COLORADO

Department of Health Care Policy & Financing

Fiscal Year 2019–2020 Site Review Report

for

Colorado Community Health Alliance

Region 6

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

In accordance with its authority under Colorado Revised Statute 25.5-1-101 et seq. and pursuant to Request for Proposals 2017000265, the Department of Healthcare Policy and Financing (the Department) executed contracts with the Regional Accountable Entities for the Accountable Care Collaborative (ACC) program, effective July 1, 2018. The Regional Accountable Entities (RAEs) are responsible for integrating the administration of physical and behavioral healthcare and will manage networks of fee-for-service (FFS) 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)—federal Medicaid managed care regulations published May 6, 2016—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 PCCM entities and PIHPs to determine compliance with federal Medicaid managed care regulations published May 6, 2016. 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) 2019–2020 site review activities for **Colorado Community Health Alliance Region 6** (**CCHA R6**). For each of the three 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 2019–2020 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2018–2019 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the denials of authorization of services (denials), grievances, and appeals record reviews. Appendix C lists HSAG, RAE, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process that the health plan will be required to complete for FY 2019–2020 and the required template for doing so. Appendix E contains a detailed description of HSAG's site review activities consistent with the Centers for Medicare & Medicaid Services (CMS) final protocol. Appendix F includes the summary of the focus topic interviews with RAE staff members used to gather information for assessment of statewide trends related to the FY 2019–2020 focus topic selected by the Department.

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 R6** 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	34	30	25	5	0	4	83%
II. Access and Availability	16	16	15	0	1	0	94%
VI. Grievances and Appeals	35	35	25	10	0	0	71%
Totals	**85**	**81**	**65**	**15**	**1**	**4**	**80%**

*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 R6** 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	90	61	49	12	29	80%
Grievances	60	53	46	7	7	87%
Appeals	48	47	39	8	1	83%
Totals	**198**	**161**	**134**	**27**	**37**	**83%**

*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

Summary of Strengths and Findings as Evidence of Compliance

CCHA substantiated having an effective utilization management (UM) system to ensure delivery of medically necessary behavioral health (BH) services and treatment, including inpatient, residential, outpatient, transitions of care, assessments, and more. Documentation submitted included policies, procedures, workflows, training reports, and template letters. HSAG reviewed all submissions and found that the documents demonstrated an overall comprehensive approach for review, authorization, and denial of RAE-covered services. **CCHA** had various policies and monitoring processes to ensure services are sufficient in amount, duration, and scope.

CCHA policies described clear roles for various staff members and appropriate oversight and monitoring. BH UM staff members reported any disproportionate utilization trends to the clinical quality management representatives. UM reports tracked various key indicators such as hospital stays, readmissions, level of care, and length of stay trends. These trends were cross-referenced with quality of care (QOC) trends to identify educational opportunities for providers. One trend of note was **CCHA**'s increase in members accessing outpatient BH services both through primary care medical providers (PCMPs) and BH providers. Penetration has been increasing since the onset of the RAE and **CCHA** confirmed that these increases are not just for higher levels of care, but that most members with new BH penetration were accessing outpatient BH services.

Although **CCHA** utilizes Anthem's corporate-level software and clinical best practices, **CCHA** does not delegate UM functions. UM staff members are available 8 hours a day to process and answer authorization questions and a "BH Call Center" operates for after-hours questions. When making authorization decisions, UM staff members considered the individual's history, geography, and other socioeconomic factors, in addition to clinical criteria. **CCHA** has implemented "daily rounds," which allow for interdisciplinary communications between medical directors, clinical quality management representatives, care coordinators, peer support specialists, and other key staff members to make informed decisions. As further example of **CCHA**'s member-focused approach, staff trainings go beyond clinical comprehensive testing to also incorporate "soft-skills."

The FACETs, MACESS, and Member 360 software support UM documentation management, notes, member notices, and member eligibility verification. Authorization requests can be submitted via fax, email, or telephone and entered into the system. For most denial record reviews, **CCHA** processed authorization requests in a timely manner and time-stamped evidence within the software system, enabling compliance with required time frames for making standard and expedited authorization decisions. The notice of adverse benefit determination (NOABD) included the required content and demonstrated that authorization decisions followed clear clinical guidelines.

Policies, workflows, and staff interviews confirmed that **CCHA** does not arbitrarily reduce or discontinue services, and limits services only in clearly defined situations. (e.g., Institutions for Mental Disease

guidelines). HSAG observed no instances in which **CCHA** reduced, suspended, or terminated a previously authorized service.

CCHA's interrater reliability (IRR) process tested UM staff members annually to ensure comprehension of UM processes and criteria. Furthermore, staff members were cross trained in reviewing all levels of care to ensure IRR and appropriate continuity of care. **CCHA** reported that, during the most recent tests, all staff members scored either at 90 or 100 percent accuracy in response to test scenarios. **CCHA** maintains further oversight through monthly manager reports, the Quality Management Committee, the Quality Improvement and Medical Operations Committee, and other corporate Anthem-level meetings.

CCHA explained that requests for authorization can be approved at different levels based on the situation and staff credentials. **CCHA** staff members apply MCG criteria (formerly known as Milliman Care Guidelines) in making authorization decisions. **CCHA**'s UM reviewers are typically licensed master's level professional counselors or certified social workers. All requests for services outside of the UM reviewer's scope of authorization are reviewed by one of **CCHA**'s Doctor of Psychology or Psychiatrist medical directors. All adverse benefit determinations were made at the medical director level.

CCHA described payment and claims processing procedures for emergency and post-stabilization services to ensure payment in all appropriate circumstances. **CCHA** has the appropriate flags within the system to ensure post-stabilization services are passed through UM to determine financial responsibility.

Summary of Findings Resulting in Opportunities for Improvement

In multiple record review cases, **CCHA** had made errors in documenting dates within the authorization software. Due to the possibility that staff members entering notes in the system may not always be real-time, HSAG cautions that consistent documentation of time and date stamps would be necessary to ensure compliance with time frames applicable to expedited authorization requests. HSAG recommends that **CCHA** implement a process to ensure staff members use the date and time stamp in the data systems to accurately document receipt of requests and decisions made on authorization requests.

HSAG noted that four of the 10 denial records reviewed included authorization requests which were sent after services were rendered. In two of these instances, the authorization request was regarding inpatient stays. HSAG recommends strengthening providers' understanding of submitting timely authorization requests, especially for inpatient stays.

In addition to the required actions regarding ease of understanding of the NOABDs, HSAG recommends that best practice for Medicaid members is to limit the explanation of the denial reason to the actual reason for the denial (e.g., your condition can be treated through outpatient services) rather than explaining the detailed clinical criteria used. Members may request a copy of the criteria used by contacting **CCHA**. However, if **CCHA** chooses to include other National Committee for Quality Assurance (NCQA)-required content in the NOABD, HSAG recommends that the member-friendly summary (documented in the letter) should precede any more detailed explanation.

During on-site discussions with staff members, it was unclear whether there was a consistent understanding among staff members of when an NOABD to the member is required for claims denials. HSAG recommends that **CCHA** educates UM and claims staff members regarding the need to generate a notice to the member when there is denial of payment of a claim (except when a claim is rejected for administrative provider procedural errors—e.g., coding, incomplete, or lack of timeliness of claims submission.)

CCHA did not provide a sample extension template letter as evidence to support its policy describing extensions. Staff members indicated that extensions are "never" pursued and described understanding that an extension needed to be requested by a provider or member. Staff members described a process whereby the provider is notified of a 24-hour window to deliver additional information; if no information is provided within this time frame, the service may be denied. HSAG recommends that, when necessary, **CCHA** utilizes extensions to obtain additional information when it is in the best interest of the member. HSAG recommends that **CCHA** implement an extension process and develop a template extension letter to notify members when applicable.

Summary of Required Actions

CCHA's definition of medical necessity did not include reference to services being clinically appropriate in terms of "type, frequency, extent, site, and duration" or that "services are not primarily for the *economic benefit* of the client, caretaker, or provider." **CCHA** must ensure that the definition of "medical necessity" includes all required components outlined in the Colorado Code of Regulations (CCR).

CCHA's UM Program Description included general language about the process of notifying a requesting provider about a peer-to-peer process but did not clearly indicate that **CCHA** will outreach to the *requesting provider* to obtain additional information when necessary. One denial record review was denied due to "lack of information" received from the provider; however, no outreach to the provider was documented. The notes within the system stated, "provider did not request a peer review." Furthermore, record reviews demonstrated inconsistency in applying the peer-to-peer procedure. **CCHA** must ensure that, when appropriate, **CCHA** outreaches to the requesting providers to obtain additional information to make an authorization decision. **CCHA** should clarify within UM procedural documents how and when this outreach will take place.

During on-site denial record reviews, HSAG identified one case in which no NOABD was sent to the member. (A second case in which no NOABD was sent was omitted from the sample.). **CCHA** must develop a mechanism to ensure that a written NOABD is sent to the member regarding any decision to deny a service authorization request or denial of payment.

In one denial record review sample, **CCHA** provided notice to the provider, but did not mail a member notice. Therefore, the case did not meet the requirement for "notice sent in required time frame." **CCHA** must ensure that NOABDs are mailed to the member within applicable time frames.

In eight of 10 denial record reviews, the NOABD included language that was not easy for a member to understand. Notices included complex clinical terms and, in some cases, a full list of clinical criteria, including acronyms that would not be easy to understand. **CCHA** must ensure that the information explaining the reason for the denial in the NOABD is written in language that may be easily understood by Medicaid members with limited reading ability.

Standard II—Access and Availability

Summary of Strengths and Findings as Evidence of Compliance

CCHA submitted a large body of evidence to substantiate compliance with access and availability requirements. **CCHA**'s submission included policies, procedures, reports, workflows, tools, contract templates, manuals, provider newsletters, trainings, and forms. HSAG reviewed all submissions and found that the documents illustrated a thorough and comprehensive approach to ensuring monitoring and maintaining network access, availability, and adequacy standards.

CCHA described several mechanisms used to monitor network capacity and anticipated changes or increases to its Medicaid enrollment. The *Primary Care Caseload Monitoring* procedure described **CCHA**'s process for monitoring the PCMP monthly rosters based on the PCMP caseload standards. **CCHA** created a Provider Roster Comparison file to monitor and provide a summary of member assignment by Medicaid ID location. **CCHA** used this tool to account for month-to-month differences in provider network and caseload capacity. The RAE expanded the use of the monthly file to conduct an annual caseload review that included all RAE providers. **CCHA** used the State's affiliation table to compare its annual caseload review and conducted additional analysis such as provider counts, ratios, each location's ability to meet the network adequacy standards of third next available appointment standards, and determined network capacity in anticipation of an increase in Medicaid enrollment. Depending on **CCHA**'s findings, the steps outlined in the caseload and capacity workflow were operationalized to lower, maintain, monitor, or conduct additional analysis of the caseload size. If the RAE determined a gap in its BH or PCMP network, **CCHA** implemented the procedures from its well-documented strategy for provider recruitment and network development.

During on-site interviews, **CCHA** described its efforts to promote the delivery of services in a culturally competent manner. The RAE's urban and rural geographic service areas include members with diverse cultural and ethnic backgrounds, disabilities, gender identities, sexual orientation, and socioeconomic conditions that are taken into consideration when anticipating and meeting the healthcare needs of its membership. **CCHA** described its robust number of care coordination staff members that were available to assist members on an individual basis; engaging them in their homes, supporting them at behavioral and physical health appointments, and partnering with community stakeholders. **CCHA** described three unique scenarios that exemplify the RAE's ability to identify member needs and enhance delivery of services in a culturally sensitive manner:

- **CCHA** described how provider town halls and specialty trainings are used as a platform to review provider network adequacy and access standards, discuss RAE initiatives to improve health outcomes, and offer continuous education specific to the unique needs and challenges of the communities within the region. The RAE partnered with a local provider and subject matter expert (SME) on the Developmental Disability (DD) population. During the training, the SME offered resources and tools to enhance each provider's ability and desire to meet the needs of the DD community and across the broad spectrum of the RAE's membership in a culturally competent care manner. Providers were encouraged to expand their knowledge of the different health risks, customs, values, and beliefs associated with their patients, ensuring that members experience care in a manner that is appropriate for them. **CCHA** expressed the positive provider feedback and attendance at this event. The RAE described identifying new ways to creatively disseminate information and education to its provider network. **CCHA** recently offered a virtual town hall to its entire provider network. The use of this technology allowed a chat box for real-time questions and a clear recording that can be made available for those providers that were unable to attend. In addition, **CCHA** observed an increase in attendance of practitioners since it was not necessary for them to leave their office in order to attend.
- **CCHA** described an emerging partnership with Servicios de la Raza, a community organization that provides human services to the Latinx communities. Their integral meetings focused on how access to more culturally competent services can be made available to **CCHA**'s Latinx and Spanish-speaking members. The RAE plans to partner with Servicios de la Raza to provide Medicaid benefit information to the Spanish-speaking population and identify outreach activities to engage this community in accessing healthcare services that align with the values, beliefs, and customs of **CCHA**'s Latinx population.
- **CCHA** described a relationship with an individual that has been a member of the RAE for several years. The member has physical, visual, and hearing disabilities and reaches out to communicate with the RAE via many avenues (i.e., email, TTY relay, and speech recognition software). The member calls frequently with specific needs and requests. After some initial frustrations and barriers, **CCHA** and the member worked to identify a communication plan to improve her access to the RAE. The member is assigned a single point of contact at **CCHA** and a dedicated hour with the contact every week to ask questions, coordinate care, and discuss and resolve any issues or concerns. The RAE and the member continue their collaborative approach, ensuring that services are delivered in a manner that is most suitable to meet the needs of this member.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to this standard.

Summary of Required Actions

CCHA's *Provider Network Adequacy and Access Standards Policy* described that the RAE works to establish a provider network that offers members a choice of at least two appropriate providers within their ZIP Code or within the maximum distance based on the county's classification. The policy further

described that **CCHA** measures and monitors network access of time and distance standards according to the standards through quarterly reporting, to support identification of any gaps in the network. However, **CCHA**'s *Quarterly Network Data and Time/Distance Results* report did not include calculations to demonstrate that its established PCMP network had a sufficient number of providers, offering each member a choice of at least two PCMPs within their ZIP Code or within the maximum time and distance for the urban or rural geographic classifications. The submitted *FY 2019–2020 Network Adequacy Quarterly Report* included a narrative describing **CCHA**'s transition from reviewing PCMP distance standards in Tableau to a recent implementation of the QGIS software. The RAE is scheduled to use the new software to calculate travel time and driving distance between where members live and the physical location of PCMPs within its region for Quarter 3 (Q3) Network Adequacy reporting. **CCHA** must implement mechanisms to conduct regular time and distance calculations to measure and monitor network access in accordance with State standards. In addition, calculations must demonstrate that the RAE's PCMP network has a sufficient number of providers so that each member has their choice of at least two PCMPs within their ZIP Code or within the maximum time and distance for the urban or rural geographic classifications.

Standard VI—Grievances and Appeals

Summary of Strengths and Findings as Evidence of Compliance

CCHA utilizes the staff members and systems of its Anthem partner to process appeals and grievances. Whereas all processes related to appeals are managed through Anthem, **CCHA** employs local grievance analysts to resolve grievances. **CCHA** maintained comprehensive policies related to both grievances and appeals, which largely incorporated policy statements that mimic federal and State regulatory language and, in most cases, were accurate and complete. **CCHA** had developed numerous template notification letters in both English and Spanish related to processing of grievances and appeals, all of which included appropriate taglines and offered assistance and auxiliary aides for members with limited English-speaking abilities and other impairments. The templated content in notices was largely written in language easy for the member to understand. **CCHA** maintained processes to accept both verbal and written grievances and appeals from the member or his or her designated representative. **CCHA** maintained resources to ensure that persons with appropriate clinical expertise were available to review and resolve grievances and appeals. Policies and member and provider materials accurately described the required time frames for processing grievances, appeals, and requesting a State fair hearing (SFH). **CCHA** scored an overall 83 percent compliance with appeal record review requirements and an overall 87 percent compliance with grievance record review requirements. Most cases were processed timely with consistently efficient acknowledgements and resolution within the initial required time frames. **CCHA** staff members stated that **CCHA** rarely used extensions of the time frame for resolving either grievances or appeals. Appeal and grievance data systems time and date-stamped all receipt of requests and resolution notices for appeals, enabling monitoring of compliance with 72-hour time frames. HSAG observed that many of the appeal requests were submitted as expedited requests and that a significant number of those requests were denied and converted to standard appeals. In each case, a denial of expedited request notice was sent to the requestor in the required time frame. Grievance and appeal data

systems collected all required information and **CCHA** demonstrated that it submitted quarterly grievance and appeals reports to the Department.

Summary of Findings Resulting in Opportunities for Improvement

While the *Member Appeals Policy* and *Member Grievance Policy* were largely accurate and complete, HSAG noted the following opportunities for improvement in policy content:

- HSAG noted an inconsistency in the definition of "adverse benefit determination" between the *Member Appeals Policy* and *Notice of Adverse Benefit Determination (NOABD) Policy*. Whereas the *Member Appeals Policy* outlined all elements of the federal regulatory definition—including "For a resident of a rural area, the denial of a Medicaid member's request to exercise his or her right to obtain services out of network"—the *NOABD Policy* did not include this element. HSAG recommends that the definition remain consistent across policies and that **CCHA** use the elements of the federal definition in its policies.
- The *Member Appeals Policy* included a section describing the time frames for proving the NOABD to the member, which is applicable to the authorization denial process, not to appeals. As this information is out of context, HSAG recommends that this section be removed from the *Member Appeals Policy*.
- The required content of the resolution letter described in the *Member Appeals Policy* included "no physician against whom the appeal has been brought will review the appeal." Whereas an appeal is not brought against a provider, HSAG recommends that **CCHA** clarifies the meaning of this statement.
- The *Member Grievances Policy* did not address the required content of the grievance resolution letter. HSAG recommends that the *Member Grievances Policy* be updated to address the required content of the grievance resolution letter and further specify that the description of the resolution must be responsive to the member's specific complaint.

CCHA lacked detailed procedural information for implementing the regulatory statements included in the *Member Appeals Policy* and *Member Grievance Policy*, and HSAG noted a variety of operational errors in implementing grievance and appeal processes. HSAG encourages **CCHA** to work with its Anthem partner to develop more detailed grievance and appeal procedures, improve staff training regarding expectations and accountabilities for implementation, and develop real-time monitoring processes to ensure time frames are met and content of notices is appropriate.

HSAG observed that the appeal resolution letters included extensive explanation of the member's BH condition compared to the criteria used and described sensitive and personal information—i.e., you were not a danger to do harm to yourself or others—that may not be appropriate for BH members. Whereas extensive explanation of detailed criteria is not required to be included in appeal resolution letters, HSAG recommends that **CCHA** consider simplifying the explanation of reason for the appeal determination, such as "We agree with the original denial decision that your condition could be treated with outpatient services. If you would like a copy of the criteria used to make our decision, you may request a copy by calling **CCHA**."

CCHA's *Member Grievance Policy* as well as member-facing grievance and appeal materials frequently referenced referring members to the Department's Ombudsman for assistance in preparing or filing a complaint or an appeal. While the Department encourages use of the Ombudsman to assist members, Federal and State regulations—i.e., 10 CCR 2505-10 8.209—clearly specify that it is the Contractor's responsibility to assist members with preparing forms or understanding procedures related to grievances and appeals. Therefore, HSAG cautions that referring members to the Ombudsman to assist with preparing and filing grievances and appeals cannot replace the assistance the RAE must offer.

During on-site interviews, staff members stated that **CCHA** rarely uses an extension of the time frame to resolve member grievances or appeals. However, HSAG noted several instances in which additional information was needed to resolve a grievance or appeal and an extension was not used to enable obtaining such information. HSAG encourages **CCHA** to use an extension when additional information is required to adequately review and resolve a grievance or an appeal.

HSAG reviewed the member information regarding grievances and appeals submitted for this review and noted some areas of clarification that present opportunities for improvement. For example, *Member Grievance and Appeal Information* displayed on the **CCHA** website stated, "If you are not happy with the service you are receiving, you have a right to complain (also called a grievance) or file an appeal." Members cannot file an appeal if they are unhappy with a service—an appeal applies to an adverse benefit determination—and may be misleading for members. HSAG recommends that **CCHA** complete a full review of its member website information to clarify language or format that may result in confusion for the member.

