CHP+

Child Health Plan *Plus*

Fiscal Year 2021–2022 Site Review Report

for

Colorado Access

February 2022

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. The updated Medicaid and Child Health Plan *Plus* (CHP+) managed care regulations published May 6, 2016, became applicable to CHIP effective July 1, 2018. Additional revisions were released in November 2020, with an effective date of December 2020. 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 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) 2021–2022 was January 1, 2021, through December 31, 2021. This report documents results of the FY 2021–2022 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 2021–2022 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2020–2021 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 credentialing and recredentialing 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 2021–2022 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: Sep 27, 2021.

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 Applicable	Score* (% of Met Elements)
III. Coordination and Continuity of Care	10	10	10	0	0	0	100%
IV. Member Rights, Protections, and Confidentiality	5	5	5	0	0	0	100%
VIII. Credentialing and Recredentialing	32	32	32	0	0	0	100%
X. Quality Assessment and Performance Improvement	18	18	17	1	0	0	94%
Totals	**65**	**65**	**64**	**1**	**0**	**0**	**98%**

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

Table 1-2 presents the scores for **COA** for the credentialing and recredentialing 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)
Credentialing	100	87	87	0	13	100%
Recredentialing	90	76	76	0	14	100%
Totals	**190**	**163**	**163**	**0**	**27**	**100%**

*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 III—Coordination and Continuity of Care

COA demonstrated systemwide resources dedicated to the coordination and continuity of care for CHP+ members, including policies and procedures, multi-disciplinary care teams, and software platforms. **COA** described a care coordination staffing structure that includes care managers and care coordinators, and that staff members were assigned to five care management teams according to their education and background.

The five care management teams consist of two behavioral health, two physical health, and one resource and referral team. The behavioral health team included management, supervisory, and care coordinator level roles, the majority of which were professionally licensed. Staff members described actively working on the development of peer-support roles. The physical health teams include registered nurses (RNs) that oversee the Colorado Regional Health Information Organization (CORHIO) admission, discharge, and transfer (ADT) data from hospital feeds for daily referrals, discharge, and transition of care as well as handling direct referrals and complex care lists from the Department. The resource and referral team coordinated new referrals, reviewed the health risk assessment (HRA) from all new members, and assigned any members to a care manager based on the member's need(s). **COA** described multiple ways a referral can come into the system, whether for a new or existing member. Staff members confirmed each referral was addressed and assigned through the Altruista Health GuidingCare software system. Care coordinators worked through a queue of referrals and reached out to the member within 48 hours. **COA** developed multiple scripts for member assessments to ensure the member's healthcare, spiritual, and financial needs were considered and respected.

COA described various registries such as diabetes, asthma, chronic obstructive pulmonary disease (COPD), the Client Overutilization Program (COUP), and Healthy Mom/Healthy Baby, and an outreach list from the Colorado Department of Corrections for lower-level outreach for members in care management. **COA** currently has 1,725 CHP+ members in care management with a reported 58 percent follow-up success rate on any HRA data that indicated additional outreach needs. Outreach is attempted multiple times through phone calls and mail, including efforts to contact the member within 90 days of enrollment. Members were informed of their assigned care manager through personal outreach calls with the care coordinator.

Staff members described well-developed procedures in place to assess member needs and develop service or treatment plans for members. Member assessments and treatment plans were reportedly shared between all applicable responsible parties involved in care. Across 19 hospitals, **COA** had care managers on site and maintained standing relationships with these facilities to ensure ease of identifying member support needed and ensuring efficient referral procedures. Notably, one hospital facility allowed direct access into its record system. To reduce duplication of services and uphold regular communications, **COA** held internal and external operational meetings with staff and agencies, including "Creative Solutions" meetings with the Department, multiple community organizations, and county human service agencies.

Through all steps of the care coordination process, **COA** outlined measures to ensure the necessary safeguards were in place regarding transferring member protected health information (PHI), including

secure information exchange (i.e., encrypted emails), staff trainings, and use of authorizations to disclose PHI.

Summary of Findings Resulting in Opportunities for Improvement

COA described the procedure for members' notification of their assigned care manager through personal care coordinator outreach calls. Though the outreach calls convey all the general required information, HSAG recommends a follow-up letter detailing the information and resources provided over the phone should the member want to reach out to their care manager.

Summary of Required Actions

HSAG identified no required actions for this standard.

Standard IV—Member Rights, Protections, and Confidentiality

Summary of Strengths and Findings as Evidence of Compliance

The Member Rights and Responsibilities policy described member rights and procedures that allow for members to exercise their rights freely without being subject to retaliation. **COA** delineated member rights and responsibilities through the provider manual, company website, and training. **COA** distributes information about rights to members through the member handbook, bulletins, member portal, and notice of privacy practices, and supports these rights further through the member complaint and appeal procedures.

COA submitted a variety of policies to show compliance with any applicable federal, State, and local laws that pertain to member rights. These policies addressed anti-discrimination, equal access for members with disabilities, privacy, and confidentiality. The Member Disability Rights Request and Complaint Resolution policy defined the Americans with Disability Act of 1990 (ADA) and the role of the organization's ADA team. During the interview, HSAG reviewed the role of the ADA team and the Member ADA Coordinator in resolving ADA requests and complaints. Staff members reported that **COA** monitors for such complaints within compliance and grievance data.

HSAG was informed during the interview that **COA** has a new Vice President of Diversity, Equity, and Inclusion who is building a seven-pillar structure plan in order for the organization and its workforce members to view ADA issues from a member's lens.

COA provided an array of documents to demonstrate how the organization protects PHI. The Clinical Staff Use and Disclosure of Member PHI policy outlined procedures applicable to clinical staff for disclosing member PHI and verifying member identity such as name, date of birth, and the last four digits of the member's Social Security number (SSN) before health information is shared with the member. The Authorizations to Disclose Member PHI policy discussed how **COA** obtains a signed

authorization for all disclosures of member PHI. Staff members described **COA**'s efforts in ensuring privacy and protection of PHI from staff who may have just recently changed job roles. In addition to this, staff members stated that **COA** reinforces confidentiality through trainings, which was evidenced in additional documents submitted by **COA**. Other policies contained the various processes for printing, storing, transmitting, disposing, and transporting forms of PHI to promote Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance and promote integrity of electronic protected health information (ePHI). Staff members discussed how the organization monitors the privacy of members through the privacy hotline. **COA**'s HIPAA Sanctions policy stated that any failure to comply with **COA**'s privacy and security provisions may result in corrective actions and in some cases sanctions against work force members.

