COLORADO

Department of Health Care Policy & Financing

Fiscal Year 2019–2020 Site Review Report

for

Colorado Community Health Alliance

Region 7

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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 (BH) 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 7** (**CCHA R7**). 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 R7** 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	26	4	0	4	87%
II. Access and Availability	16	16	15	0	1	0	94%
VI. Grievances and Appeals	35	35	26	9	0	0	74%
Totals	**85**	**81**	**67**	**13**	**1**	**4**	**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 standards in the compliance monitoring tool.

Table 1-2 presents the scores for **CCHA R7** 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	55	6	29	90%
Grievances	60	53	44	9	7	83%
Appeals	60	58	45	13	2	78%
Totals	**210**	**172**	**144**	**28**	**38**	**84%**

*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 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

HSAG noted during the denial record review that several authorization requests were sent after services were rendered. HSAG recommends strengthening providers' understanding of submitting timely authorization requests.

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.

CCHA's *Notice of Adverse Benefit Determination Policy* accurately described extensions for standard authorization decisions and staff members did describe a template to request additional information from providers. However, this process is described as occurring in a 24-hour window, and if a response is not received within that time frame, **CCHA** proceeds with denying the request. **CCHA** did not have an authorization extension template letter and during discussions staff members indicated that extensions are "never" utilized. Staff members described authorization extensions as a process that needed to be requested by a provider or member. These discussions demonstrated inconsistencies between the written policies and actual procedures regarding authorization decision extensions. HSAG recommends that **CCHA** develop procedures for staff to implement the process outlined in its written policy to utilize

extensions in the authorization decision timeframe when appropriate—i.e., to obtain additional information needed to make the authorization decision.

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 medical necessity, based on limited details on the standardized authorization form; however, no outreach to the provider was documented. Furthermore, record reviews demonstrated inconsistency in applying the peer-to-peer procedure. **CCHA** must ensure that, when appropriate, **CCHA** outreaches to the requesting provider to obtain additional information to make an authorization decision. **CCHA** should clarify within UM procedural documents how and when this outreach will take place.

In three of the 10 denial record reviews, **CCHA** did not mail the notices within applicable time frames. **CCHA** must ensure that NOABDs are mailed to the member within applicable time frames.

In two of the 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 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 their 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 a relationship with a member that identifies as transgender. The RAE assigned a care coordinator to accompany the member to physical and BH appointments. The **CCHA** care coordinator helped the member advocate for specific needs and requests, ensuring that services were delivered in a manner that is most suitable for him. The RAE reported that this collaborative approach has empowered the member to now communicate and advocate on his own behalf. In addition, this member is currently an active participant on **CCHA**'s Member Advisory Committee

and using this platform to advocate for others. In working with the member directly, the RAE felt it could offer an internal training to improve the staff members' knowledgebase about the transgender community and how to better advocate for this population.

- **CCHA** described that it is engaged with 10 to 12 members in its geographic service area that are hearing disabled and use American Sign Language (ASL) to communicate at appointments. Due to the volume of calls for assistance with scheduling appointments, the RAE developed a workflow to ensure that members have access to ASL services at their appointments. The workflow is made available to all member support services and care coordinators. **CCHA** conducts follow up calls to all members after their visits to verify that everything went as planned. These calls give the RAE and member an opportunity to address issues or eliminate barriers prior to the member's next appointment.

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 (2) 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 78 percent compliance with appeal record review requirements and an overall 83 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 some 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* outlines 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** clarify 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.

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 two 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 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 three 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.

HSAG found in appeal record reviews that four of 10 cases did not meet the required resolution time frame—some by a significant amount. In addition, five of 10 cases were *Not Met* for "resolution letter easy to understand," three of which included terminology—e.g., "MCG 22nd edition ORG-B901-IP" or BH diagnosis clinical information—in the explanation of resolution reason. Such terminology 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 clearly explains the reason for the appeal resolution decision, avoiding use of 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 40 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 or 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 Manual* 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 R7** 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 R7** 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 R7** 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 R7 submitted a proposed CAP in July 2019. HSAG and the Department reviewed and approved the proposed plan and responded to **CCHA R7**. **CCHA R7** submitted initial documents as evidence of completion in November 2019. HSAG and the Department reviewed and approved **CCHA R7**'s documents submitted as evidence of completion and responded to **CCHA R7** in December 2019.

Summary of Continued Required Actions

CCHA R7 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 7)

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 7:** ☒ 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 7:** ☒ 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 7:** ☒ 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 7:** ☐ 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 criteria within 10 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 7:** ☒ 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 7:** ☒ 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 7:** ☐ 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 record review sample was denied due to medical necessity, based on limited details on the standardized authorization form; however, no outreach to the provider was documented.		

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 provider 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 7:** ☒ 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 7:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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 7:** ☒ 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)* Contract: Exhibit B-2—8.6.6.1, 8.6.8.1	**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* The following document outlines when CCHA can extend the timeline for authorization decisions. • *I.CAS.9_Member Appeals Policy, p. 6*	**Region 7:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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 7:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: While the *NOABD Policy* addressed the requirement to provide notices in non-English languages and alternative formats, two of the 10 denial record reviews included NOABD language that was not easy for a member to understand. These letters included complex clinical terms and, in some cases, a full list of clinical criteria, including acronyms that would not be easy to understand.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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. • 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.	**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 7:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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 7:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: While the *NOABD Policy* accurately described the requirement to mail notices within the appropriate time frames, HSAG observed that in three of the 10 denial record reviews notices were not mailed to the member within the applicable time frames.		
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 7:** ☒ 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 7:** ☒ 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 7:** ☒ 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 7:** ☒ 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 7:** ☒ 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 7:** ☒ 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 7:** ☒ 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 7:** ☒ 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 7:** ☒ 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 7:** ☒ 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 7:** ☒ 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 7:** ☒ 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 7:** ☒ 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 plan physician is not available for consultation. In this situation,	**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 7:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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 7:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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 7:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	26	X	1.00	=	26
	Partially Met	=	4	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	4	X	NA	=	NA
Total Applicable		=	30	**Total Score**		=	26
Total Score ÷ Total Applicable						=	87%

