire document The following documents are templates of the written agreements that are used for network providers. They specify the terms of joining the CCHA provider network, and include statements that providers will comply with the provider manual, and that CCHA will oversee and monitor activities and services.	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• II.AA.1_ACN Agreement, pgs. 9, 11 • II.AA.1_PCMP+ Agreement, pgs. 9, 11 • II.AA.1_PCMP Agreement, pgs. 9, 11 • II.AA.1_BH Provider Agreement, pgs. 4 The Behavioral Health (BH) Provider Manual and Physical Health (PH) Provider Manual outline how CCHA maintains and monitors the provider network to ensure adequate access for all members. • II.AA.1_Behavioral Health Provider Manual, pgs. 12, 67 • II.AA.1_Physical Health Provider Manual, pgs. 15, 26 **R6-specific:** The Network Management Strategic Plan outlines CCHA's strategies for maintaining and monitoring the provider network. • II.AA.1_R6NetworkMangPln_FY22-23, pgs. 3-24 • II.AA.1_R6NetworkMangPln_FY22-23_HCPFResponse_Accepted_RAE Response, entire document The Quarterly Network Reports show results of CCHA's analysis and assessment of the provider network's adequacy to serve our members. Received	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCPF response forms are also included to demonstrate report acceptance. • II.AA.1_R6NetworkRpt_Q3FY21-22, pgs. 5-12 • II.AA.1_R6NetworkRpt_Q3FY21-22_HCPFResponse_Accepted_RAE Response, entire document • II.AA.1_R6NetworkRpt_Q4FY21-22, pgs. 5-10 • II.AA.1_R6NetworkRpt_Q4FY21-22_HCPFResponse_accepted, entire document • II.AA.1_R6NetworkRpt_Q1FY22-23, pgs. 5-10 • II.AA.1_R6NetworkRpt_Q1FY22-23_HCPFResponse_Accepted_RAEResponse, entire document • II.AA.1_R6NetworkRpt_Q2FY22-23, pgs. 6-11 **R7-specific:** The Network Management Strategic Plan outlines CCHA's strategies for maintaining and monitoring the provider network. • II.AA.1_R7NetworkMangPln_FY22-23, pgs. 3-24	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• II.AA.1_R7NetworkMangPln_FY22-23_HCPFResponse_Accepted, entire document The Quarterly Network Reports show results of CCHA's analysis and assessment of the provider network's adequacy to serve our members. Received HCPF response forms are also included to demonstrate report acceptance. • II.AA.1_R7NetworkRpt_Q3FY21-22, pgs. 5-12 • II.AA.1_R7NetworkRpt_Q3FY21-22_HCPFResponse_Accepted, entire document • II.AA.1_R7NetworkRpt_Q4FY21-22, pgs. 5-10 • II.AA.1_R7NetworkRpt_Q4FY21-22_HCPFResponse_accepted, entire document • II.AA.1_R7NetworkRpt_Q1FY22-23, pgs. 5-11 • II.AA.1_R7NetworkRpt_Q1FY22-23_HCPFResponse_Accepted_RAEResponse, entire document • II.AA.1_R7NetworkRpt_Q2FY22-23, pgs. 6-11	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following document provides an example of how Developmental Disability Health Clinic, one of CCHA's ACN providers, provides accessible care to members with physical or developmental disabilities. • II.AA.1_DDHC, entire document	
2. The Contractor ensures that its PCMP provider network complies with time and distance standards as follows: • Adult primary care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Pediatric primary care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Obstetrics or gynecology: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes *42 CFR 438.206(a); 438.68(b)* Contract: Exhibit B-8—9.4.7	**Both RAEs:** The Provider Network Adequacy and Access Standards Policy outlines how CCHA monitors and complies with time and distance standards within the provider network. • II.AA.1_Provider Network Adequacy and Access Standards Policy, pgs. 4, 7-8 **R6-specific:** The Network Management Strategic Plan and Quarterly Network Report narratives and Geoaccess Compliance files show results of how CCHA's provider network is assessed for time and distance standards. Samples are provided below. • II.AA.1_R6NetworkMangPln_FY22-23, pg. 10 • II.AA.1_R6NetworkRpt_Q3FY21-22, pgs. 23-25 • II.AA.2_R6NetworkRpt_Q3FY21-22 Geoaccess Compliance, PH tab	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	R7-specific: The Network Management Strategic Plan and Quarterly Network Report narrative and Geoaccess Compliance files show results of how CCHA's provider network is assessed for time and distance standards. Samples are provided below. • II.AA.1_R7NetworkMangPln_FY22-23, pg. 10 • II.AA.1_R7NetworkRpt_Q3FY21-22, pgs. 23-25 • II.AA.2_R7NetworkRpt_Q3FY21-22 Geoaccess Compliance, PH tab	
3. The Contractor ensures that its BH provider network complies with time and distance standards as follows: • Acute care hospitals: – Urban counties—20 miles or 20 minutes – Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes • Psychiatrists and psychiatric prescribers for both adults and children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes • Mental health providers for both adults and children: – Urban counties—30 miles or 30 minutes	**Both RAEs:** The following policy document outlines CCHA's time and distance standards for behavioral health providers. • II.AA.1_Provider Network Adequacy and Access Standards Policy, pgs. 4, 7-8 **R6-specific:** The Network Management Strategic Plan and Quarterly Network Report narratives and Geoaccess Compliance files show results of how CCHA's provider network is assessed for time and distance standards. Samples are provided below. • II.AA.1_R6NetworkMangPln_FY22-23, pg. 10	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes • SUD providers for both adults and children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes *Note: If there are no BH providers that meet the BH provider standards within the defined area for a specific member, then the Contractor shall not be bound by the time and distance requirements. (Exhibit B-8—9.4.10.1)* *42 CFR 438.206(a)* Contract: Exhibit B-8—9.4.9	• II.AA.1_R6NetworkRpt_Q3FY21-22, pgs. 23-25 • II.AA.2_R6NetworkRpt_Q3FY21-22 Geoaccess Compliance, BH tab **R7-specific:** The Network Management Strategic Plan and Quarterly Network Report narratives and Geoaccess Compliance files show results of how CCHA's provider network is assessed for time and distance standards. • II.AA.1_R7NetworkMangPln_FY22-23, pg. 10 • II.AA.1_R7NetworkRpt_Q3FY21-22, pgs. 23-25 • II.AA.2_R7NetworkRpt_Q3FY21-22 Geoaccess Compliance, BH tab	
4. The Contractor provides female members with direct access to a women's health care specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health care specialist. *42 CFR 438.206(b)(2)* Contract: Exhibit B-8—9.2.7	**Both RAEs:** The Provider Network Adequacy and Access Standards Policy outlines how CCHA ensures female members have access to a women's health care specialist. • II.AA.1_Provider Network Adequacy and Access Standards Policy, pg. *5*	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The Maternity Care Coordination Program Description outlines how CCHA care coordinators support maternity members, including collaboration with providers and providing referrals where necessary. • II.AA.4_CCHA Maternity Care Coordination Program Description, entire document The following assessments are used by CCHA care coordinators to identify member needs, and include questions regarding women's health care including pregnancy. • II.AA.4_ CCHA Care Coordination Maternity Assessment, entire document • II.AA.4_CCHA Care Coordination Adult Health Needs Assessment, pgs. 7, 8, 11, 12, 13 • II.AA.4_CCHA Care Coordination Pediatric Health Needs Assessment, pgs. 8, 13 • II.AA.4_CCHA Care Coordination Chronic Condition Assessment, pgs. 14-15 • II.AA.4_CCHA Care Coordination Maternity Screener, entire document The following provide examples of newsletter and social media publications demonstrating CCHA's efforts to provide members with access to women's health care specialists within the network for covered care necessary to provide women's routine and preventive health care services.	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• II.AA.4_CCHA Provider Newsletter_May 2022, pg. 7 • II.AA.4_CCHA Provider Newsletter_June 2022, pg. 4 • II.AA.4_CCHA Specialty Provider Newsletter_June 2022, pg. 4 • II.AA.4_CCHA Provider Newsletter_July 2022, pg. 4 • II.AA.4_CCHA Provider Newsletter_August 2022, pg. 7 • II.AA.4_CCHA Provider Newsletter_November 2022, pg. 3 • II.AA.4_CCHA Women's Health Social Media Resources, entire document • II.AA.4_CCHA Maternity Brochure, entire document • II.AA.4_CCHA Maternity Brochure_SP, entire document The following documents describe CCHA's partnership with WeeCycle, a community partner serving women and families to help support access to needed baby supplies and information on Health First Colorado benefits. • II.AA.4_Wee Cycle CCHA CIP Agreement, entire document	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• II.AA.4_Wee Cycle Partnership Summary, entire document **R6-specific:** **R7-specific:**	
5. The Contractor provides for a second opinion from a network provider or arranges for the member to obtain one outside the network (if there is no qualified provider within the network), at no cost to the member. *42 CFR 438.206(b)(3)* Contract: Exhibit B-8—9.4.17	**Both RAEs:** The following policy outlines a CCHA member's right to receive a second opinion at no cost to them. • II.AA.5_Member Rights and Responsibilities Policy, pg. 2 The following policy states that CCHA will provide for a second opinion from a network provider or arrange for the member to obtain one outside the network if a qualified provider is not within network, at no cost to the member. • II.AA.1_Provider Network Adequacy and Access Standards Policy, pg. 8 CCHA informs providers of members' rights to a second opinion via the Provider Manuals. • II.AA.1_Behavioral Health Provider Manual, pg. 71 • II.AA.1_Physical Health Provider Manual, pg. 17	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	CCHA's FAQ webpage informs members and providers that members have a right to get a second opinion. • https://www.cchacares.com/for-members/frequently-asked-questions/ **R6-specific:** **R7-specific:**	
6. If the provider network is unable to provide necessary covered BH services to a particular member in network, the Contractor must cover the services (in accordance with the access to care standards) out of network for as long as the Contractor is unable to provide them. *42 CFR 438.206(b)(4)* Contract: Exhibit B-8—14.6.1	**Both RAEs:** This document outlines CCHA's responsibility for ensuring members receive covered services if there is no in network provider available to provide the services. • II.AA.1_Provider Network Adequacy and Access Standards Policy, pg. 8 This document outlines the policy and procedure for obtaining medically necessary services from an out of network provider. • II.AA.6_BH Single Case Agreement – Out of Network Authorization Policy, pg. 2 CCHA informs providers of members' rights to be referred to a non-network provider if CCHA does not have an appropriately trained provider in our network.	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• II.AA.1_Behavioral Health Provider Manual, pgs. 69, 74, 100 • II.AA.1_Physical Health Provider Manual, pg. 17 **R6-specific:** **R7-specific:**	
7. The Contractor requires out-of-network providers to coordinate with the Contractor for payment and ensures that the cost to the member is no greater that it would be if the services were furnished within the network. *42 CFR 438.206(b)(5)* Contract: Exhibit B-8—14.6.11.1	**Both RAEs:** The following document outlines CCHA's policy for ensuring member cost for receiving care from an out of network provider is no greater than an in network provider. • II.AA.6_BH Single Case Agreement- Out of Network Authorization Policy, entire document **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor must meet, and require its providers to meet, the State standards for timely access to care and services, taking into account the urgency of the need for services. The Contractor ensures that services are available as follows: • Emergency BH care: – By phone within 15 minutes of the initial contact. – In-person within 1 hour of contact in urban and suburban areas. – In-person within 2 hours of contact in rural and frontier areas. • Urgent care within 24 hours from the initial identification of need. • Non-urgent symptomatic care visit within 7 days after member request. • Well-care visit within 1 month after member request. • Outpatient follow-up appointments within 7 days after discharge from hospitalization. • Members may not be placed on waiting lists for initial routine BH services. *42 CFR 438.206(c)(1)(i)* Contract: Exhibit B-8—9.4.13, 9.4.13.1-4, 9.4.13.5.1-2	**Both RAEs:** The Provider Network Adequacy and Access Standards Policy outlines requirements for timely access to care and how CCHA monitors these standards. • II.AA.1_Provider Network Adequacy and Access Standards Policy, pg. 4, 7-8 The following policy outlines CCHA's access to care standards for behavioral health providers. • II.AA.8_Behavioral Health Access to Care Policy, p. 2 The ACN Agreement outlines requirements for ACN providers to ensure care aligns with timely access to care standards. • II.AA.1_ACN Agreement, pg. 26 The PCMP Agreements require network providers to comply with the PH Provider Manual, which includes timely access to care standards. A sample is provided below • II.AA.1_PCMP Agreement, pg. 8 • II.AA.1_Physical Health Provider Manual, pg. 28	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This section of the Provider Manual outlines access to care standards that CCHA's behavioral health providers are required to meet. • II.AA.1_Behavioral Health Provider Manual, pg. 67 The following communications were used to inform providers and members of CCHA's access to care standards, which is also included on our website, linked below. • II.AA.8_CCHA Provider Newsletter_January 2022, pgs. 4-5 • II.AA.8_CCHA Provider Newsletter_September 2022, pg. 2 • II.AA.8_Access to Care Standards, pgs. 1-2 • https://www.cchacares.com/Dal/15a The following document outlines the process for monitoring behavioral health providers' compliance with CCHA's access to care standards. • II.AA.8_Behavioral Health Provider Appointment Availability Monitoring Policy, pg. 1	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	CCHA uses the following script to conduct phone surveys to assess BH appointment availability and compliance with access to care standards. • II.AA.8_BH Appointment Availability Survey Script, entire document CCHA uses the following letter template to communicate non-compliance with access to care standards to BH providers. • II.AA.8_BH Appt Availability Corrective Action Letter, entire document The following document outlines CCHA's procedure for monitoring the PCMP network for appointment timeliness standards, leveraging Third Next Available Appointment methodology. • II.AA.8_Third Next Available Appointment Data Collection Procedure, entire document **R6-specific:** CCHA reports on the methods used to monitor its timeliness requirements to access care in the Quarterly Network Adequacy Reports. A Region 6 sample is provided below. • II.AA.1_R6NetworkRpt_Q1FY22-23, pgs. 17-21	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	R7-specific: CCHA reports on the methods used to monitor its timeliness requirements to access care in the Quarterly Network Adequacy Reports. A Region 7 sample is provided below. • II.AA.1_R7NetworkRpt_Q1FY22-23, pgs. 17-21	