Summary of Findings Resulting in Opportunities for Improvement

Within the Member Disability Rights Request and Complaint Resolution policy, **COA** includes timelines to submit an ADA complaint and receive a resolution. HSAG noted that the timeframes to submit a complaint, resolve a complaint, and submit an appeal if the member did not agree with the outcome of the complaint resolution all follow the Office of Civil Rights timelines. However, HSAG recommends updating this policy to clarify that if a member submits a complaint with **COA**, that **COA** must resolve the grievance within the State-required timeframes. Additionally, **COA** should clarify that staff members may assist the member in submitting a complaint with the Office of Civil Rights and that the timelines and appeal procedures currently listed in the policy coincide with that external process.

Summary of Required Actions

HSAG identified no required actions for this standard.

Standard VIII—Credentialing and Recredentialing

Summary of Strengths and Findings as Evidence of Compliance

COA's robust credentialing and recredentialing policies and procedures for practitioners and organizations demonstrated compliance with the National Committee for Quality Assurance (NCQA) standards and guidelines. **COA** comprehensively described the credentialing department, software systems used for credentialing, members of the credentialing committee, and the application review process.

Throughout the interview, **COA** demonstrated that practitioners and organizations were consistently reviewed for credentialing and recredentialing in accordance with policies and procedures. All credentialing and recredentialing sample files included required information, such as Council for Affordable Quality Healthcare (CAQH) applications with signed attestations, state licensure, Drug Enforcement Administration (DEA) certifications (as applicable), board certifications (as indicated in the policy), education/training and work history (credentialing only), and current malpractice insurance with required amount. The files included verification history of professional liability claims through the National Practitioner Data Bank (NPDB) and Medicare/Medicaid sanction list through the Office of Inspector General (OIG) and System for Award Management (SAM). HSAG conducted a record review of practitioners and organizations and all sample files followed **COA** policies and NCQA requirements and guidelines, and were reviewed in a timely manner. All sample files showed documentation that staff members had verified information within the files, dates of verification, and the approval signature from the Committee Chair (Senior Medical Director). **COA** described the evaluation process for files, depending on the level of review required. L1 files were "clean" files that were ready for Medical Director signoff. L3 files required further review and discussion by the credentialing committee before approval.

COA's credentialing committee is comprised of diverse member qualifications and specialties, including physicians, psychologists, and a nurse midwife. Committee members are entrusted to maintain confidentiality and make decisions in a fair and unbiased manner. The committee sought improvement opportunities to further update credentialing procedures and welcomed feedback amongst each other. **COA** continued to demonstrate improvement in reducing initial application processing timeframes from an average of 22 days to 20 days in the last year.

COA described extensive outreach procedures to obtain critical information needed to credential or recredential providers as well as provider information. The credentialing department reported general success in receiving additional documentation when reaching out to practitioners requesting more information. While **COA** had not denied any applications in calendar year (CY) 2021, **COA** did submit documentation to HSAG regarding a practitioner who did not supply additional evidence and was then declined from joining the network. The letter provided evidence that should a provider be declined, they are provided the reason for the denial.

COA provided an overview of extensive reports monitoring provider credentialing data on a continuous basis to ensure consistency between credentialing data and the provider directory. Monitoring is performed daily and follow-up is conducted if the report shows any discrepancies. Additionally, **COA** described a proactive approach and followed-up with providers to obtain additional information, such as office hours and website updates. **COA** delegated credentialing and recredentialing activities to numerous contracted organizations. Annual monitoring of delegates is conducted by **COA** through a delegation audit ensuring compliance with activities, responsibilities, and reporting. Per **COA**, delegates in recent years have been successful during the annual audit and met the 95 percent compliance rate required for the audit. At the time of the review, staff members reported that no organizations were currently under a corrective action plan (CAP).

Summary of Findings Resulting in Opportunities for Improvement

Although **COA** reported that the credentialing committee had not declined any providers in CY 2021 and had declined very few providers in the last few years, HSAG recommends a general statement in a policy or procedure to annually review denied providers in order to verify that any providers who were denied from joining **COA**'s network were not discriminated against. NCQA recommends this review is completed on an annual basis.

Summary of Required Actions

HSAG identified no required actions for this standard.

Standard X—Quality Assessment and Performance Improvement

Summary of Strengths and Findings as Evidence of Compliance

HSAG reviewed the annual Quality Assessment and Performance Improvement (QAPI) documents, including the *QAPI Program Description 2021*, the *Quality Assessment and Performance Improvement Work Plan Fiscal Year 2021-2022*, and the *Annual Quality Report Fiscal Year 2020-2021*. Oversight of the QAPI program was provided through the Health Programming Committee.

COA's documents described a comprehensive, ongoing QAPI program. QAPI documents outlined the QAPI program structure; established governance and oversight; identified committees and workgroups; put forth key QAPI objectives; described programs and activities that took place during the state fiscal year (SFY); provided a detailed evaluation of performance against goals; and established intended goals, strategies, and interventions for the coming year. During the interview session, staff members explained how **COA** integrates quality into all aspects of the organization and ensures quality staff members are enmeshed throughout various interdepartmental meetings and available as resources.

Staff members described the new rapid-cycle performance improvement project (PIP), which is aimed to improve depression screening in primary care settings for members ages 12 to 18 years old, along with behavioral health follow-up within 30 days following a positive depression screening. In SFY 2021, the quality improvement department successfully submitted and received approval for Modules 1 and 2 of the rapid-cycle PIP to target depression screening occurring in well-visits at Every Child Pediatrics and Peak Vista Community Health Centers locations. **COA** continued to develop and finalize interventions to be implemented for Module 3 in SFY 2022.

COA adopted and disseminated clinical practice guidelines (CPGs) based on reliable evidence; input was solicited through contracted providers and approved by the appropriate **COA** medical director. The CPGs were posted to the **COA** website on the Provider Resources' Quality page and were accessible to providers as well as members. **COA** described the process for biennial review of guidelines, as well as annual review of resources in place for more than five years, to ensure CPGs remain relevant and up to date. When CPGs were revised or new CPGs were published on the website, **COA** ensured providers were notified of guideline updates through a notice in the provider newsletter, *Navigator*. Additionally, **COA** had policies and an established process in place that ensured decisions in operational areas, such as utilization management (UM), that may be impacted by the CPGs were consistent with updated CPGs.

COA described methods for detecting over- and under-utilization, where key initiatives included UM decision-making, secret shopper activities, monitoring of network adequacy, and incentive payment programs. **COA** additionally described how **COA** monitored, investigated, tracked, and resolved quality of care concerns. During the interview session, staff members described an instance of a high volume of quality of care concerns related to one facility and how **COA** worked collaboratively with the facility to implement a CAP. Finally, to evaluate access to care and identify areas of need, **COA** reviewed member

grievance data, member experience survey results, secret shopper calls, and population-based data analyses.

