CHP+

Child Health Plan *Plus*

Fiscal Year 2022–2023 Compliance Review Report

for

Colorado Access

March 2023

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

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) to comply with provisions of the Code of Federal Regulations, Title 42 (42 CFR)—Medicaid and CHIP managed care regulations published May 6, 2016, which became applicable to CHIP MCOs effective July 1, 2018. Additional revisions were released in November 2020, with an effective date of December 2020. The Department administers and oversees the Child Health Plan *Plus* (CHP+) program (Colorado's implementation of CHIP).

The CFR requires that states conduct a periodic evaluation of their MCOs and PIHPs (collectively referred to as managed care entities [MCEs]) to determine compliance with federal healthcare regulations and managed care contract requirements. The Department of Health Care Policy & Financing (the Department) has elected to complete this requirement for Colorado's CHP+ MCOs by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

In order to evaluate the CHP+ MCOs' compliance with federal managed care regulations and State contract requirements, the Department determined that the review period for fiscal year (FY) 2022–2023 was January 1, 2022, through December 31, 2022. This report documents results of the FY 2022–2023 compliance 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 2022–2023 compliance monitoring review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2021–2022 compliance review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the denials of authorization of services (denials), grievances, and appeals record reviews. Appendix C lists HSAG, CHP + MCO, and Department personnel who participated in some way in the compliance review process. Appendix D describes the corrective action plan (CAP) process the CHP+ MCO will be required to complete for FY 2022–2023 and the required template for doing so. Appendix E contains a detailed description of HSAG's compliance review activities consistent with the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[1-1]

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: 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)
I. Coverage and Authorization of Services	34	34	30	4	0	0	88%
II. Adequate Capacity and Availability of Services	14	14	14	0	0	0	100%
VI. Grievance and Appeal Systems	31	31	28	3	0	0	90%
XII. Enrollment and Disenrollment	6	6	6	0	0	0	100%
Totals	**85**	**85**	**78**	**7**	**0**	**0**	**92%**

*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 denials, grievances, and appeals record reviews. Details of the findings for the record reviews are in Appendix B—Record Review Tools.

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Denials	100	70	56	14	30	80%
Grievances	60	51	51	0	9	100%
Appeals	60	57	52	5	3	91%
Totals	**220**	**178**	**159**	**19**	**42**	**89%**

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

Standard I—Coverage and Authorization of Services

Evidence of Compliance and Strengths

COA's policies, procedures, and reporting documents outlined a comprehensive approach to review and authorize covered services using medical necessity and InterQual criteria in compliance with regulatory guidelines. Utilization management (UM) staff members participated in annual interrater reliability testing to ensure criteria are applied consistently. Staff members responsible for denial decisions had appropriate clinical expertise in treating the member's condition or disease. Ad-hoc reviewers were available through National Medical Reviews but were not frequently called upon. UM staff members were divided into specialties, one team of behavioral health and one team of physical health nurses and reviewers.

Denial sample records demonstrated a consistent process for logging and handling authorization requests in the GuidingCare (Altruista Health) system. Software updates completed during the review period included the addition of a provider authorization portal in calendar year (CY) 2022 where providers can make service requests online and documentation is seamlessly and automatically loaded into the GuidingCare system.

Case notes within the denial sample records showed that **COA** staff members outreached the requesting provider for more information when needed, typically at least once, and up to three times. In instances where the provider requested a peer-to-peer review, **COA** staff members advised the provider of specific office hours and a direct telephone number with which to reach the psychiatrist. In many denial sample cases, clinical considerations went beyond the black and white nature of InterQual guidelines to consider the individual member's situation and safety. Staff members discussed scheduling regular department meetings, working with the Department of Human Services and the court system, attending twice monthly meetings with care management staff members, and adding ad-hoc reviews as necessary, including reviewing high-needs members with the Department.

COA accurately clarified its submitted policies to remove continuation of benefits for the CHP+ line of business based on federal and State updates. Policies also included a note regarding the member's right to appeal under the Children and Youth Mental Health Treatment Act (CYMHTA), when applicable.

Policies, procedures, provider manuals, and member information regarding emergency conditions, emergency services, and post-stabilization services all contained required definitions consistent with State and federal definitions. The provider agreement, provider manual, and single case agreement information stated that **COA** does not bill Medicaid members for any charges incurred and that the State prohibits providers from balance billing Medicaid members. Internal procedures and claims systems were described to not require authorization for emergency services, whether in or out of network. Staff members in charge of claims system oversight described monitoring and updating claims coding on a regular basis to ensure all emergency service claims are paid and any questions are directed to the correct UM staff members. Customer service staff are trained in the overall benefits package and are available to clarify emergency services and post-stabilization services to members, if needed.

Opportunities for Improvement and Recommendations

HSAG recommends that **COA** include the core components of medical necessity as described in the federal definition (42 CFR 438.210[a][5]) as part of **COA**'s definition.

Although CYMHTA is mentioned in policies, **COA** CHP+ templates and notice of adverse benefit determination (NABD) samples did not mention CYMHTA. HSAG recommends adding this into template language, so it is captured in any applicable cases. Also, HSAG noted that the NABD letters to members did not include specific references to the clinical criteria (i.e., InterQual) reviewed. Although not a federal requirement, the State CHP+ NABD template encourages the CHP+ MCOs to include a reference to the health plan's criteria.

Lastly, many NABD letters included clinical terminology that may not be easy for the member to understand. HSAG recommends including a plain language explanation next to any clinical terminology (e.g., magnetic resonance imaging [MRI], a picture of your body, including bones, muscles, organs, and blood vessels).

Required Actions

Sample denial records contained the following issues:

- **COA** did not mail an NABD letter to the member in two cases and two additional cases were outside of the time frames.
- **COA** did not make two denial decisions within the required time frame.
- All NABD sample letters and templates included references to continuation of benefits, which is no longer applicable to the CHP+ line of business.
- Two sample denial records included Early and Periodic Screening, Diagnostic and Treatment (EPSDT) language that is also not applicable to the CHP+ line of business.
- NABD templates did not include information about the member's right to appeal under CYMHTA, when applicable.

To come into compliance with federal and State requirements, **COA** must:

- Update its procedures to further delineate provider claims issues which are separate from member-related issues in which a service is denied or partially denied. Policies, procedures, and monitoring must be enhanced to ensure that the member is notified in writing of the denial or partial denial of a service in a timely manner.
- Enhance its monitoring procedures to ensure that members are notified in a timely manner.

Standard II—Adequate Capacity and Availability of Services

Evidence of Compliance and Strengths

Policies, procedures, and documentation submitted by **COA** demonstrated oversight of the provider network to ensure access to covered services for members. In addition to the state-required annual and quarterly reports, staff members described reports to monitor "zero claims paid" providers who had not billed a claim in the previous two years. Staff members described this as a way to begin narrowing down providers who may have retired or closed their panels and use the list for outreach and engagement purposes.

Single case agreements are sought when needed, usually initiated through a provider authorization request. Staff members described these as priorities and completed the agreements either the same day or within four days alongside the UM department, provider relations, and the program director.

The provider manual and website included accurate information regarding time and distance standards, and provider network and quality department staff members also outreached providers to inform them of timely appointment standards prior to conducting monitoring activities such as secret shopper. Corrective action plans for providers who failed to comply with timely appointment standards were individualized based on the type of noncompliance documented and have shifted to an "opportunity" lens since the end of FY 2021–2022. Additional substance use disorder (SUD) monitoring was added in FY 2021–2022 and performed by Signal Behavioral Health Network.

Cultural competency efforts have been a focus in the organization, and staff members reported the addition of a vice president of diversity, equity, and inclusion (DEI) and an expanded team of DEI "consultants." Targeted outreach and engagement programs described during the interview included the following member groups: Latinx, homeless, refugee, and members recently released from prison. These member groups were noted as top priorities during the review period CY 2022. Related to accessibility to alternative languages, **COA**'s human resources department maintained a list of staff members who are bilingual and available to immediately translate for members and their family members as well as a 1-800 telephone line for additional languages. In terms of members with physical disabilities, the **COA** provider agreement appendix served as a data collection tool regarding providers who offered accommodations such as the ability to communicate with individuals who have hearing, vision, speech, or cognitive disabilities; and those who offered accessible office aids such as ramps, extra-wide doors, accessible treatment and examination rooms, etc. This information was also available to members as a searchable filter through the online provider directory.

Opportunities for Improvement and Recommendations

Geoaccess compliance reports, quarterly *Network Reports*, and the *Network Adequacy Plan* each included details of strengths and a few gaps in **COA**'s provider network. **COA** has an opportunity to continue working with the Department to identify ways to improve compliance with time and distance standards for:

- Urban counties: acute care hospitals, psychiatric hospitals, and psychiatric units in acute care hospitals.

- Rural counties: specialists (e.g., pediatric cardiology and pediatric endocrinology), particularly in the seven counties without access to acute care hospitals and the 14 counties without access to pediatric behavioral health, psychiatric hospitals, or psychiatric units in acute care hospitals.
- Frontier counties: specialists (e.g., pediatric cardiology and pediatric endocrinology), particularly in the two counties without access to acute care hospitals and the 14 counties without access to psychiatric hospitals or psychiatric units in acute care hospitals.

Required Actions

HSAG identified no required actions for this standard.

Standard VI—Grievance and Appeal Systems

Evidence of Compliance and Strengths

COA submitted its grievance and appeal policies and procedures, CHP+ member handbook, provider manual, and notice templates that defined key terms and provided information that supported **COA**'s implementation of requirements related to grievance and appeal systems. **COA**'s policies and procedures included information regarding members' rights such as the right to file a grievance at any time. **COA** also had a standard system, Altruista Health's GuidingCare, that tracks all information and data related to grievances and appeals.