9. The Contractor and its providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service. The Contractors network provides: • Minimum hours of provider operation from 8:00 a.m. to 5:00 p.m. Mountain Time, Monday through Friday. • Extended hours on evenings and weekends, including access to clinical staff, not just an answering service or referral service. • Alternatives for emergency department visits for after-hours urgent care. *42 CFR 438.206(c)(1)(ii)* Contract: Exhibit B-8—9.4.3–9.4.4	**Both RAEs:** The Provider Network Adequacy and Access Standards Policy defines that CCHA establishes a provider network with adequate hours of operation, extended hours on evenings and weekends, and alternatives for emergency department visits for after-hours urgent care. • II.AA.1_Provider Network Adequacy and Access Standards Policy, pgs. 3, 6 The following document outlines the hours of operations required by CCHA's behavioral health provider network. • II.AA.8_Behavioral Health Access to Care Policy, pg. 2 PCMP, PCMP+ and ACN provider agreements outline the contractual requirement for providers to provide availability of appointments outside of normal business hours.	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• II.AA.1_PCMP Agreement, pg. 8 • II.AA.1_PCMP+ Agreement, pg. 8 • II.AA.1_ACN Agreement, pg. 8 CCHA gathers this information from PCMPs through new practice applications forms gathered during contracting and maintained through annual OSR updates. • II.AA.1_New Practice Application Form, pg. 3 • II.AA.9_Office Systems Review, pgs. 2-4 • II.AA.9_Office Systems Review Procedure, entire document The BH and PH Provider Manuals outline CCHA's objectives, which include working with providers to ensure the provision of necessary and appropriate care, including inpatient care, alternative settings, and outpatient care, and include statements prohibiting discriminatory hours of operation. • II.AA.1_Behavioral Health Provider Manual, pgs. 13, 68 • II.AA.1_Physical Health Provider Manual, pg. 15 The following document outlines CCHA's access to care standards, which include standards for hours of	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	operation and alternatives for emergency department visits. This information is made publicly available on the CCHA website and was published in the following newsletters. • II.AA.8_Access to Care Standards, pg. 1 • II.AA.8_CCHA Provider Newsletter_January 2022, pgs. 4-5 • II.AA.8_CCHA Provider Newsletter_September 2022, pg. 2 **R6-specific:** CCHA reports on the methods used to monitor its timeliness requirements to access care in the Quarterly Network Adequacy Reports. A Region 6 sample is provided below. • II.AA.1_R6NetworkRpt_Q1FY22-23, pgs. 5, 7, 17-21 **R7-specific:** CCHA reports on the methods used to monitor its timeliness requirements to access care in the Quarterly Network Adequacy Reports. A Region 6 sample is provided below. • II.AA.1_R7NetworkRpt_Q1FY22-23, pgs. 5, 8, 17-21	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor shall ensure that its network provides for 24 hours a day availability of information, referral, and treatment of emergency medical conditions. *42 CFR 438.206(c)(1)(iii)* *42 CFR 438.3(q)(1)* Contract: Exhibit B-8—9.4.6	**Both RAEs:** The following policy outlines CCHA's requirements to ensure the network provides for availability of information, referrals and treatment of emergency conditions. • II.AA.8_Behavioral Health Access to Care Policy, pg. 2 The following document outlines CCHA's agreement with Rocky Mountain Crisis Partners to support the operation of the Crisis Line, providing members with access to 24/7/365 services. • II.AA.10_Rocky Mtn Crisis Partners MOU, pgs. 2, 4 The Provider Manuals include statements requiring network providers to have a system in place to ensure members may call after hours with medical questions or concerns in order to access to quality health services 24/7. • II.AA.1_Behavioral Health Provider Manual, pg. 69 • II.AA.1_Physical Health Provider Manual, pg. 26 The Map to Medicaid member brochure directs members to the Health First Colorado Nurse Advice	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Line and Colorado Crisis Services for support 24/7, and provides information on where to go for care. • II.AA.10_CCHA Map to Medicaid, pgs. 1, 2 • II.AA.10_CCHA Map to Medicaid_SP, pgs. 1, 2 CCHA includes information on its website to educate members about their options of where to go for medical care. • https://www.cchacares.com/for-members/options/ **R6-specific:** **R7-specific:**	
11. The Contractor ensures timely access by: • Establishing mechanisms to ensure compliance with access (e.g., appointment) standards by network providers. • Monitoring network providers regularly to determine compliance. • Taking corrective action if there is failure to comply. *42 CFR 438.206(c)(1)(iv)–(vi)* Contract: Exhibit B-8—9.4.14	**Both RAEs:** The Network Adequacy and Access Standards Policy outlines mechanisms CCHA uses to ensure timely access. • II.AA.1_Provider Network Adequacy and Access Standards Policy, pgs. 6-8 The following procedures outline mechanisms utilized by CCHA to ensure network provider compliance regarding access to care standards.	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• II.AA.8_Third Next Available Appointment Data Collection Procedure, entire document • II.AA.9_Office System Review Procedure, entire document • II.AA.11_Primary Care Caseload Monitoring Procedure, entire document • II.AA.11_Annual Caseload Review Instructions, entire document • II.AA.11_Provider Roster Comparison Instructions, entire document The ACN Monitoring and Oversight Policy outlines mechanisms CCHA uses to monitor and hold ACN providers accountable. • II.AA.11_ACN Monitoring and Oversight Policy, entire document The physical health provider agreements provide evidence of this requirement by stating that CCHA will monitor contractor responsibilities and will assess for the need of corrective action. • II.AA.1_ACN Agreement, pg. 11 • II.AA.1_PCMP+ Agreement, pg. 11 • II.AA.1_PCMP Agreement, pg. 11	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following document outlines CCHA's procedure for monitoring BH appointment availability standards, including corrective action for noncompliant providers. • II.AA.8_Behavioral Health Provider Appointment Availability Monitoring Policy, entire document The following documents are examples of member assessments that include questions to screen for access to care issues. • II.AA.11_CCHA Care Coordination Initial Screening Assessment, pgs. 1, 3, 4 • II.AA.4_CCHA Care Coordination Adult Health Needs Assessment, pgs. 6, 10, 11 **R6-specific:** CCHA uses the Quarterly Network Adequacy Report as a mechanism to monitor the provider network, and reports on the methods used to monitor its timeliness requirements to access care and the current status of network timeliness. A Region 6 sample is provided below. • II.AA.1_R6NetworkRpt_Q1FY22-23, pgs. 17, 19, 21 The following ad hoc report example demonstrates actions CCHA took to ensure timely and appropriate	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	access to care when a network facility closed unexpectedly. • II.AA.11_R6 Network Change Deficiency Report, entire document **R7-specific:** CCHA uses the Quarterly Network Adequacy Report as a mechanism to monitor the provider network, and reports on the methods used to monitor its timeliness requirements to access care and the current status of network timeliness. • II.AA.1_R7NetworkRpt_Q1FY22-23, pgs. 17, 19, 21	
12. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. This includes: • Making written materials that are critical to obtaining services available in prevalent non-English languages. • Providing cultural and disability competency training programs, as needed, to network providers and health plan staff regarding: – Health care attitudes, values, customs and beliefs that affect access to and benefit from health care services. – Medical risks associated with the member population's racial, ethnic, and socioeconomic conditions.	**Both RAEs:** The following document outlines CCHA's policy for providing written materials in prevalent non-English languages, as well as the provision of language assistance to CCHA members. • II.AA.12_Member and Provider Materials and Website Policy, pgs. 2-3 The Language Assistance Services Policy outlines how CCHA staff and CCHA network providers facilitate language assistance services for our members.	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Identifying members whose cultural norms and practices may affect their access to health care. These efforts shall include, but are not limited to, inquiries conducted by the Contractor of the language proficiency of individual members. • Providing language assistance services for all Contractor interactions with members. *42 CFR 438.206(c)(2)* Contract: Exhibit B-8—7.2.1–7.2.6	• II.AA.12_Language Assistance Services Policy, entire document The following policy outlines how CCHA care coordination provides services that are culturally responsive to member preferences and needs. • II.AA.12_Care Coordination Operating Policy, pgs. 1-2 The following training materials have been made available to network providers to support providers in caring for diverse populations. • II.AA.12_Cultural Competency Resources, entire document • II.AA.12_Caring for Diverse Populations Toolkit, entire document • II.AA.12_CCHA Cultural Competency Training, entire document • My Diverse Patients Training Site: *https://www.mydiversepatients.com/* The following CCHA newsletters were used to notify network providers of available resources and trainings on disability and cultural competency. • II.AA.12_CCHA Provider Newsletter_February 2022, pgs. 2, 6	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• II.AA.12_CCHA Provider Newsletter_April 2022, pg. 7 • II.AA.4_CCHA Provider Newsletter_June 2022, pg. 8 • II.AA.4_CCHA Provider Newsletter_July 2022, pg. 5 • II.AA.12_CCHA Behavioral Health Provider Bulletin_August 2022, pgs. 2-3 • II.AA.8_CCHA Provider Newsletter_September 2022, pg. 3 • II.AA.12_CCHA Specialty Provider Newsletter_September 2022, pg. 3 • II.AA.12_CCHA Behavioral Health Provider Bulletin_October 2022, pgs. 2-3 • II.AA.12_CCHA Behavioral Health Provider Bulletin_December 2022, pg. 4 The Provider Manuals outline CCHA's resources for network providers to support members with different cultural, linguistic, or accessibility needs. • II.AA.1_Behavioral Health Provider Manual, pgs. 68, 75, 103-104 • II.AA.1_Physical Health Provider Manual, pgs. 24-26 The Find a Provider function on the CCHA website demonstrates how members are able to identify	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	providers who meet their needs by including search functions for languages spoken, cultural competency training, and accommodations for people with disabilities. • https://www.cchacares.com/findadoc The following are examples of assessments that include questions to help identify a member's social and cultural norms, including their preferred language. • II.AA.4_CCHA Care Coordination Adult Health Needs Assessment, pgs. 2-5 • II.AA.4_CCHA Care Coordination Pediatric Health Needs Assessment, pgs. 2-5 • II.AA.11_CCHA Care Coordination Initial Screening Assessment, pg. 1 **R6-specific:** **R7-specific:**	
13. The Contractor must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities. *42 CFR 438.206(c)(3)* Contract: Exhibit B-8—9.1.4.5, 9.1.7.1, 9.5.1.2	**Both RAEs:** The following document outlines CCHA's policy for ensuring its provider network is adequate enough to meet the needs of members with physical and mental disabilities.	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• II.AA.1_Americans with Disabilities Act Compliance for Participating Providers Policy, pg. 1 The following document outlines members' rights to receive available and accessible covered services, and informs members of their right to file a grievance. • II.AA.5_Member Rights and Responsibilities Policy, pgs. 2-3 The New Practice Application Form demonstrates how CCHA collects information from PCMPs regarding practice accessibility at the time of application. The Office Systems Review form is used to collect information on an ongoing basis, after initial contracting. • II.AA.1_New Practice Application Form, pg. 3 • II.AA.9_Office Systems Review, pg. 2 The following documents are completed by behavioral health practitioners and facilities during the CCHA provider enrollment process, which include disability accommodation and language information. • II.AA.1_BH Practice Information Form (Facility), pgs. 1-2	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• II.AA.1_BH Provider Information Form (Facility), pg. 2 The Find a Provider function on the CCHA website provides evidence of how members are able to identify providers who meet their needs by including search functions for languages spoken, cultural competency training, and accommodations for people with disabilities. • https://www.cchacares.com/findadoc **R6-specific:** **R7-specific:**	
14. The Contractor submits to the State (in a format specified by the State) documentation to demonstrate that the Contractor offers an appropriate range of preventive, primary care, and specialty services that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. • A Network Adequacy Plan is submitted to the State annually. • A Network Report is submitted to the State quarterly. *42 CFR 438.207(b)* Contract: Exhibit B-8—9.5.1–9.5.4	**Both RAEs:** **R6-specific:** CCHA submitted the following annual plan, which outlines CCHA's strategies to ensure appropriate support for and management of the provider network. • II.AA.1_R6NetworkMangPln_FY22-23, pgs. 3-24 CCHA submitted the following Quarterly Network Reports, which demonstrate the status of the network for the 2022 calendar year.	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• II.AA.1_R6NetworkRpt_Q3FY21-22, entire document • II.AA.2_R6NetworkRpt_Q3FY21-22 Geoaccess Compliance, entire document • II.AA.1_R6NetworkRpt_Q4FY21-22, entire document • II.AA.14_R6NetworkRpt_Q4FY21-22 Geoaccess Compliance, entire document • II.AA.1_R6NetworkRpt_Q1FY22-23, entire document • II.AA.14_R6NetworkRpt_Q1FY22-23 Geoaccess Compliance, entire document • II.AA.1_R6NetworkRpt_Q2FY22-23, entire document • II.AA.14_R6NetworkRpt_Q2FY22-23 Geoaccess Compliance, entire document **R7-specific:** CCHA submitted the following annual plan, which outlines CCHA's strategies to ensure appropriate support for and management of the provider network. • II.AA.1_R7NetworkMangPln_FY22-23, pgs. 3-24 CCHA submitted the following Quarterly Network Reports, which demonstrate the status of the network for the 2022 calendar year.	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• II.AA.1_R7NetworkRpt_Q3FY21-22, entire document • II.AA.2_R7NetworkRpt_Q3FY21-22 Geoaccess Compliance, entire document • II.AA.1_R7NetworkRpt_Q4FY21-22, entire document • II.AA.14_R7NetworkRpt_Q4FY21-22 Geoaccess Compliance, entire document • II.AA.1_R7NetworkRpt_Q1FY22-23, entire document • II.AA.14_R7NetworkRpt_Q1FY22-23 Geoaccess Compliance, entire document • II.AA.1_R7NetworkRpt_Q2FY22-23, entire document • II.AA.14_R7NetworkRpt_Q2FY22-23 Geoaccess Compliance, entire document	

