

Colorado Children's Health Insurance Program
Child Health Plan *Plus* (CHP+)

FY 2012–2013 SITE REVIEW REPORT
for
State Managed Care Network

May 2013

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



3133 East Camelback Road, Suite 300 • Phoenix, AZ 85016
Phone 602.264.6382 • Fax 602.241.0757

1. Executive Summary	1-1
Overview of FY 2012–2013 Compliance Monitoring Activities	1-1
Methodology	1-2
Objective of the Site Review	1-2
2. Summary of Performance Strengths and Required Actions	2-1
Overall Summary of Performance	2-1
Standard III—Coordination and Continuity of Care	2-2
Standard IV—Member Rights and Protections	2-4
Standard VIII—Credentialing and Recredentialing	2-5
Standard X—Quality Assessment and Performance Improvement	2-6
Appendix A. Compliance Monitoring Tool.....	A-i
Appendix B. Record Review Tools.....	B-i
Appendix C. Site Review Participants.....	C-1
Appendix D. Compliance Monitoring Review Activities.....	D-1

Overview of FY 2012–2013 Compliance Monitoring Activities

Public Law 111-3, The Children’s Health Insurance Program Reauthorization Act of 2009, requires that each state’s Children’s Health Insurance Program (CHIP) applies several provisions of Section 1932 of the Social Security Act in the same manner as the provisions apply under Title XIX of the Act. This requires managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to comply with specified provisions of the Balanced Budget Act of 1997, Public Law 105-33 (BBA). The BBA requires that states conduct a periodic evaluation of their MCOs and PIHPs to determine compliance with regulations and contractual requirements. The Department of Health Care Policy and Financing (the Department) has elected to complete this requirement for Colorado’s Child Health Plan *Plus* (CHP+) managed care health plans by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This is the second annual external quality review of compliance with federal managed care regulations performed for the CHP+ program by HSAG. For the fiscal year (FY) 2012–2013 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the four performance areas chosen. The standards chosen were Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement. For the **State Managed Care Network (SMCN)**, the Department chose to evaluate the readiness of the **SMCN** to comply with federal regulations and not score the individual requirements.

The health plan’s administrative records were also reviewed to evaluate implementation of National Committee for Quality Assurance (NCQA) Standards and Guidelines related to credentialing and recredentialing. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of 5 records. Using a random sampling technique, HSAG selected the samples from all applicable practitioners who had been credentialed or recredentialled in the previous 36 months. For the record review, the health plan received a score of *Yes* (compliant), *No* (not compliant), or *Not Applicable* for each of the elements evaluated. Although compliance with NCQA Standards and Guidelines was evaluated through the credentialing and recredentialing record review tools, no point value was assigned for overall compliance scoring. Readiness to comply with federal managed care regulations was evaluated through review of the four standards.

This report documents results of the FY 2012–2013 site review activities for the review period—July 1, 2012, through December 31, 2012. Section 2 contains summaries of the findings, strengths, opportunities for improvement, and required actions for each standard area. Appendix A contains details of the findings for the review of the standards. Appendix B contains details of the findings for the credentialing and recredentialing record reviews. Appendix C lists HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process the health plan will be required to complete for FY 2012–2013 and the required template for doing so.

Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the health plan's contract requirements, NCQA Credentialing and Recredentialing Standards and Guidelines, and regulations specified by the BBA, with revisions issued June 14, 2002, and effective August 13, 2002. HSAG conducted a desk review of materials submitted prior to the on-site review activities, a review of documents and materials provided on-site, and on-site interviews of key health plan personnel to determine readiness to comply with federal managed care regulations. Documents submitted for the desk review and during the on-site document review consisted of policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials.

The four standards chosen for the FY 2012–2013 site reviews represent a portion of the Medicaid managed care requirements. Standards that will be reviewed in subsequent years are: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

The site review processes were consistent with the February 11, 2003, Centers for Medicare & Medicaid Services (CMS) final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)*. Appendix D contains a detailed description of HSAG's site review activities as outlined in the CMS final protocol.

