Fiscal Year 2020–2021 Site Review Report

for

Colorado Access

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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

Public Law 111-3, Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, requires that each state's Children's Health Insurance Program (CHIP) apply several provisions of Section 1932 of the Social Security Act (the Act) in the same manner as the provisions apply under Title XIX of the Act. This requires managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to comply with provisions of the Code of Federal Regulations, Title 42 (42 CFR)—federal Medicaid managed care regulations published May 6, 2016. Revisions to federal Medicaid managed care regulations published May 6, 2016, became applicable to CHIP effective July 1, 2018. The CFR requires that states conduct a periodic evaluation of their MCOs and PIHPs to determine compliance with federal healthcare regulations and managed care contract requirements. The Department of Health Care Policy and Financing (the Department) has elected to complete this requirement for Colorado's Child Health Plan *Plus* (CHP+) managed care health plans by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

In order to evaluate the CHP+ health plans' compliance with federal managed care regulations and State contract requirements, the Department determined that the review period for fiscal year (FY) 2020–2021 was January 1, 2020, through December 31, 2020. This report documents results of the FY 2020–2021 site review activities for **Colorado Access** (**COA**). For each of the 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 2020–2021 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2019–2020 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for both the grievance and appeal record reviews. Appendix C lists HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan (CAP) process the health plan will be required to complete for FY 2020–2021 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) External Quality Review (EQR) *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[1-1]

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: July 15, 2020.

Summary of Results

Based on conclusions drawn from the review activities, HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. HSAG assigned required actions to any requirement 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 **COA** 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 the Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Scored	Score* (% of Met Elements)
V. Member Information Requirements	21	20	19	1	0	1	95%
VI. Grievance and Appeal Systems	34	34	30	4	0	0	88%
VII. Provider Participation and Program Integrity	16	16	16	0	0	0	100%
IX. Subcontractual Relationships and Delegation	4	4	4	0	0	0	100%
Totals	**75**	**74**	**69**	**5**	**0**	**1**	**93%**

*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. Some items were marked as "Not Scored" due to regulation changes, which came into effect in December 2020.

Table 1-2 presents the scores for **COA** for the grievance and appeal 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)
Grievances	60	52	50	2	8	96%
Appeals	60	59	56	3	1	95%
Totals	**120**	**111**	**106**	**5**	**9**	**95%**

*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 V—Member Information Requirements

Summary of Strengths and Findings as Evidence of Compliance

COA submitted policies and procedures, which described the processes and standards used to develop effective communication materials for members. Criteria included the required 12-point font size, sixth-grade reading level, and tagline requirements. **COA** had an Accessibility Standards policy that included compliance with the accessibility guidelines and website testing. All materials were available in Spanish, with written and oral translation in other languages available upon request. Paper copies of the CHP+ HMO New Member Packet were mailed to new members within 30 days of enrollment notification.

COA provided benefit information and downloadable PDF documents to members, parents, or guardians on its general website, including:

- The CHP+ HMO Member Handbook.
- A search function for medical and dental providers.
- The drug formulary and pharmacy locator.
- Dental benefit information.
- CHP+ newsletters offered in English and Spanish.

A downloadable provider directory, fee schedules, and prior authorization requirements were also available. The website was well-organized and offered additional features such as an Accessibility Widget that allows the member to increase font size, adjust text spacing, highlight links, and change color contrast to accommodate a wide range of visual preferences. The bottom of each website page listed a variety of languages and that assistance is available, the customer service phone number, hours, and email.

The CHP+ HMO Member Handbook contained information about enrollment, benefits and how to access them, cost sharing, member rights, grievance and appeal processes, advance directives, how to report suspected fraud, and other helpful resource information.

Summary of Findings Resulting in Opportunities for Improvement

COA mailed the CHP+ HMO New Member Packet within 30 days of new member enrollment. Although **COA** reported that Interactive Voice Response (IVR) outreach calls are made to newly enrolled members, HSAG recommends that **COA** consider mailing the CHP+ HMO Welcome Packet in a shorter time frame, as is done for another line of business, given that newly enrolled children may have imminent medical needs.

Summary of Required Actions

HSAG tested several pages on the **COA** website using the WAVE Web Accessibility Evaluation Tool (WAVE Tool) and identified errors on provider search pages. While an "accessibility widget" was present on the website, this tool reduced contrast errors but not alternative text, form labels, multiple form labels, empty headings, empty links, alternative text, or other issues. **COA** must implement a process for testing to ensure that provider search website information complies with Section 508 specifications for accessibility (i.e., Section 508 of Section 504 of the Rehabilitation Act and World Wide Web Consortium's [W3C's] Web Content Accessibility Guidelines).

The language found in the Member Rights and Advance Directive sections of the CHP+ HMO Member Handbook varied from the federal language cited in the member information section requirements, Element 19 438.3 (j), and may not convey the intended meaning. However, this item will not be scored due to an upcoming regulatory change in which this requirement will no longer apply to CHP+ health plans.

Standard VI—Grievance and Appeal Systems

Summary of Strengths and Findings as Evidence of Compliance

COA demonstrated an internal grievance and appeal system, which managed grievances and appeals in accordance to regulations, as well as collected and tracked information in a systematic way to meet timeliness standards. Policies and procedures contained thorough details and were well-aligned with both federal and state language. Information about the grievance and appeal system was posted on the **COA** website, within the CHP+ HMO Member Handbook, provider manual, and CHP+ HMO New Member Packet.

Members and authorized representatives could submit grievances or appeals by phone, email, online, or via fax with the assistance of customer service representatives, care managers, and grievance and appeal staff members. Translation was available in English and Spanish through **COA** staff, and additional languages were accessible through the vendor Voiance.

Grievances and appeal acknowledgement and resolution letters were both 100 percent compliant with timeliness standards, based on record review findings. The software system used in both departments was Altruista, also referred to as Guiding Care. Both grievance and appeal resolution letters were mostly easy to read, with three exceptions in the appeal records. Eight of the 10 grievance resolution letters included clear details about dispositions and the process to resolve issues.

The senior director of customer service reported that the grievance department implemented additional internal monitoring in the form of a Grievance Quality Monitoring audit; this procedure was launched in August 2020. The Grievance Quality Monitoring audit checklist contained key components of the grievance process. Additionally, a new grievance supervisor was hired and has supported new oversight efforts. Staff members described increased efforts since the last audit to provide additional grievance

trainings to the care management (CM) department. Staff members reported that these additional trainings resulted in increased grievance reporting, specifically regarding the topic of billing. CM staff members were trained to better identify inappropriate provider billing and report issues appropriately. Trends such as billing issues were then shared with the compliance and provider relations departments, as appropriate.

The director of utilization management (UM) described work with **COA** medical directors and one clinical appeals coordinator. Through the virtual interview, the clinical appeals coordinator described proactive outreach efforts with members regarding appeals and emphasized the need for members to submit any supporting documentation in a timely manner. To ensure appropriate clinical review of appeals, **COA** employed a detailed procedure to monitor that medical staff were not previously involved with cases, and also required an attestation page signed by clinical staff as part of the appeal paperwork. In one appeal sample resolution, **COA** clearly indicated that services were immediately reinstated for the member; this language and process adhered to the 72-hour effectuation of reversed appeal resolution regulation. Staff members described that the efficiency of this effectuation process was supported by the Altruista system, which was used across the grievance, appeal, and UM programs.

COA reported that notices of adverse benefit determination (NABDs) were not typically issued regarding the termination, suspension, or reduction of a previously authorized service; however, policies and procedures accurately described continuation of benefits in the rare event that this situation may occur.

Summary of Findings Resulting in Opportunities for Improvement

Despite a detailed policy and description during the virtual interview, which summarized the process in which **COA** staff members offer reasonable assistance to members and authorized representatives when filing grievances and appeals, the Grievance Training 2020 and Grievance Cheat Sheet for Customer Service Representatives (CSRs) materials described that, for grievances related to billing, the member must send a copy of the bill to the grievance department prior to processing the grievance. HSAG cautions **COA** that this process may add barriers rather than ease the grievance process. HSAG recommends **COA** clarify how and when staff members can assist with filling out forms or completing other procedural processes on behalf of the member and that **COA** remove language within internal trainings that may postpone the initiation of the grievance investigation.

Although the Member Grievance Process document and staff interviews accurately described that grievances and appeals are not investigated by anyone who was previously involved with the issue, training materials included information that appeared contradictory. The CM Grievance Training document indicated that if a care manager received a statement of dissatisfaction from a member, the care manager should forward the issue to the staff member the issue was regarding (slide 23, "Should I document this grievance? No. Email the other Care manager and their Supervisor with the grievance information. Or, escalate the grievance to your Supervisor, and they will notify the other individuals.") Another slide (24) stated that forwarding the issue to the person it was in regard to would allow him or her "the opportunity to document the grievance" and "serve as a good reminder...." Slide 23 went on to say, "The same individual who documents the grievance needs to document the resolution," which in

this example, would mean the person who the grievance was about would be part of the investigation and resolution. HSAG recommends that **COA** update this training to clearly indicate that all grievances (any expression of dissatisfaction other than an NABD) are submitted to the grievance department to ensure review by staff members who have not previously been involved with the member's issue as well as adequate documentation and due process.