While not part of the required content in the provider manual, HSAG noted that the appeal information in the *BH Provider Manual* included information related to outcomes of the SFH when continued benefits are requested—i.e., "If HCPF reverses our decision…." or "If HCPF upholds our decision….". However, the provider manual did not address similar outcomes related to an appeal decision (which is likely more common). HSAG recommends that **CCHA** add or clarify information to also address the outcomes of a Contractor appeal—i.e., "If **CCHA** reverses our decision…." or "If **CCHA** upholds our decision….".

HSAG also noted that the appeal information in the *BH Provider Manual* missed opportunities to specify that (1) the provider may not request continued benefits on behalf of the member, and (2) no punitive action will be taken against a provider who supports/requests an expedited appeal. HSAG recommends that **CCHA** consider including such statements when it revises the *BH Provider Manual*.

Summary of Required Actions

During on-site grievance record reviews, HSAG found grievances that involved clinical QOC complaints in which no **CCHA** clinician reviewed the case prior to resolution. Three of three applicable grievance records were *Not Met* for "appropriate level of expertise." **CCHA** must develop a mechanism to ensure that grievances related to clinical care are reviewed and resolved by individuals with appropriate clinical expertise in treating in the member's condition.

HSAG found one of 10 on-site grievance record reviews in which the grievance resolution was not responsive to the member's grievance, and therefore was *Not Met* for "resolution letter includes required content." **CCHA** must develop a mechanism to ensure that the grievance resolution thoroughly addresses the member's complaint.

HSAG found one of 10 grievance record reviews did not meet the required acknowledgement timeline because the grievance was received by **CCHA**'s Anthem partner and was not routed timely to **CCHA** for processing. **CCHA** must develop a mechanism to ensure that grievances received by any of its partner organizations are routed timely to **CCHA**.

HSAG found that one of 10 grievance records did not meet the required resolution time frame and that no extension letter was sent to the member. In addition, in one of 10 grievance records, the resolution description included language which would not be easily understood by members with limited reading ability. **CCHA** must:

- Develop a mechanism to ensure that the grievance resolution is written in language that may be understood by Medicaid members with limited reading ability.
- Ensure that **CCHA** resolves grievances in 15 working days or sends an extension letter to the member.

Similarly, HSAG found in appeal record reviews that one of eight cases did not meet the required resolution time frame. In addition, three of eight cases were *Not Met* for "resolution letter easy to understand," as the resolution reason included industry or clinical language—e.g., "carved out FFS"—which would not be easy for the member to understand. **CCHA** must implement real-time mechanisms to ensure:

- Each appeal determination and notice to the member is processed within the required time frame.
- The reason for the appeal resolution avoids using industry or clinical terminology that may be difficult for a Medicaid member to understand.

While both the *Member Appeals Policy* and the *Member Grievances Policy* accurately addressed the requirements for providing extension notices to members, HSAG found one grievance record in which **CCHA** extended the resolution and no written extension letter was sent to the member. In addition, the template appeal extension notice did not include the reason for the delay nor the member's right to file a grievance if he or she disagreed with the extension, and the template included some language written in a confusing manner. **CCHA** must:

- Develop an extension notice for grievances and appeals that includes the required content—i.e., reason for extension, right to file a grievance—and improves the clarity of the language in the letter.
- Implement a process to ensure that members receive a written extension notice (in addition to verbal notice) when it extends the grievance resolution time frame.

The *Member Appeals Policy* addressed the content of the appeal resolution letter, which included some inadequacies or inaccuracies as follows:

- Does not specify that the notice includes the date the resolution process was completed.
- Specifies that the notice will include the member or provider's right to file an *appeal* rather than request an SFH.
- Does not clarify that the right to continue benefits during the SFH is only applicable to an original denial of previously authorized services that have been suspended or reduced and if the member had requested continued benefits during the appeal.

HSAG found 50 percent of the appeal resolution letters were *Not Met* for "required content," as each letter informed the member that he or she may request continued benefits even though the member was not eligible for continued benefits during the SFH. (Staff members stated that **CCHA** uses the Department-mandated template for appeal resolution letters, which includes continuation of benefits information.) The *Appeal Medical Necessity Uphold* letter template language stated that the member must request continued benefits during an SFH within 10 days of the date on the letter but did not inform the member how to do so. **CCHA** must:

- Update the *Member Appeals Policy* to accurately address all elements of the required content of the appeal resolution letter, including clarification that the letter includes the right to continue benefits during an SFH only if the original denial was for termination, suspension, or reduction of previously authorized services and that the member had requested that benefits continue during the appeal.
- Update the *Appeal Medical Necessity Uphold* letter template to ensure that (1) information regarding the member's right to request benefits during an SFH is included only when applicable, and (2) when applicable, the letter informs the member that continued benefits during an SFH must be requested through **CCHA**.

The *Member Appeals Policy* accurately addressed the criteria for requesting continued benefits during an appeal. However, the criteria specified that "the member seeking to have benefits continue pending the appeal *files timely*" and did not clearly address the definition of "files timely." The policy did not address continuation of benefits during an SFH. **CCHA** must update its *Member Appeals Policy* to:

- Specify that the member must file for "continued benefits" within 10 days of the NOABD and may file the appeal within 60 days of the NOABD.
- Address the criteria for requesting benefits during an SFH, which accurately modifies the language of the criteria as specified in *Findings* of Requirement #29 in the compliance monitoring tool incorporated into this report.

The *Member Appeals Policy* stated circumstances related to how long benefits will continue during an appeal or SFH; however, the circumstances included "The time period or service limits of a previously authorized service has been met," which does not apply to how long benefits will continue during either an appeal and SFH. In addition, the policy inaccurately described the criterion "10 days pass after the adverse appeal resolution and the member does not request continued benefits during an SFH" as

applicable to how long benefits will continue during an SFH. (Once continued benefits have been requested during an SFH, the benefits will continue until the member withdraws the SFH or the SFH officer issues a hearing decision.) **CCHA** must update its *Member Appeals Policy* to accurately address the criteria for how long benefits will continue during an appeal and during an SFH.

While many of the detailed grievance and appeal procedures communicated in the *Physical Health (PH) Provider Manua*l and *BH Provider Manual* were accurately described, HSAG noted several inadequacies or inaccuracies, including:

- The *PH Provider Manual* failed to describe **CCHA** assistance available in the filing of grievances or appeals.
- The *BH Provider Manual* failed to describe the availability of **CCHA** assistance in the filing of appeals, inaccurately defined the time frames for appeal acknowledgement and for resolution of an appeal, inaccurately stated the criteria and time frames for the member to request continued benefits during an appeal and during an SFH, and included inaccuracies in the description of how long benefits will continue during an appeal or an SFH.

CCHA must update the appeals and grievance information in the *PH Provider Manual* and *BH Provider Manual* to address all required information and to address any inaccuracies or incomplete information in the description of appeal or grievance procedures, as detailed in *Findings* of Requirement #35 in the compliance monitoring tool incorporated into this report.

2. Overview and Background

Overview of FY 2019–2020 Compliance Monitoring Activities

For the FY 2019–2020 site review process, the Department requested a review of three areas of performance. HSAG developed a review strategy and monitoring tools consisting of three standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services; Standard II—Access and Availability; and Standard VI—Grievances and Appeals. Compliance with applicable federal managed care regulations and managed care contract requirements was evaluated through review of all three standards. In addition, the Department requested that HSAG conduct on-site group interviews with key RAE staff members to explore individual RAE experiences related to one focus topic. The focus topic chosen by the Department for 2019–2020 was *Region-specific Initiatives Related to the Health Neighborhood.*

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the three standards, HSAG used the RAE contract requirements and regulations specified by the federal Medicaid managed care regulations published May 6, 2016. 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, 2019, through December 31, 2019. HSAG conducted a desk review of materials submitted prior to the on-site review activities; a review of records, documents, and materials provided on-site; and on-site interviews of key RAE personnel to determine compliance with applicable federal managed care regulations and contract requirements. Documents submitted for the desk review and on-site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to each of denials of authorization, grievances, and appeals.

HSAG reviewed a sample of the RAE's administrative records related to RAE denials of authorization, grievances, and appeals to evaluate implementation of applicable 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 denials, grievances, and appeals. Using a random sampling technique, HSAG selected the samples from all RAE denial records, all grievance records, and all appeal records that occurred between January 1, 2019, and December 31, 2019. For the record review, the health plan received a score of M (*Met*), NM (*Not Met*), or NA (*Not Applicable*) for each required element. HSAG separately calculated a record review score for each record and an overall record review score. Results of record reviews were considered in the review of applicable requirements in Standard I—Coverage and Authorization of Services and Standard VI—Grievances and Appeals.

To facilitate the focus topic interviews, HSAG used a semi-structured qualitative interview methodology to explore with RAE staff members information pertaining to the Department's interests related to the focus topic selected. The qualitative interview process encourages interviewees to describe experiences, processes, and perceptions through open-ended discussions and is useful in analyzing system issues and associated outcomes. Focus topic discussions were not scored. HSAG and the Department collaborated to develop the *Focus Topic Interview Guide*. Appendix F contains the summarized results of the on-site focus topic interviews.

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[2-1] Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The three standards chosen for the FY 2019–2020 site 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 and Protections, Standard V—Member Information, Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, Standard X—Quality Assessment and Performance Improvement, and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment.

Objective of the Site Review

The objective of the site 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 three 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.
- Information related to the specific focus topic area to provide insight into statewide trends, progress, and challenges in implementing the RAE and ACC programs.

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Aug 5, 2019.

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

FY 2018–2019 Corrective Action Methodology

As a follow-up to the FY 2018–2019 site review, each RAE that received one or more *Partially Met* or *Not Met* scores was required to submit a corrective action plan (CAP) to the Department addressing those requirements found not to be fully compliant. If applicable, the 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 R6** until it completed each of the required actions from the FY 2018–2019 compliance monitoring site review.

Summary of FY 2018–2019 Required Actions

For FY 2018–2019, HSAG reviewed Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services.

Related to member information, **CCHA R6** was required to complete two required actions:

- Ensure that its website is fully readily accessible per Section 508 guidelines.
- Ensure that its electronic provider directory is fully machine-readable and readily accessible per Section 508 standards.

Related to EPSDT services, **CCHA R6** was required to complete two required actions:

- Enhance provider communications to ensure that BH providers understand all requirements for the provision of applicable EPSDT-related capitated BH services.
- Ensure that medical necessity criteria for UM decisions pertaining to EPSDT-related services are consistent with **CCHA**'s EPSDT policy and correspond with the complete definition of "medical necessity" outlined in 10 CCR 2505-10—8.076.8, 8.076.8.1, and 8.280.4.E.

Summary of Corrective Action/Document Review

CCHA R6 submitted a proposed CAP in July 2019. HSAG and the Department reviewed and approved the proposed plan and responded to **CCHA R6**. **CCHA R6** submitted initial documents as evidence of completion in November 2019. HSAG and the Department reviewed and approved **CCHA R6**'s documents submitted as evidence of completion and responded to **CCHA R6** in December 2019.

Summary of Continued Required Actions

CCHA R6 successfully completed the FY 2018–2019 CAP, resulting in no continued corrective actions.

Appendix A. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Compliance Monitoring Tool
for Colorado Community Health Alliance (Region 6)

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor ensures that the 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-2—14.6.2	Note: Federal requirements only apply to MCOs and PIHPs (behavioral health services of RAEs) unless otherwise noted. **Both R6 and R7:** The following document outlines clinical criteria policies and procedures for CCHA. • *I.CAS.1_Clinical Criteria Policy, p. 3*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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-2—14.6.4	**Both R6 and R7:** The following document outlines clinical criteria policies and procedures for CCHA. • *I.CAS.1_Clinical Criteria Policy, p. 3*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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. *42 CFR 438.210(a)(4)* Contract: Exhibit B-2—14.6.5, 14.6.5.1–2	**Both R6 and R7:** The following document outlines clinical criteria policies and procedures for CCHA. • *I.CAS.1_Clinical Criteria Policy, p. 3*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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 the same		*For Information Only*

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
classification furnished to members (whether or not the benefits are furnished by the same Contractor). *HB19-1269: Section 3–10-16-104(3)(B)* Contract: Exhibit B-2—14.6.5.2.1		
5. 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 behavioral health (BH) service. *HB19-1269: Section 12—25.5-5-402(3)(h)*		*For Information Only*
6. The Contractor covers all medically necessary covered treatments for covered BH diagnoses, regardless of any co-occurring conditions. *HB19-1269: Section 12—25.5-5-402(3)(i)*		*For Information Only*
7. The RAE defines medical necessity for services as a program, good, or service that: • Will or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all. • Is provided in accordance with generally accepted professional standards for health care in the United States. • Is clinically appropriate in terms of type, frequency, extent, site, and duration. • Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider.	**Both R6 and R7:** The following document includes the medical necessity definition CCHA uses to make authorization decisions, including the updated EPSDT definition. • *I.CAS.1_Clinical Criteria Policy, p. 1-2*	**Region 6:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Is delivered in the most appropriate setting(s) required by the client's condition. • Is not experimental or investigational. • Is not more costly than other equally effective treatment options. *42 CFR 438.210(a)(5)* Contract: Exhibit B-2—2.1.62 10 CCR 2505-10 8.076.1.8		
Findings: The definition of "medical necessity" in CCHA's *Clinical Criteria Policy* excluded the following two components: • Is clinically appropriate in terms of type, frequency, extent, site, and duration. • Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider. (CCHA did not include "economic benefit.")		
Required Actions: CCHA must ensure that the definition of "medical necessity" includes all required components as defined in CCR 2505-10 8.076.1.8.		
8. 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-2—14.8.2	**Both R6 and R7:** The following document outlines the process for the review and authorization of service requests. • *I.CAS.8_BH Denial Workflow* The following document outlines CCHA's procedure for making pre-service and concurrent review decisions. • *I.CAS.8_CCHA UM Program Description, "Pre-Service (Prospective) Review Decisions, p. 12-13, and "Concurrent Review Decisions, p. 13-15*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor and its subcontractors have in place and follow written policies and procedures that include mechanisms to ensure consistent application of review criteria for authorization decisions. *42 CFR 438.210(b)(2)(i)* Contract: Exhibit B-2—None	**Both R6 and R7:** The following document outlines clinical criteria policies and procedures for CCHA. • *I.CAS.1_Clinical Criteria Policy, entire document* The following document outlines the process for the review and authorization of service requests. • *I.CAS.8_BH Denial Workflow* The following document outlines the service authorization timeline for standard and expedited service requests. • *I.CAS.9_Member Appeals Policy, p. 5, 6* The following document outlines CCHA's development and implementation of its criteria for authorization decisions. • *I.CAS.8_CCHA UM Program Description, "Criteria Selection and Implementation,' p. 10*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. The Contractor and its subcontractors have in place and follow written policies and procedures to consult with the requesting provider for medical services when appropriate. *42 CFR 438.210(b)(2)(ii)* Contract: Exhibit B-2—14.8.2.5	**Both R6 and R7:** The document below outlines CCHA's Utilization Management program in more details, including how medical necessity reviews may require provider consultations. • *I.CAS.8_UM Program Description, p. 12*	**Region 6:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: CCHA's UM Program Description included general language about the process of notifying a requesting provider about a peer-to-peer process but did not clearly indicate that CCHA will outreach to the requesting provider to obtain additional information when necessary. One denial record review was denied due to "lack of information" received from the provider; however, no outreach to the provider was documented. The notes within the system stated, "provider did not request a peer review." Furthermore, record reviews demonstrated inconsistency in applying the peer-to-peer procedure.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: CCHA must ensure that, when appropriate, CCHA outreaches to the requesting providers to obtain additional information to make an authorization decision. CCHA should clarify within UM procedural documents how and when this outreach will take place.		
11. 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. *42 CFR 438.210(b)(3)* Contract: Exhibit B-2—14.6.6	**Both R6 and R7:** The Member Appeals policy outlines the requirements for service review by an appropriate clinician, including requirements for the Medical Director to issue medical necessity denials. • *I.CAS.9_Member Appeals Policy, p. 2, 4* The following document outlines educational requirements for its Medical Directors and how the Medical Director has to issue a medical necessity denial. • *I.CAS.8_UM Program Description, p. 6, 13* The following workflow outlines the process for the review and authorization of service requests by the Medical Director. • *I.CAS.8_BH Denial Workflow, p. 1*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. 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. *42 CFR 438.210(c)* Contract: Exhibit B-2—8.6.1 10 CCR 2505-10 8.209.4.A.1	**Both R6 and R7:** The Notice of Adverse Benefit Determination Policy 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.CAS.12_Notice of Adverse Benefit Determination Policy, p. 1*	**Region 6:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: Although CCHA accurately captured this requirement in the *NOABD Policy*, during on-site denial record reviews, HSAG identified one case in which no NOABD was sent to the member. (A second case in which no NOABD was sent was eliminated from the record review sample.)		
Required Actions: CCHA must develop a mechanism to ensure that a written NOABD is sent to the member regarding any decision to deny a service authorization request or denial of payment.		
13. 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)* Contract: Exhibit B-2—8.6.6, 8.6.8 10 CCR 2505-10 8.209.4.A.3(c)	**Both R6 and R7:** The following policy outlines the timelines for CCHA to make standard and expedited authorization decisions when issuing adverse benefit determinations. • *I.CAS.12_Notice of Adverse Benefit Determination Policy, p. 2-3* The following program description outlines the authorization timelines for expedited and standard service requests. • *I.CAS.8_UM Program Description, p. 15-17* The Member Appeals Policy outlines the timelines for CCHA to make standard and expedited authorization decision. • *I.CAS.9_Member Appeals Policy, p. 5-6*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
14. 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 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)*	**Both R6 and R7:** The following document outlines when CCHA can extend the timeline for authorization decisions when issuing an adverse benefit determination. • *I.CAS.12_Notice of Adverse Benefit Determination Policy p. 3*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract: Exhibit B-2—8.6.6.1, 8.6.8.1	The following document outlines when CCHA can extend the timeline for authorization decisions. • *I.CAS.9_Member Appeals Policy, p. 6*	
15. The notice of adverse benefit determination must be written in language easy to understand, available in prevalent non-English languages in the region, and available in alternative formats for persons with special needs. *42 CFR 438.404(a)* *42 CFR 438.10 (c)* Contract: Exhibit B-2—8.6.1–8.6.1.4 10 CCR 2505-10 8.209.4.A.1	**Both R6 and R7:** The following policy outlines the requirement for the notice of adverse benefit determination, including requirements regarding language access and alternative formats. • *I.CAS.12_Notice of Adverse Benefit Determination Policy, p. 1* The Member and Provider Materials and Website Policy 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.CAS.15_Member and Provider Materials and Website Policy, p. 1-3* The following 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.CAS.15_CO BH Denial Letter with CvrSheet* The following 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.CAS.15_CO BH Denial Letter with CvrSheet SP*	**Region 6:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: While the *NOABD Policy* addressed the requirement to provide notices in non-English languages and alternative formats, eight of 10 denial record reviews included NOABD language that was not easy for a member to understand. Notices included complex clinical terms and, in some cases, a full list of clinical criteria, including acronyms that would not be easy to understand.		
Required Actions: CCHA must ensure that the information explaining the reason for the denial in the NOABD is written in language that may be easily understood by Medicaid members with limited reading ability.		
16. 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 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 R6 and R7:** The following policy 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.CAS.12_Notice of Adverse Benefit Determination Policy, p. 1-2* The following 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.CAS.15_CO BH Denial Letter with CvrSheet*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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. *42 CFR 438.404(b)(1–6)* Contract: Exhibit B-2—8.6.1.5–8.6.1.12 10 CCR 2505-10 8.209.4.A.2		
17. Notice of adverse benefit determination for denial of behavioral, mental health, or SUD benefits includes, in plain language: • A statement explaining that members are protected under the federal Mental Health Parity and Addiction Equity Act (MHPAEA), which provides that limitations placed on access to mental health and SUD benefits may be no greater than any limitations placed on access to medical and surgical benefits. • A statement providing information about contacting the office of the ombudsman for BH care if the member believes his or her rights under the MHPAEA have been violated. • A statement specifying that members are entitled, upon request to the Contractor and free of charge, to a copy of the medical necessity criteria for any behavioral, mental, and SUD benefit. *HB19-1269: Section 6—10-16-113 (I), (II), and (III)* Contract: None		*For Information Only*