Results for Standard II—Adequate Capacity and Availability of Services							
Total	Met	=	14	X	1.00	=	14
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	14	**Total Score**		=	14
				Total Score ÷ Total Applicable		=	100%

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an established internal grievance and appeal system in place for members, or providers acting on their behalf, or designated member representatives. A grievance and appeals system means the processes the Contractor implements to handle grievances and appeals of an adverse benefit determination, as well as processes to collect and track information about grievances and appeals. *42 CFR 438.400(b)* *42 CFR 438.402(a)* Contract: Exhibit B-8—8.1 10 CCR 2505-10 8.209.1	**Both RAEs:** This policy and procedure demonstrates compliance with CCHA's internal grievance system process, including record keeping requirements for grievances. • VI.GA.1_CCHA Member Grievances Policy, pg. 2-4 This document outlines CCHA's internal appeals process, including record keeping requirements. • VI.GA.1_ AG Member Appeals-CO In addition to filing an oral grievance, a member may submit a written grievance using the online grievance form submission process provided on CCHA website. • CCHA Member Online Grievance Form on Website: https://www.cchacares.com/for-members/member-benefits-services/grievance-form/ This page on the CCHA website contains information for members, families, and providers on CCHA's grievance and appeal system. • CCHA Appeals and Grievances Member Website Page: https://www.cchacares.com/for-members/appeals-and-grievances/	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This document on the CCHA website contains information for members, families, and providers on CCHA's grievance and appeal system. • Member Grievance and Appeal Information: https://www.cchacares.com/Dal/kqV This document provides an overview of how CCHA member-facing staff assist members with grievances and appeals. • VI.GA.1_CCHA Desktop Guide for Handling Grievances and Appeals, entire document The following document is an attestation that member-facing staff received training on the Quality of Care and Grievances and Appeals processes. • VI.GA.1_ QOC-GA Staff Training Attestation, entire document **R6-specific:** **R7-specific:**	

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**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 member financial liabilities). *42 CFR 438.400(b)* Contract: Exhibit B-8—2.1.3 10 CCR 2505-10 8.209.2.A	**Both RAEs:** This document outlines CCHA's definition of an adverse benefit determination. • VI.GA.1_ AG Member Appeals-CO, pg. 1 **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor defines an appeal as a review by the Contractor of an adverse benefit determination. *42 CFR 438.400(b)* Contract: Exhibit B-8—2.1.6 10 CCR 2505-10 8.209.2.B	**Both RAEs:** This document outlines CCHA's definition of an appeal. • VI.GA.1_ AG Member Appeals-CO **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor defines a grievance as an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. A grievance includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision. *42 CFR 438.400(b)* Contract: Exhibit B-8—2.1.46, 8.6.6.2 10 CCR 2505-10 8.209.2.D, 8.209.4.A.3.c.(i)	**Both RAEs:** This policy and procedure demonstrates compliance with CCHA's definition of a grievance and how a grievance differs from an adverse benefit determination. • VI.GA.1_CCHA Member Grievances Policy, pg. 1 This page on CCHA's website contains information for members regarding what constitutes as a grievance. • CCHA Appeals and Grievances Member Website Page: https://www.cchacares.com/for-members/appeals-and-grievances/ This page on CCHA's website contains information for members regarding what constitutes as a grievance. • Member Grievance and Appeal Information: https://www.cchacares.com/Dal/kqV **R6-specific:** **R7-specific:**	**RAE 6:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: CCHA defined "grievance" as an expression of dissatisfaction about any matter other than an adverse benefit determination in its policy. However, staff members reported when grievances are received, the member is asked if they would like to file a formal grievance. If the member declines, CCHA does not document the complaint in the grievance software system, NextGen, but rather in the customer service software system; therefore, the grievance cannot be tracked and trended.		

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: CCHA must enhance its messaging to the members in a way that encourages members to grieve freely without the barrier of a perceived second "formal" step. Additionally, CCHA must update and conduct a refresher training that reiterates the enhanced messaging to members expressing dissatisfaction. For example, "I understand and hear your concern. I will take this information down, look into it, and follow up with you." The customer service staff members who receive complaints should receive updated training regarding how to ensure all complaints are logged in the grievance system and ensure members receive a grievance acknowledgement letter and resolution letter. Monitoring should include a mechanism for monitoring the customer service calls to ensure all complaints are being processed as grievances, tracked within the grievance system, and reported quarterly to the Department.		
5. The Contractor has provisions for who may file: • A member may file a grievance or a Contractor-level appeal and may request a State fair hearing. • With the member's written consent, a provider or authorized representative may file a grievance or a Contractor-level appeal and may request a State fair hearing on behalf of a member. *Note: Throughout this standard, when the term "member" is used it includes providers and authorized representatives acting on behalf of the member (with the exception that providers cannot exercise the member's right to request continuation of benefits under 42 CFR 438.420).* *42 CFR 438.402(c)* Contract: Exhibit B-8—8.5.1, 8.7.1, 8.7.15.1, 8.7.5	**Both RAEs:** This policy and procedure defines who is able to file a grievance with CCHA. • VI.GA.1_CCHA Member Grievances Policy, pg. 1-2 This page on CCHA's website contains information for members regarding what constitutes as a grievance. • CCHA Appeals and Grievances Member Website Page: https://www.cchacares.com/for-members/appeals-and-grievances/ This form can be used by a member or a member's representative to file a grievance with CCHA. • Member Online Grievance Form: https://www.cchacares.com/for-members/member-benefits-services/grievance-form/ This document provides information on who is able to file grievances and/or appeals for CCHA members.	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Member Grievance and Appeal Information: https://www.cchacares.com/Dal/kqV This page provides information on who is able to file grievances and/or appeals for CCHA members. • Member Appeal and Grievance Information CCHA | Appeals and Grievances (cchacares.com) The following document is used to collect consent from a member or approved representative to file an appeal. • VI.GA.5_COFM01 Member Request for Appeal Form ENG, entire document **R6-specific:** **R7-specific:**	
6. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, as well as providing interpreter services and toll-free numbers that have adequate TeleTYpe/Telecommunications Device for the Deaf (TTY/TDD) and interpreter capability. *42 CFR 438.406(a)* Contract: Exhibit B-8—8.3	**Both RAEs:** This document outlines CCHA's policy regarding assisting members when filing an appeal, including providing auxiliary aids and interpreter services. • VI.GA.1_ AG Member Appeals-CO, pg.3 This page outlines the steps to take to file a grievance or appeal and Ombudsman information for help. • Member Appeal and Grievance Information	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10 CCR 2505-10 8.209.4.C	CCHA | Appeals and Grievances (cchacares.com) This page is where members can request support for assistance with completing any forms or procedural steps. • Member Assistance Information CCHA | Member Assistance (cchacares.com) **R6-specific:** **R7-specific:**	
7. The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who: • Were not involved in any previous level of review or decision-making nor a subordinate of any such individual. • Have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding any of the following: – An appeal of a denial that is based on lack of medical necessity. – A grievance regarding the denial of expedited resolution of an appeal. – A grievance or appeal that involves clinical issues. *42 CFR 438.406(b)(2)* Contract: Exhibit B-8—8.5.4, 8.7.4 10 CCR 2505-10 8.209.5.C, 8.209.4.E	**Both RAEs:** This document outlines the requirements for whom can make decisions on grievances filed with CCHA. • VI.GA.1_CCHA Member Grievances Policy, pg. 3 This document outlines CCHA's policy regarding who is involved in the review of the appeal, decision makers, and appropriate expertise. • VI.GA.1_ AG Member Appeals-CO, pg.3-4 **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor ensures that the individuals who make decisions on grievances and appeals: • Take into account all comments, documents, records, and other information submitted by the member or the member's representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. *42 CFR 438.406(b)(2)* Contract: Exhibit B-8—8.6.2 10 CCR 2505-10 8.209.5.C, 8.209.4.E	**Both RAEs:** This document outlines CCHA's requirements regarding the responsibilities of the decision maker when deciding a grievance. • VI.GA.1_CCHA Member Grievances Policy, Page: 3 This document outlines CCHA's policy regarding what information is taken into account during the appeal. • VI.GA.1_ AG Member Appeals-CO, pg. 4 **R6-specific:** **R7-specific:**	**RAE 6:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Policies and procedures included accurate information describing how CCHA would accept additional information from the member during a review of a filed grievance by the member. During the record review, HSAG identified one member grievance record had documentation that indicated the member called to give more information and was advised to file a new grievance on the website rather than the representative taking down the additional information.		
Required Actions: CCHA must develop a refresher training on how to handle additional information received by the member. CCHA must monitor staff member documentation to ensure that representatives are taking down additional information from a member who calls to give more information on an open case. Staff members should not direct members to file a new grievance unless that grievance indicates a different grievance that is not related to the current open case.		