The Member Grievance Process document and eight of the 10 grievance resolution letters included language regarding the disposition and resolution process. **COA**'s new Grievance Quality Monitoring process also included checks to ensure resolutions include all required information. All records reviewed included the date of completion; however, two grievance resolution letters did not include clear language regarding the disposition of the grievance or the resolution process. In these two instances, the resolution letter stated, "we want to fix it," which suggested that the grievance was not resolved at the time. The letter indicated that the issue was forwarded to the quality of care concern department for further investigation. While clinical issues may be confidential in nature and full details may not be available to share, HSAG recommends that **COA** update language to clarify that the grievance process has concluded. HSAG also suggests updating the Grievance Quality Monitoring desktop to further clarify for auditing staff members what constitutes a disposition and resolution to ensure effective monitoring.

Within the Member Appeals Process document, **COA** stated that additional information for the expedited appeal must be submitted within 48 hours of receipt to be considered part of the request for an expedited appeal. Although **COA** described that this time frame is included to ensure member information is received timely and to process expedited appeals as quickly as possible, this restricted time frame could also be seen as limiting member rights related to the appeal process.

HSAG recommends three additional points of clarification within various member-facing documents as follows:

- While the details regarding the member's right to a State fair hearing (SFH) if appeal timing requirements are not met were included within the Member Appeal Process, this detail was not included in member-facing documents such as the denial letter sample in the "How do I get a formal hearing" section. HSAG recommends updating this template to include these additional details for when a member may request an SFH.
- In the CHP+ HMO New Member Packet, **COA** described that continuation of benefits must be requested within 10 days from the NABD letter. HSAG recommends that **COA** further clarify that the member still has the full 60 days to file an appeal.
- Although the Member Appeal Process clearly described when a member may be responsible for the cost of continued services, the corresponding member letters may have lost some meaning while simplifying language to the sixth-grade reading level. HSAG recommends clarifying that *only* costs for services requested to be continued related to an appeal or SFH may be collected.

Summary of Required Actions

The Member Grievance Process document accurately defined "grievance" and explained that the term "complaint" is sometimes also used to describe a grievance. However, various training documents were not consistent with these definitions, and instructions to staff members did not indicate that all complaints would be logged as grievances and investigated by the grievance department:

- The CM Grievances Training, slide 21, stated: "At the end, some members are expected to respond by asking the care manager not to proceed with the grievance process, and this is OK. Perhaps, the member wants to vent and nothing more. When this happens, you do not need to document the grievance to the grievance team." While the directions went on to state staff members "still have the responsibility of resolving the grievance as you typically would," this is appears contradictory to the direction that "you do not need to document the grievance to the grievance team."
- The CM Grievances Training, slide 23, included an example: "A member expressed dissatisfaction with their interaction involving another Care Manager to me. Should I document this grievance? No. Email the other Care Manager and their Supervisor with the grievance information. Or, escalate the grievance to your Supervisor, and they will notify the other individuals."
- The Grievance Cheat Sheet for CSRs instructed staff members to place the member on hold while attempting to resolve the issue with the provider and stated: "Only if you receive pushback from the provider or if you are on hold for an extended amount of time, should a grievance be filed in this case."

Additionally, the two grievance resolution letters included language that switched between the terms "grievance," "complaint," and "clinical care grievance," which may be confusing to the member. **COA** must update grievance training documents to clarify that *any expression of dissatisfaction*, other than in response to an NABD, is logged in the system as a grievance and investigated and resolved in accordance with **COA**'s regular grievance procedures. **COA** must also update grievance resolution letters to streamline and/or clarify terms, such as the definition of "grievance" and terms related to the grievance process.

The Member Grievance Process document and staff members stated that **COA** does receive grievances orally and in writing, and staff members further reported during the virtual interview that there is also an online submission method. However, the Grievance Cheat Sheet for CSRs, page 2, included directions that did not align with the policy. Instead this document directed staff members to encourage the member to fill out the form themselves and required members to submit copies of bills: "If grievance is a billing issue please advise member to fill out grievance form (which they can find on the website) and to fax, email or mail it to grievance dept (info listed above). Advise member their grievance will NOT be processed without copy of bill." The Grievance Training 2020 document also indicated on slide 19 that grievances regarding a bill would not be pursued until the member submitted a copy of his or her bill: "For a billing issue: Member to send the bill to the Grievance mailing/email address; Do not send an activity in Altruista to the Grievance team at this time." **COA** must update training materials related to grievances to ensure that staff members are informed that **COA** accepts grievances orally as well as in writing. References to waiting for additional documents, such as bills, should be removed from training documents.

Although appeal resolution letters for the latter half of calendar year (CY) 2020 were easy to read and showed improvement based on previous CAP interventions, the appeal sample included three appeal resolution letters from the first half of CY 2020 with complex clinical language well above the sixth-grade reading level. **COA** must ensure that all appeal resolution letters are written at a reading level that is easy for members to understand.

As noted in the previous FY 2017–2018 Site Review Report, the provider manual itself still contained minimal information regarding the grievance and appeal process during the FY 2020–2021 review. The provider manual and provider grievance form did not include information regarding **COA** offering assistance in the grievance or appeal process. Additionally, the provider manual did not link to **COA**'s updated grievance and appeal system policy. The old policy contained inaccurate information regarding appeals, SFHs, and continuation of benefits. Both the link to the policy and a link to what appeared to be for the CHP+ HMO Member Handbook directed the user to the **COA** provider main page and required additional searching to find the specific content. **COA** must update the provider manual to include current and thorough details regarding the grievance and appeal systems. Specifically, timelines, SFH information, the availability of **COA** staff members to provide assistance in the process, and accurate details about continuation of benefits during appeals and SFHs.

Standard VII—Provider Participation and Program Integrity

Summary of Strengths and Findings as Evidence of Compliance

Regarding provider participation selection and retention efforts, **COA**'s senior provider network contractor reported that mostly providers outreached **COA** to join the network, and minimal additional outreach was needed as most providers were already in-network due to **COA**'s longstanding work in the Denver-metro area. One notable accomplishment for the year was **COA**'s work to renew contracts with some of the larger provider groups in the region. The provider network team continued to seek to fill the gap, similar to other health plans, for eating disorder specialists. Due to the reported "robust" network, single case agreements were reportedly only requested once or twice a week, and more commonly used for placement or out-of-state needs. Efforts to retain quality providers included provider newsletters, support from provider relations, and occasional webinars/calls for idea sharing.

The provider network and contracting teams used the systems ACES and Determine, which provided the functionality that **COA** needed. ACES was developed internally and Determine was described as an off-the-shelf solution. ACES was used to track follow-ups, pending contracts, what documents were out for signature, and contracts that were in the credentialing phase.

Regarding program integrity, the compliance team used "Passport Provider Trust" to screen employees. This system was implemented toward the end of CY 2019. Staff members reported that lists developed by human resources were sent to the compliance team and run through the system, scanning for any issues related to employees or temporary staff members. Provider checks were run by the configuration department.

Compliance policies and procedures included thorough details about training content, and compliance staff members developed numerous tailored trainings, which were deployed in various departments. Clear and effective lines of communication and expectations for prompt reporting were evident as well as comprehensive information about fraud, waste, and abuse. A vendor, NavEx, operated the compliance hotline, while **COA** compliance staff members conducted all investigations.

COA operated a three-tiered Compliance Committee structure, which spanned from management level, the executive team, up to the board of directors for wide-ranging oversight. Agenda topics included audits from the previous quarter; privacy and security activities, including a summary of significant issues; and a review of the health plan's risk profile, which was described as mostly stable (due to the focus being internal to **COA**, not provider focused). Reports were generated semiannually and included summaries of audits, referrals to the State, and recoupments. Additionally, the compliance team described monthly meetings with other departments such as claims, care management, provider relations, utilization management (UM), and finance to discuss trends.

Summary of Findings Resulting in Opportunities for Improvement

COA's compliance team demonstrated effective training for general staff members through annual all-staff trainings and reported an additional 20 plus customized trainings. However, **COA**'s compliance documents lacked specific training details regarding the compliance team. Documents did not include procedures or expectations for the compliance team above and beyond the annual trainings that general staff members received. HSAG recommends detailing the procedures or arrangements for compliance team staff members to receive training and education as needed for their roles.

Summary of Required Actions

HSAG identified no required actions for this standard.

Standard IX—Subcontractual Relationships and Delegation

Summary of Strengths and Findings as Evidence of Compliance

During the period under review, **COA** held delegation agreements for the following services: Cognizant (formerly TriZetto) for claims system services, Navitus for pharmacy benefit management, various entities for provider credentialing, OneTouchPoint for the fulfillment of member identification cards, and National Medical Review for the review of clinical appeals/specialist clinical review. HSAG reviewed a sample of the delegation agreements, which included language that indicated that **COA** maintained ultimate responsibility for complying with State contract terms and conditions and Medicaid managed care regulations. Written agreements outlined the delegated activities, indicated that the contractor agreed to perform the delegated activities, and included provisions for **COA** to take action, including revocation, if the contracted entity failed to meet its obligations. Within the delegation agreements, **COA** included language that the delegated entity was required to adhere to CMS and State law, retain records for 10 years, and allow for an audit upon the request of **COA** or a regulatory body.

The delegation policy noted that **COA** would retain ultimate accountability for any delegated CHP+ Medicaid managed care requirements. Within its policy, **COA** outlined the procedures for entering into an agreement with a potential delegate. This included the proper vetting of the delegate through both **COA**'s legal team and through a pre-delegation audit. During the compliance review, HSAG identified evidence that a potential credentialing delegate had undergone a pre-delegation audit, prior to contracting with **COA**. If a potential delegate failed to meet the set standard during a pre-delegation audit, **COA** had procedures in place to deny the delegation or to potentially offer the delegate the opportunity to reapply at a later time, at **COA**'s discretion.