Staff members described how they inform members of their rights if a member contacts **COA** to file a grievance and the ways the member or the member's authorized representative can submit a grievance. The member can submit a grievance by phone, e-mail, online, or fax to customer service, care managers, or other staff members, and all staff members are trained to submit grievances to the grievance team. Once the grievance is received, **COA** grievance coordinators will log, investigate, and work to resolve the issue in 15 working days. **COA** also described that if a member contacts the grievance department with a quality-of-care issue, the case will be sent to the Quality Department to be reviewed by a clinical staff member.

When a member files an appeal, in addition to sending a written acknowledgement letter, the **COA** appeals coordinator verbally contacts the member to ensure that the member, or the member's representative, is aware that they have the right to submit documents, records, and other information, and that all comments will be considered by the decision maker without regard to whether such information was submitted or considered in the initial adverse benefit determination. **COA** also listed multiple specialty physicians that are employed with **COA** to make decisions on appeals, and the appeals coordinator is responsible to ensure that the decision maker was not involved in the previous decision of the denial.

Staff members reported that translation services are available in English and Spanish to accommodate the member, if needed. **COA** also reported the availability of DocuSign, Zoom, and other technology platforms to assist the member in completing forms or other procedural steps related to grievances and appeals.

Grievance and appeal notices were written at an easy-to-understand level, at or around the sixth-grade reading level. Grievance records included in the acknowledgement letters and resolution letters provided accurate information to the member. **COA** consistently met the timeliness requirements for grievance acknowledgement and resolution notices.

Opportunities for Improvement and Recommendations

HSAG identified no opportunities for improvement or recommendations.

Required Actions

COA's appeal record reviews showed 91 percent compliance. One out of the 10 sample appeal records did not comply with the appeal acknowledgement letter time frame set forth by the State. **COA** must enhance its monitoring system to ensure that appeal acknowledgement letters are sent in a timely manner.

Additionally, **COA**'s appeal letters and website included continuation of benefits language. **COA** must remove all language that implies continuation of benefits from the appeal resolution letters and clarify on its website that continuation of benefits does not apply to CHP+ members.

HSAG reviewed the **COA** website and found an old policy that inaccurately states that the member must follow an oral request of an appeal in writing. **COA** must remove the statement that requires the member to follow an oral request by writing to adhere to federal regulations.

Standard XII—Enrollment and Disenrollment

Evidence of Compliance and Strengths

COA submitted its *Nondiscrimination* and *Member Enrollment and Disenrollment* policies that described a process and procedure to receive daily enrollment files from the State, electronically, and in the order in which they are received. Staff members described that upon receipt of the 834 files from the State, **COA** staff members have a process internally to check for errors. Staff members reported that in the past month less than 1 percent of manual updates were needed for minor data issues.

COA describes a process to ensure that it does not discriminate against members. **COA** staff members reported that if a member had a complaint related to discrimination, **COA** would assist the member to file a grievance with the grievance team and work with the member to resolve the situation to the

member's satisfaction. **COA** also described a process to run quarterly reports to ensure that grievances and disenrollments are not due to quality-of-care issues.

COA reported that it rarely disenrolls members due to extreme disruptive behavior and would work with the member in every possible way including, but not limited to, developing a communication plan to redirect the member toward appropriate behaviors and sometimes a new provider, establish boundaries, and get the member back on track with treatment goals. **COA** staff members reported that if they did request disenrollment of a member, the decision would be in conjunction with the **COA** chief executive officer and the Department. In that rare instance, **COA** would ensure there would be a warm handoff to the new health plan.

Opportunities for Improvement and Recommendations

COA submitted its *CHP+ Member Handbook* that accurately included details of new member enrollments and corresponding member rights and responsibilities. The *CHP+ Member Handbook* included a termination section on page 15 that stated, "Your CHP+ coverage ends the first time one of these things happen" and bullet points four and five included:

- *You are unable to have a good patient-provider relationship with your health care providers. This means things like not showing up for scheduled appointments. It also means not meeting other member responsibilities.*
- *You are disruptive or abusive. Also, if you make it hard to have normal business operations at Colorado Access. Or at your provider's office. Or if you pose a physical threat to your provider or our staff.*

HSAG recommends that **COA** clarify language for bullet points four and five in its *CHP+ Member Handbook,* located under the termination section, to better align with federal and State regulations as well as **COA**'s own procedures in which staff members would likely make an attempt to work with member prior to requesting disenrollment for disruptive behavior.

Required Actions

HSAG identified no required actions for this standard.

2. Overview and Background

Overview of FY 2022–2023 Compliance Monitoring Activities

For the FY 2022–2023 compliance review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services, Standard II—Adequate Capacity and Availability of Services, Standard VI—Grievance and Appeal Systems, and Standard XII—Enrollment and Disenrollment. Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Review Methodology

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

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

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

Objective of the Compliance Review

The objective of the compliance review was to provide meaningful information to the Department and the CHP + MCO regarding:

- The CHP + MCO'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 CHP + MCO 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 CHP + MCO, as assessed by the specific areas reviewed.
- Possible interventions recommended to improve the quality of the CHP + MCO's services related to the standard areas reviewed.

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

FY 2021–2022 Corrective Action Methodology

As a follow-up to the FY 2021–2022 compliance review, each CHP+ MCO 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 CHP+ MCO 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 CHP+ MCO 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 2021–2022 compliance monitoring review.

Summary of FY 2021–2022 Required Actions

For FY 2021–2022, HSAG reviewed Standard III—Coordination and Continuity of Care, Standard IV—Member Rights, Protections, and Confidentiality, Standard VIII—Credentialing and Recredentialing, and Standard X—QAPI.

Related to Standard X—QAPI, **COA** was required to complete one corrective action, which was to 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.

Summary of Corrective Action/Document Review

COA submitted a proposed CAP in March 2022. HSAG and the Department reviewed and approved the proposed plan and responded to **COA**. **COA** submitted a draft monitoring plan for disenrollment and the *CHP+ CAP Dashboard Requirements* policy in July 2022 and finalized the monitoring plan and dashboard requirements policy in July 2022.