During the interview session, staff members provided a thorough overview of **COA**'s System Architecture Diagram (V1.6). Staff members reported that health information data were collected and managed through multiple HIPAA-compliant systems and configured through **COA**'s enterprise data warehouse, which allowed **COA** to integrate and submit the necessary data to the Department in the required standardized formats. **COA** described how claims, encounter, utilization, grievance, appeal, and other data were available for extraction from the data warehouse to complete analyses and reporting, calculate performance, and identify cost and care trends for use across the organization.

COA assessed QAPI program operations annually through systematic follow-up and review of outcomes and analysis of data completed by the Health Programming Committee, and through use of a self-assessment tool, completed with input from QAPI staff members and leadership. Findings were reviewed by the Health Programming Committee to gain input and plan future quality initiatives.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Required Actions

Although **COA**'s health information system provided information about utilization, claims, and grievances and appeals, during the interview session **COA** reported that it does not collect any information related to disenrollment for reasons other than loss of eligibility. While HSAG understands there are barriers to reviewing disenrollment reasons produced by the Department, **COA** must be able to collect, analyze, integrate, and report this data if and when **COA** staff members become aware of this information.

2. Overview and Background

Overview of FY 2021–2022 Compliance Monitoring Activities

For the FY 2021–2022 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 III—Coordination and Continuity of Care, Standard IV—Member Rights, Protections, and Confidentiality, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement. 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+ credentialing and recredentialing to evaluate implementation of federal healthcare regulations. Reviewers used standardized monitoring tools based on NCQA credentialing standards and guidelines 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 credentialing and recredentialing, and three records with an oversample of an additional three records for organizational providers. Using a random sampling technique, HSAG selected the sample from all CHP+ credentialing and recredentialing records that occurred between January 1, 2021, and December 31, 2021. 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 VIII—Credentialing and Recredentialing. 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 2021–2022 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 V—Member Information Requirements, Standard VI—Grievance and Appeal Systems, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontractual Relationships and Delegation.

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 2020–2021 Corrective Action Methodology

As a follow-up to the FY 2020–2021 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 2020–2021 compliance monitoring site review.

Summary of FY 2020–2021 Required Actions

For FY 2020–2021, HSAG reviewed Standard V—Member Information, Standard VI—Grievance and Appeal Systems, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontractual Relationships and Delegation.

COA did not have any required actions for Standard VII—Provider Participation and Program Integrity.

For Standard V—Member Information, **COA** was required to develop and maintain a procedure for testing that its providers search website information complies with Section 508 specifications for accessibility.

For all required actions related to Standard VI—Grievance and Appeal Systems, **COA** was required to complete the following actions:

- Ensure that any expression of dissatisfaction, except in response to a notice of adverse benefit determination (NABD), is treated as a grievance and investigated and resolved in accordance with **COA**'s regular grievance procedures.
- Update all applicable letters and documents to clarify terms and definitions related to grievances; and update internal training materials to include language that **COA** accepts grievances orally and in writing.
- Remove from training documents references to "waiting for additional documents" prior to initiating a grievance and ensure that all appeal resolution letters are written at a reading level that is easy for members to understand.
- Update its provider manual to include accurate information regarding grievance and appeal systems, specifically timelines, State fair hearing (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.

HSAG did not have any required actions for Standard IX—Subcontractual Relationships and Delegation.

Summary of Corrective Action/Document Review

COA submitted a proposed CAP in March 2021. HSAG and the Department reviewed and approved the proposed plan and responded to **COA**. Initial documents as evidence of completion were submitted in July 2021 and additional documents in September 2021. **COA** resubmitted final CAP documents in November 2021.

Summary of Continued Required Actions

COA successfully completed the FY 2020–2021 CAP, resulting in no continued corrective actions.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements procedures to deliver care to and coordinate services for all members. These procedures meet State requirements, including: • Ensuring timely coordination with any of a member's providers, including mental health providers, for the provision of covered services. • Addressing those members who may require services from multiple providers, facilities, and agencies; and who require complex coordination of benefits and services. • Ensuring that all members and authorized family members or guardians are involved in treatment planning and consent to any medical treatment. • Criteria for making referrals and coordinating care with specialists, subspecialists, and community-based organizations. • Providing continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services. *42 CFR 438.208(b)* Contract: Exhibit B-2—10.5.1, 10.5.2, 10.5.3.3	• CM100 Colorado Access Care Coordination ○ Policy Statement ○ Policy Section B-D, I, K ○ Procedure Section 5 • CM101 Delivering Continuity and Transitions of Care ○ Policy Statement	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor ensures that each member has an ongoing source of care appropriate to the member's needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member. • The member must be provided information on how to contact the designated person or entity. *42 CFR 438.208(b)(1)* Contract: Exhibit B-2—10.5.3.1	• CHP Member Handbook ○ Section 8 Getting Involved in Care Management • CM100 Colorado Access Care Coordination ○ Procedure 2.A.3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor implements procedures to coordinate services the Contractor furnishes the member: • Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. • With the services the member receives from any other managed care plan. • With the services the member receives from community and social support providers. *42 CFR 438.208(b)(2)* Contract: Exhibit B-2—10.5.3.2.1, 10.5.3.2.1.1-2, 10.5.3.2.1.4	• CM100 Colorado Access Care Coordination ○ Procedure 2.C.1-4	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor provides best efforts to conduct an initial screening of each new member's needs within 90 days of enrollment, including: • Subsequent attempts if the initial attempt to contact the member is unsuccessful. • An assessment for special health care needs including mental health, high-risk health problems, functional	• CM DP10 CHP+ HRA Follow Up Program	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
problems, language or comprehension barriers, and other complex health problems. • Using the results of the assessment to inform member outreach and care coordination activities. *42 CFR 438.208(b)(3)* Contract: Exhibit B-2—10.4.1, 10.4.1.1, 10.4.1.2, 10.4.1.4		
5. The Contractor shares with other entities serving the member the results of identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR 438.208(b)(4)* Contract: Exhibit B-2—10.4.1.3	• CM100 Colorado Access Care Coordination ○ Procedure 2.B.4.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The Contractor ensures that each provider furnishing services to members maintains and shares, as appropriate, a member health record, in accordance with professional standards. *42 CFR 438.208(b)(5)* Contract: Exhibit B-2—10.5.6	• Provider Manual ○ Section 3 ▪ Patient Record Documentation Pages 3-3 to 3-5 • QM 302 Quality Review of Provider Medical Records ○ Policy Section	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The Contractor ensures that, in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent applicable.	• PRI100 Protecting Member PHI • PRI101 Clinical Staff Use and Disclosure of Member PHI • PRI103 Authorizations to Disclose Member PHI	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.208(b)(6) Contract: Exhibit B-2—10.5.5.9, 13.1.2	• PRI104 Member Rights and Requests Regarding PHI • PRI105 Personal Representatives and Member PHI • PRI200 Sanctions Policy • PRI204 Security of EPHI	
8. The Contractor implements mechanisms to comprehensively assess each CHP+ member identified by the State as having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. • The assessment must be completed within 30 calendar days from the completion of the initial screening, if the initial screening identified special health care needs. *42 CFR 438.208(c)(2)* Contract: Exhibit B-2—10.5.9.1.1	• CM100 Colorado Access Care Coordination ○ Definitions ▪ Special Health Care Needs ○ Procedures ▪ Section 1 A-F ▪ Section 2.B.1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor produces a treatment or service plan for members with special health care needs who are determined, through assessment, to need a course of treatment or regular care monitoring. The treatment plan must be: • Approved by the Contractor in a timely manner (if such approval is required by the Contractor). • In accordance with any applicable State quality assurance and utilization review standards. • Reviewed and revised upon reassessment of functional need, at least every 12 months, when the member's	• CM100 Colorado Access Care Coordination ○ Definition ▪ Special Health Care Needs ○ Policy Section E ○ Procedure Section 2.C.5-6 • Complex Peds_Complex Newborn Workflow	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
circumstances or needs change significantly, or at the request of the member. *42 CFR 438.208(c)(3)* Contract: Exhibit B-2—10.5.9.1.2-3		
10. For members with special health care needs determined to need a course of treatment or regular care monitoring, the Contractor must have a mechanism in place to allow members direct access to a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. *42 CFR 438.208(c)(4)* Contract: Exhibit B-2—10.5.9.1.4	• PNS219 Access to Primary and Secondary Care ○ Procedure 2 ○ Procedure 3 box 9	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	10	X	1.00	=	10
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	10	**Total Score**		=	10
				Total Score ÷ Total Applicable		=	100%