COA provided policies and procedures related to monitoring its current delegates. Each delegate was reportedly overseen by a business owner that had a direct relationship to the contractor. The credentialing manager audited a sample of records from each credentialing delegate annually. The credentialing manager used a system to calculate a score. Delegates that scored below the standard were required to complete a CAP. The claims team monitored the Cognizant claims activity and reviewed reports submitted by Cognizant monthly. The claims team reconciled activities conducted by Cognizant and discussed discrepancies to ensure a consistent standard was met. The UM team monitored the Navitus pharmacy benefits activity and reviewed reports submitted by Navitus monthly. The UM team also reviewed any member grievances pertaining to pharmacy benefits and the payment error rate to ensure Navitus was held accountable to its agreement. In addition, **COA** described a monthly sample audit of member identification cards sent to members by OneTouchPoint, as well as any member grievances pertaining to the receipt of member identification cards to ensure that this service was being provided effectively.

In the event that a delegate did not meet the standard outlined in the delegation, **COA** had policies and procedures to enact CAPs with the delegate. During the review, HSAG identified that **COA** had placed a credentialing delegate on a CAP. **COA** also had policies and procedures in place to revoke delegation if any of its delegates failed to provide the services outlined in the delegation agreement.

Summary of Findings Resulting in Opportunities for Improvement

HSAG reviewed the delegation agreements submitted by **COA** and found that, while the intent of the federally required language appeared in the delegation agreements, some of the language in the agreements did not align directly with the language required in 42 CFR 438.230(c)(2-3). Furthermore, the sample agreements did not include mention of electronic data. In order to more clearly align with the federal requirements, HSAG suggests that **COA** consider updating its language to clearly state the delegate's obligation to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions, and the right of a regulatory body (CMS, etc.) to inspect documentation that is stored electronically.

Summary of Required Actions

HSAG identified no required actions for this standard.

2. Overview and Background

Overview of FY 2020–2021 Compliance Monitoring Activities

For the FY 2020–2021 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard V—Member Information Requirements, Standard VI—Grievance and Appeal Systems, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontractual Relationships and Delegation. Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the health plan's contract requirements and regulations specified by the federal Medicaid/CHP+ managed care regulations published May 6, 2016. HSAG conducted a desk review of materials submitted prior to the site review activities; a review of records, documents, and materials requested during the site review; and interviews of key health plan personnel to determine compliance with federal managed care regulations and contract requirements. Documents submitted for the desk review and site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, and member and provider informational materials.

HSAG also reviewed a sample of the health plan's administrative records related to CHP+ grievances and CHP+ appeals to evaluate implementation of federal 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 grievances and appeals. Using a random sampling technique, HSAG selected the sample from all CHP+ grievance records that occurred between January 1, 2020, and December 31, 2020, and all CHP+ appeal records that occurred between January 1, 2020, and December 31, 2020. For the record review, the health plan received a score of *Met (M)*, *Not Met (NM)*, or *Not Applicable (NA)* for each required element. Results of record reviews were considered in the review of applicable requirements in Standard VI—Grievance and Appeal Systems. HSAG separately calculated a record review score for each record review requirement and an overall record review score.

The site review processes were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS EQR protocol. The four standards chosen for the FY 2020–2021 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement.

Objective of the Site Review

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

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

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

FY 2019–2020 Corrective Action Methodology

As a follow-up to the FY 2019–2020 site review, each health plan that received one or more *Partially Met* or *Not Met* scores was required to submit a CAP to the Department addressing those requirements found not to be fully compliant. If applicable, the health plan 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 health plan and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **COA** until it completed each of the required actions from the FY 2019–2020 compliance monitoring site review.

Summary of FY 2019–2020 Required Actions

For FY 2019–2020, HSAG reviewed Standard I—Coverage and Authorization of Services and Standard II—Access and Availability.

All required actions were related to coverage and authorization of services; **COA** was required to complete seven required actions to ensure:

- Members receive written notification of any decision to deny or partially deny a claim, and the NABD is easy for the member to understand and includes all required content (three actions).
- The NABD is mailed within required time frames and any exceptions for the NABD mailing time frame are accurately captured in policy (two actions).
- The UM policy includes accurate and detailed procedures related to post-stabilization, such as determining financial responsibility for payment of post-stabilization services that were not pre-approved (two actions).

Summary of Corrective Action/Document Review

COA submitted a proposed CAP in May 2020. HSAG and the Department reviewed and approved all but one item of the proposed plan and responded to **COA**. **COA** submitted initial documents as evidence of completion in August 2020. **COA** resubmitted final CAP documents in September 2020.

Summary of Continued Required Actions

COA successfully completed the FY 2019–2020 CAP, resulting in no continued corrective actions.