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 7:** ☒ 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* **R7-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_R7NetworkRptQ1FY19-20, p. 7-9* The following document outlines of one of CCHA's ACN providers, Developmental Disability Health Clinic, capability to provide accessible care to members with physical or developmental disabilities. • *II.AA.1_DDHC, entire document*	
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.	**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*	**Region 7:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• 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. • 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 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* 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*	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	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* 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*	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• *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* 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.	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• *II.AA.2_CCHA 2019 Telemedicine Top Billers, entire document* **R7-specific:** The following reports are used by CCHA to assess enrollment trends, including the overall population, female members, members with disabilities, and other special populations. A sample report is provided below. • *II.AA.2_Region 7 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* **R7-specific:** The FY20 Network Adequacy Plan shows results of how CCHA's provider network is assessed for time and distance standards. • *II.AA.3_R7NetworkAdequacyPlnFY19-20, p. 19-20*	**Region 7:** ☐ Met ☐ Partially Met ☒ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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 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 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	**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* **R7-specific:** The following documents (Excel and PDF documents of the same name) are the Region 7 Network Report Submissions for October-December 2019, and contain CCHA's most recent behavioral health network adequacy monitoring. • *II.AA.4_R7NetworkRptQ2FY19-20 (pdf), p. 4-1- 4-4* • *II.AA.4_R7NetworkRptQ2FY19-20 (excel), tabs for time and distance urban and rural summary*	**Region 7:** ☒ 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 • SUD providers for both adults and children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes *Note: If there are no BH providers that meet the BH provider standards within the defined area for a specific member, then the Contractor shall not be bound by the time and distance requirements. (Exhibit 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*	**Region 7:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following assessments are used by CCHA care coordinators to identify member needs, and include questions regarding women's health care including pregnancy. • *II.AA.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*	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• *II.AA.5_CCHA WH Social Media Posts, entire document* • *II.AA.5_Maternity Brochure and Appointment Reminders, entire document* 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* **R7-specific:** Rocky Mountain Rural Health (RMRH) has an MOU with St Joseph's mobile mammography unit to visit Fairplay twice per year. Reminders are sent out with a schedule of services and walk-ins are accommodated when time allows. RMRH hosts an annual breast health awareness event at the local high school to promote annual screenings and literature on breast health. • *II.AA.5_RMRH Mobile Mammography Flyer, 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 7:** ☒ 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 7:** ☒ 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 7:** ☒ 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 7:** ☒ 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* **R7-specific:** The FY20 Network Adequacy Plan shows results of providers in CCHA's network who offer family planning services. • *II.AA.3_R7NetworkAdequacyPlnFY19-20, p. 14-16*	
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 7:** ☒ 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 7:** ☒ 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 7:** ☒ 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. • *II.AA.10_Third Next Available Appointment Data Collection Procedure, entire document*	**Region 7:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• *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. • *II.AA.13_Staff Desktop Guide_Triaging Access Complaint, entire document*	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following document outlines CCHA's procedure for monitoring BH appointment availability standards, including corrective action for noncompliant providers. • *II.AA.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**
	R7-specific: CCHA uses the Quarterly Network Report as a mechanism to monitor the provider network. A sample report is provided below. • *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. • Providing language assistance services for all Contractor interactions with 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* The following training materials have been made available to network providers to support providers in caring for diverse populations.	**Region 7:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.206(c)(2) Contract: Exhibit B-2—7.2.1–7.2.6	• *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* 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*	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	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 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*	**Region 7:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	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	**R7-specific:** 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*	**Region 7:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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 7:** ☒ 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 7:** ☒ 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 7:** ☒ 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 7:** ☒ 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 7:** ☒ 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*	
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.	**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*	**Region 7:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.406(a) Contract: Exhibit B2—8.3 10 CCR 2505-10 8.209.4.C	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*	
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 7:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
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, HSAG found during on-site grievance record reviews that involved clinical quality of care complaints that 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 involving clinical care are reviewed and resolved by individuals with appropriate clinical expertise in treating in the member's condition.		

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor ensures that the individuals who make decisions on grievances and appeals: • Take into account all comments, documents, records, and other information submitted by the member or the member's representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. *42 CFR 438.406(b)(2)* Contract: Exhibit 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 7:** ☒ 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 7:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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 7:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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 7:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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.	**Region 7:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• *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*	

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 records did not meet the required resolution time frame because no extension letter was sent to the member. In addition, three of 10 records did not meet the requirement "easy to understand," as the resolution description included words such as "substantiated," which would not be easily understood by members with limited reading ability.

Required Actions:
CCHA must:

- Develop and 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.

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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, which includes the results of the grievance disposition and the date it was completed. • *VI.GA.12_Member Complaint Resolution Letter SP*	**Region 7:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The *Member Grievances Policy* did not address the required content of the grievance resolution letter. HSAG found two 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." One case involved a Health Insurance Portability and Accountability Act (HIPAA) complaint about a contracted provider that was inappropriately referred to the Medicaid Ombudsman for resolution. One case just told the member that CCHA could not substantiate his or her concern.		
Required Actions: CCHA must develop a mechanism to ensure that the grievance resolution thoroughly addresses the member's complaint.		

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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 7:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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 7:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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 7:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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*	**Region 7:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	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* 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.	**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 7:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• 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		
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 7:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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 7:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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 7:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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 7:** ☐ 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 four of 10 cases did not meet the required resolution time frame—some by a significant amount. None of these cases were eligible for extension, they were just not processed efficiently. In addition, five of 10 cases were *Not Met* for "resolution letter easy to understand," three of which included terminology—e.g., "MCG 22nd edition ORG-B901-IP" or BH diagnosis terminology—in the explanation of resolution reason. Such terminology 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 clearly explains the reason for the appeal resolution decision, eliminating the use of industry or clinical terminology that may be difficult for a Medicaid member to understand.		