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor accepts grievances orally or in writing. *42 CFR 438.402(c)(3)(i)* Contract: Exhibit B-8—8.5.3 10 CCR 2505-10 8.209.5.D	**Both RAEs:** This document outlines the ways in which CCHA can accept a grievance. • VI.GA.1_CCHA Member Grievances Policy, pg. 2 **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. Members may file a grievance at any time. *42 CFR 438.402(c)(2)(i)* Contract: Exhibit B-8—8.5.3 10 CCR 2505-10 8.209.5.A	**Both RAEs:** This document outlines when a grievance can be filed with CCHA. • VI.GA.1_CCHA Member Grievances Policy, pg. 2 **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor sends the member written acknowledgement of each grievance within two working days of receipt. *42 CFR 438.406(b)(1)* Contract: Exhibit B-8—8.1 10 CCR 2505-10 8.209.5.B	**Both RAEs:** This document outlines the policy and procedure regarding when a written acknowledgement of a grievance is sent to the member. • VI.GA.1_CCHA Member Grievances Policy, pg. 2-3 This is a copy of the notice sent to CCHA members to acknowledge their grievance was filed. • VI.GA.11_Member Complaint Acknowledgement Letter Eng This is a copy of the notice, in Spanish, sent to CCHA members to acknowledge their grievance was filed. • VI.GA.11_Member Complaint Acknowledgement Letter SP **R6-specific:** **R7-specific:**	**RAE 6:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: All grievance acknowledgement letters in the sample records were timely. However, the CCHA website included a downloadable PDF titled "What is the grievance and appeal process?" The PDF inaccurately stated the time frame for a grievance acknowledgement letter is five days.		
Required Actions: The PDF located on the CCHA website must be updated to accurately state that a grievance acknowledgement letter will be sent to the member in two working days.		

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor must resolve each grievance and provide notice as expeditiously as the member's health condition requires, and within 15 working days of when the member files the grievance. • Notice to the member must be in a format and language that may be easily understood by the member. *42 CFR 438.408(a); (b)(1); and (d)(1)* Contract: Exhibit B-8—8.5.5, 7.2.7.3, 7.2.7.5 10 CCR 2505-10 8.209.5.D	**Both RAEs:** This document outlines CCHA's timeline for resolving a grievance, including provisions to ensure all grievance forms and notices follow CCHA's Member and Provider Materials and Website Policy. • VI.GA.1_CCHA Member Grievances Policy, pg. 3 This document outlines CCHA's requirements for ensuring grievance notices are easy for members to understand and are available in alternative formats. • VI.GA.12_CCHA Member and Provider Materials and Website Policy, pg. 2 This is a copy of a clinical grievance resolution letter sent to CCHA members. • VI.GA.12_Member Complaint QOC Resolution Letter ENG This is a copy of a clinical grievance resolution letter, in Spanish, sent to CCHA members. • VI.GA.12_Member Complaint QOC Resolution Letter SP This is a copy of an administrative grievance resolution letter sent to CCHA members.	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• VI.GA.12_Member Complaint Resolution Non QOC Letter ENG This is a copy of an administrative grievance resolution letter, in Spanish, sent to CCHA members. • VI.GA.12_Member Complaint Resolution Non QOC Letter SP **R6-specific:** **R7-specific:**	
13. The written notice of grievance resolution includes: • Results of the disposition/resolution process and the date it was completed. *42 CFR 438.408(a)* Contract: Exhibit B-8—8.5.8 10 CCR 2505-10 8.209.5.G	**Both RAEs:** This page on the CCHA website informs members of the grievance process and what information their grievance resolution notice will contain. • Member Grievance and Appeal Information: https://www.cchacares.com/Dal/kqV This is a copy of a grievance resolution letter sent to CCHA members, which includes the results of the grievance disposition and the date it was completed. • VI.GA.12_Member Complaint QOC Resolution Letter ENG This is a copy of a grievance resolution letter, in Spanish, sent to CCHA members, which includes the	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	results of the grievance disposition and the date it was completed. • VI.GA.12_Member Complaint QOC Resolution Letter SP This is a copy of a grievance resolution letter sent to CCHA members, which includes the results of the grievance disposition and the date it was completed. • VI.GA.12_Member Complaint Resolution Non QOC Letter ENG This is a copy of a grievance resolution letter, in Spanish, sent to CCHA members, which includes the results of the grievance disposition and the date it was completed. • VI.GA.12_Member Complaint Resolution Non QOC Letter SP **R6-specific:** **R7-specific:**	
14. The Contractor may have only one level of appeal for members. *42 CFR 438.402(b)* Contract: Exhibit B-8—8.1.1	**Both RAEs:** This document outlines CCHA's internal appeals policy. • VI.GA.1_ AG Member Appeals-CO, pg.7	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This document is provided to members that have exhausted CCHA's internal appeal process to inform them of the State Fair Hearing process. • VI.GA.14_Member Appeal Internal Rights Exhausted Letter ENG **R6-specific:** **R7-specific:**	
15. A member may file an appeal with the Contractor within 60 calendar days from the date on the adverse benefit determination notice. *42 CFR 438.402 (c)(2)(ii)* Contract: Exhibit B-8—8.7.5.1 10 CCR 2505-10 8.209.4.B	**Both RAEs:** This document outlines CCHA's internal appeals policy including the number of days a member has to file an appeal. • VI.GA.1_ AG Member Appeals-CO, pg.3 The Health First Colorado Member Handbook, produced by HCPF, states that members have a right to file an appeal, which must be done within 60 days of the date of notice. • VI.GA.15_Member Handbook, pg. 31 **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The member may file an appeal either orally or in writing, and the Contractor must treat oral appeals in the same manner as appeals received in writing. The Contractor may not require that oral requests for an appeal be followed with a written request. *42 CFR 438.402(c)(3)(ii)* *42 CFR 438.406 (b)(3)* Contract: Exhibit B-8—8.7.6 10 CCR 2505-10 8.209.4.F	**Both RAEs:** This document outlines how an appeal is accepted including accepting verbal filings as appeals. • VI.GA.1_ AG Member Appeals-CO, pg.3 This page provides information about the different ways to file an appeal including verbal submission. • Member Grievance and Appeal Information CCHA | Appeals and Grievances (cchacares.com) **R6-specific:** **R7-specific:**	**RAE 6:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The downloadable PDF titled "What is the grievance and appeal process?" on CCHA's website inaccurately stated on page two that a verbal appeal must be followed up with a written appeal. Additionally, three out of 10 of CCHA's appeal acknowledgement letters stated a member must follow up a verbal appeal in writing.		
Required Actions: The PDF located on the CCHA website must be updated to remove the statement that a verbal appeal must be followed up with a written appeal. CCHA must also update its appeal acknowledgement letters to remove any requirement that the member must follow up a verbal appeal in writing.		

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The Contractor sends written acknowledgement of each appeal within two working days of receipt, unless the member or designated client representative requests an expedited resolution. *42 CFR 438.406(b)(1)* Contract: Exhibit B-8—8.1, 8.7.2 10 CCR 2505-10 8.209.4.D	**Both RAEs:** The document outlines when an appeal is acknowledged. • VI.GA.1_ AG Member Appeals-CO, pg.3 This document, available in English and Spanish, acknowledges a member's appeal that was submitted to CCHA. • VI.GA.17_Member Written Appeal Ack Letter ENG • VI.GA.17_Member Written Appeal Ack Letter SP **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
18. The Contractor's appeal process must provide that included, as parties to the appeal, are: • The member and the member's representative, or • The legal representative of a deceased member's estate. *42 CFR 438.406(b)(3) and (6)* Contract: Exhibit B-8—8.7.6, 8.7.7, 8.7.11 10 CCR 2505-10 8.209.4.I	**Both RAEs:** This document outlines all of the parties that will be included as parties to the appeal. • VI.GA.1_ AG Member Appeals-CO, pg.4 **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
19. The Contractor's appeal process must provide: • The member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. (The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution time frame in the case of expedited resolution.) • The case file to the member and their representative, including medical records, other documents and records, and any new or additional documents considered, relied upon, or generated by the Contractor in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame. *42 CFR 438.406(b)(4-5)* Contract: Exhibit B-8—8.7.8–8.7.10 10 CCR 2505-10 8.209. 4.G, 8.209.4.H	**Both RAEs:** This document outlines the appeals process to include the opportunity to present evidence and the right for the member to examine the case file. • VI.GA.1_ AG Member Appeals-CO, pg.4 **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
20. The Contractor maintains an expedited review process for appeals when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. The Contractor's expedited review process includes that: • The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. *42 CFR 438.410(a–b)* Contract: Exhibit B-8—8.7.14.2.1, 8.7.12 10 CCR 2505-10 8.209.4.Q-R	**Both RAEs:** This document outlines the appeals process including how expedited appeals are processed. • VI.GA.1_ AG Member Appeals-CO, pg.4 **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
21. If the Contractor denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the time frame for standard resolution. • Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and within two 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 the member disagrees with that decision. *42 CFR 438.410(c)* Contract: Exhibit B-8—8.7.14.2.2 10 CCR 2505-10 8.209.4.S	**Both RAEs:** This document outlines the appeals process including how a denial of an expedited resolution is handled. • VI.GA.1_ AG Member Appeals-CO, pg.4-5 **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
22. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)* *42 CFR 438.408(d)(2)(i)* *42 CFR 438.10* Contract: Exhibit B-8—8.7.14.1. 7.2.7.3, 7.2.7.5 10 CCR 2505-10 8.209.4.J.1	**Both RAEs:** This document outlines the appeals process including the timeline for resolution and the format of the notice. • VI.GA.1_ AG Member Appeals-CO, pg. 3 and 5 This document informs the member of how long it should take to resolve an appeal. • VI.GA.17_Member Written Appeal Ack Letter ENG **R6-specific:** **R7-specific:**	**RAE 6:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: One out of 10 member appeal resolution letters were not timely. All appeal resolution letters must be sent to the member within 10 working days.		
Required Actions: CCHA must enhance its monitoring of timeliness to ensure all appeal resolution letters are following the time frame set forth by the State contract and federal regulations.		
23. For expedited appeal, the Contractor must resolve the appeal and provide written notice of disposition to affected parties within 72 hours after the Contractor receives the appeal. • For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. *42 CFR 438.408(b)(3) and (d)(2)(ii)* Contract: Exhibit B-8—8.7.14.2.3, 8.7.14.2.6 10 CCR 2505-10 8.209.4.J.2, 8.209.4.L	**Both RAEs:** This document outlines the appeals process including the timeline for expedited resolution and verbal notification. • VI.GA.1_ AG Member Appeals-CO, pg.4 **R6-specific:** **R7-specific:**	**RAE 6:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: CCHA's *Member Appeals Policy* stated the accurate time frame to resolve expedited appeals and provide written notice of disposition to affected parties is within 72 hours after the appeal is received. However, the policy did not include that the member may file a grievance if the member disagrees with the decision.		
Required Actions: The *Member Appeals Policy* must be updated to include that the member may file a grievance. Therefore, the *Member Appeals Policy* on page 6, section 7.a. must include: • The member may file a grievance if they disagree with the decision (please see 5.b on page 6 for an example).		