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor provides all required member information to members in a manner and format that may be easily understood and is readily accessible by enrollees. *Note: Readily accessible means electronic information which complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines.* *42 CFR 438.10(b)(1)* CHP Contract: Section 21.A.	• ADM206 Culturally Sensitive Services for Diverse Populations • ADM207 Effective Communication with LEP and SI-SI Persons • ADM208 Member Materials • MKT DP03 Accessibility Standards - 508/ADA Compliance • MAC Minutes 8.18.20	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor has in place a mechanism to help members understand the requirements and benefits of the plan. *42 CFR 438.10(c)(7)* CHP+ Contract: Exhibit B1—6.3.1.15	• CHP+ HMO Welcome Letter • CHP+ HMO Member Handbook • HMO Website https://www.coaccess.com/members/chp/benefits/ • Income guidelines, summary of benefits https://www.coaccess.com/members/chp/	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. For consistency in the information provided to members, the Contractor uses the following as developed by the State: • Definitions for managed care terminology, including appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider,	• CHP DP03 Monitoring Terminology in Contracts • CHP+ HMO Member Handbook	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
rehabilitation services and devices, skilled nursing care, specialist, and urgent care. • Model member handbooks and member notices. *42 CFR 438.10(c)(4)* CHP+ Contract: Exhibit B1—2.8.4		
4. The Contractor makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • All written materials for members must: – Use easily understood language and format. – Use a font size no smaller than 12 point. – Be available in alternative formats and through provision of auxiliary aids and service that takes into consideration the special needs of members with disabilities or limited English proficiency. – Include taglines in large print (18 point) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service number, and availability of materials in alternative formats. *42 CFR 438.10(d)(3) and (d)(6)* CHP+ Contract: Exhibit B1—6.3.1.14, 14.1.3.1, 14.1.3.2, 14.1.3.4, 14.1.3.5	Written materials that are critical to obtaining services include: provider directories, member handbooks, appeal and grievance notices, and denial and termination notices. • ADM206 Culturally Sensitive Services for Diverse Populations • ADM207 Effective Communication with LEP and SI-SI • ADM208 Member Materials • MKT201 Printed Marketing/Informational and Corporate Branding Materials	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. If the Contractor makes information available electronically—Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of readily accessible above). • The information is placed in a website location that is prominent and readily accessible. • The information can be electronically retained and printed. • The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge upon request and is provided within five (5) business days. *42 CFR 438.10(c)(6)* CHP+ Contract: Exhibit B1—14.1.3.13.2	• COA Website: https://www.coaccess.com/ o Accessibility Widget in lower right corner of screen o Also see For Our Members on the homepage • MKT203 Website Design Maintenance and Oversight • MKT DP03 Accessibility Standards 508/ADA Compliance	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The Contractor makes available to members in electronic or paper form information about its formulary: • Which medications are covered (both generic and name brand). • What tier each medication is on. • Formulary drug list must be available on the Contractor's website in a machine readable file and format. *42 CFR 438.10(i)* CHP+ Contract Amendment 3: Exhibit B1—6.7.1.5	• CHP+ HMO Member Handbook- o Member Benefits Covered Services Outpatient Pharmacy and Prescription Medication, p. 79-82 • COA Website: https://www.coaccess.com/providers/resources/pharmacy/	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor makes interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and how to access them. • This includes oral interpretation and use of auxiliary aids such as TTY/TDY and American Sign Language. *42 CFR 438.10(d)(4)* CHP+ Contract: Exhibit B1—7.5, 14.1.3.3, 14.1.7.6	• ADM207 Effective Communication with LEP and SI-SI Persons • ADM208 Member Materials • CS DP28 Nextalk for TTY_TTD • CS DP29 Interpreting Services • COA Website: https://www.coaccess.com/members/services/ • Voiance MSA	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor notifies members that auxiliary aids and services are available upon request and at no cost for members with disabilities, and how to access them. *42 CFR 438.10(d)(5)* CHP+ Contract: Exhibit B1—14.1.3.5, 14.1.3.10.1.3	• ADM207 Effective Communication with LEP and SI-SI Persons • ADM208 Member Materials	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor provides each member with a member handbook in both electronic and paper format within a reasonable time after receiving notification of the member's enrollment. *42 CFR 438.10(g)(1)* CHP+ Contract Amendment 3: Exhibit B1—6.7.1	• New Member Mailing List-Requirements- BRD ○ Document that guides IT automated process for mailing out Member Handbook as part of the New Member Packet • PD OPs DP02 CHP HMO New Member Mailings • COA Website: http://3b0c642hkugknal3z1xrpau1-wpengine.netdna-ssl.com/wp-content/uploads/2020/10/CHPHMO-Member-Handbook-Full-Book.pdf (members can also access the handbook by going to the Colorado Access website, Members, Child Health Plan Plus, CHP Benefits)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor gives members written notice of any significant change (as defined by the State) in the information required at 438.10(g) at least 30 days before the intended effective date of the change. *42 CFR 438.10(g)(4)* CHP+ Contract: Exhibit B1—6.7.2, 14.1.3.13.3	• ADM328 Significant Changes in Members Rights, Benefits or Processes	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. *42 CFR 438.10(f)(1)* CHP+ Contract: Exhibit B1—7.12.2, 14.1.8.1	• ADM300 Provider Terminations	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, pharmacies, and behavioral health providers, and LTSS providers (as applicable): • The provider's name and group affiliation, street address(es), telephone number(s), website URL, specialty (as appropriate), whether the providers will accept new enrollees. • The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training.	• Provider Directory Link: https://secure.healthx.com/s/COA_Provider_DIrectory (members may also access the directory by going to the Colorado Access website, and use the Find a Provider link)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment. *Note: Information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after the Contractor receives updated provider information* *42 CFR 438.10(h)(1-3)* CHP+ Contract: Exhibit B1—14.1.3.6-7		
13. Provider directories are made available on the Contractor's website in a machine-readable file and format. *42 CFR 438.10(h)(4)* CHP+ Contract: Exhibit B1—14 1.3.8	• Provider Directory Link: https://secure.healthx.com/s/COA_Provider_DIrectory (members may also access the directory by going to the Colorado Access website, and use the Find a Provider link)	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Section 508 compliance testing on the COA website using the WAVE Tool identified errors on provider search pages. While an "accessibility widget" was present on the website, this tool reduced contrast errors but not alternative text, form labels, multiple form labels, empty headings, empty links, alternative text, or other issues.		
Required Actions: COA must implement a process for testing to ensure that provider search website information complies with Section 508 specifications for accessibility.		
14. The member handbook provided to members following enrollment includes: • The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled.	• CHP+ HMO Member Handbook- ○ Summary of Covered Benefits p. 16-18 ○ About your Health Care Coverage ▪ Primary Care Providers p.23 ▪ Choosing or Changing Your PCP p. 25	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Procedures for obtaining benefits, including authorization requirements and/or referrals for specialty care and for other benefits not furnished by the member's primary care provider. • The extent to which and how members may obtain benefits, including family planning services, from out-of-network providers. This includes an explanation that the Contractor cannot require the member to obtain a referral before choosing family planning provider. • The process of selecting and changing the member's primary care provider. • Any restrictions on the member's freedom of choice among network providers. • In the case of a counseling or referral service or CHP+ covered benefit that the Contractor does not cover due to moral or religious objections, the Contractor informs the member that the service is not covered because of moral or religious objections and how and where the member can obtain the services. *42 CFR 438.10(g)(2)(iii, iv, vi, vii, x) and (g)(ii)(A-B)* CHP+ Contract: Exhibit B1—14.1.3.10 14.1.3.13.3.7 Exhibit K—1.1.4.1–3, 1.1.14, 1.1.30 Amendment 3: Exhibit K—1.1.7	▪ Referrals p.26-27 ○ Member Benefits-Covered Services ▪ Family Planning p. 37-38 ▪ Provider Office Services p.40-42 ○ Managed Care ▪ Preauthorization for Health Care Services p.95-96 ▪ Utilization Management p.100	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The member handbook provided to members following enrollment includes the following member rights and protections as specified in 42 CFR 438.100. Members have the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for his or her dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding his or her health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. • Request and receive a copy of his or her medical records, and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for access, coverage, and coordination of medically necessary services. • Freely exercise his or her rights, and the exercising of those rights will not adversely affect the way the Contractor, its network providers, or the State Medicaid agency treats the member. *42 CFR 438.10(g)(2)(ix)* CHP+ Contract: Exhibit B1—14.1.3.10, 14.1.1.2.1-6, 14.1.1.3 Exhibit K—1.1.2	• CHP+ HMO Member Handbook- ○ Member Rights & Responsibilities p.19-20	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The member handbook provided to members following enrollment includes the following information regarding the grievance, appeal, and fair hearing procedures and time frames: • The right to file grievances and appeals. • The requirements and time frames for filing a grievance or appeal. • The right to a request a State fair hearing after the Contractor has made a determination on a member's appeal which is adverse to the member. • The availability of assistance in the filing process. • The fact that, when requested by the member: – Benefits that the Contractor seeks to reduce or terminate will continue if the member files an appeal or a request for State fair hearing is filed within the time frames specified for filing. – If benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal or State fair hearing is pending if the final decision is adverse to the member. *42 CFR 438.10(g)(2)(xi)* CHP+ Contract: Exhibit B1—14.1.3.10 Exhibit K—1.1.18, 1.1.18.1, 1.1.18.1.1, 1.1.18.1.3, 1.1.18.2.1	• CHP+ HMO Member Handbook- ○ Grievances and Appeals, p. 106-108	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The member handbook provided to members following enrollment includes the extent to which and how after-hours and emergency coverage are provided, including: • What constitutes an emergency medical condition and emergency services. • The fact that prior authorization is not required for emergency services. • The fact that the member has the right to use any hospital or other setting for emergency care. *42 CFR 438.10(g)(2)(v)* CHP+ Contract: Exhibit B1—14.1.3.10 Exhibit K—1.1.10.1, 1.1.10.1.1, 1.1.10.2, 1.1.10.5	• CHP+ HMO Member Handbook- ○ Member Benefits-Covered Services ▪ Urgent/After-Hours Care, Emergency Care and Travel Outside the Country, p. 49-52	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
18. The member handbook provided to members following enrollment includes: • Cost-sharing, if any is imposed under the State plan. • How and where to access any benefits that are available under the State plan but not covered under the Medicaid managed care contract. • How transportation is provided. • The toll-free telephone number for member services, medical management, and any other unit providing services directly to members. • Information on how to report suspected fraud or abuse. • How to access auxiliary aids and services, including information in alternative formats or languages.	• CHP+ HMO Member Handbook- ○ What is Colorado Access p.3 ○ Welcome ▪ Do You Need Special Help with this Booklet? p.4 ○ What you need to know about CHP+ HMO p.10 ○ Changing your Information p. 13 ○ Summary of Covered Benefits p.16-18 ○ What You Pay (Cost Sharing)-For Enrollment & Services ▪ Copayments (Cost Sharing) p.27-29 ○ Administrative Information ▪ Fraud p.33	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.10(g)(2)(ii, viii, xiii, xiv, xv) CHP+ Contract: Exhibit B1—14.1.3.10 Exhibit K—1.1.3, 1.1.19	○ Member Benefits-Covered Services ▪ Ambulance Transportation Services p.53-54 ○ Utilization Management p. 100 ○ Getting Involved in Care Management p. 101 ○ Footer on the bottom of every page: ▪ *Have questions? Need help? We are here to help you in the language you speak! Free interpretation services are available* Call us at 303-751-9021 or 888-214-1101 (toll free) TTY users should call 720-744-5126 or 888-803-4494 (toll free)Email us at customer.service@coaccess.com	
19. The member handbook provided to members following enrollment includes how to exercise an advance directive as required in 438.3 (j): • The member's right under the State law to make decisions regarding medical care and to formulate advance directives, including the right to accept or refuse medical or surgical treatment. • The Contractor's policies and procedures respecting implementation of advance directives, with a clear statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience. • Informing members that grievances concerning noncompliance with the advance directive requirements	• CHP+ HMO Member Handbook ○ Managed Care ▪ Advance Medical Directives p. 101-102 • https://www.coaccess.com/members/services/ ○ Advance Directives • CCS303 Advance Directives	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Scored

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
may be filed with the State Department of Public Health and Environment. *42 CFR 438.10(g)(2)(xii)* CHP+ Contract: Exhibit B1—14.1.1.2.7, 14.1.1.2.7.1, 14.1.9 Exhibit K—1.1.24		
Findings: The language found in the Member Rights and Advance Directive sections of the CHP+ HMO Member Handbook varied from the federal language cited in the member information section requirements, Element 19 438.3 (j), and may not convey the intended meaning. However, this item will not be scored due to an upcoming regulatory change in which this requirement will no longer apply to CHP+ health plans.		
20. The Contractor provides member information by either: • Mailing a printed copy of the information to the member's mailing address. • Providing the information by email after obtaining the member's agreement to receive the information by email. • Posting the information on the Contractor's website and advising the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost. • Providing the information by any other method that can reasonably be expected to result in the member receiving that information. *42 CFR 438.10(g)(3)* CHP+ Contract: Exhibit B1—14.1.3.10.1	• CHP+ New Member Packet • ADM207 Effective Communication with LEP and SI-SI Persons • ADM230 Member Disability Rights Request • See language on web, "for our members": www.coaccess.com	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
21. The Contractor must make available to members, upon request, any physician incentive plans in place. *42 CFR 438.10(f)(3)* CHP+ Contract: None	• PNS218 Physician Incentive Plans	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard V—Member Information Requirements							
Total	Met	=	19	X	1.00	=	19
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Scored	=	1	X	NS	=	NS
Total Applicable		=	20	**Total Score**		=	19
				Total Score ÷ Total Applicable		=	95%