Summary of Continued Required Actions

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

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor ensures that the services are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished. *42 CFR 438.210(a)(3)(i)* Contract: Exhibit B—11.11.1	• Utilization Management Program Description ○ Philosophy Section ○ Program Framework Section	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42 CFR 438.210(a)(3)(ii)* Contract: Exhibit B—11.11.3	• UM 102 Utilization Review Determinations ○ Policy Statement Bullet 6	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor may place appropriate limits on services— • On the basis of criteria applied under the State plan (such as medical necessity). • For the purpose of utilization control, provided that: – The services furnished can reasonably achieve their purpose. – Family planning services are provided in a manner that enables the member to be free from coercion and choose the method of family planning to be used. *42 CFR 438.210(a)(4)* Contract: Exhibit B—11.11.2, 11.11.4.1, 11.11.4.2, and 11.11.4.2.2	• UM 102 Utilization Review Determinations ○ Policy Section A-C	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor covers all medically necessary covered treatments for covered behavioral health (BH) diagnoses, regardless of any co-occurring conditions. The Contractor must ensure that the diagnosis of an intellectual or developmental disability, a neurological or neurocognitive disorder, or a traumatic brain injury does not preclude an individual from receiving a covered BH service. *HB19-1269: Section 12—25.5-5-402(3)(h-i)* Contract: Exhibit B—11.9.1.3	• UM101 Criteria for Utilization Review ○ Policy Section paragraph 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Contractor definition of "medically necessary": • Is no more restrictive than that used in Colorado's Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in Colorado statutes and regulations, the Health First Colorado plan, and other Colorado policies and procedures; and • Addresses the extent to which the CHP+ is responsible for covering services that address: – The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability. – The ability for a member to achieve age-appropriate growth and development. – The ability for a member to attain, maintain, or regain function capacity. *42 CFR 438.210(a)(5)*	• UM 101 Utilization Management Criteria ○ Definitions Section ○ Policy Section	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract: Exhibit B—2.1.71 and 11.1.2 10 CCR 2505-10 8.076.1.8		
6. The Contractor and its subcontractors have in place and follow written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42 CFR 438.210(b)(1)* Contract: Exhibit B—11.12.2	• UM 102 Utilization Review Determinations	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The Contractor and its subcontractors have mechanisms in place to ensure consistent application of review criteria for authorization decisions. *42 CFR 438.210(b)(2)(i)* Contract: Exhibit B—11.12.2	• UM 101 Criteria for Utilization Review • 2021 Inter-Rater Reliability Report	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor and its subcontractors have in place mechanisms to consult with the requesting provider for medical services when appropriate. *42 CFR 438.210(b)(2)(ii)* Contract: Exhibit B—11.12.2.4	• UM102 Utilization Review Determinations ○ Policy bullet 4 • UM 105 Peer Review Process	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by an individual who has appropriate expertise in treating the member's medical or BH needs.	• UM 100 Qualifications for Staff Engaged in Utilization Management Activities	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.210(b)(3) Contract: Exhibit B—11.11.5		
10. The Contractor notifies the requesting provider and gives the member written notice of any decision by the Contractor to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. *Note: Notice to the provider may be oral or in writing.* *42 CFR 438.210(c)* Contract: Exhibit B—8.5.1	• UM 102 Utilization Review Determinations ○ Section 7.C • CHP HMO MH.PH Denial Letter (redacted) • CHP HMO SUD Denial Letter (redacted)	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: In file samples #4 and #9, the member was not mailed an NABD letter.		
Required Actions: COA must update its procedures to further delineate provider claims issues which are separate from member-related issues in which a service is denied or partially denied. Policies, procedures, and monitoring must be enhanced to ensure that the member is notified in writing of the denial or partial denial of a service.		
11. The Contractor adheres to the following time frames for making standard and expedited authorization decisions: • For standard authorization decisions—as expeditiously as the member's condition requires and not to exceed 10 calendar days following the receipt of the request for service. • If the provider indicates, or the Contractor determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or	• UM 102 Utilization Review Determinations ○ Section 3.A ○ Section 4.A ○ Section 5.A	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
regain maximum function, the Contractor makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service. *42 CFR 438.210(d)(1–2)* Contract: Exhibit B—8.5.3.5; 8.5.3.7		
Findings: In denial file samples #4 and #9, COA did not make denial decisions within the required time frame. File #4 included a request for neonatal intensive care unit (NICU) authorization but went beyond the 72-hour requirement for expedited requests, and file #9 was a standard authorization request that did not include a decision until the 24th day with no evidence of an extension.		
Required Actions: COA must enhance its monitoring procedures to ensure that all authorization decisions are made within required time frames.		
12. The Contractor may extend the time frame for making standard or expedited authorization decisions by up to 14 additional calendar days if: • The member or the provider requests an extension, or • The Contractor justifies (to the Department, upon request) a need for additional information and how the extension is in the member's interest. *42 CFR 438.210(d)(1)(i–ii) and (d)(2)(ii)* Contract: Exhibit B—8.5.3.5.1-2; 8.5.3.7.1	• UM 102 Utilization Review Determinations ○ Section 3.E.2 ○ Section 4.D.4 • CHP and ACC Member Extension Letter • CHP and ACC Provider Extension Letter	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor provides telephonic or telecommunications response within 24 hours of a request for prior authorization of covered outpatient drugs. *42 CFR 438.210(d)(3)* *42 US Code 1396r-8(d)(5)(a)* Contract: Exhibit B—11.9.2.2.1	• Rx DP28 Medication Utilization Review ○ Section 2.A.3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The notice of adverse benefit determination must be written in language easy to understand, available in state-established prevalent non-English languages in the region, and available in alternative formats for persons with special needs. *42 CFR 438.404(a)* Contract: Exhibit B—8.5.1.1-4	• UM 102 Utilization Review Determinations ○ Section 7.D	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to and copies of all documents and records relevant to the adverse benefit determination (includes medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits). • The member's (or member's designated representative's) right to request one level of appeal with the Contractor and the procedures for doing so.	Inform CHP+ MCOs that federal rule changes in May 2016 for CHIP excluded the requirement that member information include "benefits will continue when the member files an appeal." The Department CHP+ MCO contract removed the requirement in July 2021. • UM 102 Utilization Review Determinations ○ Section 7.C • CHP MH.PH Denial Letter (redacted) • CHP SUD Denial Letter (redacted)	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The member's right to request a State review after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State review. • The circumstances under which an appeal process can be expedited and how to make this request. • The member's right to appeal under the Child and Youth Mental Health Treatment Act (CYMHTA), when applicable. *42 CFR 438.404(b)* Contract: Exhibit B—8.5.1.5-12		
Findings: All NABDs included references to continuation of benefits, which is no longer applicable to the CHP+ line of business. Two sample denial records (#8 and #10) included EPSDT language that is also not applicable to the CHP+ line of business. In sample denial file #8, notably, COA monitoring procedures discovered the error of including the EPSDT language, and COA mailed an updated letter. However, the same error occurred in sample file #10 the following month. COA included references to CYMHTA in its policies but did not include this language in its templates.		
Required Actions: COA must make necessary system and procedural updates to ensure that templates being used for CHP+ denials do not include references to continuation of benefits or EPSDT but do include information about the member's right to appeal under CYMHTA, when applicable.		
16. Notice of adverse benefit determination for denial of behavioral, mental health, or SUD benefits includes, in plain language: • A statement explaining that members are protected under the federal Mental Health Parity and Addiction Equity Act (MHPAEA), which provides that limitations placed on access to mental health and SUD benefits may be no greater than any limitations placed on access to medical and surgical benefits.	• UM 102 Utilization Review Determinations ○ Section 7 • CHP MH.PH Denial Letter (redacted) • CHP SUD Adverse Denial Letter (redacted)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• A statement providing information about contacting the office of the ombudsman for BH care if the member believes their rights under the MHPAEA have been violated. • A statement specifying that members are entitled, upon request to the Contractor and free of charge, to a copy of the medical necessity criteria for any behavioral, mental, and SUD benefit. *HB19-1269: Section 6—10-16-113 (I), and (II), and (III)* Contract: Exhibit B—8.5.1.13.1-3		
17. The Contractor mails the notice of adverse benefit determination within the following time frames: • For termination, suspension, or reduction of previously authorized CHP+-covered services, as defined in 42 CFR 431.211, 431.213 and 431.214 (see below). • For denial of payment, at the time of any denial affecting the claim. • For standard service authorization decisions that deny or limit services, no later than 10 calendar days after receipt of request for service. • For expedited service authorization decisions, no later than 72 hours after receipt of request for service. • For extended service authorization decisions, no later than the date the extension expires. • For service authorization decisions not reached within the required time frames, on the date the time frames expire. *42 CFR 438.404(c)*	• UM 102 Utilization Review Determination ○ Section 7	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.210(d) Contract: Exhibit B—8.5.3.5-7		
Findings: In file samples #4 and #9, the member was not mailed an NABD letter. File #1 was not sent within the expedited time frame of 72 hours, and file #3 was sent beyond the 10 calendar days.		
Required Actions: COA must update its procedures to further delineate provider claims issues which are separate from member-related issues in which a service is denied or partially denied. Policies, procedures, and monitoring must be enhanced to ensure that the member is notified in writing of the denial or partial denial of a service.		
18. For reduction, suspension, or termination of a previously authorized CHP+-covered service, the Contractor gives notice at least ten (10) days before the intended effective date of the proposed adverse benefit determination except: • The Contractor gives notice on or before the intended effective date of the proposed adverse benefit determination if: – The Contractor has factual information confirming the death of a member. – The Contractor receives a clear written statement signed by the member that the member no longer wishes services, or gives information that requires termination or reduction of services and indicates that the member understands that this must be the result of supplying that information. – The member has been admitted to an institution where the member is ineligible under the plan for further services. – The member's whereabouts are unknown, and the post office returns Contractor mail directed to the member indicating no forwarding address.	• UM 102 Utilization Review Determination ○ Section 7.B	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– The Contractor establishes that the member has been accepted for CHP+ services by another local jurisdiction, state, territory, or commonwealth. – A change in the level of medical care is prescribed by the member's physician. – The notice involves an adverse benefit determination made with regard to the preadmission screening requirements. • If probable member fraud has been verified, the Contractor gives notice five calendar days before the intended effective date of the proposed adverse benefit determination. *42 CFR 438.404(c)* *42 CFR 431.211* *42 CFR 431.213* *42 CFR 431.214* Contract: Exhibit B—8.5.3.1-2 and 8.5.3.3.1-8		
19. If the Contractor extends the time frame for standard authorization decisions, it must give the member written notice of the reason for the extension and inform the member of the right to file a grievance if the member disagrees with that decision. *42 CFR 438.404(c)(4)* Contract: Exhibit B—8.5.3.5.2	• UM 102 Utilization Review Determinations ○ Section 3.E.3 ○ Section 6.D.2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
20. The Contractor provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42 CFR 438.210(e)* Contract: Exhibit B—11.12.6	• UM 100 Qualifications for Staff Engaged in Utilization Management Activities ○ Section 1.A	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
21. The Contractor defines emergency medical condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part. *42 CFR 438.114(a)* Contract: Exhibit B—2.1.37.1-3	• UM 103 Emergency and Post-Stabilization Care ○ Definitions Section	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
22. The Contractor defines emergency services as covered inpatient or outpatient services furnished by a provider that is qualified to deliver these services and are needed to evaluate or stabilize an emergency medical condition. *42 CFR 438.114(a)* Contract: Exhibit B—2.1.38	• UM 103 Emergency and Post-Stabilization Care ○ Definitions Section	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
23. The Contractor defines poststabilization care services as covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or provided to improve or resolve the member's condition. *42 CFR 438.114(a)* Contract: Exhibit B—2.1.87	• UM 103 Emergency and Post- Stabilization Care ○ Definitions Section	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
24. The Contractor does not require prior authorization for emergency services or urgently needed services. *42 CFR 438.10(g)(2)(v)(B)* Contract: Exhibit B—11.9.4.8	• UM 103 Emergency and Post-Stabilization Care ○ Section 1.B	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
25. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. *42 CFR 438.114(c)(1)(i)* Contract: Exhibit B—11.9.4.2	• UM 103 Emergency and Post-Stabilization Care ○ Section 1.C	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
26. The Contractor may not deny payment for treatment obtained under either of the following circumstances: • A member had an emergency medical condition, including cases in which the absence of immediate medical attention would *not* have had the following outcomes: – Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; – Serious impairment to bodily functions; or	• UM 103 Emergency and Post-Stabilization Care ○ Definitions Section ○ Section 1.D	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Serious dysfunction of any bodily organ or part. *(Note: The Contractor bases its coverage decisions for emergency services on the severity of the symptoms at the time of presentation and covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. 42 CFR 438.114—Preamble)* • A representative of the Contractor's organization instructed the member to seek emergency services. *42 CFR 438.114(c)(1)(ii)* Contract: Exhibit B—11.9.4.4.1-2		
27. The Contractor does not: • Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms. • Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent failing to notify the member's primary care provider or the Contractor of the member's screening and treatment within 10 calendar days of presentation for emergency services. *42 CFR 438.114(d)(1)* Contract: Exhibit B—11.9.4.5 and 11.9.4.15.3	• UM 103 Emergency and Post-Stabilization Care ○ Section 1.E	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
28. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42 CFR 438.114(d)(2)* Contract: Exhibit B—11.9.4.6	• UM 103 Emergency and Post-Stabilization Care ○ Section 1.G	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
29. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment. *42 CFR 438.114(d)(3)* Contract: Exhibit B—11.9.4.9	• UM 103 Emergency and Post-Stabilization Care ○ Section 1.F	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
30. The Contractor is financially responsible for poststabilization care services that are prior authorized by an in-network provider or the Contractor's representative, regardless of whether they are provided within or outside the Contractor's network of providers. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(i)* Contract: Exhibit B—11.9.4.10	• UM 103 Emergency and Post-Stabilization Care ○ Section 2.B.1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
31. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative but are administered to maintain the member's stabilized condition within one hour of a request to the organization for pre-approval of further poststabilization care services. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(ii)* Contract: Exhibit B—11.9.4.11	• UM 103 Emergency and Post-Stabilization Care ○ Section 2.B.2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
32. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the member's stabilized condition if: • The organization does not respond to a request for pre-approval within one hour. • The organization cannot be contacted. • The organization's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the organization must give the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with care of the patient until a plan provider is reached or one of the criteria in 422.113(c)(2)(iii) is met. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(iii)* Contract: Exhibit B—11.9.4.11.1-3	• UM 103 Emergency and Post-Stabilization Care ○ Section 2.B.3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
33. The Contractor's financial responsibility for poststabilization care services it has not pre-approved ends when: • A plan physician with privileges at the treating hospital assumes responsibility for the member's care, • A plan physician assumes responsibility for the member's care through transfer, • A plan representative and the treating physician reach an agreement concerning the member's care, or • The member is discharged. *42 CFR 438.114(e)* *42 CFR 422.113(c)(3)* Contract: Exhibit B—11.9.4.13.1-4	• UM 103 Emergency and Post-Stabilization Care ○ Section 2.C	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
34. If the member receives poststabilization care services from a provider outside the Contractor's network, the Contractor does not charge the member more than they would be charged if the member had obtained the services through an in-network provider. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(iv)* Contract: Exhibit B—11.9.4.12	• UM103 Emergency and Post-Stabilization Care ○ Section 2.D	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	30	X	1.00	=	30
	Partially Met	=	4	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	34	**Total Score**		=	30
				Total Score ÷ Total Applicable		=	88%