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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 7:** ☒ 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* 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*	**Region 7:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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 7:** ☐ 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 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 or 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.

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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* 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*	**Region 7:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**

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 40 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, 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	**Evidence as Submitted by the Health Plan**	**Score**
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 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*	**Region 7:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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 7:** ☒ 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. • 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.*	**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* 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.	**Region 7:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
(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	• *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 stated 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 did 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." (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 and may file for an appeal within 60 days of the NOABD.
- Address the criteria for requesting benefits during an SFH, which includes accurate modifications to the language of the criteria as specified in *Findings.*

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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 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*	**Region 7:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The *Member Appeals Policy* stated these circumstances related to 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 is inaccurate for how long benefits will continue during both 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		

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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 7:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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 7:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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 7:** ☒ 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. – 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	**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* **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*	**Region 7:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	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*	
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.	**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/*	**Region 7:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– 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	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. • *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 provides 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 grievance filing process.
- Both the *PH Provider Manual* and *BH Provider Manual* failed to describe CCHA assistance available in the appeal filing process.
- 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—within 10 *calendar* days rather than 10 "working" days.

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– 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….". 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 defined in *Findings.*		

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

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Denials Record Review Tool
for Colorado Community Health Alliance (Region 7)

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

Requirements	File 1	File 2	File 3	File 4	File 5
Member ID	****	****	****	****	****
Date of initial request	2/14/19	3/20/19	3/26/19	5/13/19	7/3/19
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	NR	NR	NR	NR
(Standard [S], Expedited [E], or Retrospective [R])	S	S	R	R	E
Date notice of adverse benefit determination (NABD) sent	2/26/19	4/1/19	4/5/19	6/4/19	7/5/19
Notice sent to provider and member? (M or NM)*	M	M	M	M	M
Number of days for decision/notice	12	12	10	22	2
Notice sent within required time frame? (M or NM) (S = 10 Cal days after; E = 72 hours after; T = 10 Cal days before)*	NM	NM	M	NM	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	M	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)*	NA	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)*	M	M	M	M	M
Total Applicable Elements	**6**	**6**	**6**	**6**	**6**
Total Met Elements	**5**	**5**	**6**	**5**	**6**
Score (Number Met / Number Applicable) = %	**83%**	**83%**	**100%**	**83%**	**100%**

***** = 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. The request was received on 2/14/19; the decision was made on 2/15/19; and the letter was mailed on 2/26/19, which was 12 calendar days after the request.

File 2: This was a new service request. The request was received on 3/20/19; a decision was made on 3/28/19; and the letter was mailed on 4/1/19, which was 12 calendar days after the request.

File 4: This was a new service request, which was sent retrospectively (inpatient service days were 4/10/19–4/13/19 and the request was received on 5/13/19). CCHA made the decision on 5/23/19 but did not send the NOABD until 6/4/19.

Requirements	File 6	File 7	File 8	File 9	File 10
Member ID	****	****	****	****	****
Date of initial request	9/13/19	10/30/19	12/11/19	12/19/19	12/30/19
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	NR	NR	NR	NR
(Standard [S], Expedited [E], or Retrospective [R])	S	S	S	R	R
Date notice of adverse benefit determination (NABD) sent	9/16/19	11/6/19	12/16/19	12/24/19	12/31/19
Notice sent to provider and member? (M or NM)*	M	M	M	M	M
Number of days for decision/notice	3	7	5	5	1
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	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? (N or NM)*	M	M	M	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)*	NA	NM	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)*	M	NM	NM	M	M
Total Applicable Elements	**6**	**7**	**6**	**6**	**6**
Total Met Elements	**6**	**5**	**5**	**6**	**6**
Score (Number Met / Number Applicable) = %	**100%**	**71%**	**83%**	**100%**	**100%**

***** = 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 new service request. This authorization was denied due to medical necessity, based on limited details on the standardized authorization form; however, no outreach to the provider was documented. The NOABD sent to the member included a full list of clinical criteria, which would not be easy to understand.

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

Total Record Review Score*	Total Applicable Elements:	Total Met Elements:	Total Score:
	61	55	90%

* 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 7)

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	*****	03/06/19	M ☒ N ☐ N/A ☐	03/25/19	13W	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: This was a complaint about timeliness of transportation. The member was assigned a care coordinator.										
2	*****	03/06/19	M ☒ N ☐ N/A ☐	04/02/19	15W+6C	M ☐ N ☒	M ☒ N ☐ N/A ☐	M ☐ N ☒ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: Staff members reported there was a verbal request made from the RAE to the member for an extension. No written extension letter was provided to the member; therefore, the resolution was not timely since there was no valid extension. Staff members reported that they had not known a written extension letter was needed. The family member complained that the member had been fed something by a nurse that she was not supposed to have. The grievance specialist spoke to the hospital to resolve the case. No CCHA clinician reviewed the case prior to resolution.										
3	*****	03/26/19	M ☒ N ☐ N/A ☐	04/15/19	14W	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☐ N ☒ N/A ☐	M ☐ N ☒ N/A ☐
Comments: This was a HIPAA complaint about a provider. Staff members reported that the grievance specialist reached out to the provider to clarify the situation but took no action. The resolution letter stated that CCHA "could not substantiate" the member's concern. HSAG advised that the word "substantiate" is not within guidelines for easy readability. CCHA referred the member to the Medicaid Ombudsman. Staff members stated that they "cannot do anything about a HIPAA complaint about a provider and that the Medicaid Ombudsman would have to investigate it." Since this was a contracted provider, it is the RAE's responsibility to resolve the grievance. (HSAG recommended that CCHA work with the Department to clarify the RAE's responsibility.) This resolution was not responsive to the member's complaint.										
4	*****	04/01/19	M ☒ N ☐ N/A ☐	04/19/19	14W	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☒ N/A ☐	M ☐ N ☒ N/A ☐	M ☐ N ☒ N/A ☐
Comments: This was a complaint about the quality of care received in a facility. The grievance specialist reached out to the facility. The facility provided a different accounting of events. The resolution letter stated that CCHA "could not substantiate" the member's concern. The resolution was not responsive to the member's complaint. HSAG also advised that the word "substantiate" is not within guidelines for easy readability. No CCHA clinician reviewed the case prior to resolution.										
5	*****	05/09/19	M ☒ N ☐ N/A ☐	05/17/19	6W	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: This was a complaint about a home health aide. CCHA helped the member find another provider and referred the member to care coordination.										
6	*****	06/05/19	M ☒ N ☐ N/A ☐	06/12/19	5W	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: In this complaint, the member felt she had not received a timely follow-up appointment following an inpatient stay. The grievance specialist reached out to the provider's office and confirmed the member had multiple appointments within a few days of discharge. The member was referred to care coordination.										