Standard VI—Grievance and Appeal Systems		
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 appeal 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)* CHP+ Contract: Exhibit B1—7.9.1 10 CCR 2505-10—8.209.1	• ADM203 Member Grievance Process • ADM219 Member Appeal Process	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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,	• CCS307 Utilization Review Determinations ○ Definitions	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
deductibles, coinsurance, or other). • For a resident of a rural area with only one managed care plan, the denial of a Medicaid member's request to exercise his or her rights to obtain services outside of the network under the following circumstances: – The service or type of provider (in terms of training, expertise, and specialization) is not available within the network. – The provider is not part of the network, but is the main source of a service to the member—provided that: – The provider is given the opportunity to become a participating provider. – If the provider does not choose to join the network or does not meet the Contractor's qualification requirements, the member will be given the opportunity to choose a participating provider and then will be transitioned to a participating provider within 60 days. *42 CFR 438.400(b)* *42 CFR 438.52(b)(2)(ii)* CHP+ Contract: Exhibit B1—1.1.3 10 CCR 2505-10—8.209.2.A		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor defines "appeal" as a review by the Contractor of an adverse benefit determination. *42 CFR 438.400(b)* CHP+ Contract: Exhibit B1—1.1.4 10 CCR 2505-10—8.209.2.A.7	• ADM219 Member Appeals Process ○ Definitions	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor defines "grievance" as an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. 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)* CHP+ Contract: Exhibit B1—1.1.44 10 CCR 2505-10—8.209.2.D, 8.209.4.A.3.c.i	• AMD203 Member Grievance Process ○ Definitions	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Findings:
The Member Grievance Process accurately defined "grievance" and explained that the term "complaint" is sometimes also used to describe a grievance. However, various training documents were not consistent with these definitions, and instructions to staff members did not indicate that all complaints would be logged as grievances and investigated by the grievance department:

- The CM Grievances Training, slide 21, stated: "At the end, some members are expected to respond by asking the care manager not to proceed with the grievance process, and this is OK. Perhaps, the member wants to vent and nothing more. When this happens, you do not need to document the grievance to the grievance team." While the directions went on to state staff members "still have the responsibility of resolving the grievance as you typically would," this is appears contradictory to the direction that "you do not need to document the grievance to the grievance team."

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The CM Grievances Training, slide 23, included an example: "A member expressed dissatisfaction with their interaction involving another Care Manager to me. Should I document this grievance? No. Email the other Care Manager and their Supervisor with the grievance information. Or, escalate the grievance to your Supervisor, and they will notify the other individuals." • The Grievance Cheat Sheet for CSRs instructed staff members to place the member on hold while attempting to resolve the issue with the provider and stated: "Only if you receive pushback from the provider or if you are on hold for an extended amount of time, should a grievance be filed in this case." Additionally, the two grievance resolution letters included language that switched between the terms "grievance," "complaint," and "clinical care grievance," which may be confusing to the member.		
Required Actions: COA must update grievance training documents to clarify that any expression of dissatisfaction, other than in response to an NABD, is logged in the system as a grievance and investigated and resolved in accordance with COA's regular grievance procedures. COA should also update grievance resolution letters to streamline and/or clarify terms, such as the definition of "grievance" and terms related to the grievance process.		
5. The Contractor has provisions for who may file: • A member may file a grievance, 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, 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 that providers cannot exercise the member's right to request continuation of benefits under 42 CFR 438.420).* *42 CFR 438.402(c)* CHP+ Contract: Exhibit B1—14.1.4.1.1, 14.1.5.1	• AMD203 Member Grievance Process • ADM219 Member Appeal Process	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. *42 CFR 438.406(a)(1)* CHP+ Contract: Exhibit B1—None 10 CCR 2505-10—8.209.4.C	• ADM 203 Member Grievance Process ○ Procedure #9 • ADM 207 Effective Communication with LEP and SI-SI Persons • ADM 219 Member Appeal Process • COA Website-Member Services ○ Appeals: https://www.coaccess.com/members/services/appeals/ ○ Grievances: https://www.coaccess.com/members/services/grievances/	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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)* CHP+ Contract: Exhibit B1—14.1.4.1.6, 14.1.5.8 10 CCR 2505-10 8.209.5.C, 8.209.4.E	• ADM 203 Member Grievance Process ○ Procedure #4 • ADM 219 Member Appeal Process ○ Procedure #2.B	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor ensures that the individuals who make decisions on grievances and appeals: • Take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. *42 CFR 438.406(b)(2)* CHP+ Contract: None 10 CCR 2505-10—8.209.5.C, 8.209.4.E	• ADM203 Member Grievance Process ○ Procedure #5 • ADM219 Member Appeal Process ○ Procedure #2.D	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor accepts grievances orally or in writing. *42 CFR 438.402(c)(3)(i)* CHP+ Contract: Exhibit B1—14.1.5.6 10 CCR 2505-10—8.209.5.D	• ADM203 Member Grievance Process ○ Procedure #1	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Member Grievance Process document and staff members stated that COA does receive grievances orally and in writing, and staff members further reported during the virtual interview that there is also an online submission method. However, the Grievance Cheat Sheet for CSRs, page 2, included directions that did not align with the policy. Instead this document directed staff members to encourage the member to fill out the form themselves and required members to submit copies of bills: "If grievance is a billing issue please advise member to fill out grievance form (which they can find on the website) and to fax, email or mail it to grievance dept (info listed above). Advise member their grievance will NOT be processed without copy of bill." The Grievance Training 2020 document also indicated on slide 19 that grievances regarding a bill would not be pursued until the member submitted a copy of his or her bill: "For a billing issue: Member to send the bill to the Grievance mailing/email address; Do not send an activity in Altruista to the Grievance team at this time."		
Required Actions: COA must update training materials related to grievances to ensure that staff members are informed that COA accepts grievances orally as well as in writing. References to waiting for additional documents, such as bills, should be removed from training documents.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. Members may file a grievance at any time. *42 CFR 438.402(c)(2)(i)* CHP+ Contract: Exhibit B1—14.1.5.4 10 CCR 2505-10—8.209.5.A	• ADM203 Member Grievance Process ○ Procedure #2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor sends the member a written acknowledgement of each grievance within two (2) working days of receipt. *42 CFR 438.406(b)(1)* CHP+ Contract: Exhibit B1—14.1.5.5 10 CCR 2505-10 8.209.5.B	• ADM203 Member Grievance Process ○ Procedure #3 • GA DP07 Grievance Workflow- ○ Procedure #5 • CHP Grievance Acknowledgement Letter	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor must resolve each grievance and provide notice as expeditiously as the enrollee'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 B1—14.1.5.7, 14.1.5.9, 14.1.3.1 10 CCR 2505-10 8.209.5.D	• ADM203 Member Grievance Process ○ Procedure #6 • ADM208 Member Materials • GA DP07 Grievance Workflow ○ Procedure #8 • CHP Grievance Resolution Letter	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
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. CHP+ Contract: Exhibit B1—14.1.5.11 10 CCR 2505-10 8.209.5.G	• AMD203 Member Grievance Process ○ Procedure #6 • CHP Grievance Resolution Letter	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor may have only one level of appeal for members. *42 CFR 438.402(b)* CHP+ Contract: None	• ADM 219 Member Appeal Process ○ Procedure #3.C	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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)* CHP+ Contract: Exhibit B1—14.1.4.1.1 10 CCR 2505 10 8.209.4.B	• ADM 219 Member Appeal Process ○ Procedure #1.B • CHP Denial Letter Redacted	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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)* *42 CFR 438.406 (b)(3)* CHP+ Contract: Exhibit B1—14.1.4.1.2, 14.1.4.1.8.2 10 CCR 2505 10 8.209.4.B	• ADM219 Member Appeal Process ○ Procedure #1.A	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The Contractor sends written acknowledgement of each appeal within two (2) working days of receipt, unless the member or designated representative requests an expedited resolution. *42 CFR 438.406(b)(1)* CHP+ Contract: Exhibit B1—14.1.4.1.3 10 CCR 2505-10 8.209. 4.D	• ADM219 Member Appeal Process ○ Procedure #1.C • Appeal Acknowledgement Letter Redacted	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