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. 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)* Contract: Exhibit B-2—8.6.3.1, 8.6.5–8.6.8 10 CCR 2505-10 8.209.4.A.3	**Both R6 and R7:** The following policy outlines the mailing timelines for the notice of adverse benefit determination. • *I.CAS.12_Notice of Adverse Benefit Determination Policy, p. 2*	**Region 6:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: In one denial record review sample, CCHA did not mail a member notice. Notice was given to the provider, but not the member. Therefore, the case did not meet the requirement for "notice sent in required time frame."		
Required Actions: CCHA must ensure that NOABDs are mailed to the member within applicable time frames.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
19. For reduction, suspension, or termination of a previously authorized Medicaid-covered service, the Contractor gives notice at least ten (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 Agency has factual information confirming the death of a member. – The Agency receives a clear written statement signed by the member that he/she no longer wishes services or gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information. – The member has been admitted to an institution where he/she is ineligible under the plan for further services. – The member's whereabouts are unknown, and the post office returns Agency mail directed to him/her indicating no forwarding address. – The Agency 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 R6 and R7:** The following document outlines when CCHA is able to provide less than ten days' notice before the intended effective date of the adverse benefit determination. • *I.CAS.12_Notice of Adverse Benefit Determination Policy, p. 2-3*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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 (5) 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-2—8.6.3.1–8.6.3.2, 8.6.4.1–8.6.4.1.8 10 CCR 2505-10 8.209.4.A.3 (a)		
20. 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 he or she disagrees with that decision. *42 CFR 438.404(c)(4)* Contract: Exhibit B-2—8.6.6.2 10 CCR 2505-10 8.209.4.A.3 (c)(1)	**Both R6 and R7:** The following document outlines CCHA's requirements when extending a standard authorization decision timeline. • *I.CAS.12_Notice of Adverse Benefit Determination Policy, p. 3*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
21. 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-2—14.8.6	**Both R6 and R7:** 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/media/1269/aco-nl-0004-19-um-affimative-statement-final.pdf*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
22. 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. *42 CFR 438.114(a)* Contract: Exhibit B-2—2.1.33	**Both R6 and R7:** The Behavioral Health Emergency Services Policy outlines how CCHA defines an emergency medical condition. • *I.CAS.22_Behavioral Health Emergency Services Policy, p. 1*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
23. The Contractor defines emergency services as covered inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title and are needed to evaluate or stabilize an emergency medical condition. *42 CFR 438.114(a)* Contract: Exhibit B-2—2.1.34	**Both R6 and R7:** The following policy outlines how CCHA defines emergency services. • *I.CAS.22_Behavioral Health Emergency Services Policy, p. 1*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
24. 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-2—2.1.74	**Both R6 and R7:** The following policy outlines how CCHA defines post-stabilization care services • *I.CAS.24_Behavioral Health Post-Stabilization Care Policy, p. 1*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
25. 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-2—14.5.6.2.2	**Both R6 and R7:** The following policy outlines CCHA's responsibility for coverage and payment of emergency services. • *I.CAS.22_Behavioral Health Emergency Services Policy, p. 2*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
26. 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. *42 CFR 438.114(c)(1)(ii)* Contract: Exhibit B-2—14.5.6.2.6	**Both R6 and R7:** The following document outlines CCHA's responsibility for coverage and payment of emergency services. • *I.CAS.22_Behavioral Health Emergency Services Policy, p. 2*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
27. 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-2—14.5.7.2.8	**Both R6 and R7:** The following document outlines CCHA's requirements to not deny an emergency service. • *I.CAS.22_Behavioral Health Emergency Services Policy, p. 2*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
28. 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-2—14.5.6.2.9	**Both R6 and R7:** The following document outlines CCHA's requirement to not hold a member liable for receiving emergency services. • *I.CAS.22_Behavioral Health Emergency Services Policy, p. 2*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
29. 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-2—14.5.6.2.10	**Both R6 and R7:** The following policy outlines CCHA's responsibility to ensure the treating provider makes the determination of member stability. • *I.CAS.22_Behavioral Health Emergency Services Policy, p. 2*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
30. The Contractor is financially responsible for poststabilization services that are prior authorized by an in-network provider or Contractor 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)(i)* Contract: Exhibit B-2—14.5.6.2.11	**Both R6 and R7:** The following document outlines when CCHA is financially responsible for post-stabilization care services. • *I.CAS.24_Behavioral Health Post-Stabilization Care Policy, p. 1*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
31. 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 (1) hour of a request to the organization for pre-approval of further poststabilization care services. *42 CFR 438.114(e)* *42 CFR 422.113(c)(ii)* Contract: Exhibit B-2—14.5.6.2.12	**Both R6 and R7:** The following document outlines when CCHA is financially responsible for post-stabilization care services. • *I.CAS.24_Behavioral Health Post-Stabilization Care Policy, p. 1* The UM Program Description outlines CCHA's timeline for pre-approval of post-stabilization care. • *I.CAS.8_UM Program Description, p. 15*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
32. 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 1 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	**Both R6 and R7:** The following policy 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.CAS.24_Behavioral Health Post-Stabilization Care Policy, p. 1-2*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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)(3) is met. *42 CFR 438.114(e)* *42 CFR 422.113(c)(iii)* Contract: Exhibit B-2—14.5.6.2.12		
33. 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-2—14.5.6.2.14	**Both R6 and R7:** The following document outlines when CCHA's financial responsibility for post-stabilization care that was not pre-approved ends. • *I.CAS.24_Behavioral Health Post-Stabilization Care Policy, p. 2*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
34. If the member receives poststabilization services from a provider outside the Contractor's network, the Contractor does not charge the member more than he or she would be charged if he or she had obtained the services through an in-network provider. *42 CFR 438.114(e)* *42 CFR 422.113(c)(iv)* Contract: Exhibit B-2—14.5.6.2.13	**Both R6 and R7:** The following document outlines requirements regarding member charges for out of network post-stabilization care services. • *I.CAS.24_Behavioral Health Post-Stabilization Care Policy, p. 2*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	25	X	1.00	=	25
	Partially Met	=	5	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	4	X	NA	=	NA
Total Applicable		=	30	**Total Score**		=	25
				Total Score ÷ Total Applicable		=	83%

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor maintains and monitors a PCMP and BH network of providers sufficient to provide access to all covered services to all members, including those with limited English proficiency or physical or mental disabilities. The provider network includes the following provider types and areas of expertise: • Adult primary care providers • Pediatric primary care providers • OB/GYNs • Adult mental health providers • Pediatric mental health providers • SUD providers • Psychiatrists • Child psychiatrists • Psychiatric prescribers • Family planning providers *42 CFR 438.206(b)(1)* Contract: Exhibit B-2—9.5.1.1, 9.5.1.3	**Both R6 and R7:** The 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, p. 3, 5* The Accountable Care Network (ACN) and PCMP contracts outline that providers are required to comply with to comply with the provider manual. • *II.AA.1_ ACN Contract, p. 8* • *II.AA.1_ PCMP Contract, p. 6* 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 PCMP Recruitment Strategy, entire document* • *II.AA.1_Annual BH Recruitment Strategy, entire document* The following documents demonstrate how CCHA collects information from Primary Care Medical Provider (PCMPs), including details on provider specialties, telehealth services, accessibility/disability accommodations, etc. The supplemental information	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	document is used to update information for existing providers, while the new application forms are used during the initial contracting process. • *II.AA.1_New Practice Application Form, p. 1, 3* • *II.AA.1_New Primary Care Provider Application Form, p. 2* • *II.AA.1_Practice Supplemental Information Sheet, p. 2* • *II.AA.1_PH Provider Manual – Page 2: Provider Type, p. 7* The following documents are completed by behavioral health practitioners and facilities during the CCHA provider enrollment process. Providers document disability accommodation and language information on this form. • *II.AA.1_BH Practice Information Form-Practitioner, p. 2-3* • *II.AA.1_BH Practice Information Form-Facility, p. 2-3* The BH Provider Manual outlines applicable access to care standards, including appointment availability standards, access for members with disabilities, and after-hour services. • *II.AA.1_BH Provider Manual, chapter 12* The document below outlines CCHA's policy for ensuring its provider network is sufficient enough to meet the needs of members with disabilities and/or limited English proficiency.	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• *II.AA.1_Americans with Disabilities Act Compliance for Participating Providers Policy, p. 1* **R6-specific:** The Quarterly Network Reports show results of CCHA's provider network outlined in the aforementioned provider types. A sample report is provided below. • *II.AA.1_R6NetworkRptQ1FY19-20, p. 7-11*	
2. In establishing and maintaining the network adequacy standards, the Contractor considers: • The anticipated Medicaid enrollment. • The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the Contractor's service area. • The numbers, types, and specialties of network providers required to furnish the contracted Medicaid services. • The number of network providers accepting/not accepting new Medicaid members. • The geographic location of providers in relationship to where Medicaid members live, considering distance, travel time, and means of transportation used by members. • The ability of providers to communicate with limited-English-proficient members in their preferred language. • The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for members with physical or mental disabilities.	**Both R6 and R7:** The Network Adequacy and Access Standards Policy outlines the standards of network adequacy CCHA takes into consideration when establishing and maintaining the provider network. • *II.AA.1_Provider Network Adequacy and Access Standards Policy, p. 3* The following document outlines CCHA's procedure for surveying providers on available disability accommodations. • *II.AA.1_Americans with Disabilities Act Compliance for Participating Providers Policy, p. 1-2* The Language Assistance Services Policy outlines how CCHA member-facing staff and providers facilitate language assistance services for members. • *II.AA.2_Language Assistance Services Policy, entire document*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The availability of triage lines or screening systems, as well as use of telemedicine, e-visits, and/or other technology solutions. *42 CFR 438.206(a); 438.68(c)(i)–(ix)* Contract: Exhibit B-2—9.1.4, 9.1.5, 9.1.7.1, 9.5.1.2, 9.5.1.4-6	The Practice and Provider Applications demonstrate how CCHA collects information from PCMPs regarding practice location, specialties available, languages spoken, accessibility, ability to provide culturally competent care, and whether they are accepting new Medicaid members. • *II.AA.1_New Practice Application, p. 1-3* • *II.AA.1_New Primary Care Provider Application, p. 1-2* The following documents outline the information that is requested when a behavioral health practitioner or facility enroll in CCHA's provider network. • *II.AA.1_BH Practice Information Form-Practitioner, entire document* • *II.AA.1_BH Practice Information Form-Facility, entire document* The Find A Provider Tool on the CCHA website demonstrates that members can search for providers who are accepting new members, are within a certain distance or location, offer the specialty required, speak the language they prefer, can provide culturally competent care, and have accommodations for people with disabilities. • *II.AA.2_Find A Provider Tool, p. 1* The following provider recruitment strategies outline steps taken to recruit providers when gaps are identified. • *II.AA.1_Annual PCMP Recruitment Strategy, p. 1* • *II.AA.1_Annual BH Recruitment Strategy, entire document*	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	ACN and PCMP contract templates outline the contractor's requirement to comply with the provider manual, provide triage lines and screening tools, and to provide services in a culturally competent manner. • *II.AA.1_ACN Contract, p. 10-11* • *II.AA.1_PCMP Contract, p. 5-6* The PH Provider Manual outlines the contractor's requirements to update practice and provider information as needed, and also includes resources for providers on how to serve members with different cultural, linguistic, and accessibility needs. • *II.AA.1_PH Provider Manual, p. 7, 9, 14, 31-34* The following CCHA newsletters included reminders to providers to keep their practice information updated, as well as notified network providers that an update was made to the provider manual. • *II.AA.2_Newsletter 2019 March, p. 1* • *II.AA.2_Newsletter 2019 April, p. 1* • *II.AA.2_Newsletter 2019 May, p. 1* • *II.AA.2_Newsletter 2019 September, p. 3* • *II.AA.2_Newsletter 2019 December, p. 3* The following email notification was sent network providers notifying them that an update was made to the PH Provider Manual in September 2019. • *II.AA.2_PH Provider Manual Update Notification Email, entire document*	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The Office System Review (OSR) is updated during annual review with providers, and is used to update practice information. • *II.AA.2_Office System Review, entire document* The following document provides instructions for network staff on how to review anticipated enrollment to support monitoring the capacity of the provider network. • *II.AA.2_Anticipated Enrollment Review Instructions, entire document* The following document contains guidance for providers that are interested in billing CCHA for telemedicine services. For telemedicine services billed through FFS, HCPF has a telemedicine billing guide that CCHA promotes within the provider network. • *II.AA.2_CCHA Telemedicine Guide, entire document* This document contains CCHA's top 15 telemedicine billers across both regions, sorted by claims paid within the 2019 calendar year. • *II.AA.2_CCHA 2019 Telemedicine Top Billers, entire document* **R6-specific:** The following reports are used by CCHA to assess enrollment trends, including the overall population,	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	female members, members with disabilities, and other special populations. A sample report is provided below. • *II.AA.2_Region 6 Enrollment Trends, entire document*	
3. 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-2—9.4.7	**Both R6 and R7:** The 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, p. 4, 7-8* **R6-specific:** The FY20 Network Adequacy Plan shows results of how CCHA's provider network is assessed for time and distance standards. • *II.AA.3_R6NetworkAdequacyPlnFY19-20, p. 20-21*	**Region 6:** ☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: CCHA's *Provider Network Adequacy and Access Standards Policy* described that the RAE works to establish a provider network that offers members a choice of at least two appropriate providers within their ZIP Code or within the maximum distance based on the county's classification. The policy further described that CCHA measures and monitors network access of time and distance standards according to the standards through quarterly reporting, to support identification of any gaps in the network. However, CCHA's *Quarterly Network Data and Time/Distance Results* report did not include		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
calculations to demonstrate that its established PCMP network had a sufficient number of providers, offering each member a choice of at least two PCMPs within their ZIP Code or within the maximum time and distance for the urban or rural geographic classifications. Instead, each data field stated, "See narrative." The submitted *FY 2019–2020 Network Adequacy Quarterly Report* included a narrative describing CCHA's transition from reviewing PCMP distance standards in Tableau to a recent implementation of the QGIS software. The RAE is scheduled to use the new software to calculate travel time and driving distance between where members live and the physical location of PCMPs within its region for Q3 Network Adequacy reporting.		
Required Actions: CCHA must implement mechanisms to conduct regular time and distance calculations to measure and monitor network access in accordance with State standards. In addition, calculations must demonstrate that the RAE's PCMP network has a sufficient number of providers so that each member has their choice of at least two PCMPs within their ZIP Code or within the maximum time and distance for the urban or rural geographic classifications.		
4. 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 – 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	**Both R6 and R7:** 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, p. 4, 7-8* **R6-specific:** The following documents (Excel and PDF documents of the same name) are the Region 6 Network Report Submissions for October-December 2019, and contain CCHA's most recent behavioral health network adequacy monitoring. • *II.AA.4_R6NetworkRptQ2FY19-20 (pdf), p. 5-1- 5-3* • *II.AA.4_R6NetworkRptQ2FY19-20 (excel), tab time-distance urban summary*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– 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 B2—9.4.10.1)* *42 CFR 438.206(a); 438.68(b)* Contract: Exhibit B-2—9.4.9		
5. 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-2—9.2.7	**Both R6 and R7:** The 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, p. 5* The Maternity Care Coordination Program Description outlines how CCHA care coordinators support members during pregnancy, including collaboration with providers and providing referrals where necessary. • *II.AA.5_Maternity Care Coordination Program Description, p. 1, 3, 6, 8, 9* The following assessments are used by CCHA care coordinators to identify member needs, and include questions regarding women's health care including pregnancy.	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• *II.AA.5_Care Coordination Maternity Assessment, entire document* • *II.AA.5_Care Coordination Adult Health Needs Assessment, p. 16-17* • *II.AA.5_Care Coordination Pediatric Health Needs Assessment, p. 17* In 2019, CCHA contracted with ConsejoSano, a patient engagement company, to outreach female members to assess if members were pregnant, or thinking about getting pregnant, with the intent to enroll in care coordination and connect with needed resources. Results from this pilot are included in the document provided below. • *II.AA.5_ConsejoSano Outreach Results, entire document* CCHA uses multiple communication tools to inform members of women's preventive and routine health care services. Examples are provided below, including blog posts, social media posts, and printed materials. • *II.AA.2_Newsletter 2019 September, p. 4* • *II.AA.5_CCHA Blog - National Breast Cancer Awareness Month, entire document* • *II.AA.5_CCHA Blog - Preventing Cervical Cancer, entire document* • *II.AA.5_CCHA WH Social Media Posts, entire document* • *II.AA.5_Maternity Brochure and Appointment Reminders, entire document*	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Additionally, the CCHA website includes numerous health articles focused on women's health care services. Additionally, an example of a specific article is provided below. • *Link to women's health care resources on CCHAcares.com.* • *II.AA.5_Women's Health Checkup Article, entire document* **R6-specific:** CCHA partnered with Healthy Communities in R6 to create a co-branded letter to outreach members about pregnancy benefits and services. The co-branded letter has been approved by HCPF, and has been recently implemented by Healthy Communities sites in R6. • *II.AA.5_Healthy Communities Letter, entire document* Additionally, CCHA has established a shared workflow with Healthy Communities to outline referral processes, including referrals to Nurse Family Partnership, Healthy Start at Home, and HCP. An example workflow is provided below. • *II.AA.5_CCHA and Jeffco Public Health Flow Chart, entire document*	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. 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-2—9.7.6	**Both R6 and R7:** The following policy outlines a CCHA member's right to receive a second opinion at no cost to them. • *II.AA.6_Member Rights and Responsibilities Policy, p. 2* The following policy outlines CCHA's policy for when a member requests a second opinion. • *II.AA.1_Provider Network Adequacy and Access Standards Policy, p. 7* This section of the Provider Manual informs providers of CCHA's responsibility to provide a second opinion for a member. • *II.AA.1_BH Provider Manual, p. 73*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
7. If the provider network is unable to provide necessary covered services to a particular member in network, the Contractor must adequately and in a timely manner cover the services out of network for as long as the Contractor is unable to provide them. *42 CFR 438.206(b)(4)* Contract: Exhibit B-2—14.6.1.1	**Both R6 and R7:** 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.CCHA_Provider Network Adequacy and Access Standards Policy, p. 7-8* This document outlines the policy and procedure for obtaining medically necessary services from an out of network provider. • *II.AA.7_BH Single Case Agreement-Out of Network Authorization Policy, p. 2*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. 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-2—14.7.11.1	**Both R6 and R7:** 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.7_BH Single Case Agreement-Out of Network Authorization Policy, p. 2*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services. *42 CFR 438.206(b)(7)* Contract: 9.5.1.1, 9.5.1.3.10	**Both R6 and R7:** The Network Adequacy and Access Standards Policy outlines how CCHA establishes and monitors the network to include providers who offer access to family planning services. • *II.AA.1_Provider Network Adequacy and Access Standards Policy, p. 3, 5, 7* The following documents are used by network managers to collect and maintain information from PCMPs, including their ability to provide family planning services. • *II.AA.1_New Practice Application Form, p. 1* • *II.AA.1_New Primary Care Provider Application Form, p. 2* • *II.AA.1_Practice Supplemental Information Sheet, p. 1* • *II.AA.2_Office System Review, p. 1* The following assessments are used by CCHA care coordinators and member support specialists to identify member needs, and include questions regarding family planning.	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• *II.AA.5_Care Coordination Maternity Assessment, entire document* • *II.AA.5_Care Coordination Adult Health Needs Assessment, p. 16-17* • *II.AA.5_Care Coordination Pediatric Health Needs Assessment, p. 17* **R6-specific:** The FY20 Network Adequacy Plan shows results of providers in CCHA's network who offer family planning services. • *II.AA.3_R6NetworkAdequacyPlnFY19-20, p. 14-17*	
10. 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.	**Both R6 and R7:** The 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, p. 4, 7* The following policy outlines CCHA's access to care standards for behavioral health providers. • *II.AA.10_Behavioral Health Access to Care Policy, p. 2* The ACN Contract outlines requirements for ACN providers to ensure care aligns with timely access to care standards. • *II.AA.1_ACN Contract, p. 37*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• 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 B1—9.4.13	The PCMP Contract outlines requirements for network providers to comply with the PH Provider Manual, which includes timely access to care standards. • *II.AA.1_PCMP Contract, p. 6* • *II.AA.1_PH Provider Manual, p. 30* This section of the Provider Manual outlines access to care standards that CCHA's behavioral health providers are required to meet. • *II.AA.1_BH Provider Manual, p. 69* 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.10_Newsletter 2019 June, p. 3* • *II.AA.10_Newsletter 2020 February, p. 4-5* • *II.AA.10_ Access to Care Standards for HFC Members-entire document (https://www.cchacares.com/media/1263/ccha_accesss tandards_en_final_03192019.pdf - entire document)* The following document outlines the process for monitoring behavioral health providers' compliance with CCHA's access to care standards. • *II.AA.10_Behavioral Health Provider Appointment Availability Monitoring, p. 1*	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following document is an overview of our behavioral health provider appointment monitoring survey for 2019, including results. • *II.AA.10_BH Appointment Availability Report 2019, 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.10_Third Next Available Appointment Data Collection Procedure, entire document* The following document is a sample practice detail report, used by CCHA practice transformation coaches to monitor PCMP activities, including appointment availability as monitored through Third Next Available Appointment methodology. • *II.AA.10_Practice Details Summary, p. 1*	
11. 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 a.m. to 5 p.m. Monday through Friday. • Extended hours on evenings and weekends.	**Both R6 and R7:** The Network Adequacy and Access Standards Policy outlines requirements for the provider network to include hours of operation no less than hours available to members through commercial plans, and includes extended hours and alternatives for emergency department visits for urgent after-hours care. • *II.AA.1_Provider Network Adequacy and Access Standards Policy, p. 3-4, 6*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Alternatives for emergency department visits for after-hours urgent care. *42 CFR 438.206(c)(1)(ii)* Contract: Exhibit B-2—9.4.2–9.4.4	The following document outlines the hours of operations required by CCHA's behavioral health provider network. • *II.AA.10_Behavioral Health Access to Care Policy, p. 2* PCMP and ACN contracts outline the contractual requirement for providers to provide availability of appointments outside of normal business hours. • *II.AA.1_PCMP Contract, p. 5* • *II.AA.1_ACN Contract, p. 10* 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, p. 3* • *II.AA.2_Office System Review, 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. • *II.AA.1_PH Provider Manual, p. 15* • *II.AA.1_BH Provider Manual, p. 14* The following document outlines CCHA's access to care standards, which include standards for hours of operation and alternatives for emergency department visits. This	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	information is made publicly available on the CCHA website and was published in the following newsletter. • *II.AA.10_ Access to Care Standards for HFC Members, entire document* • *II.AA.10_Newsletter 2020 February, p. 4-5* The following document is a sample practice detail report, used by CCHA practice transformation coaches to monitor PCMP activities. Specifically, this document includes details of provider hours of operation. • *II.AA.10_Practice Detail Summary, p. 1*	
12. The Contractor makes services included in the contract available 24 hours a day, 7 days a week, when medically necessary. *42 CFR 438.206(c)(1)(iii)* Contract: Exhibit B-2—9.4.6	**Both R6 and R7:** The following document outlines CCHA's requirement to have services available at all times for members. • *II.AA.10_Behavioral Health Access to Care Policy, p. 2*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. 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-2—9.5.1.8	**Both R6 and R7:** 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, p. 6, 7, 8* The following procedures outline mechanisms utilized by CCHA to ensure network provider compliance regarding access to care standards.	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• *II.AA.10_Third Next Available Appointment Data Collection Procedure, entire document* • *II.AA.13_Office System Review Procedure, entire document* • *II.AA.13_Primary Care Caseload Monitoring Procedure, entire document* • *II.AA.13_Primary Care Caseload Monitoring Workflow, entire document* • *II.AA.13_Annual Caseload Review Instructions, entire document* • *II.AA.13_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.13_ACN Monitoring and Oversight Policy, p. 1-3* The ACN Contract provides 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 Contract, p. 9* The following desktop guide is used to train CCHA staff on how to identify a potential access issue raised by a member, and directs staff on how to triage the complaint.	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• *II.AA.13_Staff Desktop Guide_Triaging Access Complaint, entire document* The following document outlines CCHA's procedure for monitoring BH appointment availability standards, including corrective action for noncompliant providers. • *II.AA.10_BH Provider Appointment Availability Monitoring, entire document* The following document is an overview of our behavioral health provider appointment monitoring survey for 2019 to determine compliance with access to care standards. • *II.AA.10_BH Appointment Availability Report 2019, entire document* CCHA recently hosted a virtual provider town hall meeting, in which we reviewed access to care standards with network providers. A copy of the slide deck is provided below, and a recording of the meeting can be accessed on CCHA's website through the following link. • *II.AA.13_Provider Virtual Town Hall Slide, entire document* • *https://vimeo.com/397032344/98c55d3917* The following document is a sample practice detail report, used by CCHA practice transformation coaches to monitor PCMP activities. • *II.AA.10_Practice Detail Summary, entire document*	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	R6-specific: CCHA uses the Quarterly Network Report as a mechanism to monitor the provider network. A sample report is provided below. • *II.AA.4_R6NetworkRptQ2FY19-20* • *II.AA.4_R7NetworkRptQ2FY19-20*	
14. 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. • 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.	**Both R6 and R7:** 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.14_Member and Provider Materials and Website Policy, p. 1-2* The following policy outlines mechanisms for CCHA member facing staff and providers to access language assistance services. • *II.AA.2_Language Assistance Services Policy, entire document* The following policies outline how CCHA care coordination provides services that are culturally responsive to member preferences and needs. • *II.AA.14_Care Coordination Policy, p. 1-2* • *II.AA.14_Care Coordination Intake and Assessment Policy, p. 2-3*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Providing language assistance services for all Contractor interactions with members. *42 CFR 438.206(c)(2)* Contract: Exhibit B-2—7.2.1–7.2.6	The following training materials have been made available to network providers to support providers in caring for diverse populations. • *II.AA.14_Caring for Diverse Populations Toolkit, entire document* • *II.AA.14_Cultural Competency Training, entire document* • *II.AA.14_IDD Healthcare Cultural Competence, 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.2_Newsletter 2019 March, p. 4* • *II.AA.2_Newsletter 2019 April, p. 3* • *II.AA.2_Newsletter 2019 May, p. 6* • *II.AA.10_Newsletter 2019 June, p. 5* • *II.AA.14_Newsletter 2019 July, p. 3, 5* • *II.AA.14_Newsletter 2020 January, p. 4-5* The ACN Contract provides evidence of the contractor's assurance that services are provided in a culturally competent manner. • *II.AA.1_ACN Contract, p. 14*	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The PH Provider Manual outlines CCHA's resources for network providers to support members with different cultural, linguistic, or accessibility needs. • *II.AA.1_PH Provider Manual, p. 31-33* The Find a Provider function on the CCHA website demonstrates 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. • *II.AA.2_Find A Provider Tool, p. 1*	
15. 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-2—9.1.4.5, 9.1.7.1, 9.5.1.2	**Both R6 and R7:** 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. • *II.AA.1_Americans with Disabilities Act Compliance for Participating Providers Policy, p. 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.6_Member Rights and Responsibilities Policy, p. 3-4* The New Practice Application Form demonstrates how CCHA collects information from PCMPs regarding practice accessibility at the time of application. The	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Supplemental Information form is used to collect information on an ongoing basis, after initial contracting. • *II.AA.1_New Practice Application Form, p. 3* • *II.AA.1_Practice Supplemental Information Sheet, p. 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. • *II.AA.2_Find A Provider Tool, p. 1*	
16. 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 Adequacy Report is submitted to the State quarterly. *42 CFR 438.207(b)* Contract: Exhibit B-2—9.5.1–9.5.4	**R6-specific:** The following document is the Region 6 Network Report submission for July-September 2019. • *II.AA.1_R6NetworkRptQ1FY19-20, entire document* The following documents are the Region 6 Network Report Submissions for October-December 2019. • *II.AA.4_R6NetworkRptQ2FY19-20 (pdf and excel), entire documents* The following document is Region 6's Network Adequacy Plan for FY 19-20. • *II.AA.3_R6NetworkAdequacyPlnFY19-20, entire document*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following document is the Region 7 Network Report submission for July-September 2019. • *II.AA.1_R7NetworkRptQ1FY19-20, entire document* The following documents are the Region 7 Network Report Submissions for October-December 2019. • *II.AA.4_R7NetworkRptQ2FY19-20 (pdf and excel), entire documents* The following document is Region 7's Network Adequacy Plan for FY 19-20. • *II.AA.3_R7NetworkAdequacyPlnFY19-20, entire document*	