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has written policies regarding the member rights specified in this standard. *42 CFR 438.100(a)(1)* Contract: Exhibit B-2—7.3.6.1	• CS212 Member Rights and Responsibilities	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor complies with any applicable federal and State laws that pertain to member rights (e.g., non-discrimination, Americans with Disabilities Act) and ensures that its employees and contracted providers observe and protect those rights. *42 CFR 438.100(a)(2) and (d)* Contract: Exhibit B-2—15.10.9.2	• ADM205 Nondiscrimination ○ Policy Statement • ADM230 Member Disability Rights Request and Complaint Resolution ○ Policy Statement • CS212 Member Rights and Responsibilities ○ Policy Statement second paragraph • Provider Manual Section 2 ○ Page 2-2 Nondiscrimination ○ Page 2-6 Member Rights and Responsibilities • Colorado Access Website: ○ https://www.coaccess.com/members/services/rights/ ○ https://www.coaccess.com/nondiscrimination/	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor's policies and procedures ensure that each member is guaranteed the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for the member's dignity and privacy.	• CS212 Member Rights and Responsibilities ○ Policy Statement bulleted list • ADM208 Member Materials • Provider Manual Section 2 ○ Page 2-6 Member Rights and Responsibilities • Colorado Access Website:	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• 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 their 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 their medical records and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210). *42 CFR 438.100(b)(2) and (3)* Contract: Exhibit B-2—7.3.6.2-6	○ https://www.coaccess.com/members/services/rights/	
4. The Contractor ensures that each member is free to exercise their rights and that the exercise of those rights does not adversely affect how the Contractor, its network providers, or the Department treat(s) the member. *42 CFR 438.100(c)* Contract: Exhibit B-2—7.3.6.3.7	• ADM203 Member Grievances ○ Grievance Definition ○ Procedures Section 1 • Provider Manual Section 2 ○ Page 2-6 Member Rights and Responsibilities • COA Website	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	○ https://www.coaccess.com/members/services/rights/ • CHP Handbook ○ Pages 17-18	
5. For medical records and any other health and enrollment information which identify a particular member, the Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42 CFR 438.224* Contract: Exhibit B-2—10.5.5.9, 13.1.2	• PRI100 Protecting Member PHI • PRI101 Clinical Staff Use and Disclosure of Member PHI • PRI103 Authorizations to Disclose Member PHI • PRI104 Member Rights and Requests Regarding PHI • PRI105 Personal Representatives and Member PHI • PRI200 Sanctions Policy • PRI204 Security of EPHI • See COA Website ○ http://www.coaccess.com/documents/Notice-of-Privacy-Practices.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard IV—Member Rights, Protections, and Confidentiality							
Total	Met	=	5	X	1.00	=	5
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	5	**Total Score**		=	5
				Total Score ÷ Total Applicable		=	100%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. • The Contractor shall use National Committee on Quality Assurance (NCQA) credentialing and recredentialing standards and guidelines as the uniform and required standards for all applicable providers. *42 CFR 438.214(b)* NCQA CR1 Contract: Exhibit B-2—9.2.3.1	Note: These are NCQA health plan (HP) requirements available at the time of drafting this tool (07/2021). • CR301 Provider Credentialing and Recredentialing • CR305 Assessment of Organizational Providers	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners it credentials and recredentials. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. *Examples of BH practitioners include psychiatrists, physicians, addiction medicine specialists, doctoral or master's-level psychologists, master's-level clinical social workers, master's-level clinical nurse specialists or psychiatric nurse practitioners, and other behavioral health care specialists.*	• CR301 Provider Credentialing and Recredentialing ○ Procedure #1.A-B, #6 • CR305 Assessment of Organizational Providers ○ Procedure #1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Examples of HP practitioners include medical doctors, chiropractors, osteopaths, podiatrists, NPs, etc. *42 CFR 438.214(a)* NCQA CR1—Element A1		
2.B. The verification sources it uses. NCQA CR1—Element A2	• CR301 Provider Credentialing and Recredentialing ○ Procedure #13 • CR305 Assessment of Organizational Providers ○ Procedures #3 & #5	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	• CR301 Provider Credentialing and Recredentialing ○ Procedures #7, #9, #13, & #14 • CR305 Assessment of Organizational Providers ○ Procedures #2, #3, & #5 • CR DP04 Ongoing Monitoring of Providers	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	• CR301 Provider Credentialing and Recredentialing • CR305 Assessment of Organizational Providers	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.E. The process for managing credentialing/recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	• CR301 Provider Credentialing and Recredentialing ○ Procedures #6-14 • CR305 Assessment of Organizational Providers ○ Procedures #2-6 • CR DP02 Organizational Assessment File Audit • CR DP04 Ongoing Monitoring of Providers	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.F. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. *Examples include: non-discrimination of applicant, process for preventing and monitoring discriminatory practices, and monitoring the credentialing/recredentialing process for discriminatory practices at least annually.* NCQA CR1—Element A6	• CR301 - Provider Credentialing and Recredentialing ○ Procedure #2 • Committee Confidentiality and Non-Discrimination Statement	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.G. The process for notifying practitioners if information obtained during the Contractor's credentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A7	• CR301 Provider Credentialing and Recredentialing ○ Procedure # 4 • CR DP01 Provider Rights	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.H. The process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the Credentialing Committee's decision. NCQA CR1—Element A8	• CR301 Provider Credentialing and Recredentialing ○ Procedure #15 • CR305 Assessment of Organizational Providers ○ Procedure #7	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.I. The medical director or other designated physician's direct responsibility and participation in the credentialing program. NCQA CR1—Element A9	• CR301 - Provider Credentialing and Recredentialing ○ Procedures #3 & #8 • CR305 Assessment of Organizational Providers ○ Procedure #6.A	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.J. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law. NCQA CR1—Element A10	• CR301 Provider Credentialing and Recredentialing ○ Procedure #6	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.K. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification (including board certification, if applicable) and specialty. NCQA CR1—Element A11	• CR301 Provider Credentialing and Recredentialing ○ Procedure #16	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor notifies practitioners about their rights: 3.A. To review information submitted to support their credentialing or recredentialing application. *The contractor is not required to make references, recommendations, and peer-review protected information available.* NCQA CR1—Element B1	• CR301 Provider Credentialing and Recredentialing ○ Procedure #4 • CR DP01 Provider Rights	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3.B. To correct erroneous information. NCQA CR1—Element B2	• CR301 Provider Credentialing and Recredentialing ○ Procedure #4 • CR DP01 Provider Rights	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3.C. To receive the status of their credentialing or recredentialing application, upon request. NCQA CR1—Element B3	• CR301 Provider Credentialing and Recredentialing ○ Procedure #4 • CR DP01 Provider Rights	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing and recredentialing decisions. NCQA CR2—Element A1	• CR301 Provider Credentialing and Recredentialing ○ Procedures #2 & #8 • CR305 Assessment of Organizational Providers ○ Procedure #6 • CR DP04 On-going Monitoring of Providers ○ Procedure #3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Credentialing Committee: • Uses participating practitioners to provide advice and expertise for credentialing decisions. • Reviews credentials for practitioners who do not meet established thresholds. • Ensures that clean files are reviewed and approved by a medical director or designated physician. NCQA CR2—Element A	• CR301 Provider Credentialing and Recredentialing ○ Procedure #8 • CR305 Assessment of Organizational Providers ○ Procedure #6	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. For credentialing and recredentialing, the Contractor verifies the following within the prescribed time limits: • A current, valid license to practice (verification time limit = 180 calendar days). • A valid, current Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (verification time limit = prior to the credentialing decision). • Education and training—the highest of the following: graduation from medical/professional school graduate; completion of residency; or board certification (verification time limit = prior to the credentialing decision; if board certification, time limit = 180 calendar days). • Work history—most recent five years—if less, from time of initial licensure—from practitioner's application or CV (verification time limit = 365 calendar days). – If a gap in employment exceeds six months, the practitioner clarifies the gap verbally or in writing and notes clarification in the credentialing file. If the gap in employment exceeds one year, the practitioner clarifies the gap in writing.	• CR301 Provider Credentialing and Recredentialing o Procedures #7 & #13	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• History of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner—most recent five years (verification time limit = 180 calendar days). – The organization is not required to obtain this information for practitioners who had a hospital insurance policy during a residency or fellowship. *Note: Education/training and work history are NA for recredentialing. Verification of board certification does not apply to nurse practitioners or other health care professionals unless the organization communicates board certification of those types of providers to member.* NCQA CR3—Element A		