18. The Contractor's appeal process must provide: • That oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date). • That if the member orally requests an expedited appeal, the Contractor shall not require a written, signed appeal following the oral request. • That included, as parties to the appeal, are: – The member and his or her representative, or – The legal representative of a deceased member's estate. *42 CFR 438.406(b)(3-5)* CHP+ Contract: Exhibit B1—14.1.4.1.5.1, 14.1.4.1.8.2, 14.1.4.1.5.4 10 CCR 2505-10 8.209. 4.F, 8.209.4.I	• ADM219 Member Appeal Process ○ Procedure #1.A	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
19. The Contractor's appeal process must provide: • The member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. (The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution time frame in the case of expedited resolution.) • The 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)(3-5)* CHP+ Contract: Exhibit B1—14.1.4.1.5.2-3 10 CCR 2505-10 8.209. 4.G, 8.209.4.H	• ADM219 Member Appeal Process ○ Policy Statement 4th Paragraph ○ Procedure #1.D	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
20. The Contractor maintains an expedited review process for appeals when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life; physical or mental health; or ability to attain, maintain, or regain maximum function. The Contractor's expedited review process includes that: • The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.	• ADM219 Member Appeals Process ○ Policy Statement 3rd Paragraph ○ Procedure #4.B	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.410(a–b) CHP+ Contract: Exhibit B1—14.1.4.1.8.1, 14.1.4.1.8.5 10 CCR 2505-10 8.209.4.Q-R		
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)* CHP+ Contract: Exhibit B1—14.1.4.1.8.4.1 10 CCR 2505-10 8.209.4.S	• ADM219 Member Appeal Process ○ Procedure #4.B.1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
22. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)*	• ADM219 Member Appeal Process ○ Procedure #3.A & Procedure #4.A	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.408(d)(2) *42 CFR 438.10* CHP+ Contract: Exhibit B1—14.1.4.1.4, 14.1.3.1 10 CCR 2505-10 8.209.4.J.1		
Findings: Three appeal resolution letters in the record review included complex clinical language well above the sixth-grade reading level.		
Required Actions: COA must ensure that all appeal resolution letters are written at a reading level that is easy for members to understand.		
23. For expedited appeal, the Contractor must resolve the appeal and provide written notice of disposition to affected parties within 72 hours after the Contractor receives the appeal. • For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. *42 CFR 438.408(b)(3) and (d)(2)(ii)* CHP+ Contract: Exhibit B1—14.1.4.1.8.4.2, 14.1.4.1.8.4.5 10 CCR 2505-10 8.209.4.J.2, 8.209.4.L	• ADM219 Member Appeal Process ○ Procedure #4.B.2,4	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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)*	• ADM203 Member Grievance Process ○ Procedure #7 • ADM219 Member Appeal Process ○ Procedure #4.C • GA DP07 Grievance Workflow ○ Procedure #9 • Appeal Extension Letter Redacted • Grievance Extension Letter	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
CHP+ Contract: Exhibit B1—14.1.4.1.4.1, 14.1.4.1.8.4.3 10 CCR 2505-10 8.209.4.K, 8.209.5.E		
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)* CHP+ Contract: Exhibit B1—14.1.4.1.4.2, 14.1.4.1.8.4.4–5	• ADM203 Member Grievance Process ○ Procedure #7.A, #7.B • ADM219 Member Appeal Process ○ Procedure #4.C.1-2 • GA DP07 Grievance Workflow ○ Procedure #9 • Appeal Extension Letter_Redacted • Grievance Extension Letter	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
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 provided 10-day advance notice to terminate, suspend, or reduce. In addition, to be eligible for continued benefits during a State fair hearing, the member must have received continued benefits during the Contractor appeal process.* *42 CFR 438.408(e)* CHP+ Contract: Exhibit B1—14.1.4.1.7 10 CCR 2505-10 8.209.4.M	• ADM219 Member Appeal Process- ○ Procedure #3.A.1-3 • Appeal Upheld Letter_Redacted • Appeal Overturned Letter_Redacted	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
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)* CHP+ Contract: Exhibit B1—14.1.4.1.10.1-2 10 CCR 2505-10 8.209.4.N and O	• ADM219 Member Appeal Process ○ Procedure #6	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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)* CHP+ Contract: Exhibit B1—14.1.4.1.10.3	• ADM219 Member Appeal Process ○ Procedure #6.B	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
29. The Contractor provides for continuation of benefits/services (when requested by the member) while the Contractor-level appeal is 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	• ADM219 Member Appeal Process ○ Procedure #5 ○ Procedure #7	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal within 60 days of the notice of adverse benefit determination. **This definition of timely filing only applies for this scenario—i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced. (Note: The provider may not request continuation of benefits on behalf of the member.)* The Contractor provides for continuation of benefits/services (when requested by the member) while the State fair hearing is pending if: • The member requests a State fair hearing with a request for continuation of benefits in a timely manner—defined as on or before the following: – Within 10 days of the Contractor mailing the notice of appeal resolution not in favor of the member. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment (and the member requested and received continued		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
benefits during the Contractor appeal). • The services were ordered by an authorized provider. *42 CFR 438.420(a) and (b)* CHP+ Contract: Exhibit B1—14.1.4.1.9.1 10 CCR 2505-10 8.209.4.T		
30. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal is pending, the benefits must be continued until one of the following occurs: • The member withdraws the appeal. • The member does not request continued benefits during a State fair hearing within 10 calendar days after the Contractor sends the notice of an appeal resolution not in the member's favor. If, at the member's request, the Contractor continues or reinstates the benefits while the State fair hearing is pending, the benefits must be continued until one of the following occurs: • The member withdraws the request for a State fair hearing. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR 438.420(c)* CHP+ Contract: Exhibit B1—14.1.4.1.9.2 10 CCR 2505-10 8.209.4.U	• ADM219 Member Appeal Process ○ Procedure #5.B ○ Procedure #7.B	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
31. Member responsibility for continued services: • If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's adverse benefit determination, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. *42 CFR 438.420(d)* CHP+ Contract: Exhibit B1—14.1.4.1.9.3 10 CCR 2505-10 8.209.4.V	• ADM219 Member Appeal Process ○ Procedure #5.C	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
32. Effectuation of reversed appeal resolutions: • If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than seventy-two (72) hours from the date it receives notice reversing the determination. • If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the Contractor must pay for those services. *42 CFR 438.424* CHP+ Contract: Exhibit B1—14.1.4.1.9.4–5 10 CCR 2505-10 8.209.4.W-X	• ADM219 Member Appeal Process ○ Procedure #3.E ○ Procedure #6.D	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
33. 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* CHP+ Contract: Exhibit B1—14.1.4.1.12, 15.5.1 10 CCR 2505-10 8.209.3.C	• ADM 203 Member Grievance Process ○ Procedure #10 • ADM219 Member Appeal Process ○ Procedure #8.A • GA DP07 Grievance Workflow ○ Procedure #11 • CHP HMO Quarterly Grievances Report Q4 SFY 19-20	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
34. 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.	• COA Website ○ Appeals and State Fair Hearing: ▪ https://www.coaccess.com/providers/resources/um/ ○ Grievances: ▪ https://www.coaccess.com/providers/forms/	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing.* – The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member. * *Time frames specified for filing:* *During an appeal: Request continued benefits within 10 days of the notice of adverse benefit determination.* *During a State fair hearing: Request continued benefits within 10 days of the notice of adverse appeal resolution.* *42 CFR 438.414* *42 CFR 438.10(g)(xi)* CHP+ Contract Amendment 3: Exhibit B1—14.1.4.1.1.1, 14.1.5.1.1 10 CCR 2505-10 8.209.3.B	• Provider Manual ○ Section 2 Colorado Access Policies ▪ Member Grievances and Appeals	
Findings: The provider manual and provider grievance form did not include information regarding COA offering assistance in the grievance or appeal process. Additionally, the provider manual did not link to COA's updated grievance and appeal system policy. The old policy contained inaccurate information regarding appeals, SFHs, and continuation of benefits. Both the link to the policy and a link to what appeared to be for the member handbook directed the user to the COA provider main page and required additional searching to find the specific content.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: COA must update the provider manual to include current and thorough details regarding the grievance and appeal systems. Specifically, timelines, SFH information, the availability of COA staff members to provide assistance in the process, and accurate details about continuation of benefits during appeals and SFHs.		