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor maintains and monitors a network of providers sufficient to provide access to all covered services to all members, including those with limited English proficiency or physical or mental disabilities. The provider network includes the following provider types: primary care (adult and pediatric), OB/GYN providers, specialists, hospitals, pharmacies, and behavioral health (mental and substance use disorder, adult and pediatric). *42 CFR 438.206(b)(1)* Contract: Exhibit B—9.1.1; 9.3.1; 9.5.1.1	• PNS202 Selection and Retention of Providers • PNS217 Single Case Agreement Policy • COA-Provider-Appendix • CHP_NetworkRpt_Q1FY22-23	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor ensures that its primary care and specialty care provider network complies with time and distance standards as follows: • Pediatric primary care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Pediatric specialty care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—100 miles or 100 minutes • Obstetrics or gynecology: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes	• PNS202 Selection and Retention of Providers • CO2022-23_Q1_GeoaccessCompliance_CHP+MCO	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Physical therapy/occupational therapy/speech therapy: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—100 miles or 100 minutes • Pharmacy: – Urban counties—10 miles or 10 minutes – Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes • Acute care hospitals: – Urban counties—20 miles or 20 minutes – Rural counties—30 miles or 30 minutes – frontier counties—60 miles or 60 minutes *42 CFR 438.206(a)* Contract: Exhibit B—9.3.10		