7. The Contractor verifies the following sanction information for credentialing and recredentialing (verification time limit = 180 days): • State sanctions, restrictions on licensure or limitations on scope of practice. • Medicare and Medicaid sanctions. NCQA CR3—Element B	• CMP206 Sanction and Exclusion Screening • CR301 Provider Credentialing and Recredentialing o Procedure #13.J • CR305 Assessment of Organizational Providers o Procedure #5.A-B • CR DP04 On-going Monitoring of Providers o Procedure #2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. Applications for credentialing include the following (attestation verification time limit = 365 days): • Reasons for inability to perform the essential functions of the position, with or without accommodation. • Lack of present illegal drug use. • History of loss of license and felony convictions. • History of loss or limitation of privileges or disciplinary actions. • Current malpractice insurance coverage (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate). • Current and signed attestation confirming the correctness and completeness of the application. NCQA CR3—Element C	• CR301 Provider Credentialing and Recredentialing ○ Procedure #9.B	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor formally recredentials its practitioners within the 36-month time frame. NCQA CR4	• CR301 Provider Credentialing and Recredentialing ○ Procedure #11.B • CR305 Assessment of Organizational Providers ○ Procedure #5.I	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor implements policies and procedures for ongoing monitoring and takes appropriate action, including: • Collecting and reviewing Medicare and Medicaid sanctions. • Collecting and reviewing sanctions or limitations on licensure. • Collecting and reviewing complaints. • Collecting and reviewing information from identified adverse events. • Implementing appropriate interventions when it identifies instances of poor quality related to the above. NCQA CR5—Element A	• CR301 Provider Credentialing and Recredentialing o Procedure #10 • QM201 Quality of Care Concern Investigation o Procedure #5.A • CMP206 Sanction and Exclusion Screening • CR DP04 On-going Monitoring of Providers	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor has policies and procedures for taking action against a practitioner who does not meet quality standards: • The range of actions available to the Contractor. • Making the appeal process known to practitioners. *Examples of range of actions: how the organization reviews practitioners whose conduct could adversely affect members' health or welfare; the range of actions that may be taken to improve practitioner*	• CR301 Provider Credentialing and Recredentialing o Procedures #10 &11 • CR305 Assessment of Organizational Providers o Procedure #6 • CR306 Adverse Actions Hearing Policy and Plan for Providers • QM201 Quality of Care Concern Investigation o Procedure #5.A • CR DP04 On-going Monitoring of Providers o Procedure #3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
performance before termination; reporting actions taken to the appropriate authorities. NCQA CR6—Element A		
12. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of *organizational* health care delivery providers and specifies that before it contracts with a provider, and for at least every 36 months thereafter: 12.A. The Contractor confirms that the organizational provider is in good standing with State and federal regulatory bodies. *Policies specify the sources used to confirm--which may only include applicable state or federal agency, agent of the applicable state or federal agency, or copies of credentials (e.g., state licensure) from the provider. Attestations are not acceptable.* NCQA CR7—Element A1	• CR305 Assessment of Organizational Providers ○ Procedures #2, #3, #5, & #6 • CR DP04 On-going Monitoring of Providers	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12.B. The Contractor confirms that the organizational provider has been reviewed and approved by an accrediting body. *Policies specify the sources used to confirm—which may only include applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body,*	• CR305 Assessment of Organizational Providers ○ Procedures #2, #3, & # 5 • CR DP04 On-going Monitoring of Providers	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
copies of credentials—e.g., licensure, accreditation report or letter—from the provider. Attestations are not acceptable. NCQA CR7—Element A2		
12.C. The Contractor conducts an on-site quality assessment if the organizational provider is not accredited. *Policies include: on-site quality assessment criteria for each type of unaccredited organizational provider; a process for ensuring that the provider credentials its practitioners.* *The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: The CMS or State review is no more than three years old; the organization obtains a survey report or letter from CMS or the State, from either the provider or from the agency, stating that the facility was reviewed and passed inspection; the report meets the organization's quality assessment criteria or standards. (Exception: Rural areas.)* NCQA CR7—Element A3	• CR305 Assessment of Organizational Providers ○ Procedure #5.H	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
13. The Contractor's organizational provider assessment policies and process includes: • For behavioral health, facilities providing mental health or substance abuse services in the following settings:	• CR305 Assessment of Organizational Providers ○ Procedure #1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Inpatient – Residential – Ambulatory • For physical health, at least the following providers: – Hospitals – Home health agencies – Skilled nursing facilities – Free-standing surgical centers NCQA HP CR7-Elements B&C		
14. The Contractor has documentation that it assesses behavioral health and/or physical health providers every 36 months. NCQA HP CR7-Elements D&E	• CR305 Assessment of Organizational Providers • CR DP02 Organizational Assessment and File Audit	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. If the Contractor delegates credentialing/recredentialing activities, the Contractor has a written delegation document with the delegate that: • Is mutually agreed upon. • Describes the delegated activities and responsibilities of the Contractor and the delegated entity. • Requires at least semiannual reporting by the delegated entity to the Contractor (includes	• ADM223 Delegation • CR301 Provider Credentialing and Recredentialing ○ Procedure #5	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
details of what is reported, how, and to whom). • Describes the process by which the Contractor evaluates the delegated entity's performance. • Specifies that the organization retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making. • Describes the remedies available to the Contractor (including circumstances that result in revocation of the contract) if the delegate does not fulfill its obligations, including revocation of the delegation agreement. NCQA CR8—Element A		
16. For new delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity to meet NCQA requirements before delegation began. *NA if the contractor does not delegate or if delegation arrangements have been in effect for longer than the look-back period.* NCQA CR8—Element B	• ADM223 Delegation ○ Procedure #1.B	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. For delegation agreements in effect 12 months or longer, the Contractor: • Annually reviews its delegate's credentialing policies and procedures. • Annually audits credentialing and recredentialing files against its standards for each year that delegation has been in effect. • Annually evaluates delegate performance against its standards for delegated activities. • Semiannually evaluates regular reports specified in the written delegation agreement. NCQA CR8—Element C	• ADM223 Delegation o Procedure #3 • CR301 Provider Credentialing and Recredentialing o Procedure #5	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
18. For delegation agreements that have been in effect for more than 12 months, at least once in each of the past two years, the Contractor identified and followed up on opportunities for improvement, if applicable. NCQA CR8—Element D	• CR DP15 Delegation Audit Process	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	32	X	1.00	=	32
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	32	**Total Score**		=	32
			Total Score ÷ Total Applicable			=	100%