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
24. The Contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: • The member requests the extension; or • The Contractor shows (to the satisfaction of the Department, upon request) that there is need for additional information and how the delay is in the member's interest. *42 CFR 438.408(c)(1)* Contract: Exhibit B-8—8.7.14.2, 8.7.14.2.4, 8.5.6 10 CCR 2505-10 8.209.4.K, 8.209.5.E	**Both RAEs:** This document outlines the appeals process including the timeline and reasons to extend the timeframes for resolution. • VI.GA.1_ AG Member Appeals-CO, pg. 3 and 6 This letter, offered in English and Spanish, is sent to the member when an appeal extension is requested or required. • VI.GA.24_Member Appeal Time Frame Extension Letter **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
25. If the Contractor extends the time frames for a grievance or appeal, it must—for any extension not requested by the member: • Make reasonable efforts to give the member prompt oral notice of the delay. • Within two calendar days, give the member written notice of the reason for the delay and inform the member of the right to file a grievance if the member disagrees with that decision. • Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires (14 days following the expiration of the original grievance or appeal resolution time frame).	**Both RAEs:** This document outlines the appeals process including the process for extending the timeframe for resolution of an appeal. • VI.GA.1_ AG Member Appeals-CO, pg. 3 **R6-specific:** **R7-specific:**	**RAE 6:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.408(c)(2) Contract: Exhibit B-8—8.5.7, 8.7.14.1, 8.7.14.2.1, 8.7.14.2.5-6 10 CCR 2505-10 8.209.4.L, 8.209.4.K, 8.209.4.A. 3.C(ii), 8.209.5.E		
Findings: CCHA did not have any extension requests in the appeal sample list; however, there were extension requests for grievances. Three out of 10 grievance samples were extended; however, CCHA did not include extension letters or oral notice to the member.		
Required Actions: CCHA must enhance its policies, procedures, and training for staff members to ensure that when an extension is in the best interest of the member, an extension letter is sent to the member as well as prompt oral notice of the delay.		
26. The written notice of appeal resolution must include: • The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. – The right to request that benefits/services continue* while the hearing is pending, and how to make the request. – That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's adverse benefit determination. **Continuation of benefits applies only to previously authorized services for which the Contractor provides 10-day advance notice to terminate, suspend, or reduce.* *42 CFR 438.408(e)* Contract: Exhibit B-8—8.7.14.3, 8.7.14.4 10 CCR 2505-10 8.209.4.M	**Both RAEs:** This document identifies the information contained in a written decision notification and rights. • VI.GA.1_ AG Member Appeals-CO, pg. 5 This document, available in English and Spanish, is the appeal resolution notice used when an appeal is upheld due to medical necessity. • VI.GA.26_Member Appeal Medical Necessity Uphold Letter This document, available in English and Spanish, is the appeal resolution notice used when an appeal is overturned. • VI.GA.26_Member Appeal Overturn Letter	**RAE 6:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This document, available in English and Spanish, is the appeal resolution template letter used when an appeal is upheld due to reasons other than medical necessity. • VI.GA.26_Member Appeal Admin Uphold Letter This document, available in English and Spanish, is the appeal template letter used when an appeal is dismissed due to having exhausted the internal appeal rights. • VI.GA.26_Member Appeal Internal Rights Exhausted Letter This document, available in English and Spanish, is the appeal resolution template letter used when an appeal is upheld due to not being filed timely. • VI.GA.26_Member Appeal Past Timely Filing Letter **R6-specific:** **R7-specific:**	
Findings: CCHA appeal resolution letters included information on how to request a State fair hearing and continuation of benefits. However, the appeal resolution letters only included how to request continuation of benefits by mail or fax. While State fair hearings must be submitted in writing, the request for continuation of benefits does not need to be in writing.		

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: The appeal resolution letters must be updated to include the contact phone number and remove "written" from its language under the "Who to contact" portion of the appeal resolution letter in regard to continuation of benefits.		
27. The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of appeal resolution. • If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. *42 CFR 438.408(f)(1–2)* Contract: Exhibit B-8—8.7.15.1–8.7.15.2 10 CCR 2505-10 8.209.4.N and O	**Both RAEs:** This document contains information related to the State Fair Hearing Process. • VI.GA.1_ AG Member Appeals-CO, pg. 7 This document, available in English and Spanish, is the appeal resolution notice used when an appeal is upheld due to medical necessity, and informs the member of their right to access a State Fair Hearing. • VI.GA.26_Member Appeal Medical Necessity Uphold Letter, pg. 1 This document, available in English and Spanish, is the appeal resolution template letter used when an appeal is upheld due to reasons other than medical necessity and informs the member of their right to access a State Fair Hearing. • VI.GA.27_Member Appeal Admin Uphold Letter, pg. 1 The member handbook outlines the State Fair Hearing instructions and information. • VI.GA.15_Member Handbook, pg. 36 **R6-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	R7-specific:	
28. The parties to the State fair hearing include the Contractor as well as the member and their representative or the representative of a deceased member's estate. *42 CFR 438.408(f)(3)* Contract: Exhibit B-8—8.7.15.3	**Both RAEs:** This document identifies the parties to be included for a State Fair Hearing. • VI.GA.1_ AG Member Appeals-CO, pg. 7 **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
29. The Contractor provides for continuation of benefits/services (when requested by the member) while the Contractor-level appeal and the State fair hearing are pending if: • The member files in a timely manner* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the Contractor mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired.	**Both RAEs:** This document outlines the policy for a Continuation of Benefit. • VI.GA.1_ AG Member Appeals-CO, pg. 6-7 This document, available in English and Spanish, is the appeal resolution notice used when an appeal is upheld due to medical necessity and informs the member of the process to continue their benefits/services. • VI.GA.26_Member Appeal Medical Necessity Uphold Letter, pg. 1 This document, available in English and Spanish, is the appeal resolution notice used when an appeal is upheld	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The member requests an appeal in accordance with required time frames. ** This definition of timely filing only applies for this scenario—i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced. (Note: The provider may not request continuation of benefits on behalf of the member.)* *42 CFR 438.420(a) and (b)* Contract: Exhibit B-8—8.7.13.1 10 CCR 2505-10 8.209.4.T	and informs the member of the process to continue their benefits/services. • VI.GA.27_Member Appeal Admin Uphold Letter, pg. 1 The member handbook outlines how coverage is continued during an appeal. • VI.GA.15_Member Handbook, pg. 37 **R6-specific:** **R7-specific:**	
30. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of the following occurs: • The member withdraws the appeal or request for a State fair hearing. • The member fails to request a State fair hearing and continuation of benefits within 10 calendar days after the Contractor sends the notice of an adverse resolution to the member's appeal. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR 438.420(c)* Contract: Exhibit B-8—8.7.13.2 10 CCR 2505-10 8.209.4.U	**Both RAEs:** This document outlines the policy for a Continuation of Benefit. • VI.GA.1_ AG Member Appeals-CO, pg. 7 **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
31. Member responsibility for continued services: • If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's adverse benefit determination, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. *42 CFR 438.420(d)* Contract: Exhibit B-8—8.7.13.3 10 CCR 2505-10 8.209.4.V	**Both RAEs:** This document outlines the policy for a Continuation of Benefit as it pertains to cost recovery. • VI.GA.1_ AG Member Appeals-CO, pg. 7 The document notifies the member that they may bear the responsibility to pay for services if the final resolution is adverse to the member. • VI.GA.15_Member Handbook, pg. 37 This document, available in English and Spanish, is the appeal resolution notice used when an appeal is upheld and informs the member they may be responsible for the cost of continued services if the decision is upheld. • VI.GA.26_Member Appeal Medical Necessity Uphold Letter, pg. 1 This document, available in English and Spanish, is the appeal resolution notice used when an appeal is upheld and informs the member they may be responsible for the cost of continued services if the decision is upheld. • VI.GA.27_Member Appeal Admin Uphold Letter, pg. 1 **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
32. If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services as promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. *42 CFR 438.424(a)* Contract: Exhibit B-8—8.7.13.4 10 CCR 2505-10 8.209.4.W	**Both RAEs:** This document outlines the policy for a Continuation of Benefit as it pertains to a reversal of the determination. • VI.GA.1_ AG Member Appeals-CO, pg. 7 **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
33. If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the Contractor must pay for those services. *42 CFR 438.424(b)* Contract: Exhibit B-8—8.7.13.5 10 CCR 2505-10 8.209.4.X	**Both RAEs:** This document outlines the policy for a Continuation of Benefit as it pertains to a reversal of the determination. • VI.GA.1_ AG Member Appeals-CO, pg. 7 **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
34. The Contractor maintains records of all grievances and appeals. The records must be accurately maintained in a manner accessible to the State and available on request to CMS. • The record of each grievance and appeal must contain, at a minimum, all of the following information: – A general description of the reason for the grievance or appeal. – The date received. – The date of each review or, if applicable, review meeting. – Resolution at each level of the appeal or grievance. – Date of resolution at each level, if applicable. – Name of the person for whom the appeal or grievance was filed. • The Contractor quarterly submits to the Department a Grievance and Appeals report including this information. *42 CFR 438.416* Contract: Exhibit B-8—8.9.1–8.9.1.6 10 CCR 2505-10 8.209.3.C	**Both RAEs:** This document outlines the record keeping requirements for appeals and for reporting quarterly. • VI.GA.1_ AG Member Appeals-CO, pg. 8 This is an example of the template for grievances and appeals reporting that CCHA provides to the state on a quarterly basis for Regions 6 and 7. • VI.GA.34_Copy of GrieveAppealRpt **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
35. The Contractor provides the information about the grievance, appeal, and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals.	**Both RAEs:** This document identifies that members are providers are made aware of the grievance and appeals process. • VI.GA.1_ AG Member Appeals-CO, pg. 3 This webpage provides public facing information on CCHA's grievance and appeals process.	**RAE 6:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. – The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member. *42 CFR 438.414* Contract: Exhibit B-8—8.4 10 CCR 2505-10 8.209.3.B	• CCHA Appeals and Grievances Webpage: https://www.cchacares.com/for-members/appeals-and-grievances/ These documents outline the information given to providers in the manual when the provider or subcontractor enters into a contract. • VI.GA.35_Behavioral Health Provider Manual, pgs. 48-56 • VI.GA.35_Physical Health Provider Manual, pgs. 14, 16-18 **R6-specific:** **R7-specific:**	

Findings:
Although CCHA's provider manuals for behavioral health and physical health included two separate sections for grievances and appeals, on page 48 of the *Behavioral Health Provider Manual*, there was one section that combined the two processes with three bullet points that did not apply to appeals. The three bullet points should be located under the grievance section only on page 49. Additionally, page 49 under "Members: Filing a Grievance" stated that the member "must" attach documents to a grievance request as evidence for an investigation. However, the member has the right to call or fax, email, or mail documents. Page 52 did not include "For notice of an expedited resolution, the Contractor must also *make reasonable efforts to provide oral notice of resolution*."