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Grievance Record Review Tool
for Colorado Community Health Alliance (Region 7)

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
7	*****	06/28/19	M ☒ N ☐ N/A ☐	07/03/19	3W	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 by a provider. The letter indicated that CCHA spoke with the provider and let the member know that if she received another bill to call the grievance specialist's direct line to let her know.										
8	*****	07/11/19	M ☒ N ☐ N/A ☐	07/23/19	8W	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☐ N ☒ N/A ☐
Comments: This was a complaint about a home health agency. The resolution letter stated that CCHA "could not substantiate" the member's concern. HSAG advised that the word "substantiate" is not within guidelines for easy readability. The grievance specialist offered to help the member find another provider.										
9	*****	09/12/19	M ☒ N ☐ N/A ☐	10/01/19	13W	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: This was a complaint that the member's money was stolen while in a facility.										
10	*****	06/27/19	M ☒ N ☐ N/A ☐	07/16/19	12W	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 complaint. The grievance specialist resolved the case based on discussions with the facility. The resolution letter stated that the medical director "will" review the situation. No CCHA clinician reviewed the case prior to resolution. Staff members stated that clinical review of some cases identified as quality of care issues are reviewed by a clinical team, but results are not considered in the resolution of the grievance. The review and resolution of the case was determined by the grievance specialist based on discussions with the facility. The member was referred to care coordination. No CCHA clinician reviewed the case prior to resolution.										
Do not score shaded columns below.										
Column Subtotal of Applicable Elements			**10**			**10**	**10**	**3**	**10**	**10**
Column Subtotal of Compliant (Met) Elements			**10**			**9**	**10**	**0**	**8**	**7**
Percent Compliant (Divide Met by Applicable)			**100%**			**90%**	**100%**	**0%**	**80%**	**70%**

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

Total Applicable Elements	**53**
Total Compliant (Met) Elements	**44**
Total Percent Compliant	**83%**

* 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 7)

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	****	01/03/19	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	01/03/19	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: This was an expedited appeal request. The acknowledgement letter was sent on 1/3/19. The appeal decision overturned the original denial decision.											
2	****	01/28/19	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	02/04/19	M ☒ N ☐	M ☐ N ☒	M ☒ N ☐
Comments: The acknowledgement letter was sent on 1/29/19. This was a standard appeal of a denial of a pre-service request for residential treatment services. The resolution letter informed the member that he/she may request continued benefits even though the member was not eligible for continuing benefits during the SFH.											
3	****	01/28/19	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☐ N ☐ N/A ☒	Yes ☐ No ☒	Yes ☐ No ☒	02/21/19	M ☐ N ☒	M ☐ N ☒	M ☐ N ☒
Comments: Acknowledgement letter was sent on 1/28/19. This was a standard appeal of an administrative denial. The original authorization decision was "not a covered benefit" (not clinical). The resolution letter was sent 19 working days following receipt of the request. 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. In addition, the resolution reason stated that the member was not "eligible for services at the time of the original service request." Whereas the resolution reason did not correlate with the original reason for the denial, this information would be confusing to the member.											
4	****	03/05/19	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	03/05/19	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: The acknowledgement letter was sent on 3/5/19. This was an expedited appeal, as the member was still hospitalized at the time of the appeal. 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.											
5	****	03/15/19	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	04/15/19	M ☐ N ☒	M ☒ N ☐	M ☒ N ☐
Comments: The acknowledgement letter was sent on 3/19/19. This was a standard appeal of a denial of a pre-service request. The resolution letter was sent 21 working days following receipt of the request. The appeal decision overturned the original denial decision.											
6	****	03/09/19	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	03/10/19	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: The acknowledgement letter was sent on 3/9/19. This was an expedited appeal as it was a concurrent review for continued hospitalization. The appeal decision overturned the original denial decision.											
7	****	04/09/19	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	04/11/19	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: The acknowledgement letter was sent on 4/9/19. This was an expedited appeal, as the member was still hospitalized at the time of the appeal. The resolution reason referenced "MCG 22nd edition ORG-B901-IP" to describe the criteria used in making the decision. Such technical terminology is not easy for the member to understand.											
8	****	04/18/19	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☐ N ☐ N/A ☒	Yes ☐ No ☒	Yes ☐ No ☒	06/06/19	M ☐ N ☒	M ☐ N ☒	M ☒ N ☐

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Appeals Record Review Tool
for Colorado Community Health Alliance (Region 7)