Results for Standard II—Access and Availability							
Total	Met	=	15	X	1.00	=	15
	Partially Met	=	0	X	.00	=	0
	Not Met	=	1	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	16	**Total Score**		=	15
				Total Score ÷ Total Applicable		=	94%

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an internal grievance and appeal system in place for members. 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 B2—8.1 10 CCR 2505-10—8.209.1	Note: Federal requirements related to appeals apply only to MCOs and PIHPs (BH services of RAEs). The contract requires that regulations related to grievances apply to all RAE members. **Both R6 and R7:** The Member Grievances Policy outlines CCHA's internal grievance process, including record keeping requirements. • *VI.GA.1_Member Grievances Policy, entire document* The Member Appeals Policy outlines CCHA's internal appeal process, including record keeping requirements. • *VI.GA.1_Member Appeals Policy, entire document* The following document outlines the requirements regarding CCHA's internal appeal process as it relates to the notice of adverse benefit determination. • *VI.GA.1_Notice of Adverse Benefit Determination Policy, entire document* The following page on the CCHA website contains information for members, families, and providers on CCHA's grievance and appeal system. • *CCHA Appeals and Grievances Page:* https://www.cchacares.com/for-members/appeals-and-grievances/	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
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 B2—2.1.3 10 CCR 2505-10—8.209.2.A	**Both R6 and R7:** The Member Appeals Policy outlines CCHA's definition of adverse benefit determination. • *VI.GA.1_Member Appeals Policy, p. 1* The following document outlines CCHA's definition of adverse benefit determination as it relates to the notice of adverse benefit determination. • *VI.GA.1_Notice of Adverse Benefit Determination Policy, p. 3*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
3. The Contractor defines an appeal as a review by the Contractor of an adverse benefit determination. *42 CFR 438.400(b)* Contract: Exhibit B2—2.1.5 10 CCR 2505-10—8.209.2.B	**Both R6 and R7:** The Member Appeals Policy outlines CCHA's definition of an appeal. • *VI.GA.1_Member Appeals Policy, p. 1*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
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 B2—2.1.42, 8.6.6.2 10 CCR 2505-10—8.209.2.D, 8.209.4.A.3.c.(i)	**Both R6 and R7:** The Member Appeals Policy outlines CCHA's definition of a grievance as it relates to a complaint, as well as a reference to CCHA's overall grievance and appeal system. • *VI.GA.1_Member Appeals Policy, p. 1-2* The Member Grievances Policy outlines CCHA's definition of a grievance and how it differs from an adverse benefit determination. • *VI.GA.1_Member Grievances Policy, p. 1* The following page on CCHA's website contains information for members regarding what constitutes a grievance. • *CCHA Appeals and Grievances Page: https://www.cchacares.com/for-members/appeals-and-grievances/*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. The Contractor has provisions for who may file: • A member may file a grievance or a Contractor-level appeal and may request a State fair hearing. • With the member's written consent, a provider or authorized representative may file a grievance or a Contractor-level appeal and may request a State fair hearing on behalf of a member. *Note: Throughout this standard, when the term "member" is used it includes providers and authorized representatives (with the exception*	**Both R6 and R7:** The Member Grievances Policy document defines who is able to file a grievance with CCHA. • *VI.GA.1_Member Grievances Policy, p. 1-2* The Member Appeals Policy defines who is able to file an internal appeal with CCHA, as well as who may request a State Fair Hearing. • *VI.GA.1_Member Appeals Policy, p. 2, 6-7*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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 B2—8.5.1, 8.5.3, 8.7.1, 8.7.15.1, 8.7.5	The following is a document used by CCHA's appeal team to request written consent for an authorized representative to file an appeal on behalf of a CCHA member. • *VI.GA.5_Member Appeal Request_Designated Representative Form, p. 2-3* The following form can be used by a member or a member's representative to file a grievance with CCHA. • *Member Grievance Form: https://www.cchacares.com/for-members/member-benefits-services/grievance-form/* The following document provides information on who is able to file grievances and/or appeals for CCHA members. • *VI.GA.5_Member Grievance and Appeal Information, p. 1, 2*	

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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 TTY/TDD and interpreter capability. *42 CFR 438.406(a)* Contract: Exhibit B2—8.3 10 CCR 2505-10 8.209.4.C	**Both R6 and R7:** The Member Appeals Policy outlines CCHA's policy regarding assisting members when filing an appeal, including providing auxiliary aids and translation services. • *VI.GA.1_Member Appeals Policy, p. 3-4* The following document outlines CCHA's policy regarding assisting members when filing a grievance, including providing language assistance services. • *VI.GA.1_Member Grievances Policy, p. 3*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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 B2—8.5.4, 8.7.4 10 CCR 2505-10 8.209.5.C, 8.209.4.E	**Both R6 and R7:** The Member Appeals Policy outlines the requirements for the Medical Director making appeal decisions for CCHA. • *VI.GA.1_Member Appeals Policy, p.3-4* The Member Grievances Policy outlines the requirements for whom can make decisions on grievance filed with CCHA. • *VI.GA.1_Member Grievances Policy, p. 3*	**Region 6:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: Both the *Member Grievances Policy* and *Member Appeals Policy* described the circumstances related to individuals who make decisions on grievances and appeals. On-site appeal record reviews demonstrated that appropriate reviewers rendered decisions in all cases. However, during on-site grievance record reviews, HSAG found grievances that involved clinical quality of care complaints in which no CCHA clinician reviewed the case prior to resolution. Three of three applicable grievance records were *Not Met* for "appropriate level of expertise."		
Required Actions: CCHA must develop a mechanism to ensure that grievances related to clinical care are reviewed and resolved by individuals with appropriate clinical expertise in treating in the member's condition.		
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 B2—None	**Both R6 and R7:** The Member Appeals Policy outlines CCHA's requirements regarding the responsibilities of the decision maker when deciding an appeal. • *VI.GA.1_Member Appeals Policy, p. 4* The Member Grievances Policy outlines CCHA's requirements regarding the responsibilities of the decision maker when deciding a grievance. • *VI.GA.1_Member Grievances Policy, p. 3*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor accepts grievances orally or in writing. *42 CFR 438.402(c)(3)(i)* Contract: Exhibit B2—8.5.3 10 CCR 2505-10—8.209.5.D	**Both R6 and R7:** The Member Grievances Policy outlines the ways in which CCHA can accept a grievance. • *VI.GA.1_Member Grievances Policy, p. 2*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. Members may file a grievance at any time. *42 CFR 438.402(c)(2)(i)* Contract: Exhibit B2—8.5.3 10 CCR 2505-10—8.209.5.A	**Both R6 and R7:** The Member Grievances Policy outlines when a grievance can be filed with CCHA. • *VI.GA.1_Member Grievances Policy, p. 2*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11. The Contractor sends the member written acknowledgement of each grievance within two (2) working days of receipt. *42 CFR 438.406(b)(1)* Contract: Exhibit B2—8.1 10 CCR 2505-10 8.209.5.B	**Both R6 and R7:** The following document outlines the policy and procedure regarding when a written acknowledgement of a grievance is sent to the member. • *VI.GA.1_Member Grievances Policy, p. 2-3* The following document is a copy of the notice sent to CCHA members to acknowledge their grievance was filed. • *VI.GA.11_Member Complaint Acknowledgement Letter Eng* The following document 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*	**Region 6:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The *Member Grievances Policy* accurately stated that an acknowledgement letter is sent to the member within two working days; however, HSAG found one of 10 record reviews did not meet the required timeline. Staff members stated that the grievance was received by CCHA's Anthem partner and was not routed timely to CCHA for processing.		
Required Actions: CCHA must develop a mechanism to ensure that grievances received by any of its partner organizations are routed timely to CCHA.		
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) and (b)(1) and (d)(1)* Contract: Exhibit B2—8.5.5, 7.2.7.3, 7.2.7.5 10 CCR 2505-10 8.209.5.D	**Both R6 and R7:** The Member Grievances Policy 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_Member Grievances Policy, p. 2* The following policy outlines CCHA's requirements for ensuring grievance notices are easy for members to understand and are available in alternative formats. • *VI.GA.12_Member and Provider Materials and Website Policy, p. 2* The following document is a copy of a grievance resolution letter sent to CCHA members. • *VI.GA.12_Member Complaint Resolution Letter ENG* The following document is a copy of a grievance resolution letter, in Spanish, sent to CCHA members. • *VI.GA.12_Member Complaint Resolution Letter SP*	**Region 6:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The *Member Grievances Policy* accurately stated that grievance resolution and notice would be provided within 15 working days. The *Member and Provider Materials and Website Policy* stated that grievance notices will be available in non-English languages and alternative formats and be written in easily understood language. The template language in the *Member Complaint Resolution Letter* was in compliance with requirements. However, HSAG found that one of 10 grievance records did not meet the required resolution time frame and that no extension letter was sent to the member (staff members stated that they did not understand that extensions required a written extension letter as well as verbal notification.) In addition, one of 10 records did not meet the requirement "easy to understand," as the resolution description included words such as "allegedly" and "substantiated," which would not be easily understood by members with limited reading ability.		
Required Actions: CCHA must: • Develop a mechanism to ensure that the grievance resolution is written in language that may be understood by Medicaid members with limited reading ability. • Ensure that members receive a written extension letter for any grievance that requires more than 15 working days to resolve.		
13. The written notice of grievance resolution includes: • Results of the disposition/resolution process and the date it was completed. Contract: Exhibit B2—8.1 10 CCR 2505-10 8.209.5.G	**Both R6 and R7:** This page on the CCHA website informs members of the grievance process and what information their grievance resolution notice will contain. • *VI.GA.5_Member Grievance and Appeal Information, p. 2* The following document 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 Letter ENG* The following document is a copy of a grievance resolution letter, in Spanish, sent to CCHA members,	**Region 6:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	which includes the results of the grievance disposition and the date it was completed. • *VI.GA.12_Member Complaint Resolution Letter SP*	
Findings: The *Member Grievances Policy* did not address the required content of the grievance resolution letter. HSAG found one of 10 grievance record reviews in which the grievance resolution was not responsive to the member's grievance and, therefore, was *Not Met* for "resolution letter includes required content." HSAG recommends that the *Member Grievances Policy* be updated to address the required content of the grievance resolution letter, including that the description of the resolution must be responsive to the member's specific complaint.		
Required Actions: CCHA must develop a mechanism to ensure that the grievance resolution thoroughly addresses the member's complaint.		
14. The Contractor may have only one level of appeal for members. *42 CFR 438.402(b)* Contract: Exhibit B2—None	**Both R6 and R7:** The following document outlines CCHA's policy for members accessing the appeal process. • *VI.GA.1_Member Appeals Policy, p. 1* The following 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_CO AG Appeal Internal Rights Exhausted ENG* The following document is provided to members, in Spanish, that have exhausted CCHA's internal appeal process to inform them of the State Fair Hearing Process • *VI.GA.14_CO AG Appeal Internal Rights Exhausted SP*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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 B2—8.7.5.1 10 CCR 2505 10 8.209.4.B	**Both R6 and R7:** The Member Appeals Policy outlines the timeline for a member filing an appeal with CCHA. • *VI.GA.1_Member Appeals Policy, p. 2* The following document, also found on CCHA's website, informs members of the timeline to file an appeal with CCHA. • *VI.GA.5_Member Grievance and Appeal Information, p. 2*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
16. The member may file an appeal either orally or in writing, and must follow the oral request with a written, signed appeal (unless the request is for expedited resolution). *42 CFR 438.402(c)(3)(ii)* Contract: Exhibit B2—8.7.5.2 10 CCR 2505-10 8.209.4.F	**Both R6 and R7:** The Member Appeals Policy outlines CCHA's policy for accepting oral and written appeal requests. • *VI.GA.1_Member Appeals Policy, p. 2-3* The following form is used by members to follow an oral appeal with a written, signed appeal request. • *VI.GA.5_Member Appeal Request_Designated Representative Form, entire document* The following document informs members of the requirement to follow an oral appeal with a written appeal, unless the request was for an expedited appeal. • *VI.GA.5_Member Grievance and Appeal Information, p. 2*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The Contractor sends written acknowledgement of each appeal within two (2) working days of receipt, unless the member or designated client representative requests an expedited resolution. *42 CFR 438.406(b)(1)* Contract: Exhibit B2—8.1, 8.7.2 10 CCR 2505-10 8.209. 4.D	**Both R6 and R7:** The following document contains CCHA's policy for sending a written acknowledgement of an appeal within two business days of receipt. • *VI.GA.1_Member Appeals Policy, p. 2* The following documents, available in English and Spanish, acknowledge a member's appeal that was submitted in writing to CCHA. • *VI.GA.17_CO AG Appeal Ack Letter- Written ENG* • *VI.GA.17_CO AG Appeal Ack Letter- Written SP* The following documents, available in English and Spanish, acknowledge a member's verbal appeal and informs the member of the requirements for a written, signed appeal to be submitted, unless the appeal request was for an expedited appeal. • *VI.GA.17_CO AG Appeal Ack Ltr-Verbal ENG* • *VI.GA.17_CO AG Appeal Ack Ltr-Verbal SP* The following document is mailed with the verbal appeal acknowledgement letter to provide members with a method to submit a written, signed appeal for a standard appeal request. • *VI.GA.5_Appeal Request_Designated Representative Form*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following document informs members of the appeal process, including when they will receive written acknowledgement of their appeal request. • *VI.GA.5_Member Grievance and Appeal Information, p. 3*	
18. The Contractor's appeal process must provide: • That oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date). • That if the member orally requests an expedited appeal, the Contractor shall not require a written, signed appeal following the oral request. • That included, as parties to the appeal, are: – The member and his or her representative, or – The legal representative of a deceased member's estate. *42 CFR 438.406(b)(3) and (6)* Contract: Exhibit B2—8.7.6, 8.7.7, 8.7.11 10 CCR 2505-10 8.209. 4.F, 8.209.4.I	**Both R6 and R7:** The following document outlines CCHA's policy for using verbal appeals to establish the earliest filing date, that expedited appeal requests do not require a written, signed appeal, and which individuals are included as parties to the appeal. • *VI.GA.1_Member Appeals Policy, p. 2-4*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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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 member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional documents considered, relied upon, or generated by the Contractor in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame. *42 CFR 438.406(b)(4-5)* Contract: Exhibit B2—8.7.8–8.7.10 10 CCR 2505-10 8.209. 4.G, 8.209.4.H	**Both R6 and R7:** The following document outlines CCHA's policy regarding the member's ability to present evidence for their appeal request and their right to examine the member's case file, including medical records and other documents considered during the appeal process. The document also notes CCHA's communications with members regarding the limited time frame to do so during expedited appeals. • *VI.GA.1_Member Appeals Policy, p. 3-4*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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 B2—8.7.14.2.1, 8.7.12 10 CCR 2505-10 8.209.4.Q-R	**Both R6 and R7:** The Member Appeals policy outlines CCHA's expedited appeal process, including a policy to not take punitive action against a provider that requests or supports a member's expedited appeal. • *VI.GA.1_Member Appeals Policy, p. 4*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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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 (2) calendar days provide the member written notice of the reason for the decision and inform the member of the right to file a grievance if he or she disagrees with that decision. *42 CFR 438.410(c)* Contract: Exhibit B2—8.7.14.2.2 10 CCR 2505-10 8.209.4.S	**Both R6 and R7:** The Member Appeals Policy outlines CCHA's procedure when an expedited appeal request is denied. • *VI.GA.1_Member Appeals Policy, p. 4*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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)* *42 CFR 438.10* Contract: Exhibit B2—8.7.14.1. 7.2.7.3, 7.2.7.5 10 CCR 2505-10 8.209.4.J.1	**Both R6 and R7:** The following document outlines CCHA's timeline for resolving standard appeals, as well as requirements for the written notice of appeal resolution. • *VI.GA.1_Member Appeals Policy, p. 3-4* The following policy outlines CCHA's requirements for materials that are critical to obtaining services, including appeal notices. • *VI.GA.12_Member and Provider Materials and Website Policy, p. 2*	**Region 6:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The *Member Appeals Policy* accurately described the required time frames for providing notice to the member and that the specific reason for the appeal decision be written in easily understandable language. However, HSAG found in appeal record reviews that one of eight cases did not meet the required		