Required Actions:
CCHA must update its *Behavioral Health Provider Manual* with the following:

- Remove "appeal" from the last section on page 48 and relocate the three bullet points under grievances.

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Remove the word "must" on page 49 regarding requiring the member to attach documents. CCHA can enhance this sentence by saying "can" or "may," or adding that the member can call or fax, email, or mail documentation or additional documents. • On page 52, include "For notice of an expedited resolution, the Contractor must also *make reasonable efforts to provide oral notice of resolution*." HSAG recommends CCHA to update the *Physical Health Provider Manual* to be comparable to the *Behavioral Health Provider Manual* in regard to information included.		

Results for Standard VI—Grievances and Appeal Systems							
Total	Met	=	26	X	1.00	=	26
	Partially Met	=	9	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	35	**Total Score**		=	26
				Total Score ÷ Total Applicable		=	74%

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor agrees to accept individuals eligible for enrollment into its RAE in the order in which they apply without restriction (unless authorized by CMS) up to the limits set under that contract. *42 CFR 438.3(d)(1)* Contract: Exhibit B-8—6.6	**Both RAEs:** The Enrollment Policy states that CCHA will accept all eligible individuals in the order in which they apply and without restriction. • XII.ED.1_Enrollment Policy, entire document The Transitions of Care Policy outlines our process for supporting members through transitions between coverage, including fee-for-service and between Regional Accountable Entities (RAEs). • XII.ED.1_Transitions of Care Policy, entire document The Physical Health Provider Manual outlines that primary care medical providers (PCMPs) will accept all eligible members HCPF assigns to their practice without restriction, based on attribution and assignment policies. • XII.ED.1_PH Provider Manual, pg. 1 This form helps facilitate warm hand-offs for members with care coordination needs when transitioning between RAEs. • XII.ED.1_RAE to RAE Member Transition of Care Coordination Form, entire document **R6-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	R7-specific:	
2. The Contractor does not discriminate against individuals eligible to enroll or use any policy or practice that has the effect of discriminating against individuals, based upon health status or need for health care services, race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs, or disability. *42 CFR 438.3(d)(3-4)* Contract: Exhibit B-8—6.5	**Both RAEs:** CCHA's Enrollment Policy includes a non-discrimination statement that complies with this requirement. • XII.ED.1_Enrollment Policy, pg. 1 The non-discrimination statement is featured in the Behavioral Health and Physical Health Provider Manuals. • XII.ED.2_BH Provider Manual, pgs. 9-10 • XII.ED.1_PH Provider Manual, pgs. 4-5 CCHA posts its non-discrimination statement on its website, and includes a link to it at the bottom of every page. • XII.ED.2_Website Language – Non Discrimination, entire document **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor may not request disenrollment of a member because of an adverse change in the member's health status or because the member's: • Utilization of medical services • Diminished mental capacity • Uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the Contractor's ability to furnish services to the member or to other members) *42 CFR 438.56(b)(2)* Contract: Exhibit B-8—None	**Both RAEs:** The Disenrollment Policy states that the RAE shall not disenroll nor encourage a member to disenroll for any reason, including the reasons outlined in this requirement. • XII.ED.3_Disenrollment Policy, pg. 2 **R6-specific:** **R7-specific:**	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. To initiate disenrollment of a member's participation with the RAE, the Contractor must provide the Department with documentation justifying the proposed disenrollment. *42 CFR 438.56(b)(3)* Contract: Exhibit B-8—None	**Both RAEs:** The Disenrollment Policy outlines how CCHA will process disenrollments from the RAE. • XII.ED.3_Disenrollment Policy, entire document The Reporting Change in Member Circumstance Affecting Eligibility Policy outlines the process CCHA employs to notify HCPF when CCHA is made aware of a change in a member's circumstances that affect their eligibility, including member death and change in residency outside the state of Colorado. • XII.ED.4_Reporting Change in Member Circumstance Affecting Eligibility, entire document	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following template is used to report such changes in member circumstance that affect eligibility to HCPF via monthly deliverables. • XII.ED.4_Change in Member Circ. Reporting Template, entire document The Physical Health Provider Manual informs the network that members may contact the Health First Colorado Enrollment department to support member-driven enrollment decisions. • XII.ED.1_PH Provider Manual, pg. 7 The Behavioral Health Provider Manual informs the BH network that providers are expected to support transitions of care when a member disenrolls. • XII.ED.2_BH Provider Manual, pgs. 69-70, 77 **R6-specific:** **R7-specific:**	

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The member may request disenrollment as follows: • For cause at any time, including: – The member has moved out of the Contractor's service area – The Contractor does not (due to moral or religious objections) cover the service the member seeks – The member needs related services to be performed at the same time, not all related services are available from the Contractor's plan, and the member's primary care provider (or another provider) determines that receiving the services separately would subject the member to unnecessary risk – Poor quality of care – Lack of access, or lack of access to providers experienced with dealing with the members specific needs • Without cause at the following times: – During the 90 days following the date of the member's initial enrollment – At least once every 12 months thereafter – Upon automatic re-enrollment if temporary loss of eligibility has caused the member to miss the annual disenrollment opportunity – When the Department has imposed sanctions on the RAE (consistent with 42 CFR 438.702(a)(4) *42 CFR 438.56(c)-(d)(2)*	**Both RAEs:** The Disenrollment Policy outlines the reasons for which a member may request disenrollment. • XII.ED.3_Disenrollment Policy, pgs. 1-3 The Reporting Change in Member Circumstance Affecting Eligibility Policy outlines the process CCHA employs to notify HCPF when CCHA is made aware of a change in a member's circumstances that affect their eligibility, including member death and change in residency outside the state of Colorado. • XII.ED.4_Reporting Change in Member Circumstance Affecting Eligibility, entire document The following template is used to report such changes in member circumstance that affect eligibility to HCPF via monthly deliverables. • XII.ED.4_Change in Member Circ. Reporting Template, entire document CCHA informs members on its FAQ webpage that it does not restrict or limit any Health First Colorado services because of moral or religious objections, and that if their provider will not provide a covered service due to such reasons to contact Member Support Services for additional support. We strive to address	**RAE 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract: Exhibit B-8—6.10	and resolve any identified issues that may lead a member to want to disenroll. • https://www.cchacares.com/for-members/frequently-asked-questions/ **R6-specific:** **R7-specific:**	

Results for Standard XII—Enrollment and Disenrollment							
Total	Met	=	5	X	1.00	=	5
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	5	**Total Score**		=	5
				Total Score ÷ Total Applicable		=	100%

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2022–2023 External Quality Review
Denials Record Review
for
Colorado Community Health Alliance RAE 6

Review Period:	January 1, 2022–December 31, 2022
Date of Review:	April 3, 2023
Reviewer:	Sarah Lambie, MA, CPHQ
Participating MCE Staff Member(s):	Kelli Gill and Marsha Penn

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Member ID #	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****					
Date of Initial Request [XX/XX/XXXX]	1/19/2022	4/7/2022	7/28/2022	8/19/2022	8/29/2022	9/19/2022	9/30/2022	11/2/2022	11/23/2022	12/30/2022					
Type of Denial: Termination (T), New Request (NR), Claim (CL)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR					
Type of Request: Standard (S), Expedited (E), Retrospective (R), SUD Inpatient/Residential (SUD), or SUD Inpatient/Residential Special Connections (SUD SC)	S	E	S	S	S	E	E	E	S	E					
Date of Decision for Adverse Benefit Determination [XX/XX/XXXX]	1/20/2022	4/7/2022	7/28/2022	8/19/2022	9/6/2022	9/20/2022	10/3/2022	11/3/2022	11/23/2022	12/30/2022					
Date Notice of Adverse Benefit Determination (NABD) Sent [XX/XX/XXXX]	1/24/2022	4/8/2022	8/2/2022	8/22/2022	9/6/2022	9/21/2022	10/3/2022	11/4/2022	11/28/2022	12/30/2022					
Notice Sent to Provider and Member? [I.11]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Number of Hours or Days for Decision (H/D)	1 D	0 D	0 D	0 D	8 D	1 D	3 D	1 D	0 D	0 D					
Number of Hours or Days for Notice (H/D)	5 D	1 D	5 D	3 D	8 D	2 D	3 D	2 D	5 D	0 D					
Adverse Benefit Determination Decision Made Within Required Time Frame? [I.12] Standard: 10 calendar days Expedited: 72 hours SUD: 72 hours (calendar) or 24 hours (calendar) for special connections	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Notice Sent Within Required Time Frame? [I.17] Standard: 10 calendar days Expedited: 72 hours SUD: 72 hours (calendar) or 24 hours (calendar) for special connections Termination: 10 calendar days before the date of action	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Was Authorization Decision Timeline Extended? Yes or No	No	No	No	No	No	No	No	No	No	No					
If Extended, Extension Notification Sent to Member? [I.19]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA					
If Extended, Extension Notification Includes Required Content? [I.19]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA					
NABD Includes Required Content [I.15-16]	Not Met	Not Met	Not Met	Not Met	Met	Not Met	Met	Met	Met	Not Met					
Authorization Decision Made by Qualified Clinician? [I.10]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
If Denied for Lack of Information, Was the Requesting Provider Contacted for Additional Information or Consulted (if applicable)? [I.9]	NA	NA	NA	NA	NA	NA	NA	NA	NA	Met					
Was the Decision Based on Established Authorization Criteria (i.e., not arbitrary)? [I.2]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Was Correspondence With the Member Easy to Understand? [I.14]	Met	Met	Met	Met	Met	Met	Not Met	Met	Met	Met					

Scoring	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Applicable Elements	7	7	7	7	7	7	7	7	7	8					
Compliant (Met) Elements	6	6	6	6	7	6	6	7	7	7					
Percent Compliant	86%	86%	86%	86%	100%	86%	86%	100%	100%	88%					
Overall Total Applicable Elements	**71**														
Overall Total Compliant Elements	**64**														
Overall Total Percent Compliant	**90%**														

Comments:
Files 1 through 4, and 6: Did not state that the member can grieve the quick appeal request. The member appeal request form stated that the member must sign the appeal, which is no longer a requirement.
Files 1, 4, and 10: NABDs only included ASAM dimensions that were not met.
File 7: Original NABD stated the incorrect diagnosis for the member; an updated NABD was sent on 10/18/2022.