Results for Standard VI—Grievance and Appeal Systems							
Total	Met	=	30	X	1.00	=	30
	Partially Met	=	4	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	34	**Total Score**		=	30
Total Score ÷ Total Applicable						=	88%

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements written policies and procedures for selection and retention of providers. *42 CFR 438.214(a)* CHP+ Contract: Exhibit B1—14.2.1.1	• PNS202 Selection and Retention of Providers	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor follows a documented process for credentialing and recredentialing of providers that complies with the standards of the National Committee for Quality Assurance (NCQA). The Contractor shall assure that all laboratory-testing sites providing services under this contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration. *42 CFR 438.214(b) and (e)* CHP+ Contract: Exhibit B1—14.2.1.3, 14.2.1.5	• CR301 Provider Credentialing and Recredentialing • CR305 Assessment of Organizational Providers	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor's provider selection policies and procedures include provisions that the Contractor does not: • Discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. • Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42 CFR 438.12(a)(1) and (2)* *42 CFR 438.214(c)* CHP+ Contract: Exhibit B1—14.2.1.1.2.1—2	• PNS202 Selection and Retention of Providers • CR301 Provider Credentialing and Recredentialing ○ Procedure #2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This is not construed to: • Require the Contractor to contract with providers beyond the number necessary to meet the needs of its members. • Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. • Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members. *42 CFR 438.12(a-b)* CHP+ Contract: Exhibit B1—14.2.1.1.2.4, 14.2.1.1.5	• PNS202 Selection and Retention of Providers ○ Procedure #1.F • CR301 Provider Credentialing and Recredentialing • CR305 Assessment of Organizational Providers	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Contractor has a signed contract or participation agreement with each provider. *42 CFR 438.206(b)(1)* CHP+ Contract: Exhibit B1—10.1	• PNS202 Selection and Retention of Providers ○ Procedure #1.G-H • PNS217 Single Case Agreements Policy • Provider Participation Agreement	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor does not employ or contract with providers or other individuals or entities excluded for participation in federal health care programs under either Section 1128 or 1128 A of the Social Security Act. *(This requirement also requires a policy.)* *42 CFR 438.214(d)* *42 CFR 438.610* CHP+ Contract: Exhibit B1—14.2.1.6, 19.1.1	• CMP206 Sanction and Exclusion Screening • CR DP04 Ongoing Monitoring of Providers	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549. *42 CFR 438.610* CHP+ Contract: Exhibit B1—19.1.1 and 19.1.2	• CMP206 Sanction and Exclusion Screening • CMP DP08 Compliance Program Operations Manual ○ Conducting Exclusion Screens • CR DP04 Ongoing Monitoring of Providers	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: • The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered. • Any information the member needs in order to decide among all relevant treatment options.	• CS212 Member Rights & Responsibilities • Provider Agreement ○ Section #H.4 • Provider Manual Section 2 ○ Alternative Treatment Options	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The risks, benefits, and consequences of treatment or non-treatment. • The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. *42 CFR 438.102(a)(1)* CHP+ Contract: Exhibit B1—10.4.3		
9. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: • To the State upon contracting or when adopting the policy during the term of the contract. • To members before and during enrollment. • To members within 90 days after adopting the policy with respect to any particular service. *42 CFR 438.102(b)* CHP+ Contract: Exhibit B1—14.1.3.13.3.7 Amendment 3: Exhibit K—1.1.7	• Colorado Access does not object to providing any services under the contract • Provider Manual Section 2 ○ Moral or Religious Objections	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor has administrative and management arrangements or procedures, including a compliance program to detect and prevent fraud, waste, and abuse and includes: • Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal, State, and contract requirements. • The designation of a compliance officer who is responsible for developing and implementing policies, procedures and	• Colorado Access Compliance Plan • CMP204 Compliance Education and Training • CMP211 Fraud Waste and Abuse • CMP212 False Claims Acts • CMP213 Internal Compliance Reviews • CM DP08 Compliance Operations Manual • Board of Directors FACC Charter	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
practices to ensure compliance with requirements of the contract and reports directly to the CEO and Board of Directors. • The establishment of a Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program. • Training and education of the compliance officer, management, and organization's staff members for the federal and State standards and requirements under the contract. • Effective lines of communication between the compliance officer and the Contractor's employees. • Enforcement of standards through well-publicized disciplinary guidelines. • Implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks. • Procedures for prompt response to compliance issues as they are raised, investigation of potential compliance problems identified in the course of self-evaluation and audits, corection of such problems quickly and thoroughly to reduce the potential for reoccurence, and ongoing compliance with the requirements under the contract. *42 CFR 438.608(a)(1)* CHP+ Contract: Exhibit B1—14.2.5.2–3, 14.2.5.4.1–2, 14.2.5.4.9, 14.2.7.2–5	• Code of Conduct • New Hire Training Compliance FWA	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor's administrative and management procedures to detect and prevent fraud, waste, and abuse include: • Written policies for all employees, contractors or agents that provide detailed information about the False Claims Act, including the right of employees to be protected as whistleblowers. • Provisions for prompt referral of any potential fraud, waste, or abuse to the Department and any potential fraud to the State Medicaid Fraud Control Unit. • Provisions for suspension of payments to a network provider for which the State determines there is credible allegation of fraud (in accordance with 455.12.) *42 CFR 438.608 (a)(6-8)* CHP+ Contract: Exhibit B1—14.2.6.1, 14.2.7.1, 14.2.7.6	• Colorado Access Compliance Plan • CM DP08 Compliance Operations Manual ○ Overpayments ○ Reporting Suspected Provider or Member Fraud-Suspending Payments • CMP211 Fraud Waste and Abuse • CMP212 False Claims Acts	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor's Compliance Program includes: • Provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potenial fraud. • Provision for prompt notification to the State about member circumstances that may affect the member's eligibility, including change in residence and member death. • Provision for notification to the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including termination of the provider agreement with the Contractor.	• ADM300 Provider Termination • ADM DP02 Notification to the State-Change in Network Providers Circumstances • CM DP08 Compliance Operations Manual ○ Overpayments ○ Member Services Verification • CS DP25 Change in Member Status	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Provision for a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. *42 CFR 438.608 (a)(2-5)* CHP+ Contract: Exhibit B1—14.2.5.4.3–7		
13. The Contractor ensures that all network providers are enrolled with the State as CHP+ providers consistent with the provider disclosure screening, and enrollment requirements of the State. • The Contractor may execute network provider agreements pending the outcome of the State's screening and enrollment process of up to one-hundred and twenty (120) days, but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one one-hundred and twenty (120)-day period without enrollment of the provider, and notify affected enrollees. *42 CFR 438.608 (b)* CHP+ Contract: None	• CR301 Provider Credentialing and Recredentialing ○ Procedure #7 • CR305 Assessment of Organizational Providers ○ Procedure 2 • PNS 202 Selection and Retention of Providers ○ Procedure 1.B • Provider Agreement Template	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor has procedures to provide to the State: • Written disclosure of any prohibited affiliation (as defined in 438.610). • Written disclosure of ownership and control (as defined in 455.104) • Identification within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract.	• CMP 206 Sanction Screening • LGL DP02 Disclosure of Change in Ownership and Control • The State automatically adjusts capitation payments	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.608(c) CHP+ Contract: Exhibit B1—19.4.1, 19.4.4		
15. The Contractor has a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days of identifying the overpayment, and to notify the Contractor in writing of the reason for the overpayment. • The Contractor reports annually to the State on recoveries of overpayments. *42 CFR 438.608(d)(2) and (3)* CHP+ Contract: Exhibit B1—16.3.4.1.6	• CM DP08 Compliance Operations Manual o Overpayments • CLM DP10 Provider Identified Claim Overpayments • Provider Manual Sections 2 & 6 o Overpayments	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. The Contractor provides that members are not held liable for: • The Contractor's debts in the event of the Contractor's insolvency. • Covered services provided to the member for which the State does not pay the Contractor. • Covered services provided to the member for which the State or the Contractor does not pay the health care provider that furnishes the services under a contractual, referral, or other arrangement. • Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. *42 CFR 438.106* CHP+ Contract Amendment 3: Exhibit B1—16.4.1	• Provider Agreement o Section C.7 • CM DP08 Compliance Operations Manual o Investigating and Reporting Member Balance Billing Issues	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard VII—Provider Participation and Program Integrity							
Total	Met	=	16	X	1.00	=	16
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	16	**Total Score**		=	16
Total Score ÷ Total Applicable						=	100%

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. Notwithstanding any relationship(s) with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. *42 CFR 438.230(b)(1)* CHP+ Contract: Exhibit B1—5.5.3.3	• ADM223 Delegation	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. All contracts or written arrangements between the Contractor and any subcontractor specify— • The delegated activities or obligations and related reporting responsibilities. • That the subcontractor agrees to perform the delegated activities and reporting responsibilities. • Provision for revocation of the delegation of activities or obligations or specify other remedies in instances where the Contractor determines that the subcontractor has not performed satisfactorily. *Note: Subcontractor requirements do not apply to network provider agreements. In addition, wholly-owned subsidiaries of the health plan are not considered subcontractors.* *42 CFR 438.230(b)(2) and (c)(1)* CHP+ Contract: Exhibit B1—2.3	• ADM223 Delegation	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's written agreement with any subcontractor includes: • The subcontractor's agreement to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions. *42 CFR 438.230(c)(2)* CHP+ Contract: Exhibit B1—20.B	• ADM223 Delegation	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The written agreement with the subcontractor includes: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State. • The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems related to Medicaid enrollees. • The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. • If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. *42 CFR 438.230(c)(3)* CHP+ Contract: Exhibit B1—2.3	• ADM223 Delegation	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Appeals Record Review Tool
for Colorado Access

Review Period:	January 1, 2020–December 31, 2020
Date of Review:	December 8–10, 2020
Reviewer:	Erica Arnold-Miller
Participating Health Plan Staff Member(s):	Lindsay Cowee, Elizabeth Strammiello, Reyna Garcia

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	****	01/16/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	01/21/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
2	****	01/29/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	02/03/20	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: Language in resolution letter tested at Flesch-Kincaid grade level 13.3 and included language that would not be easy for a member, parent, or guardian to understand.											
3	****	02/21/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	02/27/20	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: Language in resolution letter tested at Flesch-Kincaid grade level 12.1 and included language that would not be easy for a member, parent, or guardian to understand.											
4	****	03/26/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	03/27/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
5	****	04/22/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	05/05/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
6	****	05/15/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	05/18/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
7	****	06/22/20	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	06/25/20	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: Language in resolution letter tested at Flesch-Kincaid grade level 13.6 and included language that would not be easy for a member, parent, or guardian to understand.											
8	****	07/16/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	07/23/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
9	****	08/21/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	09/01/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
10	****	09/28/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	10/01/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Appeals Record Review Tool
for Colorado Access

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
Do not score shaded columns below.											
		Column Subtotal of Applicable Elements	**9**	**10**	**10**				**10**	**10**	**10**
		Column Subtotal of Compliant (Met) Elements	**9**	**10**	**10**				**10**	**10**	**7**
		Percent Compliant (Divide Met by Applicable)	**100%**	**100%**	**100%**				**100%**	**100%**	**100%**

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

Total Applicable Elements	**59**
Total Compliant (Met) Elements	**56**
Total Percent Compliant	**95%**

***Appeal resolution letter time frame** does not exceed 10 working days from the day the health plan receives the appeal (unless expedited—three calendar days; or unless extended—+14 calendar days).

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

**** = Redacted Member ID

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Grievance Record Review Tool
for Colorado Access

Review Period:	January 1, 2020–December 31, 2020
Date of Review:	December 8–10, 2020
Reviewer:	Erica Arnold-Miller
Participating Health Plan Staff Member(s):	Lindsay Cowee, Elizabeth Strammiello, Reyna Garcia

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	****	01/08/20	M ☒ N ☐ N/A ☐	01/23/20	10	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments:										
2	****	01/14/20	M ☒ N ☐ N/A ☐	02/04/20	14	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments:										
3	****	02/10/20	M ☒ N ☐ N/A ☐	02/28/20	13	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments:										
4	****	02/27/20	M ☒ N ☐ N/A ☐	03/10/20	8	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: Billing issue, addressed by plan.										
5	****	04/02/20	M ☒ N ☐ N/A ☐	04/08/20	4	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments:										
6	****	04/17/20	M ☒ N ☐ N/A ☐	04/28/20	7	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments:										
7	****	07/10/20	M ☒ N ☐ N/A ☐	07/28/20	12	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments:										
8	****	08/11/20	M ☒ N ☐ N/A ☐	08/21/20	8	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments:										
9	****	09/23/20	M ☒ N ☐ N/A ☐	09/25/20	2	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☐ N ☒ N/A ☐	M ☒ N ☐ N/A ☐
Comments: The resolution letter did not include sufficient detail regarding the outcome of the grievance.										