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
Comments: The acknowledgement letter was sent on 4/19/19. 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" due to the member having other primary insurance (not clinical). The appeal resolution letter was not sent until 6/6/19, well beyond the required time frame. Staff members explained that the appeal was initially sent to a medical reviewer who did not follow through with processing the appeal decision because it did not require a clinical reviewer. When discovered, the appeal was referred back to a non-clinical reviewer for processing. 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.										
9	****	09/17/19	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	10/07/19	M ☐ N ☒	M ☐ N ☒	M ☐ N ☒
Comments: The acknowledgement letter was sent on 9/18/19. 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 resolution letter was sent 14 working days following receipt of the request. 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. In addition, the resolution reason referenced "MCG 22nd edition B-902-RES" 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.											
10	****	11/29/19	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	12/02/19	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: This was an expedited appeal as the member was still hospitalized at the time of the appeal. The appeal was acknowledged and resolved in one letter. The original authorization decision denied inpatient services effective 11/21/19 going forward. The appeal was verbally requested by the provider on 11/29/19 and the member remained hospitalized during the appeal. Although the appeal resolution letter stated that services were approved 11/21/19 through 11/27/19, it failed to inform the member of denial of continued inpatient services from 11/27/19 forward. Because the resolution reason did not completely address all dates of service, the resolution letter would not be easily understood by the member.											
Do not score shaded columns below.											
Column Subtotal of Applicable Elements			**10**	**10**	**8**				**10**	**10**	**10**
Column Subtotal of Compliant (Met) Elements			**10**	**10**	**8**				**6**	**6**	**5**
Percent Compliant (Divide Met by Applicable)			**100%**	**100%**	**100%**				**60%**	**60%**	**50%**

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

***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.

Total Applicable Elements	**58**
Total Compliant (Met) Elements	**45**
Total Percent Compliant	**78%**

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2019–2020 site review of **CCHA R7**.

Table C-1—HSAG Reviewers and CCHA R7 and Department Participants

HSAG Review Team	Title
Kathy Bartilotta	Associate Director
Sarah Lambie	Project Manager II
Erika Bowman	Project Manager I
CCHA R7 Participants	**Title**
Abigail Roa Justiniano	Director, Compliance
Amy Yutzy	Director, Region 7 Medicaid Programs
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
Diane Seifert	Region 7 Network Manager
Elizabeth Holden	Director, BH Quality Improvement
Erica Kloehn	Director, BH Network Management
Gelissa Garcia-Diaz	Director, Utilization Management
Irene Kim	Clinical Health Information
Jason Eberle	Business Change Manager
Jessica Zaiger	Region 7 Manager, Care Coordination
Josie Dostie	Region 6 Senior Network Manager
Katie Mortensen	Quality Program Manager
Kelli Gill	Region 6 Director, BH Utilization Management
Kim Cassidy	Manager, BH Services
Krista Newton	Director, Care Coordination
Kristen Kidwell	Director, Quality Program Management
Kristen Mader	Provider Data Analyst

CCHA R7 Participants	Title
Laura Johnson	Region 6 Manager, Care Coordination
Lina Quintero	Manager, Grievances and Appeals Non-Clinical
Megan Lujan	Administrative Assistant
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**
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 R7

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. • Is not more costly than other equally effective treatment options.	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 criteria within 10 CCR 2505-10 8.076.1.8.

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
2 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 record review sample was denied due to medical necessity, based on limited details on the standardized authorization form; however, no outreach to the provider was documented.	CCHA must ensure that, when appropriate, CCHA outreaches to the requesting provider 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**
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, two of the 10 denial record reviews included NOABD language that was not easy for a member to understand. These letters 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	While the *NOABD Policy* accurately described the requirement to mail notices within the appropriate time frames, HSAG observed that in three of the 10 denial record reviews notices were not mailed to the member within the applicable time frames.	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. 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, HSAG found during on-site grievance record reviews that involved clinical quality of care complaints that 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 involving 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**
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 records did not meet the required resolution time frame because no extension letter was sent to the member. In addition, three of 10 records did not meet the requirement "easy to understand," as the resolution description included words such as "substantiated," which would not be easily understood by members with limited reading ability.	CCHA must: • Develop and 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:		
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 two 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." One case involved a Health Insurance Portability and Accountability Act (HIPAA) complaint about a contracted provider that was inappropriately referred to the Medicaid Ombudsman for resolution. One case just told the member that CCHA could not substantiate his or her concern.	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 four of 10 cases did not meet the required resolution time frame—some by a significant amount. None of these cases were eligible for extension, they were just not processed efficiently. In addition, five of 10 cases were *Not Met* for "resolution letter easy to understand," three of which included terminology—e.g., "MCG 22nd edition ORG-B901-IP" or BH diagnosis terminology—in the explanation of resolution reason. Such terminology 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 clearly explains the reason for the appeal resolution decision, eliminating the use of 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 or 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:		
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 40 percent of the appeal resolution letters were	CCHA must: • Update the *Member Appeals Policy* to accurately address all elements of the required content, 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 stated 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 did 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 and may file for an appeal within 60 days of the NOABD. • Address the criteria for requesting benefits during an SFH, which includes accurate modifications to 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 these circumstances (as defined 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 is inaccurate for how long benefits will continue during both 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:		
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 provides 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 grievance filing process. • Both the *PH Provider Manual* and *BH Provider Manual* failed to describe CCHA assistance available in the appeal filing process. • 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—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	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 defined 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 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.

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 R7**.

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. In the three counties that make up Region 7—El Paso, Teller, and Park—the demographics and healthcare resources are widely diverse. Most of the region's population and largely all healthcare resources are concentrated in the Colorado Springs area of El Paso County, with a very sparse population and limited or no resources in rural Park and Teller counties. Region 7 has few large providers systems, one Federally Qualified Health Center (FQHC), one community mental health center (CMHC), one single entry point (SEP)/community-centered board (CCB), 100 PCMP locations, and 2,930 BH providers (statewide). In addition, the headquarters of the Colorado Department of Corrections (DOC) and the El Paso County Department of Human Services (DHS) are in Colorado Springs. **CCHA** characterized Colorado Springs as a small contained community of providers and stakeholders who are engaged and vocal, but sometimes cautious in developing new partnerships. Transportation throughout the region is dependent on several small transportation vendors. Within the rural counties, **CCHA** engages with rural contractors for many services.