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
resolution time frame (by over two months). Staff members stated that the case was "lost" in the referral process to the medical reviewer. In addition, three of eight cases were *Not Met* for "resolution letter easy to understand," as the resolution reason used terminology—"carved out FFS" or "MCG 22nd edition" with the BH diagnosis title—which would not be easy for the member to understand.		
Required Actions: CCHA must implement mechanisms to ensure: • Each appeal determination and notice to the member is processed within the required time frame. • The reason for the appeal resolution avoids using industry or clinical terminology that may be difficult for a Medicaid member to understand.		
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 B2—8.7.14.2.3, 8.7.14.2.6 10 CCR 2505-10 8.209.4.J.2, 8.209.4.L	**Both R6 and R7:** The Member Appeals Policy outlines CCHA's timeline for resolving expedited appeals, as well as CCHA's policy to provide verbal notification to members of their expedited appeal resolution. • *VI.GA.1_Member Appeals Policy, p. 3-4*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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 B2—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 R6 and R7:** The Member Grievances Policy outlines the timeline in which CCHA can extend the resolution of a grievance. • *VI.GA.1_Member Grievances Policy, p. 2* The Member Appeals Policy outlines the timeline in which CCHA can extend a standard or expedited appeal resolution, as well as the requirements for when a resolution can be extended. • *VI.GA.1_Member Appeals Policy, p. 3, 6*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following document is a copy of a letter sent to a member when an appeal extension is requested. • *VI.GA.24_CO AG Appeal Time Frame Ext Notif Ltr ENG* The following document is a copy of a letter, in Spanish, sent to a member when an appeal extension is requested. • *VI.GA.24_CO AG Appeal Time Frame Ext Notif Ltr SP*	
25. If the Contractor extends the time frames, it must—for any extension not requested by the member: • Make reasonable efforts to give the member prompt oral notice of the delay. • Within two (2) calendar days, give the member written notice of the reason for the delay and inform the member of the right to file a grievance if he or she disagrees with that decision. • Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. *42 CFR 438.408(c)(2)* Contract: Exhibit B2—8.5.7, 8.7.14.1, 8.7.14.2.1, 8.7.14.2.5-6	**Both R6 and R7:** The following document contains CCHA's policy for required actions when CCHA extends the grievance resolution time frame not at the member's request. • *VI.GA.1_Member Grievances Policy, p. 2-3* The following document contains CCHA's policy for required actions when CCHA extends the appeal resolution time frame not at the member's request. • *VI.GA.1_Member Appeals Policy, p. 6*	**Region 6:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: Both the *Member Appeals Policy* and the *Member Grievances Policy* accurately addressed member notification of extensions. HSAG observed no written notices of extension in either the grievance record reviews or appeals record reviews; however, HSAG found one grievance record in which CCHA extended the resolution and no written extension letter was sent to the member. In addition, the template appeal extension notice did not include the reason for the delay nor the member's right to file a grievance if he or she disagreed with the extension. The language in the template extension letter also		

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
stated that "we will send you a letter within two calendar days if we decide we need more time to review your appeal," which would seem to be a duplication of the extension letter and is, therefore, confusing.		
Required Actions: CCHA must: • Develop an extension notice for grievances and appeals that includes the required content—i.e., reason for extension, right to file a grievance—and improves the clarity of the language in the letter. • Implement a process to ensure that members receive a written extension notice (in addition to verbal notice) when it extends the grievance resolution time frame.		
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 B2—8.7.14.3, 8.7.14.4 10 CCR 2505-10 8.209.4.M	**Both R6 and R7:** The following document outlines the requirements for CCHA's written notice of appeal resolution. • *VI.GA.1_Member Appeals Policy, p. 4-5* The following 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_CO AG Appeal Admin Uphold Ltr ENG* • *VI.GA.26_CO AG Appeal Admin Uphold Ltr SP* The following document, available in English and Spanish, is the appeal resolution notice used when an appeal is upheld due to medical necessity. • *VI.GA.26_CO AG Appeal Medical Necessity Uphold Ltr ENG* • *VI.GA.26_CO AG Appeal Medical Necessity Uphold Ltr SP*	**Region 6:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following document, available in English and Spanish, is the appeal resolution notice used when an appeal is overturned. • *VI.GA.26_CO AG Appeal Overturn Ltr ENG* • *VI.GA.26_CO AG Appeal Overturn Ltr SP*	

Findings:

The *Member Appeals Policy* addressed the content of the appeal resolution letter, which included some inadequacies or inaccuracies. These included:

- Does not specify that the notice includes the date the resolution process was completed.
- Specifies that the notice will include the member or provider's right to file an *appeal*. (The right to file an appeal should not be included in the appeal resolution letter, as the appeal is completed. It should specify the right to request an SFH and how to do so.)
- Includes "no physician against whom the appeal has been brought will review the appeal." (An appeal is not brought against a provider.)
- Includes the right to request and receive benefits while the SFH is pending and that the member may be held liable for continued benefits. However, it does not clarify that the right to continue benefits during the SFH is only applicable to an original denial of previously authorized services that have been suspended or reduced, and if the member had requested continued benefits during the appeal.

During on-site record reviews, HSAG found 50 percent of the appeal resolution letters were *Not Met* for "required content," as each letter informed the member that he or she may request continued benefits even though the member was not eligible for continued benefits during the SFH. Staff members stated that CCHA uses the Department-mandated template for appeal resolution letters, which includes continuation of benefits information.

The *Appeal Medical Necessity Uphold* letter template language stated, "If you want to continue benefits during the hearing, your request must be submitted within 10 days of the date on the letter" but did not inform the member how to do so (continued benefits must be requested through CCHA).

In addition, the *Member Appeals Policy* included a section describing the time frames for proving the NOABD to the member, which is applicable to the authorization denial process, not to appeals. As this information is out of context, HSAG recommends that this section be removed from the *Member Appeals Policy*.

Required Actions:

CCHA must:

- Update the *Member Appeals Policy* to accurately address all elements of the required content of the appeal resolution letter, including clarification that the letter includes the right to continue benefits during an SFH only if the original denial was for termination, suspension, or reduction of

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
previously authorized services and that the member had requested that benefits continue during the appeal. • Update the *Appeal Medical Necessity Uphold* letter template to ensure that information regarding the member's right to request benefits during an SFH is included only when applicable—i.e., the member had requested and received continued benefits during the appeal. • Update the *Appeal Medical Necessity Uphold* letter template to ensure that, when applicable, the letter informs the member that continued benefits during an SFH must be requested through CCHA.		
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 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 B2—8.7.15.1–8.7.15.2 10 CCR 2505-10 8.209.4.N and O	**Both R6 and R7:** The following document outlines CCHA's policy regarding State Fair Hearing requests by members, including when a member is eligible for a State Fair Hearing. • *VI.GA.1_Member Appeals Policy, p. 7* The following document provides member information on when and how to request a State Fair Hearing. • *VI.GA.5_Member Grievance and Appeal Information, p. 3* The following 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.26_CO AG Appeal Admin Uphold Ltr ENG* • *VI.GA.26_CO AG Appeal Admin Uphold Ltr SP* The following document, available in English and Spanish, is the appeal resolution notice used when an	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	appeal is upheld due to medical necessity, and informs the member of their right to access a State Fair Hearing. • *VI.GA.26_CO AG Appeal Medical Necessity Uphold Ltr ENG* • *VI.GA.26_CO AG Appeal Medical Necessity Uphold Ltr SP*	
28. The parties to the State fair hearing include the Contractor as well as the member and his or her representative or the representative of a deceased member's estate. *42 CFR 438.408(f)(3)* Contract: Exhibit B2—8.7.15.3	**Both R6 and R7:** The Member Appeals Policy outlines the applicable parties to a State Fair Hearing. • *VI.GA.1_Member Appeals Policy, p. 7*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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 R6 and R7:** The following document outlines CCHA's policies when a member requests continuation of benefits during an appeal or a State Fair Hearing, including timelines for requesting continuation of benefits. • *VI.GA.1_Member Appeals Policy, p. 6* The following document, available in English and Spanish, is the notice used to inform members of the adverse action taken by CCHA, as well as information regarding the appeal process and how to request a continuation of benefits during the appeal. • *VI.GA.29_CO BH Denial Letter with CvrSheet ENG* • *VI.GA.29_CO BH Denial Letter with CvrSheet SP*	**Region 6:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

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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 B2—8.7.13.1 10 CCR 2505-10 8.209.4.T	The following 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 and have their benefits continue during the hearing. • *VI.GA.26_CO AG Appeal Admin Uphold Ltr ENG* • *VI.GA.26_CO AG Appeal Admin Uphold Ltr SP* The following 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 and have their benefits continue during the hearing. • *VI.GA.26_CO AG Appeal Medical Necessity Uphold Ltr ENG* • *VI.GA.26_CO AG Appeal Medical Necessity Uphold Ltr SP*	

Findings:
The *Member Appeals Policy* accurately addressed the criteria for requesting continued benefits during an appeal. However, the criteria specified that "the member seeking to have benefits continue pending the appeal *files timely* on or before 10 days…." When used in this context, "files timely" is a vague term. (The member must file for "continued benefits" within 10 days and may file for an appeal within 60 days of the NOABD.) The policy does not address continuation of benefits during an SFH.

During on-site reviews, HSAG clarified that the criteria for requesting continued benefits during an SFH include the following modifications to the language specified in the federal requirement related to appeals, as follows:

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Bullet #1—"files timely for continued benefits" is defined as on or before "within 10 days of the Contractor mailing the notice of *adverse appeal resolution*"; "The intended effective date of the proposed adverse benefit determination" *does not apply.* • Bullet #4—"The original period covered by the original authorization has not expired" *does not apply.* • Bullet #5—"The member requests an *SFH* in accordance with required time frames." (120 days from the adverse appeal resolution notice.)		
Required Actions: CCHA must update its *Member Appeals Policy* to: • Specify that the member must file for "continued benefits" within 10 days of the NOABD and may file the appeal within 60 days of the NOABD. • Address the criteria for requesting benefits during an SFH, which accurately modifies the language of the criteria as specified in *Findings.*		
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 B2—8.7.13.2 10 CCR 2505-10 8.209.4.U	**Both R6 and R7:** The Member Appeals Policy outlines when CCHA is no longer responsible for continuing a member's benefits while an appeal or State Fair Hearing are pending. • *VI.GA.1_Member Appeals Policy, p. 6* The following document, available in English and Spanish, is the notice used to inform members of the adverse action taken by CCHA, as well as information regarding the appeal process and how to request a continuation of benefits during the appeal. • *VI.GA.29_CO BH Denial Letter with CvrSheet ENG* • *VI.GA.29_CO BH Denial Letter with CvrSheet SP* The following 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	**Region 6:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
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	a State Fair Hearing and have their benefits continue during the hearing. • *VI.GA.26_CO AG Appeal Admin Uphold Ltr ENG* • *VI.GA.26_CO AG Appeal Admin Uphold Ltr SP*	
Findings: The *Member Appeals Policy* stated these circumstances related to how long benefits will continue during an appeal or SFH; however, the policy also includes "The time period or service limits of a previously authorized service has been met," which does not apply to how long benefits will continue during either an appeal and SFH. In addition, the second bullet in the requirement—i.e., "10 days pass after the adverse appeal resolution and the member does not request continued benefits during an SFH" applies to how long benefits will continue during an appeal, but not to during an SFH. (Once continued benefits have been requested during an SFH, the benefits will continue until the member withdraws the SFH or the SFH officer issues a hearing decision.)		
Required Actions: CCHA must update its *Member Appeals Policy* to accurately address the criteria for how long benefits will continue during an appeal and during an SFH.		
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 B2—8.7.13.3 10 CCR 2505-10 8.209.4.V	**Both R6 and R7:** The following document outlines when CCHA is able to recover the cost of continued services when the final appeal resolution is adverse to the member. • *VI.GA.1_Member Appeals Policy, p. 6*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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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 B2—8.7.13.4 10 CCR 2505-10 8.209.4.W	**Both R6 and R7:** The Member Appeals Policy outlines CCHA's requirement to provide services expeditiously to a member when CCHA or a State Fair Hearing officer reverses the initial adverse benefit determination. • *VI.GA.1_Member Appeals Policy, p. 6*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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 B2—8.7.13.5 10 CCR 2505-10 8.209.4.X	**Both R6 and R7:** The Member Appeals Policy outlines CCHA's requirements for payment of a disputed service when CCHA or a State Fair Hearing officer reverses a service authorization denial. • *VI.GA.1_Member Appeals Policy, p. 6*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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.	**Both R6 and R7:** The Member Appeals Policy outlines CCHA's appeal record requirements, as well as the requirements for the quarterly report submission. • *VI.GA.1_Member Appeals Policy, p. 7* The Member Grievances Policy outlines CCHA's grievance record requirements, as well as the requirements for the quarterly report submission. • *VI.GA.1_Member Grievances Policy, p. 4*	**Region 6:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– 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 B2—8.9.1–8.9.1.6 10 CCR 2505-10 8.209.3.C	**R6-specific:** The following document is the Region 6 Grievance and Appeals report for January-March, 2019. • *VI.GA.34_R6GrieveAppealQ3FY18-19* The following documents are the Region 6 Grievance and Appeals Report and Narrative for April-June, 2019. • *VI.GA.34_R6GrieveAppealQ4FY18-19* • *VI.GA.34_R6GrieveAppealQ4FY18-19Part2* The following documents are the Region 6 Grievance and Appeals Report and Narrative for July-September, 2019. • *VI.GA.34_R6GrieveAppealQ1FY19-20* • *VI.GA.34_R6GrieveAppealQ1FY19-20Part2* The following documents are the Region 6 Grievance and Appeals Report and Narrative for October-December, 2019. • *VI.GA.34_R6GrieveAppealQ2FY19-20* • *VI.GA.34_R6GrieveAppealQ2FY19-20Part2*	

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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* *42 CFR 438.10(g)(xi)* Contract: Exhibit B2—8.4 10 CCR 2505-10 8.209.3.B	**Both R6 and R7:** The Member Grievances Policy references the communication strategy for informing members and providers of the grievance system. • *VI.GA.1_Member Grievances Policy, p. 2* The Member Appeals Policy outlines how members and providers are informed of the grievance and appeal process through the CCHA website. • *VI.GA.1_Member Appeals Policy, p. 3* The following webpage provides public facing information on CCHA's grievance and appeals process. • *CCHA Appeals and Grievances Webpage*: *https://www.cchacares.com/for-members/appeals-and-grievances/* The CCHA BH provider manual outlines the requirements, timelines, and process for member grievances and appeals. Behavioral health providers agree to review the provider manual upon contracting with CCHA. • *VI.GA.35_BH Provider Manual, p. 51-56* This CCHA PH Provider Manual informs CCHA's physical health providers on CCHA's grievance and appeal system, including references on how to file appeals for physical health and behavioral health claims.	**Region 6:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• *VI.GA.35_PH Provider Manual, p. 19-21* This template of the BH provider contract requires provider compliance with the information in the CCHA BH Provider Manual, including the grievance system. • *VI.GA.35_CCHA_BH_Provider Agreement Template, p. 4*	

Findings:
CCHA provided information regarding appeals and grievance procedures through the *BH Provider Manual* and *PH Provider Manual*. Many of the detailed grievance and appeal procedures were accurately described; however, the provider manuals included the following inadequacies or inaccuracies:

- The *PH Provider Manual* failed to describe CCHA assistance available in the filing of grievances.
- Both the *PH Provider Manual* and *BH Provider Manual* failed to describe CCHA assistance available in the filing of appeals.
- The *BH Provider Manual*:
  - Inaccurately stated the time frames for providing an appeal acknowledgement letter—*three* working days rather than "two" working days.
  - Inaccurately specified the time frame for resolution of an appeal—within 10 *calendar* days rather than 10 "working" days.
  - Inaccurately stated that the criteria for the member to request continued benefits during either an appeal or SFH included filing the *appeal* within 10 calendar days of the NOABD—the member must request continued benefits within 10 days of the NOABD; the member must file the appeal within 60 days of the NOABD. In addition, the criteria for requesting continued benefits during an SFH included: must file the SFH within 10 days of the NOABD. The member must request continued benefits within 10 days of receiving the *adverse appeal resolution* and may request an SFH within 120 days of the appeal resolution.
  - The description of how long benefits will continue during an appeal or SFH included the same inaccuracies outlined in the findings of Requirement #30.
  - The information related to outcomes of the SFH when continued benefits are requested stated "if HCPF reverses our decision…." or "if HCPF upholds our decision….". Whereas these circumstances also apply to the outcomes of an appeal, the information should also address "if CCHA reverses our decision…." or "if CCHA upholds our decision….".