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor ensures that its BH provider network complies with time and distance standards as follows: • Acute care hospitals: – Urban counties—20 miles or 20 minutes – Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes • Psychiatrists and psychiatric prescribers for children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes • Mental health providers for children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes • SUD providers for children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes *Note: If there are no BH providers that meet the BH provider standards within the defined area for a specific member, then the Contractor shall not be bound by the time and distance requirements. (Exhibit B—9.3.11.2)* *42 CFR 438.206(a)* Contract: Exhibit B-1—10.2.1.12, 10.2.1.13.1	• PNS202 Selection and Retention of Providers • CO2022-23_Q1_GeoaccessCompliance_CHP+MCO	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor provides female members with direct access to a women's health care specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health care specialist. *42 CFR 438.206(b)(2)* Contract: Exhibit B—9.3.13	• PNS202 Selection and Retention of Providers • CHP_NetworkRpt_Q1FY22-23	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Contractor provides for a second opinion from a network provider or arranges for the member to obtain one outside the network (if there is no qualified provider within the network), at no cost to the member. *42 CFR 438.206(b)(3)* Contract: Exhibit B—9.3.22	• PNS219 Access to Primary and Secondary Care • COA Provider Manual ○ Section 4 Provider Responsibilities ▪ Page 4-3 Second Opinion	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. If the provider network is unable to provide necessary covered services to a particular member in network, the Contractor must cover the services (timely and without compromising the member's quality of care or health) out of network for as long as the Contractor is unable to provide them. *42 CFR 438.206(b)(4)* Contract: Exhibit B—9.3.23.1	• PNS217 Single Case Agreement Policy • PNS219 Access to Primary and Secondary Care • Single Case Agreement_CHP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor requires out-of-network providers to coordinate with the Contractor for payment and ensures that the cost to the member is no greater that it would be if the services were furnished within the network. *42 CFR 438.206(b)(5)* Contract: Exhibit B—9.3.23.2	• PNS217 Single Case Agreement Policy • Single Case Agreement_CHP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor must meet, and require its providers to meet, the State standards for timely access to care and services, taking into account the urgency of the need for services. The Contractor ensures that services are available as follows: • Emergency BH care: – By phone within 15 minutes of the initial contact. – In-person within 1 hour of contact in urban and suburban areas. – In-person within 2 hours of contact in rural and frontier areas. • Urgent care within 24 hours from the initial identification of need. • Non-urgent symptomatic care visit within 7 calendar days after member request. • Non-urgent medical or non-symptomatic well care within one month after member request (unless required sooner to ensure the American Academy of Pediatrics Bright Futures Schedule). • Outpatient follow-up appointments within seven days after discharge from hospitalization.	• COA Website ○ Member Services Quality https://www.coaccess.com/members/services/quality • COA Provider Manual ○ Section 3 Quality Management ▪ Pages 3-3 to 3-5 Accessibility and Availability of Services	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Members may not be placed on waiting lists for initial routine BH services. *42 CFR 438.206(c)(1)(i)* Contract: Exhibit B—9.3.17		
9. The Contractor and its providers offer hours of operation that are no less than the hours of operation offered to commercial members or that are comparable to other CHP+ providers. The Contractors network provides: • Minimum hours of provider operation from 8:00 a.m. to 5:00 p.m. Mountain Time, Monday through Friday. • Extended hours on evenings and weekends, including access to clinical staff, not just an answering service or referral service staff. • Alternatives for emergency department visits for after-hours urgent care. *42 CFR 438.206(c)(1)(ii)* Contract: Exhibit B—7.3.4.2; 9.3.5-9.3.6.1	• PNS306 Provider Availability • COA-Provider-Appendix • Provider Manual ○ Sections 4 Provider Responsibilities ▪ Page 4-1 Primary Care Providers ▪ Pages 4-2 to 4-3 Specialty Care Providers • COA Website (can search provider directory for urgent care providers) ○ Find A Provider	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor makes services included in the contract available 24 hours a day, 7 days a week, when medically necessary. *42 CFR 438.206(c)(1)(iii)* Contract: Exhibit B—9.3.8; 9.3.9; 9.3.17.1; 11.9.4.7	• PNS306 Provider Availability • Provider Manual ○ Sections 4 Provider Responsibilities ▪ Page 4-1 Primary Care Providers ▪ Pages 4-2 to 4-3 Specialty Care Providers	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor ensures timely access by: • Establishing mechanisms to ensure compliance with access (e.g., appointment) standards by network providers. • Monitoring network providers regularly to determine compliance, including research to determine solutions for any causal systemic issues. • Taking corrective action and notifying the Department if there is failure to comply. *42 CFR 438.206(c)(1)(iv)–(vi)* Contract: Exhibit B—9.3.17-9.3.19	• PNS306 Provider Availability • PNS DP01Complaints Regarding Access to Care • QAPI Program Description_2022 ○ Page 9 Accessibility and Availability of Services • CHP HMO_QualityRpt_FY21-22 ○ Pages 38-41 Secret Shopper	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. This includes:	• ADM206 Culturally Sensitive Services for Diverse Populations • ADM207 Communications for LEP and SI-SI Persons • ADM208 Member Materials • Staff Training	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Developing and/or providing cultural competency training programs, as needed, to network providers and health plan staff regarding: – Health care attitudes, values, customs, and beliefs that affect access to and benefit from health care services. – Medical risks associated with the member population's racial, ethnic, and socioeconomic conditions. • Identifying members whose cultural norms and practices may affect their access to health care. These efforts shall include, but are not limited to, inquiries conducted by the Contractor of the language proficiency of individual members during orientation or while being served by providers. *42 CFR 438.206(c)(2)* Contract: Exhibit B—2.1.27; 7.2	○ COA DEI Core Curriculum • Provider Training ○ COA Website: https://www.coaccess.com/providers/resources/trainings/ ▪ Cultural Responsiveness • COA Provider Manual ○ Section 2 Colorado Access Policies ▪ Page 2-1 Diversity and Cultural Competency Training Program ▪ Pages 2-1 to 2-2 Effective Communication and Language Assistance	
13. The Contractor must ensure that network providers have the ability to provide physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities. *42 CFR 438.206(c)(3)* Contract: Exhibit B—9.1.6.7	• COA-Provider-Appendix ○ Page 4 • COA Website ○ Find A Provider: • COA Provider Manual ○ Section 2 Colorado Access Policies ▪ Page 2-1 Diversity and Cultural Competency Training Program ▪ Pages 2-1 to 2-2 Effective Communication and Language Assistance	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor submits to the State (in a format specified by the State) documentation to demonstrate that the Contractor offers an appropriate range of preventive, primary care, and specialty services that is adequate in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. • A *Network Adequacy Plan* is submitted to the State annually. • A *Network Report* is submitted to the State quarterly. • A *Network Changes and Deficiencies Report* is submitted to the State within five days after the Contractor's knowledge of an unexpected or anticipated material change to the network or a network deficiency that could affect service delivery, availability, or capacity within the network. *42 CFR 438.207(b)* Contract: Exhibit B—9.4-9.5	• CHP_NetworkRpt_Q1FY22-23	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an established internal grievance and appeal system in place for members, or providers acting on their behalf, or designated member representatives. A grievance and appeal system means the processes the Contractor implements to handle grievances and appeals of an adverse benefit determination, as well as processes to collect and track information about grievances and appeals. *42 CFR 438.400(b)* *42 CFR 438.402(a)* CHP+ Contract: Exhibit B—8.1 10 CCR 2505-10 8.209.1	• ADM203 Member Grievance Process • UM106 Member Appeal Process	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor defines adverse benefit determination as: • The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. • The reduction, suspension, or termination of a previously authorized service. • The denial, in whole, or in part, of payment for a service. • The failure to provide services in a timely manner, as defined by the State. • The failure to act within the time frames defined by the State for standard resolution of grievances and appeals. • The denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other).	• UM102 Utilization Review Determinations ○ Definitions • UM106 Member Appeal Process ○ Definitions section	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Note: A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a ''clean claim'' at 42 CFR §447.45(b) is not an adverse benefit determination. *42 CFR 438.400(b)* CHP+ Contract: Exhibit B—2.1.1 10 CCR 2505-10 8.209.2.A		
3. The Contractor defines "appeal" as a review by the Contractor of an adverse benefit determination. *42 CFR 438.400(b)* CHP+ Contract: Exhibit B—2.1.3 10 CCR 2505-10 8.209.2.B	• UM106 Member Appeals Process ○ Definitions Section	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor defines "grievance" as an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. A grievance includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision. *42 CFR 438.400(b)* CHP+ Contract: Exhibit B—2.1.50 10 CCR 2505-10 8.209.2.D, 8.209.4.A.3.c.i	• ADM203 Member Grievance Process ○ Definitions Section	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor has provisions for who may file: • A member may file a grievance, a Contractor-level appeal, and may request a State fair hearing. • With the member's written consent, a provider or authorized representative may file a grievance, a Contractor-level appeal, and may request a State fair hearing on behalf of a member. *Note: Throughout this standard, when the term "member" is used, it includes providers and authorized representatives acting on behalf of the member.* *42 CFR 438.402(c)* CHP+ Contract: Exhibit B—8.5.1.7; 8.6.5	• AMD203 Member Grievance Process ○ Definitions Section ○ Policy Section • UM106 Member Appeal Process ○ Definitions section ○ Policy section, paragraph 1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, providing interpreter services and toll-free numbers that have adequate TeleTYpe/Telecommunications Device for the Deaf (TTY/TTD) and interpreter capability. *42 CFR 438.406(a)* CHP+ Contract: Exhibit B—8.2 10 CCR 2505-10 8.209.4.C	• ADM 203 Member Grievance Process ○ Section 9 • ADM 207 Effective Communication with LEP and SI-SI Persons • UM106 Member Appeal Process ○ Policy section, second paragraph • COA Website-Member Services Appeals: https://www.coaccess.com/members/services/appeals/ • COA Website-Member Services Grievances: https://www.coaccess.com/members/services/grievances/	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who: • Were not involved in any previous level of review or decision-making nor a subordinate of any such individual. • Have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding any of the following: – An appeal of a denial that is based on lack of medical necessity. – A grievance regarding the denial of expedited resolution of an appeal. – A grievance or appeal that involves clinical issues. *42 CFR 438.406(b)(2)* CHP+ Contract: Exhibit B—8.4.4; 8.6.3 10 CCR 2505-10 8.209.5.C, 8.209.4.E	• ADM203 Member Grievance Process o Section 4 • UM106 Member Appeal Process o Section 2.B	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor ensures that the individuals who make decisions on grievances and appeals: • Take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. *42 CFR 438.406(b)(2)* CHP+ Contract: Exhibit B—8.5.2 10 CCR 2505-10 8.209.5.C, 8.209.4.E	• ADM203 Member Grievance Process o Section 5 • UM106 Member Appeal Process o Section 2.D	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor accepts grievances orally or in writing. *42 CFR 438.402(c)(3)(i)* CHP+ Contract: Exhibit B—8.4.3 10 CCR 2505-10 8.209.5.D	• ADM203 Member Grievance Process ○ Section 1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. Members may file a grievance at any time. *42 CFR 438.402(c)(2)(i)* CHP+ Contract: Exhibit B—8.4.3 10 CCR 2505-10 8.209.5.A	• ADM203 Member Grievance Process ○ Section 1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor sends the member a written acknowledgement of each grievance within two working days of receipt. *42 CFR 438.406(b)(1)* CHP+ Contract: Exhibit B—8.4.5 10 CCR 2505-10 8.209.5.B	• ADM203 Member Grievance Process ○ Section 3 • CHP_ACK_letter	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor must resolve each grievance and provide written notice of the resolution as expeditiously as the enrollee's health condition requires, and within 15 working days of when the member files the grievance. • Notice to the member must be in a format and language that may be easily understood by the member. *42 CFR 438.408(a); (b)(1); and (d)(1)*	• ADM203 Member Grievance Process ○ Section 6 • ADM 208 Member Materials • CHP_RES_letter	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract: Exhibit B—8.4.6; 8.4.8 10 CCR 2505-10 8.209.5.D		
13. The written notice of grievance resolution includes: • Results of the disposition/resolution process and the date it was completed. *42 CFR 438.408(a)* CHP+ Contract: Exhibit B1—8.4.6. 10 CCR 2505-10 8.209.5.G	• ADM203 Member Grievance Process ○ Section 6 • CHP_RES_letter	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor may have only one level of appeal for members. *42 CFR 438.402(b)* CHP+ Contract: None	• UM106 Member Appeal Process ○ Section 3.C	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. A member may file an appeal with the Contractor within 60 calendar days from the date on the adverse benefit determination notice. *42 CFR 438.402(c)(2)(ii)* CHP+ Contract: Exhibit B—8.6.5.1 10 CCR 2505 10 8.209.4.B	• UM106 Member Appeal Process ○ Section 1.B	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. The member may file an appeal either orally or in writing, and the Contractor must treat oral appeals in the same manner as appeals received in writing. The Contractor may not require that oral requests for an appeal be followed with a written request. *42 CFR 438.402(c)(3)(ii)* *42 CFR 438.406 (b)(3)* CHP+ Contract: Exhibit B—8.6.5.2 10 CCR 2505 10 8.209.4.F	• UM106 Member Appeal Process ○ Section 1.A.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The Contractor sends written acknowledgement of each appeal within two working days of receipt, unless the member or designated representative requests an expedited resolution. *42 CFR 438.406(b)(1)* CHP+ Contract: Exhibit B—8.6.2.1 10 CCR 2505-10 8.209. 4.D	• UM106 Member Appeal Process ○ Section 1.C. • CHP and ACC Appeal Acknowledgement Letter (redacted)	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: COA's member appeal policy describes the correct State required time frame of an appeal acknowledgement letter to be sent to a member when an appeal is requested. However, one appeal acknowledgment letter was not sent to the member after the member requested the appeal.		
Required Actions: COA must enhance its monitoring system to ensure that the appeal acknowledgement letters are sent in two working days.		
18. The Contractor's appeal process must provide that included, as parties to the appeal, are: • The member and the member's representative, or • The legal representative of a deceased member's estate. *42 CFR 438.406(b)(3) and (6)* CHP+ Contract: Exhibit B—8.6.11 10 CCR 2505-10 8.209.4.I	• UM106 Member Appeal Process ○ Section 1.A.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
19. The Contractor's appeal process must provide: • The member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. (The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution time frame in the case of expedited resolution.) • The case file to the member and their representative, including medical records, other documents and records, and any new or additional documents considered, relied upon, or generated by the Contractor in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame. *42 CFR 438.406(b)(4-5)* CHP+ Contract: Exhibit B—8.6.8-8.6.10 10 CCR 2505-10 8.209. 4.G, 8.209.4.H	• UM106 Member Appeal Process ○ Policy section, paragraph 4	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
20. The Contractor maintains an expedited review process for appeals when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. The Contractor's expedited review process includes that: • The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. *42 CFR 438.410(a–b)*	• UM106 Member Appeals Process ○ Policy section, paragraph 3 ○ Section 4.B.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
CHP+ Contract: Exhibit B—8.6.12; 8.6.13.2 10 CCR 2505-10 8.209.4.Q-R		
21. If the Contractor denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the time frame for standard resolution. • Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and within two calendar days provide the member written notice of the reason for the decision and inform the member of the right to file a grievance if the member disagrees with that decision. *42 CFR 438.410(c)* CHP+ Contract: Exhibit B—8.6.13.2.2 10 CCR 2505-10 8.209.4.S	• UM106 Member Appeal Process ○ Section 4.B.1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
22. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)* *42 CFR 438.408(d)(2)(i)* *42 CFR 438.10* CHP+ Contract: Exhibit B—8.6.13.1 10 CCR 2505-10 8.209.4.J.1	• UM106 Member Appeal Process ○ Section 3.A ○ Section 4.A	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
23. For expedited appeal, the Contractor must resolve the appeal and provide written notice of disposition to affected parties within 72 hours after the Contractor receives the appeal. • For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. *42 CFR 438.408(b)(3) and (d)(2)(ii)* CHP+ Contract: Exhibit B—8.6.13.2.3; 8.6.13.2.6 10 CCR 2505-10 8.209.4.J.2, 8.209.4.L	• UM106 Member Appeal Process ○ Section 4.B	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
24. The Contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: • The member requests the extension; or • The Contractor shows (to the satisfaction of the Department, upon request) that there is need for additional information and how the delay is in the member's interest. *42 CFR 438.408(c)(1)* CHP+ Contract: Exhibit B—8.4.7; 8.6.13.2.4 10 CCR 2505-10 8.209.4.K, 8.209.5.E	• ADM203 Member Grievance Process ○ Section 7 • UM106 Member Appeal Process ○ Section 4.C. • GA DP07 Grievance Workflow ○ Section 10 • CHP and ACC Appeal Extension Letter (redacted) • CHP_EXT_Letter	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
25. If the Contractor extends the time frames for a grievance or appeal, it must—for any extension not requested by the member: • Make reasonable efforts to give the member prompt oral notice of the delay. • Within two (2) calendar days, give the member written notice of the reason for the delay and inform the member of the right to file a grievance if the member disagrees with that decision. • Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires (14 days following the expiration of the original grievance or appeal resolution time frame). *42 CFR 438.408(c)(2)* CHP+ Contract: Exhibit B—8.4.7.1; 8.6.13.2.5 10 CCR 2505-10 8.209.4.L, 8.209.4.K, 8.209.4.A. 3.C(ii), 8.209.5.E	• ADM203 Member Grievance Process ○ Section 7 • UM106 Member Appeal Process ○ Section 4.C. • GA DP07 Grievance Workflow ○ Section 10 • CHP_EXT_Letter	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
26. The written notice of appeal resolution must include: • The results of the resolution process, and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. *42 CFR 438.408(e)* CHP+ Contract: Exhibit B—8.6.13.3 10 CCR 2505-10 8.209.4.M	In May 2016, the federal rule changes for CHIP excluded from the requirement that member information must include "benefits will continue when the member files an appeal." However, the Department removed the statement from the CHP+ MCO contract requirement in July 2021. • UM106 Member Appeal Process ○ Section 3.A.1-3 • CHP and ACC Appeal Upheld Letter (redacted)	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• CHP and ACC Appeal Overturned Letter (redacted)	
Findings: COA describes in its policy that continuation of benefits does not apply to CHP+ members. However, language implying continuation of benefits was evident in the appeal resolution letter. Additionally, COA implies continuation of benefits on its website under "Services" and does not clarify that this does not apply to CHP+ members.		
Required Actions: COA must remove any language that refers to continuation of benefits from its appeals resolution letters. COA must clarify language on its website that continuation of benefits only applies to Medicaid lines of business or does not apply to CHP+ members to be consistent with its policies.		
27. The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of appeal resolution. • If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. *42 CFR 438.408(f)(1–2)* CHP+ Contract: Exhibit B—8.6.14.1 10 CCR 2505-10 8.209.4.N and O	• UM106 Member Appeal Process ○ Section 6.A	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
28. The parties to the State fair hearing include the Contractor as well as the member and their representative or the representative of a deceased member's estate. *42 CFR 438.408(f)(3)* CHP+ Contract: Exhibit B—8.6.14.3	• UM106 Member Appeal Process ○ Section 6.B	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
29. Effectuation of reversed appeal resolutions: • If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. *42 CFR 438.424* CHP+ Contract: Exhibit B—8.6.13.4 10 CCR 2505-10 8.209.4.W	• UM106 Member Appeal Process ○ Section 3.E ○ Section 6.D	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
30. The Contractor maintains records of all grievances and appeals. The records must be accurately maintained in a manner accessible to the State and available on request to CMS. • The record of each grievance and appeal must contain, at a minimum, all of the following information: – A general description of the reason for the grievance or appeal. – The date received. – The date of each review or, if applicable, review meeting. – Resolution at each level of the appeal or grievance. – Date of resolution at each level, if applicable.	• ADM203 Member Grievance Process ○ Section 10 • UM106 Member Appeal Process ○ Section 8 • GA DP07 Grievance Workflow ○ Section 7 • GrieveAppealRpt_CHPHMO_Q1_FY22-23 • CHP+GrieveAppealRpt_Q1_FY 22-23	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Name of the person for whom the appeal or grievance was filed. • The Contractor must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the Department's quality strategy. • The Contractor quarterly submits to the Department a Grievance and Appeals report including this information. *42 CFR 438.416* CHP+ Contract: Exhibit B—8.1; 8.7 10 CCR 2505-10 8.209.3.C		
31. The Contractor provides the information about the grievance, appeal, and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. *42 CFR 438.414* CHP+ Contract Exhibit B—8.3 10 CCR 2505-10 8.209.3.B	• COA Website ○ Appeals and State Fair Hearing: ▪ https://www.coaccess.com/providers/resources/um/ ○ Grievances: ▪ https://www.coaccess.com/providers/forms/ • Provider Manual ○ Section 2 Colorado Access Policies ▪ Pages 2-6 to 2-7 Member Grievances and Appeals	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: COA provided an electronic provider manual through its website that points to an old policy, which inaccurately states that members must follow an oral request for an appeal in writing. This required step was removed from the federal regulations in December 2020.		
Required Actions: COA must remove the inaccurate statement in its *Member Appeal Process* policy located on its website that states that a member must follow an oral request for an appeal in writing.		