At the inception of the RAE, **CCHA** was an unfamiliar entity to providers and stakeholders in the region. In addition, the Medicaid BH network in the region was historically perceived as "closed" with most services being delivered through the CMHC. As such, many independent BH providers (added to the RAE through the open behavioral health network) and many stakeholders were unfamiliar with the Medicaid program, necessitating that **CCHA**'s initial Health Neighborhood activities were heavily focused on educating the community regarding Medicaid and the RAE. Region 7's large number of

Medicaid members yet few large providers presented many opportunities for collaboration within the Health Neighborhood to reduce duplication of services and coordinate care for members. **CCHA** had a pre-established staffing model of integrated care coordination; community liaison staff members; and provider network practice transformation coaches, which have been aligned with providers and a variety of community organizations. Some of **CCHA**'s community liaisons have defined areas of expertise—e.g., criminal justice. Practice transformation coaches are assigned to all practices with more than 300 attributed RAE members. **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. Care coordinators are co-located in some hospitals and the DHS office to enable engaging with members at the point of service. **CCHA** contracts with Rocky Mountain Rural Health in Park County and Aspen Mine Center in Teller County to provide care coordination to local RAE members. In addition, 55 percent of members in Region 7 are attributed to Accountable Care Network (ACN) providers who provide care coordination for their members.

CCHA's internal strategy 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. In addition, in 2020, **CCHA** expanded direct access to its Essette care coordination platform to its rural care coordination contractors in Park and Teller counties. **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 7 processed 20 community incentive program (CIP) applications resulting in six awards; **CCHA** allocated over two million dollars in 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 the RAE with developing programing for chronic condition management; focused outreach to members identified as high risk for coronavirus disease 2019 (COVID-19).
- June 2020 through December 2020—Continuing 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.

Examples of established community partnerships in which Region 7 participates:

- Collaborative Management Programs in all three counties—Interagency Oversight Groups (IOGs) addressing services for high-risk youth

Examples of partners engaged in RAE-focused initiatives include:

- Ute Pass Regional Ambulance District (UPRAD)—BH and PH crisis response provider in Teller and Park counties; recipient of CIP funds.
- Ascending to Health Respite Care—provides recoupment and respite care services and case management for members who are homeless
- Springs Rescue Mission—provides shelter and other resources for the homeless population; recipient of CIP funds.
- Envida—transportation provider; recipient of CIP funds to expand transportation services for members in the rural areas
- El Paso Healthy Communities
- The Resource Exchange (TRE)—SEP/CCB
- Dublin Primary Care—serves as a pain management PCMP; receives referrals from other PCMPs as well as referrals from a nephrologist to support diabetic members with pain management.
- Heart-Centered Counseling—BH telehealth services
- Creative Treatment Options—substance use disorder (SUD) provider
- Project Angel Heart—medically-tailored meals for members with chronic conditions and post-hospitalization
- No Smile Left Behind—mobile dental clinic
- AspenPointe CMHC

CCHA noted that the primary inducements for Health Neighborhood initiatives include: identification of shared concerns regarding gaps in needed services and the collective resources available in the community to address those gaps, data sharing, reinvesting funds to support RAE performance measures, and aligning common goals and bringing something of value to each participating partner organization. In all cases, **CCHA** emphasized that identifying shared goals among collaborative partners

is essential in achieving successful outcomes and drives the priorities and activities of individual Health Neighborhood participants. The RAE's specific role in most Health Neighborhood initiatives to date has primarily been one or more of: providing care coordination for individual complex or high-cost members, providing Medicaid data to identify and track individual members and targeted objectives, improving access to BH services, or funding of select community programs. Most partnership activities in Region 7 have involved small groups of organizations focused on shared targeted objectives and addressing specific populations. Some of these initiatives are further described in later sections of this report.

Improving Access to Specialist Providers

The RAE does not contract with medical specialists and the Department has the claims data regarding utilization of specialist services. **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, specialist 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, urology, and rheumatology. In addition to specialists associated with major hospital systems—e.g., Centura Health (Centura), UCHealth—Region 7 has several integrated primary care/specialty care practices as sources of specialty providers available to Medicaid members. Optum Primary Care, with several locations in region, employs a specialty care provider group that serves as the medical home for many RAE members. Peak Vista, the PCMP network serving 40 percent of the RAE members, has established select specialty clinics and, due to its size, also has enough influence to access specialists in the community. Mathew-Vu Medical Group, with four primary care locations, also employs select specialists. Dublin Primary Care serves as a pain management provider. While the associated primary care providers of these practices have preferred access to the group's specialists, RAE members may also be referred by other PCMPs. Each of these RAE-contracted PCMPs has improved overall access to specialists for Medicaid members. In addition, **CCHA** contracted with the PCMP group aligned with UCHealth, which has improved RAE member access to obstetrics/gynecology (OB/GYN) providers. With the May 2019 opening of Children's Hospital Colorado, Colorado Springs (Children's–CS), access to pediatric specialty services in the region has increased. In addition, individual members continue to be referred to specialists in the Denver Metro area. **CCHA** stated it has not developed initiatives with the large hospital systems to improve RAE member access to hospital-aligned specialty providers. **CCHA** reported that, without specialist-specific data, **CCHA** has been unable to estimate what proportion of RAE members are provided specialty care through the various sources in the region.

CCHA reported Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[F-1] data indicated that members were able to access specialists but were not receiving timely appointments and follow-up. For example, imaging and radiology practices were not getting back to referring PCMPs with results. To promote care compacts between PCMPs and specialists, **CCHA** has used its practice

[F-1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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 direct conversations between the PCMP and specialty office managers. Practice transformation coaches encourage providers to use the care compacts to improve the process of referrals and to follow up with members referred to a specialist to determine member perceptions. **CCHA** has developed communication materials for both PCMPs and specialists to outline the parameters of care compacts and provide guidance on billing. Communication materials also encouraged both primary care and specialist providers to contact **CCHA** care coordinators to assist with eligibility, no-shows, transportation, or other needs of high-need members. Although written care compacts serve only as a piece of paper, **CCHA** reported that care compacts serve to start conversations between provider offices and have been useful to bring providers together to discuss referral issues and develop one-on-one relationships. While some of the larger PCMPs have access to in-house specialists, care compacts have been particularly useful in developing relationships among smaller practices in Region 7.