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. *42 CFR 438.330(a)(1)* Contract: Exhibit B-2—14.1.1	• Quality Assessment and Performance Improvement Program ○ Quality Assessment and Performance Improvement Program Description pages 3-5 (as identified in the document) • Quality Assessment and Performance Improvement Plan SFY21-22	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor's QAPI Program includes conducting and submitting (to the State) annually and when requested by the Department performance improvement projects (PIPs) that focus on both clinical and nonclinical areas. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. Each PIP includes the following: • Measurement of performance using objective quality indicators. • Implementation of interventions to achieve improvement in the access to and quality of care. • Evaluation of the effectiveness of the interventions based on the objective quality indicators. • Planning and initiation of activities for increasing or sustaining improvement. *42 CFR 438.330(b)(1) and (d)(2) and (3)* Contract: Exhibit B-2—14.2.1.1, 14.3	• Quality Assessment and Performance Improvement Program ○ Performance Improvement Projects page 13 (as identified in the document) • Annual Quality Report CHP+ HMO ○ Performance Improvement Projects pages 27-31 (as identified in the document)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's QAPI Program includes collecting and submitting (to the State) annually: • Performance measure data using standard measures identified by the State. • Data, specified by the State, which enable the State to calculate the Contractor's performance using the standard measures identified by the State. • A combination of the above activities. *42 CFR 438.330(b)(2) and (c)* Contract: Exhibit B-2—14.4	• Quality Assessment and Performance Improvement Program • Annual Quality Report CHP+ HMO	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42 CFR 438.330(b)(3)* Contract: Exhibit B-2—14.6	• UM101 Medical Criteria for Utilization Review • UM102 Utilization Review Determinations • Quality Assessment and Performance Improvement Program ○ Quality Assessment and Performance Improvement Program Components ▪ Mechanisms to Detect Under-utilization and Over-utilization of services page 10 (as identified in the document)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor's QAPI Program includes mechanisms for identifying, investigating, analyzing, tracking, trending, and resolving any alleged quality of care concerns. Contract: Exhibit B-2—14.7.1-2	• QM201 Quality of Care Concern Investigations • Annual Quality Report CHP+ HMO ○ Quality of Care Concerns Monitoring pages 48-49 (as identified in the document)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. *Note: Persons with special health care needs shall mean persons having ongoing health conditions that have a biological, psychological, or cognitive basis; have lasted or are estimated to last for at least one year; and produce one or more of the following: (1) a significant limitation in areas of physical, cognitive, or emotional function; (2) dependency on medical or assistive devices to minimize limitation of function or activities; (3) for children: significant limitation in social growth or developmental function; need for psychological, educational, medical, or related services over and above the usual for the child's age; or special ongoing treatments such as medications, special diets, interventions or accommodations at home or at school.* *42 CFR 438.330(b)(4)* Contract: Exhibit B-2—14.6.1	• Quality Assessment and Performance Improvement Plan ○ Quality Assessment and Performance Improvement Program Components ▪ Quality, Safety, and Appropriateness of Clinical Care and Members with Special Health Care needs page 11 (as identified in the document) • Annual Quality Report CHP+ HMO ○ Mechanisms to Detect Quality and Appropriateness of Care for Members with Special Health Care Needs Page 46 (as identified in the document)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program at least annually. *42 CFR 438.330(e)(2)* Contract: Exhibit B-2—14.2.5	• Quality Assessment and Performance Improvement Program ○ QAPI Program Impact and Effectiveness Analysis pages 14-15 (as identified in the document) ○ Appendix A: QAPI Self-Assessment Tool pages 17-21 (as identified in the document)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor adopts or develops practice guidelines that meet the following requirements: • Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. • Consider the needs of the Contractor's members. • Are adopted in consultation with participating providers. • Are reviewed and updated periodically, as appropriate. *42 CFR 438.236(b)* Contract: Exhibit B-2—10.5.8.2-4	• QM311 Clinical Practice Guidelines • Provider Manual Section 3 ○ Clinical Practice Guidelines page 3-6 • COA Website: ○ https://www.coaccess.com/providers/resources/quality/ ▪ Clinical Practice Guidelines	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor adopts or develops practice guidelines for the following: • Perinatal, prenatal, and postpartum care. • Conditions related to persons with a disability or special health care needs. • Well-child care. Contract: Exhibit B-2—10.5.8.1	• QM311 Clinical Practice Guidelines • COA Website: ○ https://www.coaccess.com/providers/resources/quality/ ▪ Clinical Practice Guidelines	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor disseminates the guidelines to all affected providers and, upon request, members and potential members. *42 CFR 438.236(c)* Contract: Exhibit B-2—10.5.8	• QM311 - Clinical Practice Guidelines ○ Procedure 2 • COA Website ○ https://www.coaccess.com/providers/resources/quality/	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42 CFR 438.236(d)* Contract: Exhibit B-2—10.5.8.5	• QM311 Clinical Practice Guidelines • UM101 Medical Criteria for Utilization Review	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42 CFR 438.242(a)* Contract: Exhibit B-2—13.1.1	• Systems to Manage Health Information Data • COA Architecture Diagram V1.6	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor's health information system provides information about areas including but not limited to utilization, claims, grievances and appeals, and disenrollment for other than loss of CHP+ eligibility. *42 CFR 438.242(a)* Contract: Exhibit B-2—13.1.1, 8.1	• Systems to Manage Health Information Data • COA Architecture Diagram V1.6	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: COA's health information system provided information about utilization, claims, and grievances and appeals. However, during the interview session, COA reported that it does not collect any information related to disenrollment.		
Required Actions: COA must ensure that its health information system is able to collect, analyze, integrate, and report information about disenrollment for reasons other than loss of CHP+ eligibility if and when COA staff members become aware of this information.		
14. The Contractor's claims processing and retrieval systems collect data elements necessary to enable the mechanized claims processing and information retrieval systems operated by the State. • Contractor electronically submits encounter claims data in the interChange ANSI X12N 837 format directly to the Department's fiscal agent using the Department's data transfer protocol. The 837-format encounter claims (reflecting claims paid, adjusted, and/or denied by the Contractor) shall be submitted via a regular batch process.	• COA Architecture Diagram V1.6 • Claims SW-01	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.242(b)(1) Contract: Exhibit B-2—13.1.6.2		
15. The Contractor collects data on member and provider characteristics and on services furnished to members through an encounter data system (or other methods specified by the State). *42 CFR 438.242(b)(2)* Contract: Exhibit B-2—13.1.5.1, 13.1.6.2	• Systems to Manage Health Information Data • COA Architecture Diagram V1.6 • Claims SW-01	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. The Contractor ensures that data received from providers are accurate and complete by: • Verifying the accuracy and timeliness of reported data, including data from network providers compensated through capitation payments. • Screening the data for completeness, logic, and consistency. • Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies used for CHP+ quality improvement and care coordination efforts. *42 CFR 438.242(b)(3) and (4)* Contract: Exhibit B-2—13.6.1, 13.1.6.5.1	• Mechanisms to Ensure Accurate and Complete Data • Systems to Manage Health Information Data	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The Contractor: • Collects and maintains sufficient member encounter data to identify the provider who delivers any items or services to members. • Submits member encounter data to the State in Accredited Standards Committee (ASC) X12N 837, National Council for Prescription Drug Programs (NCPDP), and ASC X12N 835 formats as appropriate. • Submits member encounter data to the State at the level of detail and frequency specified by the State. *42 CFR 438.242(c)* Contract: Exhibit B-2—13.1.6.2, 13.1.6.3.1, 13.1.6.4-5	• Claims SW-01	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
18. The Contractor monitors members' perceptions of accessibility and adequacy of services provided, including: • Member surveys. • Anecdotal information. • Grievance and appeals data. • Call center data.	• Quality Assessment and Performance Improvement Program o Member Experience of Care pages 10-11 (as identified in the Document) • Annual Quality Report CHP+ HMO o Member Experience of Care pages 19-26 (as identified in the document)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[A-1] surveys. Contract: Exhibit B-2—14.5.1-2		