Results for Standard VI—Grievance and Appeal Systems							
Total	Met	=	28	X	1.00	=	28
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	31	**Total Score**		=	28
				Total Score ÷ Total Applicable		=	90%

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor agrees to accept individuals eligible for enrollment into its MCO in the order in which they apply without restriction (unless authorized by CMS) up to the limits set under that contract. • The Contractor may not apply limits to newborns. • In the event that the Contractor reaches the enrollment limits, the Contractor shall notify the Department. *42 CFR 438.3(d)(1)* Contract: Exhibit B—6.3.3; 6.3.7	• MA 100 Member Enrollment and Disenrollment o Policy Section paragraph 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor does not discriminate against individuals eligible to enroll or use any policy or practice that has the effect of discriminating against individuals, based upon health status or need for health care services, race, color, national origin, sex, sexual orientation, gender identity, or disability. *42 CFR 438.3(d)(3-4)* Contract: Exhibit B—6.3.3.1	• ADM 205 Nondiscrimination • Colorado Access Website o https://www.coaccess.com/nondiscrimination/ • CHP+ Member Handbook o Page 123-Discrimination is Against the Law	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor may not request disenrollment of a member because of an adverse change in the member's health status or because of the member's: • Utilization of medical services • Diminished mental capacity or adverse changes in the member's health status. • Behavior (e.g., uncooperative or disruptive) resulting from the member's special needs (except when the	• MA 100 Member Enrollment and Disenrollment o Policy Statement paragraph 1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
member's continued enrollment seriously impairs the Contractor's ability to furnish services to the member or to other members). • Failure to pay a copayment if that member is a child. *42 CFR 438.56(b)(2)* Contract: Exhibit B—6.5.2.2		
4. The Contractor may initiate disenrollment of any member's participation in the MCO upon one or more of the following grounds: • Uncooperative or disruptive behavior such that continued enrollment would seriously impair the Contractor's ability to furnish services to the member or to other members. • For cause, at any time under the following circumstances: – The member has moved out of the Contractor's service area – The Contractor does not (due to moral or religious objections) cover the service the member needs – The member needs related services to be performed at the same time, not all related services are available from the Contractor's network, and the member's primary care provider (or another provider) determines that receiving the services separately would subject the member to unnecessary risk	• MA 100 Member Enrollment and Disenrollment ○ Section 6 • CHP+ Member Handbook ○ Page 13-Termination Policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Administrative error on the part of the Department or its designee or the Contractor including, but not limited to, system error – Poor quality of care – Lack of access to covered services, or lack of access to providers experienced with dealing with the member's specific needs *42 CFR 438.56(b)(1)* Contract: Exhibit B—6.5.5.1		
5. To initiate disenrollment of a member's participation with the MCO, the Contractor must provide the Department with documentation justifying the proposed disenrollment. *42 CFR 438.56(b)(3)* Contract: Exhibit B—6.5.2.1.9.3.1	• MA 100 Member Enrollment and Disenrollment ○ Section 6	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The member may request disenrollment as follows: • For cause at any time, including: – The member has moved out of the Contractor's service area – The Contractor does not (due to moral or religious objections) cover the service the member needs – The member needs related services to be performed at the same time, not all related services are available	• MA 100 Member Enrollment and Disenrollment ○ Section 5 • CHP+ Handbook ○ Page 2 ○ Page 14	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
from the Contractor's network, and the member's primary care provider (or another provider) determines that receiving the services separately would subject the member to unnecessary risk – Administrative error on the part of the Department or its designee or the Contractor including, but not limited to, system error – Poor quality of care – Lack of access to covered services, or lack of access to providers experienced with dealing with the member's specific needs • Without cause at the following times: – During the 90 days following the date of the member's initial passive enrollment – At least once every 12 months thereafter – Upon automatic re-enrollment if temporary loss of eligibility has caused the member to miss the annual disenrollment opportunity – When the Department has imposed sanctions on the MCO (consistent with 42 CFR 438.702(a)(4) *42 CFR 438.56(c)-(d)(2)* Contract: Exhibit B—6.5.5		

Results for Standard XII—Enrollment and Disenrollment							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	6	**Total Score**		=	6
				Total Score ÷ Total Applicable		=	100%