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
HSAG also noted that the *BH Provider Manual* missed the opportunity to specify that (1) the provider may not request continued benefits on behalf of the member, and (2) no punitive action will be taken against a provider who supports/requests an expedited appeal. While these are not requirements, HSAG recommends that CCHA include such statements when it revises the *BH Provider Manual*.		
Required Actions: CCHA must update the appeals and grievance information in the *PH Provider Manual* and *BH Provider Manual* to address all required information and to address any inaccuracies or incomplete information in the description of appeal or grievance procedures, as detailed in *Findings*.		

Results for Standard VI—Grievances and Appeals							
Total	Met	=	25	X	1.00	=	25
	Partially Met	=	10	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	35	**Total Score**		=	25
			Total Score ÷ Total Applicable			=	71%

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Denials Record Review Tool
for Colorado Community Health Alliance (Region 6)

Review Period:	January 1, 2019–December 31, 2019
Date of Review:	April 21, 2020
Reviewer:	Sarah Lambie
Participating Plan Staff Member(s):	Kelli Gill

Requirements	File 1	File 2	File 3	File 4	File 5
Member ID	****	****	****	****	****
Date of initial request	2/5/19	2/26/19	3/11/19	5/9/19	5/30/19
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	NR	NR	NR	NR
(Standard [S], Expedited [E], or Retrospective [R])	R	R	R	S	S
Date notice of adverse benefit determination (NABD) sent	2/7/19	3/5/19	Not Sent	5/16/19	6/6/19
Notice sent to provider and member? (M or NM)*	M	M	NM	M	M
Number of days for decision/notice	2	7	Not Sent	7	7
Notice sent within required time frame? (M or NM) (S = 10 Cal days after; E = 72 hours after; T = 10 Cal days before)*	M	M	NM	M	M
Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
If extended, extension notification sent to member? (M, NM, or NA)*	NA	NA	NA	NA	NA
If extended, extension notification includes required content? (M, NM, or NA)*	NA	NA	NA	NA	NA
NABD includes required content? (M or NM)*	M	M	NM	M	M
Authorization decision made by qualified clinician? (M, NM, or NA)*	M	M	M	M	M
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (M, NM, or NA)*	NM	NA	NA	NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (M or NM)*	M	M	M	M	M
Was correspondence with the member easy to understand? (M or NM)*	NM	NM	NM	NM	NM
Total Applicable Elements	**7**	**6**	**6**	**6**	**6**
Total Met Elements	**5**	**5**	**2**	**5**	**5**
Score (Number Met / Number Applicable) = %	**71%**	**83%**	**33%**	**83%**	**83%**

***** = Reference Denial Record Review Instructions for Corresponding Requirement in Compliance Monitoring Tool
M = Met, **NM** = Not Met, **NA** = Not Applicable, **Cal** = Calendar, **Y** = Yes, **N** = No (Yes and No = not scored—informational only)
**** = Redacted Member ID

Comments:

File 1: This was a new service request. This request was denied for lack of clinical information from the facility. CCHA stated that there is a typical process to reach out for more information; however, the note within this denial record stated, "Provider did not request a peer review." The NOABD included the following language: "We asked the facility to explain the symptoms, but they did not provide us with this information"; however, there was no note in the file that indicated CCHA requested more information from the provider.

The NOABD sent to the member included language such as "Residential treatment facility for a mental health condition known as a depressive disorder" and referred to clinical materials such as "MCG" and "BH Guideline, 22nd edition" that would not be easy to understand. Additionally, the following statement is standard in all CCHA NOABDs: "We based our decision on clinical received from facility." This is confusing since the facility did not provide enough information and the denial reason is "lack of clinical information."

File 2: This was a new service request. CCHA's standard NOABD statement: "We based our decision on clinical received from facility" does not apply to this NOABD as it was administratively denied due to late notification. The letter also included words such as "administratively denied" to describe the reason for the adverse benefit determination. This language would not be easy for the member to understand.

File 3: This was an authorization request for approval of an RTC member weekend pass that was requested after the pass was taken. Staff stated that no NOABD was mailed due to being "overwhelmed with requests for weekend passes." As there was no NOABD mailed, all requirements related to the member notice/NOABD were *Not Met.*

File 4: This was a new service request. The NOABD sent to the member included the following wording, despite the provider sending additional information to CCHA on 5/16/2019: "Your provider did not submit a complete request for psychological testing" and "We do not know what billing codes your provider wants to use." The NOABD also included language such as "medically necessary," "comprehensive clinical examination," "rating scales," "Psychological testing," and references such as "MCG" and "ORG." This language would not be easy to understand.

File 5: This was a new service request. The NOABD sent to the member included language such as "condition has to be measured," "psychiatric and substance abuse disorders," "chronic use," "mental health treatment planning," "Psychological testing," and references such as "DHS," "MCG," and "ORG B807" that would not be easy to understand.

Appendix B. Colorado Department of Health Care Policy and Financing FY 2019–2020 Denials Record Review Tool for Colorado Community Health Alliance (Region 6)

Requirements	File 6	File 7	File 8	File 9	File 10
Member ID	****	OMIT	****	****	****
Date of initial request	7/24/19		9/18/19	6/27/19	12/17/19
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR		NR	NR	NR
(Standard [S], Expedited [E], or Retrospective [R])	E		R	E	S
Date notice of adverse benefit determination (NABD) sent	7/25/19		9/20/19	6/28/19	12/24/19
Notice sent to provider and member? (M or NM)*	M		M	M	M
Number of days for decision/notice	1		2	1	7
Notice sent within required time frame? (M or NM) (S = 10 Cal days after; E = 72 hours after; T = 10 Cal days before)*	M		M	M	M
Was authorization decision timeline extended? (Y or N)	N		N	N	N
If extended, extension notification sent to member? (M, NM, or NA)*	NA		NA	NA	NA
If extended, extension notification includes required content? (M, NM, or NA)*	NA		NA	NA	NA
NABD includes required content? (N or NM)*	M		M	M	M
Authorization decision made by qualified clinician? (M, NM, or NA)*	M		M	M	M
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (M, NM, or NA)*	NA		NA	NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (M or NM)*	M		M	M	M
Was correspondence with the member easy to understand? (M or NM)*	M		NM	M	NM
Total Applicable Elements	**6**		**6**	**6**	**6**
Total Met Elements	**6**		**5**	**6**	**5**
Score (Number Met / Number Applicable) = %	**100%**		**83%**	**100%**	**83%**

***** = Reference Denial Record Review Instructions for Corresponding Requirement in Compliance Monitoring Tool
M = Met, **NM** = Not Met, **NA** = Not Applicable, **Cal** = Calendar, **Y** = Yes, **N** = No (Yes and No = not scored—informational only)

**** = Redacted Member ID

Comments:

File 7: This was a claims denial in which no NOABD was sent, and on-site discussions with staff members did not provide clarity regarding processes for sending an NOABD for claims. Due to the complex nature of interpreting the circumstances of this case, the case was omitted from the sample, and replaced with an oversample case.

File 8: This was a new service request. The NOABD sent to the member included terminology such as: "neurocognitive impairment" and "covered diagnosis," which would not be easy to understand.

File 10: This was a new service request. The NOABD sent to the member included terminology such as "neuropsychological testing" and a full list of clinical decision criteria, which would not be easy to understand

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Denials Record Review Tool
for Colorado Community Health Alliance (Region 6)

Requirements	OS 1	OS 2	OS 3	OS 4	OS 5
Member ID	****				
Date of initial request	4/1/19				
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR				
(Standard [S], Expedited [E], or Retrospective [R])	E				
Date notice of adverse benefit determination (NABD) sent	4/4/19				
Notice sent to provider and member? (M or NM)*	M				
Number of days for decision/notice	3				
Notice sent within required time frame? (M or NM) (S = 10 Cal days after; E = 72 hours after; T = 10 Cal days before)*	M				
Was authorization decision timeline extended? (Y or N)	N				
If extended, extension notification sent to member? (M, NM, or NA)*	NA				
If extended, extension notification includes required content? (M, NM, or NA)*	NA				
NABD includes required content? (M or NM)*	M				
Authorization decision made by qualified clinician? (M, NM, or NA)*	M				
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (M, NM, or NA)*	NA				
Was the decision based on established authorization criteria (i.e., not arbitrary)? (M or NM)*	M				
Was correspondence with the member easy to understand? (M or NM)*	NM				
Total Applicable Elements	**6**				
Total Met Elements	**5**				
Score (Number Met / Number Applicable) = %	**83%**				

***** = Reference Denial Record Review Instructions for Corresponding Requirement in Compliance Monitoring Tool
M = Met, **NM** = Not Met, **NA** = Not Applicable, **Cal** = Calendar, **Y** = Yes, **N** = No (Yes and No = not scored—informational only)

**** = Redacted Member ID

Comments:

File OS1: This was a new service request. The NOABD sent to the member included multiple dates in reference to the denial (e.g., 4/2/2019 and after and "4/2–4/2"), which would not be easy to understand.

Total Record Review Score*	Total Applicable Elements: 61	Total Met Elements: 49	Total Score: 80%

* Only requirements with an "*" in the tool were used to calculate the score. The total record review score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements.

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Grievance Record Review Tool
for Colorado Community Health Alliance (Region 6)

Review Period:	January 1, 2019–December 31, 2019
Date of Review:	April 21, 2020
Reviewer:	Barbara McConnell
Participating Health Plan Staff Member(s):	Cathy Herrera and Lina Quintero

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame*	Decision Maker Not Previous Level	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
1	*****	02/25/19	M ☒ N ☐ N/A ☐	03/06/19	7W	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: This was a complaint about being billed (not clinical).										
2	*****	03/11/19	M ☐ N ☒ N/A ☐	04/12/19	15W+11C	M ☐ N ☒	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: The acknowledgement letter was sent on 3/18/19. The complaint had been received by CCHA's Anthem partner and did not get identified as a grievance and, therefore, was not routed timely. This was a complaint about the member having paid for out-of-state care. Staff members stated the resolution—for CCHA to reimburse the member—took longer than anticipated. There was no extension letter sent to the member (CCHA gave verbal notification of an extension). Since verbal notification of an extension is not a valid extension, the timely resolution requirement is not met.										
3	*****	03/22/19	M ☒ N ☐ N/A ☐	04/11/19	14W	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: The member saw a non-contracted provider (staff reported that this was likely a new member and a continuity of care situation). The provider refused to bill CCHA. CCHA worked with provider, but after continued refusal to work with CCHA, CCHA escalated the case to the Medicaid Ombudsman. CCHA did let the member know in the resolution letter that Medicaid members cannot be billed for covered services.										
4	*****	04/15/19	M ☒ N ☐ N/A ☐	04/25/19	8W	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: This member complained that the clinic changed his provider. The member was referred to care coordination, who helped him find another provider.										
5	*****	05/06/19	M ☒ N ☐ N/A ☐	05/20/19	10W	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☒ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: This member complained about the quality of care received in the ER. The grievance specialist resolved the case based on discussions with the facility, which stated that it found that the care was an appropriate standard of care. A CCHA clinician did not review or resolve the grievance.										
6	*****	06/12/19	M ☒ N ☐ N/A ☐	06/25/19	9W	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: This was a complaint about an interaction with a nurse in the ER. The resolution was that the nurse offered an apology and was retrained.										
7	*****	06/19/19	M ☒ N ☐ N/A ☐	07/10/19	14W	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☒ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: This was a complaint that poor care at an ER caused this member's finger to be amputated. The grievance specialist resolved the case based on discussions with the facility, which stated that it found that the care was an appropriate standard of care. Although staff members stated that this case was referred to the medical director for review, the review and resolution of the case was determined by the grievance specialist based on discussions with the facility. No CCHA clinician reviewed the case prior to resolution.										

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Grievance Record Review Tool
for Colorado Community Health Alliance (Region 6)

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame*	Decision Maker Not Previous Level	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
8	*****	07/15/19	M ☒ N ☐ N/A ☐	07/25/19	8W	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: The member was having trouble getting durable medical equipment (DME). The grievance specialist helped the member access an authorization for the equipment.										
9	*****	09/25/19	M ☒ N ☐ N/A ☐	10/02/19	5W	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☐ N ☒ N/A ☐	M ☐ N ☒ N/A ☐
Comments: The resolution letter explained that the complaint "allegedly" happened and that the complaint could not be substantiated. The resolution was not responsive to the member's compliant. HSAG also advised that the word "substantiate" is not within guidelines for easy readability.										
10	*****	12/03/19	M ☒ N ☐ N/A ☐	12/20/19	13W	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☒ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: This was a quality of care concern. The grievance specialist resolved the case by speaking with the facility. Although staff members stated that the grievance went to the quality review team, the review and resolution of the case were determined by the grievance specialist based on discussions with the facility. No CCHA clinician reviewed the case prior to resolution.										
		Column Subtotal of Applicable Elements	**10**			**10**	**10**	**3**	**10**	**10**
		Column Subtotal of Compliant (Met) Elements	**9**			**9**	**10**	**0**	**9**	**9**
		Percent Compliant (Divide Met by Applicable)	**90%**			**90%**	**100%**	**0%**	**90%**	**90%**

Key: M = Met; N = Not Met
N/A = Not Applicable
***** = Redacted member ID

Total Applicable Elements	**53**
Total Compliant (Met) Elements	**46**
Total Percent Compliant	**87%**

* Grievance timeline for resolution and notice sent is 15 working days.
**Grievance resolution letter required content includes (1) results of the disposition/resolution process and (2) the date the disposition/resolution process was completed.

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Appeals Record Review Tool
for Colorado Community Health Alliance (Region 6)

Review Period:	January 1, 2019–December 31, 2019
Date of Review:	April 21, 2020
Reviewer:	Kathy Bartilotta
Participating Health Plan Staff Member(s):	Jason Eberle

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame*	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
1	****	01/17/19	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	01/23/19	M ☒ N ☐	M ☐ N ☒	M ☐ N ☒
Comments: The acknowledgement letter was sent on 1/21/19. This was an expedited request that was denied and converted to a standard request. A denial of expedited request letter was sent to the member. The original authorization decision was "not a covered benefit." The resolution letter informed the member that he or she may request continued benefits even though the member was not eligible for continuing benefits during the SFH. The resolution reason included the language "carved out FFS," which would not be understood by the member.											
2	****	02/21/19	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	01/22/19	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: This was an expedited request. The acknowledgement letter was sent on 2/21/19. The appeal decision overturned the original denial decision.											
3	****	05/24/19	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	05/30/19	M ☒ N ☐	M ☐ N ☒	M ☐ N ☒
Comments: The acknowledgement letter was sent on 5/24/19. This was an expedited request that was denied and converted to a standard request. A denial of expedited request letter was sent to the member. The original authorization decision was "not a covered benefit." The resolution letter informed the member that he or she may request continued benefits even though the member was not eligible for continuing benefits during the SFH. The resolution reason included the language "carved out FFS," which would not be understood by the member.											
4	****	05/24/19	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	08/09/19	M ☐ N ☒	M ☐ N ☒	M ☒ N ☐
Comments: This was an expedited request that was denied and converted to a standard request. A denial of expedited request letter was sent to the member. The appeal resolution letter was not sent until 8/9/19, well beyond the required time frame. Staff members explained that the appeal was lost in the process and the appeal resolution letter was sent as soon as the case was discovered. The resolution letter informed the member that he or she may request continued benefits even though the member was not eligible for continued benefits during the SFH.											
5	****	06/05/19	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	06/05/19	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: The acknowledgement letter was sent 6/5/19. This was an expedited appeal.											
6	****	06/18/19	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	06/20/19	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: The acknowledgement letter was sent on 6/18/19. This was an expedited appeal as it was a concurrent review for continued hospitalization. The resolution reason referenced "MCG 22nd edition" and the diagnosis title of the criteria used in making the decision, which included BH diagnosis terminology that may not be familiar to or appropriate for the member. Such technical terminology would not be easy for the member to understand.											
7	****	06/26/19	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	07/08/19	M ☒ N ☐	M ☐ N ☒	M ☒ N ☐
Comments: The acknowledgement letter was sent on 6/26/19. This was a post-service appeal. The resolution letter informed the member that he or she may request continued benefits even though the member was not eligible for continued benefits during the SFH.											

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Appeals Record Review Tool
for Colorado Community Health Alliance (Region 6)

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame*	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
8	****	07/11/19	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	07/17/19	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: This was an expedited request that was denied and converted to a standard request. This was a post-service appeal. The appeal decision overturned the original denial decision.											
9	****	OMIT	M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: This was a standard request, which was acknowledged the same day as received. The acknowledgement letter requested that a designated client representative (DCR) form be completed. When no DCR form was received within 10 working days, the appeal was dismissed and a letter was sent to the member informing the member of the dismissal. As no DCR was ever received, this was not a valid appeal request and was not processed; therefore, the file was omitted from the sample.											
10			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: There were no additional files in the sample submitted by the health plan.											
Do not score shaded columns below.											
Column Subtotal of Applicable Elements			**7**	**8**	**8**				**8**	**8**	**8**
Column Subtotal of Compliant (Met) Elements			**7**	**8**	**8**				**7**	**4**	**5**
Percent Compliant (Divide Met by Applicable)			**100%**	**100%**	**100%**				**88%**	**50%**	**63%**

Key: M = Met; N = Not Met
N/A = Not Applicable
Yes; No = Not scored—information only
**** = Redacted member ID

Total Applicable Elements	**47**
Total Compliant (Met) Elements	**39**
Total Percent Compliant	**83%**

***Appeal resolution letter time frame** does not exceed 10 working days from the day the health plan receives the appeal.

****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.

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2019–2020 site review of **CCHA R6**.

Table C-1—HSAG Reviewers and CCHA R6 and Department Participants

HSAG Review Team	Title
Kathy Bartilotta	Associate Director
Sarah Lambie	Project Manager II
Erika Bowman	Project Manager I
CCHA R6 Participants	**Title**
Amy Yutzy	Director, Region 7 Medicaid Programs
Abby Lisowski	Director, Client Services
Abigail Roa Justiniano	Director, Compliance
Andrea Skubal	Accountable Care Network Program Manager
Cara Hebert	Supervisor, Community Partnerships
Cathy Herrera	Grievance and Appeals Audit Specialist
Cindi Terra	Manager, Quality and Practice Transformation
Clara Cabanis	Senior Manager, Strategy and Performance
Colleen Daywalt	Manager, Marketing and Communications
Colleen McKinney	Compliance Manager
Darren Lish	Region 7 Medical Director
Deb Munley	Senior Vice President, Clinical and Quality Programs
Diane Seifert	Region 7 Network Manager
Elizabeth Holden	Director, BH Quality Improvement
Erica Kloehn	Director, BH Network Management
Frank Clepper	Executive Leadership
Gelissa Garcia-Diaz	Director, Utilization Management
Irina Yuffa	Director, BH Plans and Performance
Jason Eberle	Business Change Manager
Jessica Zaiger	Region 7 Manager, Care Coordination
Josie Dostie	Region 6 Senior Network Manager
Katie Mortenson	Quality Program Manager
Kelli Gill	Region 6 Director, BH Utilization Management
Ken Nielsen	Executive Leadership

CCHA R6 Participants	Title
Kim Cassidy	Manager, BH Services
Krista Newton	Director, Care Coordination
Kristen Mader	Provider Data Analyst
Laura Johnson	Region 6 Manager, Care Coordination
Lina Quintero	Manager, Grievance and Appeals Non-Clinical
Monica Bender	Director, Grievance and Appeals
Patrick Fox	Region 6 Medical Director
Sabrina Voltaggio	Project Coordinator
Sophie Thomas	Medicaid Program Manager
Tiffany Lloyd	Region 7 Utilization Management Lead
Tony Olimpio	Manager, Member Services
Zula Solomon	Director, Quality Improvement
Department Observers	**Title**
Amanuel Melles	ACC Program Administrator—HCPF
Amy Luu	Parity Administrator—HCPF
Megan Comer	Program Management Section—HCPF
Morgan Anderson	Program Management Selection—HCPF
Russell Kennedy	Quality & Compliance Specialist—HCPF

Appendix D. Corrective Action Plan Template for FY 2019–2020

If applicable, the RAE 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 RAE should identify the planned interventions and complete the attached CAP template. Supporting documents should not be submitted and will not be considered until the CAP has been approved by the Department. Following Department approval, the RAE 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 RAE will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final compliance site review report via email or through the file transfer protocol (FTP) site, with an email notification to HSAG and the Department. The RAE must submit the CAP using the template provided. For each element receiving a score of *Partially Met* or *Not Met*, the CAP must describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training and follow-up activities, and documents to be sent following the completion of the planned interventions.
Step 2	**Prior approval for timelines exceeding 30 days**
	If the RAE is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.
Step 3	**Department approval**
	Following review of the CAP, the Department and HSAG will: • Approve the planned interventions and instruct the RAE to proceed with implementation, or • Instruct the RAE to revise specific planned interventions and/or documents to be submitted as evidence of completion and also to proceed with implementation.
Step 4	**Documentation substantiating implementation**
	Once the RAE has received Department approval of the CAP, the RAE will have a time frame of 90 days (three months) to complete proposed actions and submit documents. The RAE will submit documents as evidence of completion one time only on or before the three-month deadline for all required actions in the CAP. (If necessary, the RAE will describe in the CAP document any revisions to the planned interventions that were required in the initial CAP approval document or determined by the RAE within the intervening time frame.) If the RAE is unable to submit documents of completion for any required action on or before the three-month deadline, it must obtain approval in writing from the Department to extend the deadline.