Objective of the Site Review

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

- ◆ The health plan's compliance with federal regulations, NCQA Credentialing and Recredentialing Standards and Guidelines, and contract requirements in the four areas selected for review.
- ◆ Strengths, opportunities for improvement, and actions required to bring the health plan into compliance with federal health care regulations and contract requirements in the standard areas reviewed.
- ◆ The quality and timeliness of, and access to, services furnished by the health plan, as assessed by the specific areas reviewed.
- ◆ Possible interventions to improve the quality of the health plan's services related to the areas reviewed.

2. Summary of Performance Strengths and Required Actions *for State Managed Care Network*

Overall Summary of Performance

Colorado Access is a health plan with several lines of business, one of which is the **State Managed Care Network (SMCN)** that provides administrative services to the State of Colorado and a CHP+ health benefits plan to selected Colorado CHP+ members. Colorado Access' strongest performances were in Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, and Standard X—Quality Assessment and Performance Improvement. Although HSAG identified opportunities for improvement or recommendations in each standard, Colorado Access demonstrated strong performance overall and an understanding of the federal health care regulations, the Colorado CHP+ Managed Care Contract, and NCQA Standards and Guidelines.

Standard III—Coordination and Continuity of Care

Summary of Strengths

Colorado Access had extensive experience with the CHP+ population, as well as an understanding of the unique characteristics of the **SMCN** population and the related impact on Colorado Access operations. Colorado Access had a defined care coordination program and processes that were applicable to all lines of business, including the **SMCN** population, and therefore was well resourced with staff and systems dedicated to care coordination. Because the **SMCN** Prenatal Care Program members were the largest population receiving care coordination, Colorado Access developed a specialized Healthy Moms, Healthy Babies pregnancy management program and related care management tools for this segment of the **SMCN** population.

Colorado Access had qualified care coordination staff members that were health care professionals and demonstrated commitment to frequent monitoring of the members' needs and progress. Care coordination staff members were actively involved in coordinating necessary services with providers and agencies on behalf of the member and family. Colorado Access was invested in using the Altruista case management software to support the documentation of the detailed comprehensive care coordination record.

Summary of Opportunities for Improvement and Recommendations

Colorado Access policies and procedures outlined the responsibilities of the primary care physician (PCP) to coordinate covered services and provide continuity of care for **SMCN** members. Policies and procedures also described providing a member health risk assessment (HRA) to identify members with special health care needs, and performing comprehensive assessments of individual health care needs by qualified health care professionals for members referred to Care Coordination. Colorado Access policies described coordinating care with multiple providers, agencies, and pay sources. Policies outlined the process for developing an individualized care coordination plan with member and family involvement in treatment plan decisions, and addressed the multiple circumstances in which members are allowed direct access to a specialist. Policies and procedures also described the processes to ensure the confidentiality and security of member protected health information in coordinating care. Colorado Access allowed members to select a PCP and assigned the PCP, when required.

Although the member cannot be simultaneously enrolled in **SMCN** and another health maintenance organization (HMO), Colorado Access appropriately coordinated with other HMOs upon member transition into or out of the **SMCN** to ensure continuity of care. Colorado Access also communicated pertinent member needs with other health care providers and organizations, as required, to obtain services to meet the member's needs and to prevent duplication of services. The short-term transitional enrollment of most members in **SMCN** resulted in the identification of very few members for case management services, with the exception of women enrolled in the CHP+ Prenatal Care Program.

Colorado Access demonstrated the Altruista case management software, which was used to document all components of the care coordination member record, including member assessments, individualized care plans, and follow-up progress notes. Colorado Access used a specialized, comprehensive assessment tool for women referred to the pregnancy program. The provider manual communicated the responsibilities of the PCP to develop a member treatment plan and outlined the required components of the treatment record, but it did not communicate the requirement to involve the member or family in treatment planning. In addition, Colorado Access did not clearly document member agreement in the case management record. HSAG recommended that Colorado Access consider mechanisms to clearly document the member's agreement with the care coordination plan in the Altruista case management file and inform providers of the requirement for member and family participation in the development of the treatment plan.

Although Colorado Access had processes to allow members direct access to specialists, the Member Benefits Booklet did not include that members with special health care needs may directly access specialists. HSAG recommended that Colorado Access clarify member materials to communicate that members with special health care needs are allowed direct access to a specialist.