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

Review Period:	January 1, 2022–December 31, 2022
Date of Review:	January 4, 2023
Reviewer:	Sarah Lambie, MA, CPHQ
Participating MCE Staff Member(s):	Lindsay Cowee, Lisa Stellar, and Georgia Silver

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Member ID #	****	****	****	****	****	****	****	****	****	****					
Date of Initial Request [XX/XX/XXXX]	1/14/2022	2/11/2022	4/15/2022	6/15/2022	7/27/2022	8/29/2022	9/28/2022	10/13/2022	10/10/2022	11/2/2022					
Type of Denial: Termination (T), New Request (NR), Claim (CL)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR					
Type of Request: Standard (S), Expedited (E), Retrospective (R), SUD Inpatient/Residential (SUD), or SUD Inpatient/Residential Special Connections (SUD SC)	E	S	S	E	E	S	S	S	S	S					
Date of Decision for Adverse Benefit Determination [XX/XX/XXXX]	1/17/2022	2/13/2022	4/25/2022	6/21/2022	7/27/2022	9/1/2022	9/29/2022	10/13/2022	11/3/2022	11/3/2022					
Date Notice of Adverse Benefit Determination (NABD) Sent [XX/XX/XXXX]	1/18/2022	2/15/2022	4/26/2022	None	7/28/2022	9/1/2022	9/29/2022	10/14/2022	11/3/2022	11/3/2022					
Notice Sent to Provider and Member? [I.10]	Met	Met	Met	Not Met	Met	Met	Met	Met	Not Met	Met					
Number of Hours or Days for Decision (H/D)	3 D	2 D	10 D	6 D	0 D	3 D	1 D	0 D	24 D	1 D	0 D	0 D	0 D	0 D	0 D
Number of Hours or Days for Notice (H/D)	4 D	4 D	11 D		1 D	3 D	1 D	1 D	24 D	1 D	0 D	0 D	0 D	0 D	0 D
Adverse Benefit Determination Decision Made Within Required Time Frame? [I.11] Standard: 10 calendar days Expedited: 72 hours SUD: 72 hours (calendar) or 24 hours (calendar) for special connections	Met	Met	Met	Not Met	Met	Met	Met	Met	Not Met	Met					
Notice Sent Within Required Time Frame? [I.17] Standard: 10 calendar days Expedited: 72 hours SUD: 72 hours (calendar) or 24 hours (calendar) for special connections Termination: 10 calendar days before the date of action	Not Met	Met	Not Met	Not Met	Met	Met	Met	Met	Not Met	Met					
Was Authorization Decision Timeline Extended? Yes or No	No	No	No	No	No	No	No	No	No	No					
If Extended, Extension Notification Sent to Member? [I.19]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA					
If Extended, Extension Notification Includes Required Content? [I.19]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA					
NABD Includes Required Content [I.15-16]	Met	Met	Met	Not Met	Met	Met	Met	Not Met	Not Met	Not Met					
Authorization Decision Made by Qualified Clinician? [I.9]	Met	Met	Met	NA	Met	Met	Met	Met	Met	Met					
If Denied for Lack of Information, Was the Requesting Provider Contacted for Additional Information or Consulted (if applicable)? [I.8]	NA	NA	NA	Met	NA	NA	NA	NA	NA	NA					
Was the Decision Based on Established Authorization Criteria (i.e., not arbitrary)? [I.2]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Was Correspondence With the Member Easy to Understand? [I.14]	Met	Met	Met	Not Met	Met	Met	Met	Met	Not Met	Met					

Scoring	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Applicable Elements	7	7	7	7	7	7	7	7	7	7					
Compliant (Met) Elements	6	7	6	2	7	7	7	6	2	6					
Percent Compliant	86%	100%	86%	29%	100%	100%	100%	86%	29%	86%					
Overall Total Applicable Elements	**70**														
Overall Total Compliant Elements	**56**														
Overall Total Percent Compliant	**80%**														

Comments:
All files include references to continuation of benefits, which does not apply to CHP+.
File 1: Timeliness of decision met within the hour, but member NABD timeliness not met.
File 3: Universe file mis-stated decision date as 4/20 when it was 4/25. NABD sent 4/26, not met.
File 4: NICU request. Outreach attempted three times for clinicals. No NABD to member.
File 8: 10/14 NABD accidentally included EPSDT; updated NABD mailed on 10/25.
File 9: DME request. Decision date mis-stated in universe file as 10/10, denial decision was 11/3. Dates go beyond 10 calendar days for standard and no NABD to member.
File 10: NABD includes incorrect reference to EPSDT.

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

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

Review Period:	January 1, 2022–December 31, 2022
Date of Review:	January 10–11, 2023
Reviewer:	Crystal Brown, CCMA
Participating MCE Staff Member(s):	Reyna Garcia

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Member ID #	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****					
Date Grievance Received [XX/XX/XXXX]	1/6/2022	2/23/2022	3/30/2022	4/25/2022	5/4/2022	6/9/2022	9/16/2022	10/7/2022	10/27/2022	11/4/2022					
Date of Acknowledgement Letter [XX/XX/XXXX]	1/6/2022	2/25/2022	3/30/2022	4/25/2022	5/5/2022	6/10/2022	9/20/2022	10/7/2022	10/27/2022	11/7/2022					
Days From Grievance Received to Acknowledgement	0	2	0	0	1	1	2	0	0	1					
Acknowledgement Letter Sent in 2 Working Days [VI.11]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Date of Written Notice [XX/XX/XXXX]	1/19/2022	3/1/2022	4/14/2022	4/29/2022	5/24/2022	6/17/2022	10/20/2022	10/17/2022	11/4/2022	11/11/2022					
# of Days to Notice	8	4	10	4	14	6	23	6	6	4					
Resolved and Notice Sent in Time Frame* [VI.12,24] Standard: 15 working days Extension: 15 working days + 14 calendar days	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Decision-Maker Not Involved in Grievance [VI.7]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Appropriate Level of Expertise (If Clinical) [VI.7]	NA	Met	NA	NA	NA	NA	NA	NA	NA	NA					
Resolution Letter Includes Required Content [VI.13]**	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Resolution Letter Easy to Understand [VI.12]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Scoring	**File 1**	**File 2**	**File 3**	**File 4**	**File 5**	**File 6**	**File 7**	**File 8**	**File 9**	**File 10**	**File OS1**	**File OS2**	**File OS3**	**File OS4**	**File OS5**
Applicable Elements	5	6	5	5	5	5	5	5	5	5					
Compliant (Met) Elements	5	6	5	5	5	5	5	5	5	5					
Percent Compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%					
Overall Total Applicable Elements	**51**														
Overall Total Compliant Elements	**51**														
Overall Total Percent Compliant	**100%**														
Comments:															

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

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

**** = Redacted Member ID

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

Review Period:	January 1, 2022–December 31, 2022
Date of Review:	January 10–11, 2023
Reviewer:	Crystal Brown, CCMA
Participating MCE Staff Member(s):	Jenine Fountain

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Member ID #	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****					
Date Appeal Received [XX/XX/XXXX]	2/16/2022	2/28/2022	3/23/2022	4/19/2022	5/4/2022	6/17/2022	7/12/2022	8/30/2022	9/2/2022	10/6/2022					
Date of Acknowledgement [XX/XX/XXXX]	2/16/2022	None	3/23/2022	None	5/4/2022	6/17/2022	None	8/31/2022	9/2/2022	None					
Days From Appeal Received to Acknowledgement	0		0		0	0		1	0						
Acknowledgement Sent Within 2 Working Days? [VI.17]	Met	Not Met	Met	NA	Met	Met	NA	Met	Met	NA					
Decision-Maker Not Previous Level [VI.7]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Decision-Maker—Clinical Expertise [VI.7]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Expedited Appeal: Yes or No	No	No	No	Yes	No	No	Yes	No	No	Yes					
Time Frame Extended: Yes or No	No	No	No	No	No	No	No	No	No	No					
Date Resolution Notice Sent [XX/XX/XXXX]	2/17/2022	3/4/2022	4/6/2022	4/19/2022	5/5/2022	6/27/2022	7/13/2022	9/2/2022	9/2/2022	10/6/2022					
Hours or Days From Appeal Filed to Resolution Notice Sent	0 D	4 D	9 D	0 D	1 D	5 D	1 D	3 D	0 D	0 D					
Notice Sent Within Time Frame*? [VI.22-25] Standard Resolution: 10 working days Expedited Resolution: 72 hours Time Frame Extended: +14 calendar days	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Resolution Letter Includes Required Content [VI.26]**	Not Met	Not Met	Met	Met	Met	Not Met	Met	Met	Met	Not Met					
Resolution Letter Easy to Understand [VI.22]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					

Scoring	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Applicable Elements	6	6	6	5	6	6	5	6	6	5					
Compliant (Met) Elements	5	4	6	5	6	5	5	6	6	4					
Percent Compliant	83%	67%	100%	100%	100%	83%	100%	100%	100%	80%					
Overall Total Applicable Elements	**57**														
Overall Total Compliant Elements	**52**														
Overall Total Percent Compliant	**91%**														

Comments:
File 2: COA did not send an acknowledgement letter to the member.
Files 1, 2, 6, and 10: Appeal letters included "continuation of benefits" language, which does not apply to CHP+.