Yes and No = not scored—for informational purposes only
**** = Redacted Member ID

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2022–2023 External Quality Review
Grievances Record Review
for
Colorado Community Health Alliance RAE 6

Review Period:	January 1, 2022–December 31, 2022
Date of Review:	April 11–12, 2023
Reviewer:	Crystal Brown, CCMA
Participating MCE Staff Member(s):	LaTosha Brown and Vanessa DeBrick

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Member ID #	****	****	****	****	****	****	****	****	****	****					
Date Grievance Received [XX/XX/XXXX]	3/10/2022	6/28/2022	8/16/2022	8/19/2022	8/29/2022	9/28/2022	10/24/2022	10/26/2022	11/29/2022	12/21/2022					
Date of Acknowledgement Letter [XX/XX/XXXX]	3/10/2022	6/29/2022	8/16/2022	8/19/2022	8/29/2022	9/28/2022	10/25/2022	10/27/2022	11/29/2022	12/21/2022					
Days From Grievance Received to Acknowledgement	0	1	0	0	0	0	1	1	0	0					
Acknowledgement Letter Sent in 2 Working Days [VI.11]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Date of Written Notice [XX/XX/XXXX]	4/13/2022	8/3/2022	9/22/2022	9/7/2022	9/12/2022	10/12/2022	11/9/2022	11/11/2022	12/13/2022	1/16/2023					
# of Days to Notice	27	29	23	13	9	9	12	11	10	19					
Resolved and Notice Sent in Time Frame* [VI.12,24] Standard: 15 working days Extension: 15 working days + 14 calendar days	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Decision-Maker Not Involved in Grievance [VI.7]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Appropriate Level of Expertise (If Clinical) [VI.7]	Met	Met	Met	Met	Met	NA	Met	Met	NA	NA					
Resolution Letter Includes Required Content [VI.13]**	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Resolution Letter Easy to Understand [VI.12]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Scoring	**File 1**	**File 2**	**File 3**	**File 4**	**File 5**	**File 6**	**File 7**	**File 8**	**File 9**	**File 10**	**File OS1**	**File OS2**	**File OS3**	**File OS4**	**File OS5**
Applicable Elements	6	6	6	6	6	5	6	6	5	5					
Compliant (Met) Elements	6	6	6	6	6	5	6	6	5	5					
Percent Compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%					
Overall Total Applicable Elements	**57**														
Overall Total Compliant Elements	**57**														
Overall Total Percent Compliant	**100%**														

Comments:
Files 1, 2, 3, and 10: Were extended. Met time frame for resolution letter; however, no extension letter or oral outreach attempts were documented. See the Compliance Monitoring Tool.

* Grievance timeline for resolution and notice sent is 15 working days (unless extended, then up to 14 calendar days).

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

**** = Redacted Member ID

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2022–2023 External Quality Review
Appeals Record Review
for
Colorado Community Health Alliance RAE 6

Review Period:	January 1, 2022–December 31, 2022
Date of Review:	April 11–12, 2023
Reviewer:	Crystal Brown, CCMA
Participating MCE Staff Member(s):	LaTosha Brown and Vanessa DeBrick

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Member ID #	****	****	****	****	****		****	****	****	****	****				
Date Appeal Received [XX/XX/XXXX]	2/21/2022	6/4/2022	9/7/2022	9/16/2022	10/5/2022		9/12/2022	9/26/2022	12/22/2022	4/25/2022	9/4/2022				
Date of Acknowledgement [XX/XX/XXXX]	2/23/2022	6/6/2022	9/8/2022	9/17/2022	10/5/2022		9/12/2022	9/27/2022	12/22/2022	4/26/2022	9/6/2022				
Days From Appeal Received to Acknowledgement	2	0	1	0	0		0	1	0	1	2				
Acknowledgement Sent Within 2 Working Days? [VI.17]	Met	Met	Met	Met	Met		Met	Met	Met	Met	Met				
Decision-Maker Not Previous Level [VI.7]	Met	Met	Met	Met	Met		Met	Met	Met	Met	Met				
Decision-Maker—Clinical Expertise [VI.7]	Met	Met	Met	NA	Met		Met	Met	Met	Met	Met				
Expedited Appeal: Yes or No	No	No	No	No	Yes		Yes	No	No	Yes	No				
Time Frame Extended: Yes or No	No	No	No	No	No		No	No	No	No	No				
Date Resolution Notice Sent [XX/XX/XXXX]	2/25/2022	6/14/2022	9/9/2022	11/1/2022	10/10/2022		9/14/2022	9/28/2022	12/29/2022	4/27/2022	9/6/2022				
Hours or Days From Appeal Filed to Resolution Notice Sent	4 D	6 D	2 D	31 D	3 D		2 D	2 D	4 D	2 D	2 D				
Notice Sent Within Time Frame*? [VI.22-25] Standard Resolution: 10 working days Expedited Resolution: 72 hours Time Frame Extended: +14 calendar days	Met	Met	Met	Not Met	Met		Met	Met	Met	Met	Met				
Resolution Letter Includes Required Content [VI.26]**	Not Met	Not Met	Not Met	Met	Not Met		Not Met	Not Met	Not Met	Not Met	Met				
Resolution Letter Easy to Understand [VI.22]	Met	Met	Met	Met	Met		Met	Met	Met	Met	Met				
Scoring	**File 1**	**File 2**	**File 3**	**File 4**	**File 5**	**File 6**	**File 7**	**File 8**	**File 9**	**File 10**	**File OS1**	**File OS2**	**File OS3**	**File OS4**	**File OS5**
Applicable Elements	6	6	6	5	6		6	6	6	6	6				
Compliant (Met) Elements	5	5	5	4	5		5	5	5	5	6				
Percent Compliant	83%	83%	83%	80%	83%		83%	83%	83%	83%	100%				
Overall Total Applicable Elements	**59**														
Overall Total Compliant Elements	**50**														
Overall Total Percent Compliant	**85%**														

Comments:
Files 1, 2, 3, 5, 7, 8, 9, and 10: Appeal resolution letter did not include continuation of benefits can be requested verbally.
Files 1, 3, and 7: Acknowledgment letter states member has to follow up verbal appeal in writing.
File 4: Appeal resolution letter was sent late.
File 6: Appeal removed due to provider administrative appeal.

*__Appeal resolution letter time frame__ does not exceed 10 working days from the day the MCE receives the appeal (unless expedited—72 hours; or unless extended—+14 calendar days).

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

**** = Redacted Member ID

Appendix C. Compliance Review Participants

Table C-1 lists the participants in the FY 2022–2023 compliance review of **CCHA**.

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

HSAG Review Team	Title
Sarah Lambie	Senior Project Manager
Crystal Brown	Project Manager I
CCHA Participants	**Title**
Abigail Roa	Director, Compliance
Amy Yutz	Executive Director
Andrea Skubal	Accountable Care Network Program Manager
Camila Joao	Manager, Clinical Quality Program
Cara Hebert	Manager, Stakeholder Engagement and Program Officer
Carrie Young	Manager, Enrollment Data
Cathy Herrera	Grievance and Appeal Audit Specialist
Cindi Terra	Quality and Practice Transformation Manager
Clara Cabanis	Strategy and Performance Management, Senior Manager
Colleen Daywalt	Corporate and Public Affairs Director
Dr. Melanie Rylander	Medical Director, Region 7
Dr. Patricia Payne	Medical Director, Region 6
Erica Kloehn	Provider Solutions Director
Gina Wendling	Program Director, Care Management
Jalesa Johnson	Administrative Assistant
Josie Dostie	Network Manager
Kalena Wilkinson	Communications Program Specialist
Kathryn Morrison	Director, Behavioral Health Quality Management
Kelli Gill	Director, Behavioral Health Services
Krista Newton	Director, Care Coordination
Kristen Mader	Provider Data Analyst, Provider Solutions
LaTosha Brown	Director, Behavioral Health Programs and Services
Lisa Banks-Finn	Manager, Grievance and Appeals
Lisa Niguidula	Manager, Grievance and Appeals
Lizbeth Villaruz	Manager, Internal Audits

CCHA Participants	Title
Marianne Lynn	Manager, Compliance
Marsha Penn	Manager, Behavioral Health Services
Matt Wilkins	Manager, Behavioral Health Services, Region 7
Megan Lujan	Medicaid Clinical Writer
Michelle Blady	Manager, Behavioral Health Services, Region 6
Millicent Bahamonde	Project Administrator
Natalie Johnson	Manager, Behavioral Health Care
Sophie Thomas	Manager, Medicaid Programs
Tony Olimpio	Manager, Member Engagement and Outreach Operations
Vanessa DeBrick	Manager, Grievance and Appeals
Department Observers	**Title**
Russ Kennedy	Quality Program Manager
Helen Desta	Quality Section Manager
Michelle Maddrell	Program Specialist, RAE 6
Blue Parish	Program Specialist, RAE 3

Appendix D. Corrective Action Plan Template for FY 2022–2023

If applicable, the MCE 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 MCE must identify the planned interventions, training, monitoring and follow-up activities, and proposed documents in order to 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 MCE 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 MCE will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final compliance review report via email or through the file transfer protocol (FTP) site, with an email notification to HSAG and the Department. The MCE 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, monitoring and follow-up activities, and final evidence to be submitted following the completion of the planned interventions.	
Step 2	**Prior approval for timelines exceeding 30 days**
If the MCE is unable to submit the CAP proposal (i.e., the outline of the plan to come into compliance) 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: • Review and approve the planned interventions and instruct the MCE to proceed with implementation, or • Instruct the MCE to revise specific planned interventions, training, monitoring and follow-up activities, and/or documents to be submitted as evidence of completion and also to proceed with resubmission.	
Step 4	**Documentation substantiating implementation**
Once the MCE has received Department approval of the CAP, the MCE will have a time frame of 90 days (three months) to complete proposed actions and submit documents. The MCE will submit documents as evidence of completion one time only on or before the 90-day deadline for all required actions in the CAP. If any revisions to the planned interventions are deemed necessary by the MCE during the 90 days, the MCE should notify the Department and HSAG. If the MCE is unable to submit documents of completion for any required action on or before the three-month deadline, it must obtain approval in advance from the Department to extend the deadline.	

Step	Action
Step 5	**Technical assistance**
At the MCE's request or at the recommendation of the Department and HSAG, technical assistance (TA) calls/webinars are available. The session may be scheduled at the MCE's discretion at any time the MCE 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 MCE as to whether or not the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements. Any documentation that is considered unsatisfactory to complete the CAP requirements at the three-month deadline will result in a continued corrective action with a new date for resubmission established by the Department. HSAG will continue to work with the MCE until all required actions are satisfactorily completed.	

The CAP template follows on the next page.

Table D-2—FY 2022–2023 Corrective Action Plan for CCHA RAE 6

Standard I—Coverage and Authorization of Services
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
9. The Contractor and its subcontractors have in place mechanisms to consult with the requesting provider for medical services when appropriate. *42 CFR 438.210(b)(2)(ii)* Contract: Exhibit B-8—14.8.2.5
Findings
Documentation such as the *Behavioral Health Provider Manual*, *P2P Desktop Process*, *UM Workflow*, *UM Program Description*, *UM Review Desktop Procedure*, and *Letter Desktop Procedure* outlined that, in some cases, peer-to-peer consultations occurred after the member was mailed the NABD. Documentation submitted by CCHA and interviews with staff members referenced "reconsideration" of denials and "overturning" denial procedures, which do not comply with managed care regulations. While most cases reviewed in the denial samples demonstrated that CCHA outreached the requesting providers when necessary, in some instances, CCHA would make the decision sooner than the required 72-hour and 10-day authorization decision timelines. Furthermore, staff members reported that CCHA did not use extensions for authorization decisions during the review period. Staff members stated that the Department was interested in denial decisions that were overturned during appeals; however, CCHA reported that the data were difficult to pinpoint.
Required Actions
CCHA must update its *Behavioral Health Provider Manual*, *P2P Desktop Process*, *UM Workflow*, *UM Program Description*, *UM Review Desktop Procedure*, *Letter Desktop Procedure*, and any related policies and procedures to clarify that the peer-to-peer process must occur prior to issuing the member an NABD. CCHA should consider enhancing these same policies, procedures, and workflows to better define instances in which staff members could consider and use extensions.
Planned Interventions:
Person(s)/Committee(s) Responsible:

Standard I—Coverage and Authorization of Services
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard I—Coverage and Authorization of Services
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
15. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to and copies of all documents and records relevant to the adverse benefit determination (includes medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits). • The member's right (or member's designated representative) to request one level of appeal with the Contractor and the procedures for doing so. • The date the appeal is due. • The member's right to request a State fair hearing after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State fair hearing. • The circumstances under which an appeal process can be expedited and how to make this request. • The member's rights to have benefits/services continue (if applicable) pending the resolution of the appeal, how to request that benefits continue, and the circumstances (consistent with State policy) under which the member may be required to pay the cost of these services. • How each dimension of the most recent edition of ASAM criteria was considered when determining medical necessity for any adverse determination concerning residential or inpatient substance use disorder services. *42 CFR 438.404(b)* *SB21-137: Section 10-25.5-5-424(3)* Contract: Exhibit B-8—8.6.1.5–8.6.1.13 10 CCR 2505-10 8.209.4.A.2