Step	Action
Step 5	**Technical Assistance**
	At the RAE's request, HSAG will schedule an interactive, verbal consultation and technical assistance session during the three-month time frame. The session may be scheduled at the RAE's discretion at any time the RAE 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 RAE 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 completion established by the Department. HSAG will continue to work with the RAE until all required actions are satisfactorily completed.

The CAP template follows.

Table D-2—FY 2019–2020 Corrective Action Plan for CCHA R6

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
7. The RAE defines medical necessity for services as a program, good, or service that: • Will or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all. • Is provided in accordance with generally accepted professional standards for health care in the United States. • Is clinically appropriate in terms of type, frequency, extent, site, and duration. • Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider. • Is delivered in the most appropriate setting(s) required by the client's condition. • Is not experimental or investigational.	The definition of "medical necessity" in CCHA's *Clinical Criteria Policy* excluded the following two components: • Is clinically appropriate in terms of type, frequency, extent, site, and duration. • Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider. (CCHA did not include "economic benefit.")	CCHA must ensure that the definition of "medical necessity" includes all required components as defined in CCR 2505-10 8.076.1.8.

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
• Is not more costly than other equally effective treatment options. *42 CFR 438.210(a)(5)* Contract: Exhibit B-2—2.1.62 10 CCR 2505-10 8.076.1.8		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
10. The Contractor and its subcontractors have in place and follow written policies and procedures to consult with the requesting provider for medical services when appropriate. *42 CFR 438.210(b)(2)(ii)* Contract: Exhibit B-2—14.8.2.5	CCHA's UM Program Description included general language about the process of notifying a requesting provider about a peer-to-peer process but did not clearly indicate that CCHA will outreach to the requesting provider to obtain additional information when necessary. One denial record review was denied due to "lack of information" received from the provider; however, no outreach to the provider was documented. The notes within the system stated, "provider did not request a peer review." Furthermore, record reviews demonstrated inconsistency in applying the peer-to-peer procedure.	CCHA must ensure that, when appropriate, CCHA outreaches to the requesting providers to obtain additional information to make an authorization decision. CCHA should clarify within UM procedural documents how and when this outreach will take place.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
12. 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. *42 CFR 438.210(c)* Contract: Exhibit B-2—8.6.1 10 CCR 2505-10 8.209.4.A.1	Although CCHA accurately captured this requirement in the *NOABD Policy*, during on-site denial record reviews, HSAG identified one case in which no NOABD was sent to the member. (A second case in which no NOABD was sent was eliminated from the record review sample.)	CCHA must develop a mechanism to ensure that a written NOABD is sent to the member regarding any decision to deny a service authorization request or denial of payment.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
15. The notice of adverse benefit determination must be written in language easy to understand, available in prevalent non-English languages in the region, and available in alternative formats for persons with special needs. *42 CFR 438.404(a)* *42 CFR 438.10 (c)* Contract: Exhibit B-2—8.6.1–8.6.1.4 10 CCR 2505-10 8.209.4.A.1	While the *NOABD Policy* addressed the requirement to provide notices in non-English languages and alternative formats, eight of 10 denial record reviews included NOABD language that was not easy for a member to understand. Notices included complex clinical terms and, in some cases, a full list of clinical criteria, including acronyms that would not be easy to understand.	CCHA must ensure that the information explaining the reason for the denial in the NOABD is written in language that may be easily understood by Medicaid members with limited reading ability.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
18. 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)* Contract: Exhibit B-2—8.6.3.1, 8.6.5–8.6.8 10 CCR 2505-10 8.209.4.A.3	In one denial record review sample, CCHA did not mail a member notice. Notice was given to the provider, but not the member. Therefore, the case did not meet the requirement for "notice sent in required time frame."	CCHA must ensure that NOABDs are mailed to the member within applicable time frames.

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

Standard II—Access and Availability		
Requirement	**Findings**	**Required Action**
3. 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-2—9.4.7	CCHA's *Provider Network Adequacy and Access Standards Policy* described that the RAE works to establish a provider network that offers members a choice of at least two appropriate providers within their ZIP Code or within the maximum distance based on the county's classification. The policy further described that CCHA measures and monitors network access of time and distance standards according to the standards through quarterly reporting, to support identification of any gaps in the network. However, CCHA's *Quarterly Network Data and Time/Distance Results* report did not include calculations to demonstrate that its established PCMP network had a sufficient number of providers, offering each member a choice of at least two PCMPs within their ZIP Code or within the maximum time and distance for the urban or rural geographic classifications. Instead, each data field stated, "See narrative." The submitted *FY 2019–2020 Network Adequacy Quarterly Report* included a narrative describing CCHA's transition from reviewing PCMP distance standards in Tableau to a recent implementation of the QGIS software.	CCHA must implement mechanisms to conduct regular time and distance calculations to measure and monitor network access in accordance with State standards. In addition, calculations must demonstrate that the RAE's PCMP network has a sufficient number of providers so that each member has their choice of at least two PCMPs within their ZIP Code or within the maximum time and distance for the urban or rural geographic classifications.

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

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
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 B2—8.5.4, 8.7.4 10 CCR 2505-10 8.209.5.C, 8.209.4.E	Both the *Member Grievances Policy* and *Member Appeals Policy* described the circumstances related to individuals who make decisions on grievances and appeals. On-site appeal record reviews demonstrated that appropriate reviewers rendered decisions in all cases. However, during on-site grievance record reviews, HSAG found grievances that involved clinical quality of care complaints in which no CCHA clinician reviewed the case prior to resolution. Three of three applicable grievance records were *Not Met* for "appropriate level of expertise."	CCHA must develop a mechanism to ensure that grievances related to clinical care are reviewed and resolved by individuals with appropriate clinical expertise in treating in the member's condition.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
11. The Contractor sends the member written acknowledgement of each grievance within two (2) working days of receipt. *42 CFR 438.406(b)(1)* Contract: Exhibit B2—8.1 10 CCR 2505-10 8.209.5.B	The *Member Grievances Policy* accurately stated that an acknowledgement letter is sent to the member within two working days; however, HSAG found one of 10 record reviews did not meet the required timeline. Staff members stated that the grievance was received by CCHA's Anthem partner and was not routed timely to CCHA for processing.	CCHA must develop a mechanism to ensure that grievances received by any of its partner organizations are routed timely to CCHA.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
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) and (b)(1) and (d)(1)* Contract: Exhibit B2—8.5.5, 7.2.7.3, 7.2.7.5 10 CCR 2505-10 8.209.5.D	The *Member Grievances Policy* accurately stated that grievance resolution and notice would be provided within 15 working days. The *Member and Provider Materials and Website Policy* stated that grievance notices will be available in non-English languages and alternative formats and be written in easily understood language. The template language in the *Member Complaint Resolution Letter* was in compliance with requirements. However, HSAG found that one of 10 grievance records did not meet the required resolution time frame and that no extension letter was sent to the member (staff members stated that they did not understand that extensions required a written extension letter as well as verbal notification.) In addition, one of 10 records did not meet the requirement "easy to understand," as the resolution description included words such as "allegedly" and "substantiated," which would not be easily understood by members with limited reading ability.	CCHA must: • Develop a mechanism to ensure that the grievance resolution is written in language that may be understood by Medicaid members with limited reading ability. • Ensure that members receive a written extension letter for any grievance that requires more than 15 working days to resolve.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
13. The written notice of grievance resolution includes: • Results of the disposition/resolution process and the date it was completed. Contract: Exhibit B2—8.1 10 CCR 2505-10 8.209.5.G	The *Member Grievances Policy* did not address the required content of the grievance resolution letter. HSAG found one of 10 grievance record reviews in which the grievance resolution was not responsive to the member's grievance and, therefore, was *Not Met* for "resolution letter includes required content."	CCHA must develop a mechanism to ensure that the grievance resolution thoroughly addresses the member's complaint.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
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)* *42 CFR 438.10* Contract: Exhibit B2—8.7.14.1. 7.2.7.3, 7.2.7.5 10 CCR 2505-10 8.209.4.J.1	The *Member Appeals Policy* accurately described the required time frames for providing notice to the member and that the specific reason for the appeal decision be written in easily understandable language. However, HSAG found in appeal record reviews that one of eight cases did not meet the required resolution time frame (by over two months). Staff members stated that the case was "lost" in the referral process to the medical reviewer. In addition, three of eight cases were *Not Met* for "resolution letter easy to understand," as the resolution reason used terminology—"carved out FFS" or "MCG 22nd edition" with the BH diagnosis title—which would not be easy for the member to understand.	CCHA must implement mechanisms to ensure: • Each appeal determination and notice to the member is processed within the required time frame. • The reason for the appeal resolution avoids using industry or clinical terminology that may be difficult for a Medicaid member to understand.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
25. If the Contractor extends the time frames, it must—for any extension not requested by the member: • Make reasonable efforts to give the member prompt oral notice of the delay. • Within two (2) calendar days, give the member written notice of the reason for the delay and inform the member of the right to file a grievance if he or she disagrees with that decision. • Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. *42 CFR 438.408(c)(2)* Contract: Exhibit B2—8.5.7, 8.7.14.1, 8.7.14.2.1, 8.7.14.2.5-6	Both the *Member Appeals Policy* and the *Member Grievances Policy* accurately addressed member notification of extensions. HSAG observed no written notices of extension in either the grievance record reviews or appeals record reviews; however, HSAG found one grievance record in which CCHA extended the resolution and no written extension letter was sent to the member. In addition, the template appeal extension notice did not include the reason for the delay nor the member's right to file a grievance if he or she disagreed with the extension. The language in the template extension letter also stated that "we will send you a letter within two calendar days if we decide we need more time to review your appeal," which would seem to be a duplication of the extension letter and is, therefore, confusing.	CCHA must: • Develop an extension notice for grievances and appeals that includes the required content—i.e., reason for extension, right to file a grievance—and improves the clarity of the language in the letter. • Implement a process to ensure that members receive a written extension notice (in addition to verbal notice) when it extends the grievance resolution time frame.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
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 B2—8.7.14.3, 8.7.14.4 10 CCR 2505-10 8.209.4.M	The *Member Appeals Policy* addressed the content of the appeal resolution letter, which included some inadequacies or inaccuracies. These included: • Does not specify that the notice includes the date the resolution process was completed. • Specifies that the notice will include the member or provider's right to file an *appeal*. (The right to file an appeal should not be included in the appeal resolution letter, as the appeal is completed. It should specify the right to request an SFH and how to do so.) • Includes "no physician against whom the appeal has been brought will review the appeal." (An appeal is not brought against a provider.) • Includes the right to request and receive benefits while the SFH is pending and that the member may be held liable for continued benefits. However, it does not clarify that the right to continue benefits during the SFH is only applicable to an original denial of previously authorized services that have been suspended or reduced, and if the member had requested continued benefits during the appeal. During on-site record reviews, HSAG found 50 percent of the appeal resolution letters were	CCHA must: • Update the *Member Appeals Policy* to accurately address all elements of the required content of the appeal resolution letter, including clarification that the letter includes the right to continue benefits during an SFH only if the original denial was for termination, suspension, or reduction of previously authorized services and that the member had requested that benefits continue during the appeal. • Update the *Appeal Medical Necessity Uphold* letter template to ensure that information regarding the member's right to request benefits during an SFH is included only when applicable—i.e., the member had requested and received continued benefits during the appeal. • Update the *Appeal Medical Necessity Uphold* letter template to ensure that, when applicable, the letter informs the member that continued benefits during an SFH must be requested through CCHA.

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
	Not Met for "required content," as each letter informed the member that he or she may request continued benefits even though the member was not eligible for continued benefits during the SFH. Staff members stated that CCHA uses the Department-mandated template for appeal resolution letters which includes continuation of benefits information. The *Appeal Medical Necessity Uphold* letter template language stated, "If you want to continue benefits during the hearing, your request must be submitted within 10 days of the date on the letter" but did not inform the member how to do so (continued benefits must be requested through CCHA).	
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
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. • 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*	The *Member Appeals Policy* accurately addressed the criteria for requesting continued benefits during an appeal. However, the criteria specified that "the member seeking to have benefits continue pending the appeal *files timely* on or before 10 days…." When used in this context, "files timely" is a vague term. (The member must file for "continued benefits" within 10 days and may file for an appeal within 60 days of the NOABD.) The policy does not address continuation of benefits during an SFH. During on-site reviews, HSAG clarified that the criteria for requesting continued benefits during an SFH include the following modifications to the language specified in the federal requirement related to appeals, as follows: • Bullet #1—"files timely for continued benefits" is defined as on or before "within 10 days of the Contractor mailing the notice of *adverse appeal resolution*"; "The intended effective date of the proposed adverse benefit determination" *does not apply*. • Bullet #4—"The original period covered by the original authorization has not expired" *does not apply*. • Bullet #5—"The member requests an *SFH* in accordance with required time frames."	CCHA must update its *Member Appeals Policy* to: • Specify that the member must file for "continued benefits" within 10 days of the NOABD and may file the appeal within 60 days of the NOABD. • Address the criteria for requesting benefits during an SFH, which accurately modifies the language of the criteria as specified in *Findings.*

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
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 B2—8.7.13.1 10 CCR 2505-10 8.209.4.T	(120 days from the adverse appeal resolution notice.)	
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
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 B2—8.7.13.2 10 CCR 2505-10 8.209.4.U	The *Member Appeals Policy* stated the circumstances (as outlined in the requirement) regarding how long benefits will continue during an appeal or SFH; however, the policy also included "The time period or service limits of a previously authorized service has been met," which does not apply to how long benefits will continue during either an appeal and SFH. In addition, the second bullet in the requirement—i.e., "10 days pass after the adverse appeal resolution and the member does not request continued benefits during an SFH" applies to how long benefits will continue during an appeal, but not to during an SFH. (Once continued benefits have been requested during an SFH, the benefits will continue until the member withdraws the SFH or the SFH officer issues a hearing decision.)	CCHA must update its *Member Appeals Policy* to accurately address the criteria for how long benefits will continue during an appeal and during an SFH.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
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.	CCHA provided information regarding appeals and grievance procedures through the *BH Provider Manual* and *PH Provider Manual*. Many of the detailed grievance and appeal procedures were accurately described; however, the provider manuals included the following inadequacies or inaccuracies: • The *PH Provider Manual* failed to describe CCHA assistance available in the filing of grievances. • Both the *PH Provider Manual* and *BH Provider Manual* failed to describe CCHA assistance available in the filing of appeals. • The *BH Provider Manual*: – Inaccurately stated the time frames for providing an appeal acknowledgement letter—*three* working days rather than "two" working days. – Inaccurately specified the time frame for resolution of an appeal—within 10 *calendar* days rather than 10 "working" days. – Inaccurately stated that the criteria for the member to request continued benefits during either an appeal or SFH included filing the *appeal* within 10 calendar days of the NOABD—the member must request continued benefits within 10 days of	CCHA must update the appeals and grievance information in the *PH Provider Manual* and *BH Provider Manual* to address all required information and to address any inaccuracies or incomplete information in the description of appeal or grievance procedures, as detailed in *Findings*.

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
42 CFR 438.414 *42 CFR 438.10(g)(xi)* Contract: Exhibit B2—8.4 10 CCR 2505-10 8.209.3.B	the NOABD; the member must file the appeal within 60 days of the NOABD. In addition, the criteria for requesting continued benefits during an SFH included: must file the SFH within 10 days of the NOABD. The member must request continued benefits within 10 days of receiving the *adverse appeal resolution* and may request an SFH within 120 days of the appeal resolution. – The description of how long benefits will continue during an appeal or SFH included the same inaccuracies outlined in the findings of Requirement #30. – The information related to outcomes of the SFH when continued benefits are requested stated "if HCPF reverses our decision…." or "if HCPF upholds our decision….". Whereas these circumstances also apply to the outcomes of an appeal, the information should also address "if CCHA reverses our decision…." or "if CCHA upholds our decision….".	
Planned Interventions:		

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

Appendix E. Compliance Monitoring Review Protocol Activities

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

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal managed care regulations and contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, on-site agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all site reviewers to ensure consistency in scoring across plans.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided group technical assistance and training, as needed. • Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the RAE in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the three standards and on-site activities. Thirty days prior to the review, the RAE provided documentation for the desk review, as requested. • Documents submitted for the desk review and on-site review consisted of the completed desk review form, the compliance monitoring tool with the RAE's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The RAEs also submitted lists of denials of authorization of services (denials), grievances, and appeals that occurred between January 1, 2019, and December 31, 2019 (to the extent available at the time of the site visit). HSAG used a random sampling technique to select records for review during the site visit. • The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct Site Visit**
	• During the on-site portion of the review, HSAG met with the RAE's key staff members to obtain a complete picture of the RAE's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the RAE's performance. • HSAG reviewed a sample of administrative records to evaluate denials, grievances, and appeals. • While on-site, HSAG collected and reviewed additional documents as needed. • At the close of the on-site portion of the site review, HSAG met with RAE staff and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2019–2020 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. • HSAG analyzed the findings. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the Department**
	• HSAG populated the report template. • HSAG submitted the draft site review report to the RAE and the Department for review and comment. • HSAG incorporated the RAE's and Department's comments, as applicable, and finalized the report. • HSAG distributed the final report to the RAE and the Department.

Appendix F. Focus Topic Discussion

Overview of FY 2019–2020 Focus Topic Discussion

For the FY 2019–2020 site review process, the Department requested that HSAG conduct open-ended on-site interviews with RAE staff members to gather information on each RAE's experience regarding *Region-specific Initiatives Related to the Health Neighborhood.* Focus topic interviews were designed to obtain a better understanding of the infrastructure and strategies the RAEs have implemented/are implementing to actively build, support, and monitor Health Neighborhood providers, particularly those serving members with complex health needs ("impactable populations"). HSAG collaborated with the Department to develop an interview guide to facilitate discussions and gather similar information from each RAE. Information gathered during the interviews will be analyzed in the FY 2019–2020 RAE Aggregate Report to determine and document statewide trends related to RAE region-specific activities to integrate with and build Health Neighborhoods. This section of the report contains a summary of the focus topic discussion for **CCHA R6**.