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

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

**** = Redacted Member ID

Appendix C. Compliance Review Participants

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

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

HSAG Review Team	Title
Sarah Lambie	Senior Project Manager
Crystal Brown	Project Manager I
Lauren Gomez	Project Manager I
Heidi Oliver	Senior Project Manager
COA Participants	**Title**
Amanda Fitzsimons	Compliance Program Manager
Lydia Brogren	Senior Compliance Auditor
Jess Kelly	Compliance Specialist
Ward Peterson	Director of Enrollment and Child Health Plan (CHP)
Taylor Mitchell	CHP Program Manager
Lisa Hug	Director of Program Operations—Program Deliverable Operations
Cassidy Smith	Senior Program Director—Program Deliverable Operations
Gretchen McGinnis	Senior Vice President of Healthcare Systems and Accountable Care
Reyna Garcia	Senior Director of Customer Service
Elizabeth Foster	Manager of Customer Service
Lindsay Cowee	Senior Director of Behavioral Health Network Performance
Lisa Stellar	Manager of Behavioral Health Utilization Management
Thomas Mayo	Utilization Management Program Manager
Georgia Silver	Manager of Physical Health and Pharmacy Utilization Management
Jenine Fountain	Clinical Appeals Coordinator
Beth Coleman	Director of Provider Contracting
Anne Taylor	Provider Recruitment Program Manager
Marissa Kaesemeyer	Director of Provider Affairs
Jeni Sargent	Director of Member and Provider Data Integrity
Stacy Garza	Supervisor of Member Data Integrity

Department Observers	Title
Russell Kennedy	Quality Program Manager
Sandra Wetenkamp	Health Network Accountability Specialist
Matthew Pfeifer	Accountable Care Collaborative (ACC) Program Specialist
Jeff Helm	Program Manager
Amy Ryan	CHP+ Program Supervisor

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

If applicable, the MCE is required to submit a CAP to the Department for all elements within each standard scored as *Partially Met* or *Not Met*. The CAP must be submitted within 30 days of receipt of the final report. For each required action, the MCE must identify the planned interventions, training, monitoring and follow-up activities, and proposed documents in order to complete the attached CAP template. Supporting documents should not be submitted and will not be considered until the CAP has been approved by the Department. Following Department approval, the MCE must submit documents based on the approved timeline.

Table D-1—Corrective Action Plan Process

Step	Action
Step 1	**Corrective action plans are submitted**
If applicable, the MCE will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final compliance review report via email or through the file transfer protocol (FTP) site, with an email notification to HSAG and the Department. The MCE must submit the CAP using the template provided. For each element receiving a score of *Partially Met* or *Not Met*, the CAP must describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training, monitoring and follow-up activities, and final evidence to be submitted following the completion of the planned interventions.	
Step 2	**Prior approval for timelines exceeding 30 days**
If the MCE is unable to submit the CAP proposal (i.e., the outline of the plan to come into compliance) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.	
Step 3	**Department approval**
Following review of the CAP, the Department and HSAG will: • Review and approve the planned interventions and instruct the MCE to proceed with implementation, or • Instruct the MCE to revise specific planned interventions, training, monitoring and follow-up activities, and/or documents to be submitted as evidence of completion and also to proceed with resubmission.	
Step 4	**Documentation substantiating implementation**
Once the MCE has received Department approval of the CAP, the MCE will have a time frame of 90 days (three months) to complete proposed actions and submit documents. The MCE will submit documents as evidence of completion one time only on or before the 90-day deadline for all required actions in the CAP. If any revisions to the planned interventions are deemed necessary by the MCE during the 90 days, the MCE should notify the Department and HSAG. If the MCE is unable to submit documents of completion for any required action on or before the three-month deadline, it must obtain approval in advance from the Department to extend the deadline.	

Step	Action
Step 5	**Technical assistance**
At the MCE's request or at the recommendation of the Department and HSAG, technical assistance (TA) calls/webinars are available. The session may be scheduled at the MCE's discretion at any time the MCE determines would be most beneficial. HSAG will not document results of the verbal consultation in the CAP document.	
Step 6	**Review and completion**
Following a review of the CAP and all supporting documentation, the Department or HSAG will inform the MCE as to whether or not the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements. Any documentation that is considered unsatisfactory to complete the CAP requirements at the three-month deadline will result in a continued corrective action with a new date for resubmission established by the Department. HSAG will continue to work with the MCE until all required actions are satisfactorily completed.	

The CAP template follows on the next page.

Table D-2—FY 2022–2023 Corrective Action Plan for COA

Standard I—Coverage and Authorization of Services
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
10. The Contractor notifies the requesting provider and gives the member written notice of any decision by the Contractor to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. *Note: Notice to the provider may be oral or in writing.* *42 CFR 438.210(c)* Contract: Exhibit B—8.5.1
Findings
In file samples #4 and #9, the member was not mailed an NABD letter.
Required Actions
COA must update its procedures to further delineate provider claims issues which are separate from member-related issues in which a service is denied or partially denied. Policies, procedures, and monitoring must be enhanced to ensure that the member is notified in writing of the denial or partial denial of a service.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:

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

Standard I—Coverage and Authorization of Services
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
11. The Contractor adheres to the following time frames for making standard and expedited authorization decisions: • For standard authorization decisions—as expeditiously as the member's condition requires and not to exceed 10 calendar days following the receipt of the request for service. • If the provider indicates, or the Contractor determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service. *42 CFR 438.210(d)(1–2)* Contract: Exhibit B—8.5.3.5; 8.5.3.7
Findings
In denial file samples #4 and #9, COA did not make denial decisions within the required time frame. File #4 included a request for neonatal intensive care unit (NICU) authorization but went beyond the 72-hour requirement for expedited requests, and file #9 was a standard authorization request that did not include a decision until the 24th day with no evidence of an extension.
Required Actions
COA must enhance its monitoring procedures to ensure that all authorization decisions are made within required time frames.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:

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

Standard I—Coverage and Authorization of Services
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
15. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to and copies of all documents and records relevant to the adverse benefit determination (includes medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits). • The member's (or member's designated representative's) right to request one level of appeal with the Contractor and the procedures for doing so. • The member's right to request a State review after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State review. • The circumstances under which an appeal process can be expedited and how to make this request. • The member's right to appeal under the Child and Youth Mental Health Treatment Act (CYMHTA), when applicable. *42 CFR 438.404(b)* Contract: Exhibit B—8.5.1.5-12
Findings
All NABDs included references to continuation of benefits, which is no longer applicable to the CHP+ line of business. Two sample denial records (#8 and #10) included EPSDT language that is also not applicable to the CHP+ line of business. In sample denial file #8, notably, COA monitoring procedures discovered the error of including the EPSDT language, and COA mailed an updated letter. However, the same error occurred in sample file #10 the following month. COA included references to CYMHTA in its policies but did not include this language in its templates.

Standard I—Coverage and Authorization of Services
Required Actions
COA must make necessary system and procedural updates to ensure that templates being used for CHP+ denials do not include references to continuation of benefits or EPSDT but do include information about the member's right to appeal under CYMHTA, when applicable.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard I—Coverage and Authorization of Services
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
17. The Contractor mails the notice of adverse benefit determination within the following time frames: • For termination, suspension, or reduction of previously authorized CHP+-covered services, as defined in 42 CFR 431.211, 431.213 and 431.214 (see below). • For denial of payment, at the time of any denial affecting the claim. • For standard service authorization decisions that deny or limit services, no later than 10 calendar days after receipt of request for service. • For expedited service authorization decisions, no later than 72 hours after receipt of request for service. • For extended service authorization decisions, no later than the date the extension expires. • For service authorization decisions not reached within the required time frames, on the date the time frames expire. *42 CFR 438.404(c)* *42 CFR 438.210(d)* Contract: Exhibit B—8.5.3.5-7
Findings
In file samples #4 and #9, the member was not mailed an NABD letter. File #1 was not sent within the expedited time frame of 72 hours, and file #3 was sent beyond the 10 calendar days.
Required Actions
COA must update its procedures to further delineate provider claims issues which are separate from member-related issues in which a service is denied or partially denied. Policies, procedures, and monitoring must be enhanced to ensure that the member is notified in writing of the denial or partial denial of a service.

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

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
17. The Contractor sends written acknowledgement of each appeal within two working days of receipt, unless the member or designated representative requests an expedited resolution. *42 CFR 438.406(b)(1)* CHP+ Contract: Exhibit B—8.6.2.1 10 CCR 2505-10 8.209. 4.D
Findings
COA's member appeal policy describes the correct State required time frame of an appeal acknowledgement letter to be sent to a member when an appeal is requested. However, one appeal acknowledgment letter was not sent to the member after the member requested the appeal.
Required Actions
COA must enhance its monitoring system to ensure that the appeal acknowledgement letters are sent in two working days.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:

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

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
26. The written notice of appeal resolution must include: • The results of the resolution process, and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. *42 CFR 438.408(e)* CHP+ Contract: Exhibit B—8.6.13.3 10 CCR 2505-10 8.209.4.M
Findings
COA describes in its policy that continuation of benefits does not apply to CHP+ members. However, language implying continuation of benefits was evident in the appeal resolution letter. Additionally, COA implies continuation of benefits on its website under "Services" and does not clarify that this does not apply to CHP+ members.
Required Actions
COA must remove any language that refers to continuation of benefits from its appeals resolution letters. COA must clarify language on its website that continuation of benefits only applies to Medicaid lines of business or does not apply to CHP+ members to be consistent with its policies.
Planned Interventions:
Person(s)/Committee(s) Responsible:

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

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
31. The Contractor provides the information about the grievance, appeal, and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. *42 CFR 438.414* CHP+ Contract Exhibit B—8.3 10 CCR 2505-10 8.209.3.B
Findings
COA provided an electronic provider manual through its website that points to an old policy, which inaccurately states that members must follow an oral request for an appeal in writing. This required step was removed from the federal regulations in December 2020.
Required Actions
COA must remove the inaccurate statement in its *Member Appeal Process* policy located on its website that states that a member must follow an oral request for an appeal in writing.
Planned Interventions:
Person(s)/Committee(s) Responsible:

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

Appendix E. Compliance Monitoring Review Protocol Activities

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

Table E-1—Compliance Monitoring Review Activities Performed

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

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