Standard I—Coverage and Authorization of Services
Findings
A review of 10 sample denial records showed issues such as: • Three out of 10 NABDs included an attachment that stated the member must sign the appeal form and that verbal appeals must be followed by a written appeal, which is no longer required. However, since CCHA removed this attachment early in the review period, no required action is needed; CCHA is currently in compliance regarding this finding. • Three out of 10 NABDs regarding ASAM level of care requests did not include all dimensions, as required. • One NABD included a diagnosis that was incorrect.
Required Actions
Since CCHA removed the appeal form early in the review period, no required action is needed for that issue. However, CCHA must update its NABD templates and letter writing procedure for SUD requests to include information about all dimensions. Lastly, CCHA should enhance its oversight and monitoring to ensure accurate letters for members.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
4. The Contractor defines a grievance as an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. A grievance includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision. *42 CFR 438.400(b)* Contract: Exhibit B-8—2.1.46, 8.6.6.2 10 CCR 2505-10 8.209.2.D, 8.209.4.A.3.c.(i)
Findings
CCHA defined "grievance" as an expression of dissatisfaction about any matter other than an adverse benefit determination in its policy. However, staff members reported when grievances are received, the member is asked if they would like to file a formal grievance. If the member declines, CCHA does not document the complaint in the grievance software system, NextGen, but rather in the customer service software system; therefore, the grievance cannot be tracked and trended.
Required Actions
CCHA must enhance its messaging to the members in a way that encourages members to grieve freely without the barrier of a perceived second "formal" step. Additionally, CCHA must update and conduct a refresher training that reiterates the enhanced messaging to members expressing dissatisfaction. For example, "I understand and hear your concern. I will take this information down, look into it, and follow up with you." The customer service staff members who receive complaints should receive updated training regarding how to ensure all complaints are logged in the grievance system and ensure members receive a grievance acknowledgement letter and resolution letter. Monitoring should include a mechanism for monitoring the customer service calls to ensure all complaints are being processed as grievances, tracked within the grievance system, and reported quarterly to the Department.

Standard VI—Grievance and Appeal Systems
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
8. The Contractor ensures that the individuals who make decisions on grievances and appeals: • Take into account all comments, documents, records, and other information submitted by the member or the member's representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. *42 CFR 438.406(b)(2)* Contract: Exhibit B-8—8.6.2 10 CCR 2505-10 8.209.5.C, 8.209.4.E
Findings
Policies and procedures included accurate information describing how CCHA would accept additional information from the member during a review of a filed grievance by the member. During the record review, HSAG identified one member grievance record had documentation that indicated the member called to give more information and was advised to file a new grievance on the website rather than the representative taking down the additional information.
Required Actions
CCHA must develop a refresher training on how to handle additional information received by the member. CCHA must monitor staff member documentation to ensure that representatives are taking down additional information from a member who calls to give more information on an open case. Staff members should not direct members to file a new grievance unless that grievance indicates a different grievance that is not related to the current open case.
Planned Interventions:
Person(s)/Committee(s) Responsible:

Standard VI—Grievance and Appeal Systems
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
11. The Contractor sends the member written acknowledgement of each grievance within two working days of receipt. *42 CFR 438.406(b)(1)* Contract: Exhibit B-8—8.1 10 CCR 2505-10 8.209.5.B
Findings
All grievance acknowledgement letters in the sample records were timely. However, the CCHA website included a downloadable PDF titled "What is the grievance and appeal process?" The PDF inaccurately stated the time frame for a grievance acknowledgement letter is five days.
Required Actions
The PDF located on the CCHA website must be updated to accurately state that a grievance acknowledgement letter will be sent to the member in two working days.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:

Standard VI—Grievance and Appeal Systems
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
16. The member may file an appeal either orally or in writing, and the Contractor must treat oral appeals in the same manner as appeals received in writing. The Contractor may not require that oral requests for an appeal be followed with a written request. *42 CFR 438.402(c)(3)(ii)* *42 CFR 438.406 (b)(3)* Contract: Exhibit B-8—8.7.6 10 CCR 2505-10 8.209.4.F
Findings
The downloadable PDF titled "What is the grievance and appeal process?" on CCHA's website inaccurately stated on page two that a verbal appeal must be followed up with a written appeal. Additionally, three out of 10 of CCHA's appeal acknowledgement letters stated a member must follow up a verbal appeal in writing.
Required Actions
The PDF located on the CCHA website must be updated to remove the statement that a verbal appeal must be followed up with a written appeal. CCHA must also update its appeal acknowledgement letters to remove any requirement that the member must follow up a verbal appeal in writing.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:

Standard VI—Grievance and Appeal Systems
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
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Standard VI—Grievance and Appeal Systems
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Requirement
22. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)* *42 CFR 438.408(d)(2)(i)* *42 CFR 438.10* Contract: Exhibit B-8—8.7.14.1. 7.2.7.3, 7.2.7.5 10 CCR 2505-10 8.209.4.J.1
Findings
One out of 10 member appeal resolution letters were not timely.
Required Actions
CCHA must enhance its monitoring of timeliness to ensure all appeal resolution letters are following the time frame set forth by the State contract and federal regulations.
Planned Interventions:
Person(s)/Committee(s) Responsible:

Standard VI—Grievance and Appeal Systems
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
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Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
23. For expedited appeal, the Contractor must resolve the appeal and provide written notice of disposition to affected parties within 72 hours after the Contractor receives the appeal. • For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. *42 CFR 438.408(b)(3) and (d)(2)(ii)* Contract: Exhibit B-8—8.7.14.2.3, 8.7.14.2.6 10 CCR 2505-10 8.209.4.J.2, 8.209.4.L
Findings
CCHA's *Member Appeals Policy* stated the accurate time frame to resolve expedited appeals and provide written notice of disposition to affected parties is within 72 hours after the appeal is received. However, the policy did not include that the member may file a grievance if the member disagrees with the decision.
Required Actions
The *Member Appeals Policy* on page 6, section 7.a., must be updated to include that the member may file a grievance if they disagree with the decision (please see 5.b on page 6 for an example).
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:

Standard VI—Grievance and Appeal Systems
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
25. If the Contractor extends the time frames for a grievance or appeal, it must—for any extension not requested by the member: • Make reasonable efforts to give the member prompt oral notice of the delay. • Within two calendar days, give the member written notice of the reason for the delay and inform the member of the right to file a grievance if the member disagrees with that decision. • Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires (14 days following the expiration of the original grievance or appeal resolution time frame). *42 CFR 438.408(c)(2)* Contract: Exhibit B-8—8.5.7, 8.7.14.1, 8.7.14.2.1, 8.7.14.2.5-6 10 CCR 2505-10 8.209.4.L, 8.209.4.K, 8.209.4.A. 3.C(ii), 8.209.5.E
Findings
CCHA did not have any extension requests in the appeal sample list; however, there were extension requests for grievances. Three out of 10 grievance samples were extended; however, CCHA did not include extension letters or oral notice to the member.
Required Actions
CCHA must enhance its policies, procedures, and training for staff members to ensure that when an extension is in the best interest of the member, an extension letter is sent to the member as well as prompt oral notice of the delay.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:

Standard VI—Grievance and Appeal Systems
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
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☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
26. The written notice of appeal resolution must include: • The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. – The right to request that benefits/services continue* while the hearing is pending, and how to make the request. – That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's adverse benefit determination. **Continuation of benefits applies only to previously authorized services for which the Contractor provides 10-day advance notice to terminate, suspend, or reduce.* *42 CFR 438.408(e)* Contract: Exhibit B-8—8.7.14.3, 8.7.14.4 10 CCR 2505-10 8.209.4.M
Findings
CCHA appeal resolution letters included information on how to request a State fair hearing and continuation of benefits. However, the appeal resolution letters only included how to request continuation of benefits by mail or fax. While State fair hearings must be submitted in writing, the request for continuation of benefits does not need to be in writing.
Required Actions
The appeal resolution letters must be updated to include the contact phone number and remove "written" from its language under the "Who to contact" portion of the appeal resolution letter in regard to continuation of benefits.
Planned Interventions:

Standard VI—Grievance and Appeal Systems
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
35. The Contractor provides the information about the grievance, appeal, and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. – The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member. *42 CFR 438.414* Contract: Exhibit B-8—8.4 10 CCR 2505-10 8.209.3.B
Findings
Although CCHA's provider manuals for behavioral health and physical health included two separate sections for grievances and appeals, on page 48 of the *Behavioral Health Provider Manual*, there was one section that combined the two processes with three bullet points that did not apply to appeals. The three bullet points should be located under the grievance section only on page 49. Additionally, page 49 under "Members: Filing a Grievance" stated that the member "must" attach documents to a grievance request as evidence for an investigation. However, the member has the right to call or fax, email, or mail documents. Page 52 did not include "For notice of an expedited resolution, the Contractor must also *make reasonable efforts to provide oral notice of resolution*."

Standard VI—Grievance and Appeal Systems
Required Actions
CCHA must update its *Behavioral Health Provider Manual* with the following: • Remove "appeal" from the last section on page 48 and relocate the three bullet points under grievances. • Remove the word "must" on page 49 regarding requiring the member to attach documents. CCHA can enhance this sentence by saying "can" or "may," or adding that the member can call or fax, email, or mail documentation or additional documents. • On page 52, include "For notice of an expedited resolution, the Contractor must also *make reasonable efforts to provide oral notice of resolution*." HSAG recommends CCHA to update the *Physical Health Provider Manual* to be comparable to the *Behavioral Health Provider Manual* in regard to information included.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

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 the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the review to assess compliance with federal managed care regulations and Department 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 desk request forms, compliance monitoring tools, record review tools, report templates, agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all reviewers to ensure consistency in scoring across MCEs.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided MCEs with proposed review dates, group technical assistance, and training, as needed. • HSAG confirmed a primary MCE contact person for the review and assigned HSAG reviewers to participate in the review. • Sixty days prior to the scheduled date of the review, HSAG notified the MCE in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and review agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and the review activities. Thirty days prior to the review, the MCE provided documentation for the desk review, as requested. • Documents submitted for the review consisted of the completed desk review form, the compliance monitoring tool with the MCE's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. • The MCEs also submitted lists denials, grievances, and appeals that occurred between January 1, 2022, and December 31, 2022 (to the extent available at the time of the review). MCEs submitted the lists to HSAG 10 days following receipt of the desk review request. HSAG used a random sampling technique to select records for the review. HSAG notified the MCE five days following receipt of the lists of records regarding the sample records selected.

For this step,	HSAG completed the following activities:
	• The HSAG review team reviewed all documentation submitted prior to the review and prepared a request for further documentation and an interview guide to use during the review.
Activity 3:	**Conduct the Review**
	• During the review, HSAG met with groups of the MCE's key staff members to obtain a complete picture of the MCE's compliance with federal healthcare regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the MCE's performance. • HSAG requested, collected, and reviewed additional documents as needed. • At the close of the review, HSAG provided MCE staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2022–2023 Department-approved Compliance Review Report template to compile the findings and incorporate information from the pre-review and review activities. • HSAG analyzed the findings and calculated final scores based on Department-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the Department**
	• HSAG populated the Department-approved report template. • HSAG submitted the draft Compliance Review Report to the MCE and the Department for review and comment. • HSAG incorporated the MCE and Department comments, as applicable, and finalized the report. • HSAG included a pre-populated CAP template in the final report for all elements determined to be out of compliance with managed care regulations. • HSAG distributed the final report to the MCE and the Department.