Results for Standard X—Quality Assessment and Performance Improvement							
Total	Met	=	17	X	1.00	=	17
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	18	**Total Score**		=	17
Total Score ÷ Total Applicable						=	94%

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

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2021–2022 Credentialing Record Review Tool
for Colorado Access

Review Period:	January 1, 2021—December 31, 2021
Date of Review:	December 14, 2021
Reviewer:	Sarah Lambie and Lauren Gomez
Health Plan Participant:	Travis Roth

Sample #	1	2	3	4	5	6	7	8	9	10
	Valid License/No Sanctions	DEA/CDS Certificate	Education/ Training	Board Certified	Work History	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits
File #1 Provider ID: **** Credentialing Date: 02/06/21	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #2 Provider ID: **** Credentialing Date: 03/04/21	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #3 Provider ID: **** Credentialing Date: 03/19/21	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #4 Provider ID: **** Credentialing Date: 04/19/21	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #5 Provider ID: **** Credentialing Date: 06/03/21	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2021–2022 Credentialing Record Review Tool
for Colorado Access

Sample #	1	2	3	4	5	6	7	8	9	10
	Valid License/No Sanctions	DEA/CDS Certificate	Education/ Training	Board Certified	Work History	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits
File #6 Provider ID: **** Credentialing Date: 06/30/21	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #7 Provider ID: **** Credentialing Date: 07/21/21	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #8 Provider ID: **** Credentialing Date: 08/19/21	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #9 Provider ID: **** Credentialing Date: 09/08/21	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #10 Provider ID: **** Credentialing Date: 10/13/21	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
Number of Applicable Elements	**10**	**5**	**10**	**2**	**10**	**10**	**10**	**10**	**10**	**10**
Number of Compliant Elements	**10**	**5**	**10**	**2**	**10**	**10**	**10**	**10**	**10**	**10**
Percentage Compliant	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Total Number of Applicable Elements	**87**
Total Number of Compliant Elements	**87**
Overall Percentage Compliant	**100%**

Key: Y = Yes; N = No; NA = Not Applicable

Instructions:

1. Current, valid license with verification that no State sanctions exist
2. Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate (applicable to practitioners qualified to write prescriptions—e.g., psychiatrists, MD, DO)
3. Education/training—the highest of board certification, residency, graduation from medical/professional school
4. Applicable if the practitioner states on the application that he or she is board certified
5. Most recent five years or from time of initial licensure (if less than five years)
6. Malpractice settlements in most recent five years
7. Current malpractice insurance (physicians: $500,000/$1.5 million) verified through certificate of insurance
8. Verified that provider is not excluded from participation in federal programs
9. Application must be complete (see compliance tool for elements of complete application)
10. Verification time limits:

Prior to Credentialing Decision	180 Calendar Days	365 Calendar Days
• DEA or CDS certificate • Education and training	• Current, valid license • Board certification status • Malpractice history • Exclusion from federal programs	• Signed application/attestation • Work history

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2021–2022 Recredentialing Record Review Tool
for Colorado Access

Review Period:	January 1, 2021—December 31, 2021
Date of Review:	December 14, 2021
Reviewer:	Sarah Lambie and Lauren Gomez
Health Plan Participant:	Travis Roth

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
File #1 Provider ID: **** Current Recredentialing Date: 01/31/21 Prior Credentialing or Recredentialing Date: 04/20/18	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #2 Provider ID: **** Current Recredentialing Date: 03/26/21 Prior Credentialing or Recredentialing Date: 06/01/18	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #3 Provider ID: **** Current Recredentialing Date: 05/20/21 Prior Credentialing or Recredentialing Date: 08/07/18	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #4 Provider ID: **** Current Recredentialing Date: 06/15/21 Prior Credentialing or Recredentialing Date: 08/20/18	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
Comments:									
File #5 Provider ID: **** Current Recredentialing Date: 07/07/21 Prior Credentialing or Recredentialing Date: 09/07/18	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #6 Provider ID: **** Current Recredentialing Date: 08/10/21 Prior Credentialing or Recredentialing Date: 10/11/18	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #7 Provider ID: **** Current Recredentialing Date: 09/20/21 Prior Credentialing or Recredentialing Date: 11/27/18	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #8 Provider ID: **** Current Recredentialing Date: 10/19/21 Prior Credentialing or Recredentialing Date: 12/23/18	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
File #9 Provider ID: **** Current Recredentialing Date: 10/19/21 Prior Credentialing or Recredentialing Date: 12/23/18	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #10 Provider ID: **** Current Recredentialing Date: 10/19/21 Prior Credentialing or Recredentialing Date: 12/23/18	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
Number of Applicable Elements	**10**	**6**	**NA**	**10**	**10**	**10**	**10**	**10**	**10**
Number of Compliant Elements	**10**	**6**	**NA**	**10**	**10**	**10**	**10**	**10**	**10**
Percentage Compliant	**100%**	**100%**	**NA**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Total Number of Applicable Elements	**76**
Total Number of Compliant Elements	**76**
Overall Percentage Compliant	**100%**

Key: Y = Yes; N = No; NA = Not Applicable

Instructions:

1. Current, valid license with verification that no State sanctions exist
2. Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate (applicable to practitioners qualified to write prescriptions—e.g., psychiatrists, MD, DO)

3. Applicable if the practitioner states on the application that he or she is board certified

4. Malpractice settlements in most recent five years

5. Current malpractice insurance (physicians: $500,000/$1.5 million) verified through certificate of insurance

6. Verified that provider is not excluded from participation in federal programs

7. Application must be complete (see compliance tool for elements of complete application)

8. Verification time limits:

Prior to Credentialing Decision	180 Calendar Days	365 Calendar Days
• DEA or CDS certificate	• Current, valid license • Board certification status • Malpractice history • Exclusion from federal programs	• Signed application/attestation

9. Within 36 months of previous credentialing or recredentialing approval date

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2021–2022 site review of **COA**.

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

HSAG Review Team	Title
Sarah Lambie	Project Manager III
Sara Dixon	Project Manager II
Eva Ogbon	Project Manager I
Lauren Gomez	Project Manager I
COA Participants	**Title**
Amanda Fitzsimons	Compliance Program Manager, Colorado Access
Elizabeth Foster	Manager of Customer Service, Colorado Access
Elizabeth Strammiello	Chief Compliance Officer, Colorado Access
Joseph Anderson	Director of Care Management, Colorado Access
Laura Coleman	Senior Quality Improvement Program Manager, Colorado Access
Marsha Aliaga-Dickens	Manager of Care Management, Colorado Access
Mika Gans	Director of Quality Improvement, Colorado Access
Reyna Garcia	Senior Director of Customer Service, Colorado Access
Stacy Stapp	Senior Quality Improvement Program Manager, Colorado Access
Taylor Mitchell	CHP+ Program Manager, Colorado Access
Travis Roth	Manager of Credentialing and Provider Data, Colorado Access
Ward Peterson	Director of Enrollment and CHP+, Colorado Access
Department Observers	**Title**
Jeffrey Jaskunas	CHP+ Program Manager
Jeff Helm	Program Design and Policy
Russell Kennedy	Quality and Compliance Specialist

Appendix D. Corrective Action Plan Template for FY 2021–2022

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 protocol (FTP) 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 2021–2022 Corrective Action Plan for COA

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
13. The Contractor's health information system provides information about areas including but not limited to utilization, claims, grievances and appeals, and disenrollment for other than loss of CHP+ eligibility. *42 CFR 438.242(a)* Contract: Exhibit B-2—13.1.1, 8.1	COA's health information system provided information about utilization, claims, and grievances and appeals. However, during the interview session, COA reported that it does not collect any information related to disenrollment.	COA must ensure that its health information system is able to collect, analyze, integrate, and report information about disenrollment for reasons other than loss of CHP+ eligibility if and when COA staff members become aware of this information.
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:		
HSAG Initial Review:		
Documents for Final Submission:		
Date of Final Evidence:		

Appendix E. Compliance Monitoring Review Protocol Activities

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

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the review to assess compliance with federal managed care regulations and Department contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all reviewers to ensure consistency in scoring across health plans.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided health plans with proposed review dates, group technical assistance, and training, as needed. • HSAG confirmed a primary health plan contact person for the review and assigned HSAG reviewers to participate in the review. • Sixty days prior to the scheduled date of the review, HSAG notified the health plan in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and review agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and the review activities. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. • Documents submitted for the review consisted of the completed desk review form, the compliance monitoring tool with the 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 credentialing, recredentialing, and organizational provider records that occurred between January 1, 2021, and December 31, 2021 (to the extent available at the time of the 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 the review. HSAG notified the health plan five days following receipt of the lists of records regarding the sample records selected.

For this step,	HSAG completed the following activities:
	• The HSAG review team reviewed all documentation submitted prior to the review and prepared a request for further documentation and an interview guide to use during the review.
Activity 3:	**Conduct the Review**
	• During the review, HSAG met with groups of the 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 review, HSAG provided health plan staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2021–2022 Department-approved Site Review Report template to compile the findings and incorporate information from the pre-review and review activities. • HSAG analyzed the findings and calculated final scores based on Department-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the Department**
	• HSAG populated the Department-approved report template. • HSAG submitted the draft 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.