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 allow 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.

CCHA described initiatives to facilitate improved access to BH services as follows:

- At initiation of the RAE, Region 7 Medicaid members had limited access to independent BH providers. Through **CCHA**'s Anthem partner, **CCHA** contracted with numerous BH providers, significantly improving member choice and BH penetration rates in the region.
- **CCHA** conducted outreach with independent practice network (IPN) providers who identified that BH specialty needs in the region included eating disorder specialists, SUD providers, and psychiatrists for members transitioning from higher levels of care. **CCHA** identified Heart-Centered Counseling, Creative Treatment Options (SUD provider), and AspenPointe CMHC as collaborative resources to address these needs. As part of the collaborative project, IPN providers identified that they needed improved direct provider communications among inpatient BH facilities, the CMHC, and other BH providers, including psychiatrists. The RAE arranged individual provider meetings to facilitate connections between inpatient facilities and the CMHC or a psychiatrist. The RAE also provides the collaborative partners with member tracking data from its claims database and provides care coordination to facilitate referrals to eating disorder specialists and other BH specialty services to support this initiative. Although **CCHA** initially addressed objectives through meetings with individual providers, **CCHA** anticipated this collaborative will evolve to address larger BH program needs.
- The Teller County Mental Health Alliance is a collaborative of county public health agencies, DHS, UPRAD, and the RAE's contracted care coordination entities in Teller and Park counties to develop

strategies for providing crisis services to members in the rural areas. **CCHA** extended CIP funding to support UPRAD in the provision of home-based services to members experiencing a BH crisis or who cannot get to a primary care provider to obtain physical health checks. Partners exchange member data and the RAE identifies members needing post-hospitalization follow-up services.

Collaborative Initiatives with Hospitals

Region 7 has seven physical health hospitals in the region and three inpatient BH facilities. Of the seven physical health hospitals, two of the larger hospitals—St. Francis Medical Center and Penrose Hospital—are aligned with Centura (**CCHA**'s ownership partner); three are aligned with UCHealth—Memorial Hospital Central, Memorial Hospital North, UCHealth Grandview, and Pikes Peak Regional Hospital; and one is Children's–CS—a new facility opened in May 2019. Both the Centura and UCHealth hospital systems are working collaboratively among their hospitals statewide to identify a consistent set of measures for the Hospital Transformation Program (HTP). In addition, different hospital systems have been convening together, facilitated by the Colorado Health Institute (CHI). 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. **CCHA** reported that the HTP initiatives of the two Centura hospitals align with RAE goals in the following areas: sharing data related to perinatal and postpartum depression screenings and social determinants of health, and addressing transitions of care for members with complex needs. **CCHA** has also executed two letters of support for UCHealth's statewide measures and initiatives to implement a collaborative discharge planning process for those members with a mental health diagnosis or substance use disorder. Due to being the first year of operations, the Children's–CS hospital is exempted from the HTP program. At the time of on-site review, all HTP activities had been temporarily suspended due to COVID-19 priorities.

Apart from the HTP program, **CCHA** described that collaboration with individual hospitals in the region has been focused on care coordination of RAE members either being transitioned from the hospital or members with complex needs. Examples include:

- In both Centura hospitals, **CCHA** has co-located BH and RN care coordinators who receive referrals of members with complex needs to assist in transitions of care and coordinate post-discharge services. In addition, **CCHA** has assigned a maternity program RN care coordinator to receive referrals from St. Francis Medical Center's mother/baby unit. Care coordinators also participate in weekly complex care rounds with the hospitals' care management teams.
- Memorial Hospital Central—Within the past six months, **CCHA** has co-located a social work (SW) care coordinator in the emergency department (ED), co-located a SW care coordinator in the BH HOPE unit to assist homeless members and members with mental health needs, and co-located a BH care coordinator to support any hospitalized member. In addition, **CCHA**'s maternity program RN receives daily calls from the hospital prenatal unit regarding members who may need services, and receives a weekly list of pregnant members who have visited the ED. Care coordinators assist members with transitions of care and post-discharge needs and participate in weekly complex care rounds.

- Memorial Hospital North—As a smaller hospital located in a suburban area with a low volume of Medicaid members, **CCHA** has no co-located care coordinators in the hospital but has assigned a SW care coordinator as a single point of contact for referral of any members with complex needs. The care coordinator also participates in weekly complex care rounds with hospital staff members.
- Pike's Peak Regional Hospital—Located in Teller County, **CCHA**'s rural contracted care coordination entity—Aspen Mine Center—has developed a close alliance with the hospital for coordinating transition of care services for members. In addition, although in the pre-application phase of the HTP, staff reported that UCHealth has developed relationships with the Teller County Mental Health Alliance, UPRAD, and Aspen Mine Center to prepare to explore HTP initiatives—e.g., MAT services for members with SUD.
- Children's–CS Hospital—Due to its recent establishment in the region, **CCHA** and Children's–CS do not yet meet regularly. However, staff members stated that Children's–CS has a competent care management system internally and refers RAE members with complex needs to the RAE's pediatric care coordination team. Staff members attend **CCHA** care coordination staffings and reach out to **CCHA** concerning program development. **CCHA** stated that many referred members need placement in a residential treatment center (RTC).
- In the region's three BH facilities—AspenPointe Acute Treatment Unit, Cedar Springs, and Peak View—**CCHA** has co-located two BH coordinators at each facility as a single point of contact for RAE members. Care coordinators prioritize members most in need of care coordination services to prevent rapid readmission. **CCHA** described an example of a diabetic member needing RTC services post-discharge, which required locating an out-of-state facility offering diabetes care. **CCHA** configured a team from UM, DHS, and a children's diabetic specialist to identify a facility, arrange transportation, and accompany the member during transfer to the facility. Care coordinators also facilitate case management conferences with hospital staff members while on-site.