Infrastructure and Strategies

CCHA's definition of "Health Neighborhood partners" incorporates both providers and community agencies and organizations. **CCHA** differentiates the type of partner organizations according to those providers and organizations that bill for Medicaid services and those who do not—such as schools. Regardless of how categorized, each Health Neighborhood initiative engages a combination of providers and community organizations based on the objectives of the individual initiative. As the previous Regional Care Collaborative Organization (RCCO) in Region 6, **CCHA** had pre-established relationships with many providers and other organizations in the region and had established trusted relationships with many stakeholders. In addition, stakeholders were familiar with the Medicaid program and **CCHA** at the inception of the RAE, streamlining efforts to engage in activities with Health Neighborhood partners. Region 6 has a large number of provider resources, including large health systems and hospitals, two single entry points (SEPs), two community centered boards (CCBs), three community mental health centers (CMHCs), three Federally Qualified Health Centers (FQHCs), 138 PCMP locations, and 2,930 BH providers (statewide). **CCHA** also had a pre-established infrastructure of care coordinators, community liaison staff members, and provider network practice transformation coaches aligned and working with providers and a variety of community organizations. Some of **CCHA**'s community liaisons have defined areas of expertise—e.g., criminal justice. Care coordinators are co-located in or have established a single point of contact with numerous PCMP offices, as well as some hospitals, to enable engaging with members at the point of service. **CCHA** employs BH professionals, registered nurses (RNs), and social workers as care coordinators and aligns care coordinators with specific special program focus areas based on their levels of expertise. In addition, 30 percent of members in Region 6 are attributed to Accountable Care Network (ACN) providers who provide care coordination for their members. Practice transformation coaches are assigned to all practices with more than 300 attributed RAE members. As such, **CCHA**'s individual staff members

throughout the network have been instrumental in establishing relationships with Health Neighborhood organizations. In addition, **CCHA**'s ownership structure—Centura Health (Centura), Anthem, Physician Health Partners, and Primacy Physician Partners—has also been a conduit to facilitate access to Health Neighborhood partners and initiatives, as evidenced in examples of Health Neighborhood activities described below.

CCHA's internal strategies for pursuing Health Neighborhood initiatives is largely data-driven, incorporating both RAE data and Department data to identify impactable populations and to address key performance indicators (KPIs) and other performance measures. **CCHA** demonstrated its use of a data dashboard that is used internally, as well as shared with PCMPs and BH providers. **CCHA** uses a value-based performance pool for providers—withheld from primary care provider per member per month (PMPM) payments—and the entirety of the RAE's KPI dollars to stimulate and fund Health Neighborhood objectives. While 75 percent of KPI awards are distributed to PCMPs, the remaining 25 percent of KPI dollars are being directed to community partners to fund innovative programs that address high-priority community health and member needs. This community incentive fund is controlled through **CCHA**'s regional Performance Improvement Advisory Committee (PIAC), ensuring that awards are determined by **CCHA**'s community stakeholders. Organizations seeking support funds submit applications to the PIAC, which then uses county health needs assessments and other data to identify access needs and barriers in local communities, considers alignment of applications with the RAE's goals, and determines the awards. Staff members reported that, in the past year, Region 6 processed 22 applications resulting in five awards. **CCHA** allocated over two million dollars in community incentive program (CIP) funds to projects in Region 6 and Region 7 combined. Staff members described that **CCHA**'s strategy to identify targeted Health Neighborhood priorities has continuously evolved since the inception of the RAE in response to changing expectations of the Department, as follows:

- July to December 2018—**CCHA** identified community priorities that aligned with the ACC goals by leveraging community health needs assessments, State PIAC priorities, and hospital environmental scans.
- January through March 2019—Conducted widespread outreach based on population health priorities; integrated potentially avoidable costs (PACs) introduced by the Department.
- April through December 2019—Aligned Health Neighborhood efforts with KPIs and BH incentives, aligned CIP applications with KPI and BH incentive priorities, and pivoted strategy from population health to focused interventions for high-cost members.
- January through June 2020—The Department charged RAE to develop programing for condition management; focused outreach to members identified as high risk for COVID-19.
- June 2020 through December 2020—Continue focus on high cost members, PAC, and condition management; will align performance pool metrics and CIP applications with new focus areas.

Throughout its process of working collaboratively with Health Neighborhood partners, **CCHA** has been a participant in both pre-established Health Neighborhood alliances as well as collaboratives focused more specifically on RAE priorities. Partnership activities range from collaboratives with a large number of multifaceted organizations to smaller or single organization partnerships focused on shared targeted

objectives addressing specific populations. The RAE's role in most Health Neighborhood initiatives is primarily: providing care coordination for individual complex or high-cost members, aligning diverse stakeholders with the goals of the ACC, providing Medicaid data to identify and track individual members and targeted objectives, improving access to BH services for Medicaid members, and funding of select community programs.

Examples of established community partnerships in which Region 6 participates:

- Jefferson County Health Alliance—public health, human services, education, hospitals, behavioral health, and **CCHA** collaboration.
- Metro Denver Partnership for Health—public health, hospitals, and **CCHA** collaboration.
- Boulder County Health Improvement Collaborative (BCHIC)—Collaboration with specialist and primary care doctors to improve access to specialty care for members in Boulder and Broomfield counties.
- Collaborative Management Program—Interagency Oversight Groups addressing services for high-risk youth.

Examples of RAE-focused initiatives include:

- Evergreen Christian Outreach (EChO)—Provides services to members in Clear Creek County, including vehicle repair and food assistance. Funded through a CIP grant.
- Jefferson County Public Health Healthy Communities Collaboration—Partnership includes a shared care coordination workflow among **CCHA**, Healthy Communities, HCP, and Nurse Family Partnership addressing services to improve the health of pregnant women and children.
- Developmental Disability (DD) Resource Center (CCB)—Data sharing and shared care coordination for individual DD members with complex needs.
- Imagine! (CCB)—Data sharing and shared care coordination for individual members with complex needs.
- Adult Care Management Inc. (SEP)—Data sharing and shared care coordination for individual members with complex needs.
- Options for Long-Term Care (SEP)—Data sharing and shared care coordination for individual members with complex needs.
- Heart Centered Counseling—BH telehealth services.
- Project Angel Heart—Serves medically tailored meals to members leaving hospitals or who are diagnosed with a chronic condition.
- No Smile Left Behind—Mobile dental clinic.
- Creative Treatment Options—Substance use disorder (SUD) provider.

In all cases, staff members stated that identifying shared goals among collaborative partners is essential in achieving successful outcomes and drives the priorities and activities of individual participants. For example, **CCHA** noted that improving access to BH services was identified in community health needs

assessments as a high-priority need throughout the region. As such, **CCHA**'s expansion of the independent provider network in the region was of great interest to large community collaboratives. Within smaller, more focused Health Neighborhood collaboratives, increasing individual member access to needed services through shared care coordination efforts has been a primary focus. More specific examples are outlined in subsequent sections of this report.

Improving Access to Specialist Providers

Since the RAE does not contract with medical specialists and the Department has the claims data regarding utilization of specialist services, the RAE has used a variety of mechanisms to gain understanding of specialist access needs in the region. **CCHA** has used Department specialist claims data to identify overall trends in specialist service utilization; however, Department data are not categorized to allow drill-down to individual specialist providers. Therefore, **CCHA** has used input from its PCMP network, specialty referral requests received by **CCHA**'s call center, and care coordinator input to identify high-demand/short-supply specialist types in the region—i.e., neurology, endocrinology, pain management, psychiatry, and optometry. Over several years, the member call center staff members have developed a robust list of specialty care providers available to Medicaid members. These lists were derived from extensive cold-calling research to obtain referral information from PCMPs, Centura, and feedback from members. For each specialty provider on the list, **CCHA** has outreached to the specialist office to determine Medicaid panel requirements, types of referrals accepted (e.g., hips, knees, etc.), and other information that will assist **CCHA** in properly triaging members to specific specialists. The call center receives calls from members and from providers seeking access to a specialist. The call center will make simple specialist referrals for members or, for members with more complex needs, will refer the member to a care coordinator to complete a more thorough assessment of the member's needs. When receiving calls from providers, call center staff members will explore whether the needed referral is for a one-time consultation or ongoing specialty care of the member. The call center staff members also follow up with specialist offices to whom they made a referral, as well as the individual members, to obtain feedback on the appropriateness of the referral and the member's experience.

To promote care compacts between PCMPs and specialists, **CCHA** has used its practice transformation coaches associated with each practice to outreach particular specialist offices used frequently by the PCMP, introduce the concept of the care compact, and facilitate a conversation between the PCMP and specialty office managers. While the care compact serves only as a piece of paper, the direct conversations between offices tend to solidify the relationship and commitments that can then be implemented by these providers. **CCHA** reported a significant increase in the provider care compact KPI using this approach. Staff members also stated that some PCMPs are more open to executing care compacts than others. In order to reduce no-shows to specialist appointments, call center staff members who make referrals emphasize the importance of maintaining specialist appointments and refer members to **CCHA** care coordinators if additional member assistance is needed. Similarly, **CCHA** has outreached individual practitioners and has placed messaging on its specialist provider webpage to encourage specialists to refer RAE members to **CCHA** care coordination. Care coordinators arrange transportation,

educate members for an upcoming specialist visit, and accompany members to specialist appointments as needed.

Additional examples of initiatives related to improving access to specialists included:

- BCHIC—A pre-existing collaboration among primary care physicians and specialists in Boulder and Broomfield which the RAE joined two years ago. The goals include improving access to specialists, increasing Medicaid access to specialists, and improving appropriate utilization of specialists. BCHIC is a recipient of RAE CIP funds.
- **CCHA** facilitated a relationship between Columbine Family Practice (CFP) and Heart Centered Counseling to deliver real-time BH telehealth consultation and appointments for patients of CFP.
- Front Range Health Partners (FRHP)—a collaboration among Jefferson County Mental Health (JCMH) and Mental Health Partners (MHP) and other CMHCs to deliver integrated health services to special BH populations, including corrections system-involved members and SUD patients. The goals are to deliver consistent messaging to members and the community regarding services available, eliminate duplication of services, and facilitate efficient access to services. **CCHA** has assigned a subject matter expert UM representative as a single point of contact for this initiative.
- Creative Treatment Option (SUD provider with a clinic in Boulder) is working with the RAE to identify and improve gaps in SUD services for Department of Corrections (DOC) members. **CCHA** meets with Creative Treatment Solutions to coordinate referrals for DOC members with SUD and BH needs.

CCHA identified that challenges and barriers related to improving access to physical health specialty services in the region include:

- Lacking access to claims data that allows for identification of referral patterns to specific medical specialists.
- Difficulty in connecting with medical specialists not contracted with the RAE.
- RAE incentives do not align with specialists and do not benefit specialists, resulting in limited motivation for specialists to cooperate with the RAE or increase access to Medicaid members.

Collaborative Initiatives With Hospitals

CCHA reported that the status of the Hospital Transformation Programs (HTP) in the region varies by hospital system. Region 6 has nine large hospitals in the region, three aligned with Centura, three aligned with UCHealth, two aligned with SCL Health, and Boulder Community Health (BCH). The larger hospital systems are working collaboratively among their hospitals statewide to identify a consistent set of measures. In addition, different hospital systems have been convening together, facilitated by the Colorado Health Institute (CHI). Most hospital systems are still in the process of defining their measures and to date have engaged with **CCHA** as needed in HTP activities. **CCHA** and BCH do not engage in regular HTP meetings, although **CCHA** provides data or reviews HTP deliverables as requested by BCH. Staff members reported that **CCHA** has maintained consistent

collaboration with St. Anthony Hospital (SAH) as SAH leadership and staff changes have occurred. **CCHA** care coordination leadership has outlined RAE goals with SAH's new leadership in anticipation of helping SAH operationalize the HTP measures that it chooses. In addition, **CCHA** has executed two letters of support for UCHealth indicating that UCHealth's statewide measures specifically provide opportunities for implementing a collaborative discharge planning process for those members with a mental health diagnosis or substance use disorder. Staff members stated that **CCHA** approaches all HTP initiatives with the intent to identify what resources the RAE can provide to help—e.g., care coordination—and to identify any HTP measures that might align with RAE measures and goals. At the time of on-site review, all HTP activities had been temporarily suspended due to COVID-19.

Although it is premature for the RAE to be engaged in HTP measure alignment or specific initiatives with most hospitals, **CCHA** reported that its engagement with hospitals has increased significantly over the past two years. Collaboration with individual hospitals has been focused on care coordination of RAE members either being transitioned from the hospital or members with complex needs. Examples include:

- BCH—**CCHA** BH and RN care coordinators are co-located at BCH four days per week, receive referrals from inpatient care (including BH inpatients) and the emergency department (ED), and work with BCH case managers and outpatient clinics to implement transition of care (TOC) protocols for **CCHA** members. **CCHA** participates with BCH in weekly complex care rounds. **CCHA** facilitates quick referrals to outpatient clinics and community resources, and assists members with medications, transportation, and other post-discharge needs.
- SAH (Centura)—BH and RN care coordinators were previously co-located at SAH through the RCCO, and two years ago **CCHA** co-located a non-clinical care coordinator in the ED. Care coordinators participate in daily complex care rounds with the SAH care management team and receive referrals from inpatient care managers to coordinate post-discharge services for members with complex care needs. **CCHA** reported that it has received anecdotal feedback confirming that **CCHA** and SAH have been building a continuously stronger relationship; **CCHA** will begin sharing data to allow length of stay comparison between **CCHA** and other payors' members to determine the impact of co-located care coordination.
- Lutheran Medical Center (SCL Health)—**CCHA** has co-located both BH and RN care coordinators to facilitate TOC for **CCHA** members and has assigned a specialized, co-located care coordinator for the maternity program. All care coordinators participate multiple times per week in discussions with hospital and ED care managers and facilitate post-discharge services for transitioning members back into the community.
- Adventist Hospital (Centura)—**CCHA** has no co-location of care coordinators, although it receives referrals and follows up with members on **CCHA**'s high-cost list, including referrals from the newborn intensive care unit. **CCHA** has met with hospital leadership to determine what the RAE can do to support maternity members with SUD and community resource needs.
- Within the three UCHealth hospitals in the region, **CCHA** has no co-located care coordinators but has established a single point of contact (SPOC) for referrals from Longs Peak Hospital and Broomfield Hospital. The SPOC attends weekly on-site complex care rounds and visits members while on-site. **CCHA** is working to expand this relationship to the Anschutz Medical Campus.

- Longmont United Hospital (Centura)—**CCHA** has no co-located care coordinator, but the BH care coordinators attend weekly complex care rounds and receive daily census and admit, discharge, transfer (ADT) data feeds of members to begin preparing TOC protocols.
- BH Inpatient Hospitals: Centennial Peaks, Highlands Behavioral Health System (Highlands), and Medical Center of Aurora—**CCHA** has worked with each of the three inpatient BH facilities to implement a TOC program tailored to the individual needs of each facility. Highlands has no co-located **CCHA** care coordinator, but Highlands staff members admit **CCHA**'s BH care coordinator to its units to make connections with **CCHA** members during hospitalization. At Medical Center of Aurora, BH care coordinators have a phone connection with care managers at the facility to determine individual needs of members and follow up with members and the member's PCMP post-discharge. Centennial Peaks treats the highest volume of **CCHA** members and is, therefore, the RAE's priority. A **CCHA** BH coordinator is co-located two days per week to open TOC cases and arrange for post-discharge appointments. JCMH and MHP take the lead to connect members with the CMHCs post-discharge. Peer support specialists are also co-located to advocate for members; **CCHA** reported that the peer support strategy has been very effective. **CCHA** and Centennial Peaks have developed care coordination workflows and meet monthly to review barriers to care.

CCHA also participates with hospitals in multi-organizational collaborative alliances. The Jefferson County Health Alliance, which includes Centura and Lutheran Medical Center, collectively examine and address the healthcare needs within Jefferson County. The Metro Denver Partnership for Health, including cross-regional hospitals and public health directors, examines high-level community health needs metro-wide.

Other Health Neighborhood Initiatives

For purposes of stratifying the RAE population to identify members who most need the care coordination services of the RAE, **CCHA** stratifies members into four quadrants, which look at whole person needs, considering high-cost members, chronic conditions, and other complex needs. Rather than putting members into buckets—e.g., high-cost, chronic condition management—as defined by the Department, **CCHA** uses multiple data feeds and considers additional elements such as members' involvement in multiple systems, members with both high physical health and high BH needs, and members with frequent ED visits to identify members who are most "impactable" and to prioritize members for care coordination. **CCHA** has developed a stratification data dashboard, which incorporates data from multiple sources—i.e., the Department's utilization and high-cost data, members on foster care waivers or SEP waivers, ADT data from hospitals, DOC data, CCB lists, Accountable Care Organization data—and enables data analysis to select members for care coordination who appear in multiple sectors in the dashboard. Once engaged, members are assigned to care coordination within specialty-defined program areas—e.g. maternity, BH, DOC—and then are interviewed to assess the member's comprehensive needs. **CCHA** stated that most high-cost members are already engaged in services, which makes these members easier to locate and to work collaboratively with partner organizations to either develop programs or individual shared care coordination plans. **CCHA** shares its data with its collaborative partner teams to present the whole-person picture of resources being accessed

and resources needed by members. **CCHA** provided several examples of Health Neighborhood initiatives in which **CCHA** has provided resources to fill gaps in services for members:

- As part of its maternity care coordination program, **CCHA** outreached to Jefferson County **Healthy Communities, HCP, and Nurse Family Partnership** to improve prenatal and postpartum maternity care; provide services to children at risk for physical, behavioral, or emotional conditions and other special needs; and to avoid duplication of care coordination services among the organizations. The initiative identified a workflow, whereby the strengths and contributions of each organization were recognized and resulted in referral of members among the care coordinators of each organization based on the member's identified needs. **CCHA**'s role in the partnership is to coordinate BH services (including SUD) and social support system needs for individuals, as applicable.
- **CCHA** formulated an alliance with the **SEPs and CCBs** in the region to address high-cost members, many of whom are on home- and community-based waivers and are receiving numerous supports in the Health Neighborhood. The goals of the initiative are to strengthen alignment of goals between the RAE, SEPs, and CCBs; reduce avoidable services; and enhance care coordination for members receiving long-term services and supports (LTSS). The initiative includes performance measurements based on collectively defined goals and tied to **CCHA** incentive payments.
- Clear Creek and Gilpin Counties have limited healthcare resources and also have limited existing funding for **transportation** services for members. **CCHA** has partnered with EChO and extended CIP funds to support an innovative pilot program to provide vehicle repairs for Medicaid members in these counties.
- **CCHA** has recently partnered with FRHP to develop a more innovative approach to **BH telehealth services** for efficient access to a psychiatric prescriber. The intent is to have co-located care coordinators who identify a member's need for psychiatric services to refer members directly to JCMH. JCMH will assign a prescriber for a telehealth appointment within 24 hours, thereby bridging the appointment gap for medication services. **CCHA** care coordinators will simultaneously address the member's SDOH needs. **CCHA** has stimulated this telehealth initiative with CIP funds.

What the Department Can Do

Due to the lack of information from the Department's UM program regarding access to physical health specialists and utilization of specific specialists, it is difficult for RAEs to identify or execute opportunities to improve access to physical health specialists. In addition, establishing relations with specialists working in large hospital systems can be cumbersome and primary care groups associated with hospital systems have priority access to the hospitals' aligned specialists. To that end, **CCHA** suggested the following:

- The Department might facilitate meetings between the Department's UM vendor and the RAEs to collaborate on identifying specialist utilization patterns, opportunities for the Department to contract with select specialists, and what the RAEs can do to support relationships with medical specialists.
- The Department might consider developing a "preferred" Medicaid specialist provider network. By doing so, the RAEs could better target initiatives to engage with specialists.

- The Department should execute its goal of leveraging relationships with large hospital systems, enabling the RAEs to better partner with hospitals to improve access to specialty care.
- The Department should revitalize its eConsult program to target the higher need medical specialty areas.

CCHA also identified general recommendations for the Department that would facilitate the RAE's collaborative Health Neighborhood efforts.

- The Department should work at the State level to align cross-agency goals, initiatives, measures and incentives among the RAEs, DHS, SEPs, CCBs, and DOC.
- Continuously shifting Department priorities complicate the processes and relationships required to work with Health Neighborhood entities and partnerships. **CCHA** recommends that the Department's priorities remain consistent over time.
- The Department should consider mechanisms to enhance or approve data sharing among Health Neighborhood entities.
- **CCHA** suggested that the Department consider using the RAE Learning Collaborative forum to encourage RAEs to share information on Health Neighborhood initiatives and thereby identify any transferability of initiatives across regions.