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Grievance Record Review Tool
for Colorado Access

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
10	****	09/24/20	M ☒ N ☐ N/A ☐	10/01/20	5	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☐ N ☒ N/A ☐	M ☒ N ☐ N/A ☐
Comments: The resolution letter did not include sufficient detail regarding the outcome of the grievance.										
Do not score shaded columns below.										
Column Subtotal of Applicable Elements			**10**			**10**	**10**	**2**	**10**	**10**
Column Subtotal of Compliant (Met) Elements			**10**			**10**	**10**	**2**	**8**	**10**
Percent Compliant (Divide Met by Applicable)			**100%**			**100%**	**100%**	**100%**	**80%**	**100%**

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

Total Applicable Elements	**52**
Total Compliant (Met) Elements	**50**
Total Percent Compliant	**96%**

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

**** = Redacted Member ID

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2020–2021 site review of **COA**.

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

HSAG Review Team	Title
Gina Stepuncik	Associate Director
Sarah Lambie	Project Manager II
Erica Arnold-Miller	Project Manager II
COA Participants	**Title**
Amanda Fitzsimons	Senior Privacy Analyst
Bill Huron	Compliance Program Manager
Elizabeth Foster	Customer Service Manager
Elizabeth Strammiello	Chief Compliance Officer
Jason Smith	Senior Network Provider Contractor
Jenine Fountain	Clinical Appeals Coordinator
Lindsay Cowee	Director of Utilization Management
Reyna Garcia	Senior Director of Customer Service
Sarrah Knause	CHP+ Program Manager
Ward Peterson	Director of Enrollment and CHP+
Department Observers	**Title**
Amy Ryan	CHP+ Contract and Program Administrator
Elizabeth Mattes	CHP+ Project Coordinator
Jeffrey Jaskuna	CHP+ Program Manager
Russell Kennedy	Quality Program Manager

Appendix D. Corrective Action Plan Template for FY 2020–2021

If applicable, the health plan 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 health plan 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 health plan 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 health plan 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 SAFE site, with an email notification to HSAG and the Department. The health plan 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 health plan 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 health plan to proceed with implementation, or • Instruct the health plan 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 health plan has received Department approval of the CAP, the health plan will have a time frame of 90 days (three months) to complete proposed actions and submit documents. The health plan 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 health plan will describe in the CAP document any revisions to the planned interventions that were required in the initial CAP approval document or determined by the health plan within the intervening time frame.) If the health plan 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 health plan'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 health plan's discretion at any time the health plan determines would be most beneficial. HSAG will not document results of the verbal consultation in the CAP document.
Step 6	**Review and completion**
	Following a review of the CAP and all supporting documentation, the Department or HSAG will inform the health plan 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 health plan until all required actions are satisfactorily completed.

The CAP template follows.

Table D-2—FY 2020–2021 Corrective Action Plan for COA

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
13. Provider directories are made available on the Contractor's website in a machine-readable file and format. *42 CFR 438.10(h)(4)* CHP+ Contract: Exhibit B1—14 1.3.8	Section 508 compliance testing on the COA website using the WAVE Tool identified errors on provider search pages. While an "accessibility widget" was present on the website, this tool reduced contrast errors but not alternative text, form labels, multiple form labels, empty headings, empty links, alternative text, or other issues.	COA must implement a process for testing to ensure that provider search website information complies with Section 508 specifications for accessibility.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
4. The Contractor defines "grievance" as an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. 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)* CHP+ Contract: Exhibit B1—1.1.44 10 CCR 2505-10—8.209.2.D, 8.209.4.A.3.c.i	The Member Grievance Process accurately defined "grievance" and explained that the term "complaint" is sometimes also used to describe a grievance. However, various training documents were not consistent with these definitions, and instructions to staff members did not indicate that all complaints would be logged as grievances and investigated by the grievance department: • The CM Grievances Training, slide 21, stated: "At the end, some members are expected to respond by asking the care manager not to proceed with the grievance process, and this is OK. Perhaps, the member wants to vent and nothing more. When this happens, you do not need to document the grievance to the grievance team." While the directions went on to state staff members "still have the responsibility of resolving the grievance as you typically would," this is appears contradictory to the direction that "you do not need to document the grievance to the grievance team." • The CM Grievances Training, slide 23, included an example: "A member expressed dissatisfaction with their interaction involving another Care Manager to me. Should I document this grievance? No. Email the other Care	COA must update grievance training documents to clarify that any expression of dissatisfaction, other than in response to an NABD, is logged in the system as a grievance and investigated and resolved in accordance with COA's regular grievance procedures. COA should also update grievance resolution letters to streamline and/or clarify terms, such as the definition of "grievance" and terms related to the grievance process.

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
	Manager and their Supervisor with the grievance information. Or, escalate the grievance to your Supervisor, and they will notify the other individuals." • The Grievance Cheat Sheet for CSRs instructed staff members to place the member on hold while attempting to resolve the issue with the provider and stated: "Only if you receive pushback from the provider or if you are on hold for an extended amount of time, should a grievance be filed in this case." Additionally, the two grievance resolution letters included language that switched between the terms "grievance," "complaint," and "clinical care grievance," which may be confusing to the member.	
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
9. The Contractor accepts grievances orally or in writing. *42 CFR 438.402(c)(3)(i)* CHP+ Contract: Exhibit B1—14.1.5.6 10 CCR 2505-10—8.209.5.D	The Member Grievance Process document and staff members stated that COA does receive grievances orally and in writing, and staff members further reported during the virtual interview that there is also an online submission method. However, the Grievance Cheat Sheet for CSRs, page 2, included directions that did not align with the policy. Instead this document directed staff members to encourage the member to fill out the form themselves and required members to submit copies of bills: "If grievance is a billing issue please advise member to fill out grievance form (which they can find on the website) and to fax, email or mail it to grievance dept (info listed above). Advise member their grievance will NOT be processed without copy of bill." The Grievance Training 2020 document also indicated on slide 19 that grievances regarding a bill would not be pursued until the member submitted a copy of his or her bill: "For a billing issue: Member to send the bill to the Grievance mailing/email address; Do not send an activity in Altruista to the Grievance team at this time."	COA must update training materials related to grievances to ensure that staff members are informed that COA accepts grievances orally as well as in writing. References to waiting for additional documents, such as bills, should be removed from training documents.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

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

Standard VI—Grievance and Appeal Systems		
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* CHP+ Contract: Exhibit B1—14.1.4.1.4, 14.1.3.1 10 CCR 2505-10 8.209.4.J.1	Three appeal resolution letters in the record review included complex clinical language well above the sixth-grade reading level.	COA must ensure that all appeal resolution letters are written at a reading level that is easy for members 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—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
34. 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.	The provider manual and provider grievance form did not include information regarding COA offering assistance in the grievance or appeal process. Additionally, the provider manual did not link to COA's updated grievance and appeal system policy. The old policy contained inaccurate information regarding appeals, SFHs, and continuation of benefits. Both the link to the policy and a link to what appeared to be for the member handbook directed the user to the COA provider main page and required additional searching to find the specific content.	COA must update the provider manual to include current and thorough details regarding the grievance and appeal systems. Specifically, timelines, SFH information, the availability of COA staff members to provide assistance in the process, and accurate details about continuation of benefits during appeals and SFHs.

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
* *Time frames specified for filing:* *During an appeal: Request continued benefits within 10 days of the notice of adverse benefit determination.* *During a State fair hearing: Request continued benefits within 10 days of the notice of adverse appeal resolution.* *42 CFR 438.414* *42 CFR 438.10(g)(xi)* CHP+ Contract Amendment 3: Exhibit B1—14.1.4.1.1.1, 14.1.5.1.1 10 CCR 2505-10 8.209.3.B		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review Protocol Activities

The following table describes the activities performed throughout the compliance monitoring process. The activities listed below are consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal managed care regulations and Department contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all site reviewers to ensure consistency in scoring across health plans.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided health plans with proposed site review dates, group technical assistance, and training, as needed. • HSAG confirmed a primary health plan contact person for the site review and assigned HSAG reviewers to participate in the site review. • Sixty days prior to the scheduled date of the site review, HSAG notified the health plan in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and site review agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and the site review activities. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. • Documents submitted for the desk review and site review consisted of the completed desk review form, the compliance monitoring tool with the health plan's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. • The health plans also submitted a list of all member grievance and all member appeal records that occurred between January 1, 2020, and December 31, 2020 (to the extent available at the time of the site review). Health plans submitted the lists to HSAG 10 days following receipt of the desk review request. HSAG used a random sampling technique to select records for desk review and the site review. HSAG notified the

For this step,	HSAG completed the following activities:
	health plan five days following receipt of the lists of records regarding the sample records selected. • The HSAG review team reviewed all documentation submitted prior to the site review and prepared a request for further documentation and an interview guide to use during the site review.
Activity 3:	**Conduct Health Plan Site Review**
	• During the site review, HSAG met with groups of the health plan's key staff members to obtain a complete picture of the health plan's compliance with federal healthcare regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan's performance. • HSAG requested, collected and reviewed additional documents as needed. • At the close of the site review, HSAG provided health plan staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2020–2021 Department-approved Site Review Report Template to compile the findings and incorporate information from the pre-site review and site review activities. • HSAG analyzed the findings and calculated final scores based on Department-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the Department**
	• HSAG populated the Department-approved report template. • HSAG submitted the draft Site Review Report to the health plan and the Department for review and comment. • HSAG incorporated the health plan and Department comments, as applicable, and finalized the report. • HSAG included a pre-populated CAP template in the final report for all elements determined to be out of compliance with managed care regulations. • HSAG distributed the final report to the health plan and the Department.