CCHA reported that relationships with all hospitals in the region have grown since the inception of the RAE, with complex case management services being the primary stimulus. Co-location of care coordinators has led to more well-developed relationships with hospitals. In addition, some hospitals are voting members on the regional PIAC.

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 that consider whole-person needs, including 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 to consider 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 (admit, discharge, transfer) data from hospitals, DOC data,

CCB lists, ACN data—and enables data analysis to select members for care coordination who appear in multiple sectors in the dashboard. 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 related to PAC, RAE KPIs, or through which **CCHA** has provided resources to fill gaps in services for members:

- Colorado Springs has a significant **veteran and homeless population**, recognized by the community and **CCHA** as highly underserved populations. **CCHA** has collaborated with its long-term partner, Ascending to Health Respite Care, and the Springs Rescue Mission to support initiatives that serve these populations. Ascending to Health Respite Care provides homeless persons a safe place to recover when discharged from local hospitals, including access to medical care, transportation, nutrition, case management, benefits enrollment, connections to primary care and BH providers and opportunities for long-term supportive housing. Springs Rescue Mission provides critically needed food, clothing, and emergency shelter to persons experiencing homelessness, poverty, and addiction and is a recipient of significant **CCHA** CIP funds.
- Region 7 has 40 **home health agencies.** The Independence Center, which provides traditional and self-directed home health services to members with disabilities, identified an issue with lack of timely turnaround of home health orders by referring physicians, resulting in increased ED visits. Associated with 13 home health agencies, the Independence Center invited the RAE to convene the remaining competitive home health agencies in the region to participate in a collaborative to explore barriers and solutions for this problem. Collaborative efforts included: obtaining Peak Vista's list of home health agency FAX numbers and direct contact persons to invite participants to the collaborative; analyzing home health data to identify trends in provider turn-around times for home health orders; developing uniform guidelines for home health orders and educating referring providers; monitoring home health aging data to identify specific providers not signing home health orders within the required turn-around time; adding a due date cover sheet to home health order forms; using the RAE practice transformation coaches to educate providers and deliver home health orders to delinquent providers; and identifying that a barrier was the inability of nurse practitioners to sign home health orders and requesting the assistance of the State in resolving this licensing issue. **CCHA** reported that both provider and agency feedback regarding this initiative was positive. **CCHA** will monitor RAE KPI data—e.g., decreasing ED utilization—to evaluate outcomes.
- The Resource Exchange (TRE), which serves as the **SEP and CCB** for all three counties in Region 7, has been a long-term partner of both the RAE and the previous Regional Care Collaborative Organization. **CCHA** reported that the relationship with TRE has evolved to include more sophisticated data exchange through a data dashboard, which identifies the top chronic conditions, ED visits, and high-cost members of the TRE population. In addition, shared care coordination of members with complex needs has increased and includes monthly case reviews of members in shared care coordination, identification of high ED utilizers for outreach calls to members, and

working collaboratively to reduce preventable ED visits. As part of the TRE initiative, **CCHA** has implemented its SEP and CCB incentive program to strengthen alignment of goals between the RAE and SEP/CCB related to case management of high-cost members receiving long-term services and supports through home- and community-based services (HCBS) waivers. The incentive program is funded through KPI performance pool dollars.

- **CCHA** has worked with multiple Health Neighborhood partners to improve access to **dental services** in the region. Upon identifying that members in Region 7 were having difficulty accessing Medicaid dental providers, **CCHA** collaborated with DentaQuest to make joint visits to multiple dental offices to identify providers willing to take Medicaid. In order to target members with diabetes (a RAE PAC goal), the RAE and DentaQuest performed mapping of pharmacy providers serving a high number of insulin-dependent members and developed educational materials regarding dental self-care and services to be distributed to diabetic members through the high-touch pharmacies. **CCHA** worked with schools in the region to arrange bringing the mobile dental clinic to schools to serve members on-site. **CCHA** also worked with school districts to develop a social media campaign to educate families on the importance of well-child and dental visits and included RAE and Medicaid information in the media campaign. Working with its IOG partners (addressing services for high-risk youth), the RAE shares member data regarding well-child checks and dental visits, and individualized service and support team case reviews include referrals to RAE care coordination for members needing dental or well-child services. In addition, Peak Vista opened a new location with an on-site dental clinic for Medicaid members. **CCHA** reported that once these initiatives were implemented, the RAE made rapid positive progress in meeting its dental service KPI goals.
- **CCHA** updated its existing memorandum of understanding (MOU) with its El Paso **Healthy Communities** (HC) partner to further detail the functions and commitments of each organization to improve access to physical, behavioral, and dental services for pregnant women and children. The MOUs delineated responsibilities of each party to outreach members, provide care coordination, make referrals to other organizations or between HC and **CCHA**, participate in specific collaboration meetings, exchange member outreach lists and other data, and develop shared communication materials. **CCHA** will measure outcomes of the program through prenatal and child well-visit and dental visit KPIs.
- El Paso County DHS and the RAE have many shared **foster care** members and have identified mutually defined goals and overlap in performance measures of the two agencies, including the RAE's foster care KPI and performance measures for foster care BH assessments, PCMP placement, and access to dental services. Since inception of the RAE, **CCHA** has educated DHS on what the RAE can offer and has developed a DHS tip sheet. **CCHA** has co-located a member support services staff member at the DHS offices one day per week to interface with child welfare and adult welfare clients, attend care coordination staffings, and manage care coordination referrals. DHS and **CCHA** have mutually developed information for foster care members and families.
- **CCHA** has earmarked funds for additional innovative programs to address high-cost RAE members, including: telehealth psychiatry through AspenPointe, chronic disease management through the YMCA, and medically-tailored meals through Project Angel Heart.

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, accessing specialists often requires working through large hospital systems, which is cumbersome and competes with primary care groups associated with the hospital systems who 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 working with non-profit hospital systems to better partner with the RAEs regarding access to specialty care.
- The Department should revitalize its eConsult program to target 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.