During the on-site review, Colorado Access presented a care coordination case for a 26-year-old female with a high-risk pregnancy, hemophilia, and a history of premature labor, who was enrolled in the Healthy Moms, Healthy Babies program. The case presentation demonstrated assignment of an obstetrics PCP, multiple individual needs assessments designed specifically for the pregnancy management program, implementation of a care coordination plan with interventions based on assessed needs, and frequent follow-up with the member regarding progress. The case presentation also demonstrated that Colorado Access coordinated care with the member, physician, hospital, and pharmacy, as required to meet the member's needs.

Standard IV—Member Rights and Protections

Summary of Strengths

Colorado Access/the **SMCN** had processes for ensuring that members and providers understand member rights. The **SMCN** also provided periodic communication that reminded staff, members, and providers about member rights and the need to ensure member rights are taken into consideration at all times. Processes for ensuring member rights are taken into account were consistent across lines of business. Colorado Access/the **SMCN** provided frequent training for staff and employees. The **SMCN** had several mechanisms to engage providers in a partnership (e.g., a user-friendly Web site, frequent provider newsletters available electronically, and an impressive number of trainings delivered in person and/or via Webinar, publicized through its Web site.

Summary of Opportunities for Improvement and Recommendations

Colorado Access/the **SMCN** had numerous policies and procedures that included each of the member rights. The **SMCN** had mechanisms to notify members of their rights (e.g., the member handbook and newsletters). Providers were notified of member rights and the requirement that providers take those rights into consideration through the provider manual. Colorado Access had processes for initial and ongoing training for its staff and providers, including cultural competency.

HSAG recommended that Colorado Access consider placing member rights information under the provider tab on the Web site, including brief member rights trainings as part of the provider overview training, or including topic-specific rights information in the provider bulletin periodically.

Standard VIII—Credentialing and Recredentialing

Summary of Strengths

Colorado Access performed the credentialing and recredentialing processes for the **SMCN**, a line of business that provides administrative services to the Department for the CHP+ program and provides benefits management for a selected CHP+ population. Colorado Access' Credentialing Committee meeting minutes were detailed and demonstrated the role of the medical director consistent with the Colorado Access policy. The minutes also evidenced that the committee reviewed files that did not initially meet the required criteria. The Credentials Committee also reviewed ongoing monitoring for sanction activity, quality of care issues, and delegates' reports of credentialing activities.

Practitioner credentialing and recredentialing files were comprehensive, neat, and very well organized as were organizational provider records. Practitioner and provider records demonstrated Colorado Access' performance of all required credentialing and recredentialing activities.

Summary of Opportunities for Improvement and Recommendations

Colorado Access had a well-defined credentialing program that included NCQA-compliant policies, procedures, and practices. The policies and procedures delineated each type of practitioner subject to Colorado Access' credentialing processes, acceptable methods for primary source verification, and specific criteria required for acceptance into and continued participation in the Colorado Access/**SMCN** provider network. HSAG found ample evidence that Colorado Access monitored and provided oversight of its delegates. On-site review of credentialing and recredentialing records demonstrated that primary source verification for credentialing and recredentialing was completed within the required time frames and that recredentialing was completed within the required 36-month time frame.

Standard X—Quality Assessment and Performance Improvement

Summary of Strengths

Colorado Access had experienced management staff to support the **SMCN** line of business, and who understood the unique characteristics of the **SMCN** population and related operations. Colorado Access also had the experience of managing a CHP+ HMO Plan. Management staff worked closely with the Department to resolve issues and anticipate revisions to the 2013 **SMCN** contract. Colorado Access defined a Quality Improvement (QI) program that was applicable to all lines of business and that enabled the **SMCN** to be well resourced with QI policies, staff, systems, and committees. Colorado Access was invested in the development of high-functioning health information systems (HISs) that had the ability to integrate **SMCN** QI data with CHP+HMO member information or segregate the data to enable monitoring **SMCN** as a unique population.

Summary of Opportunities for Improvement and Recommendations

Colorado Access defined a comprehensive Quality Assessment and Performance Improvement (QAPI) program, applicable to all lines of business, including **SMCN** members and members with special health care needs. The program was accountable to the Colorado Access Board of Directors through the Quality Improvement Committee (QIC) and the Medical Behavioral Quality Improvement Committee (MBQIC), whose members reviewed information on the outcomes of QI monitoring and initiatives conducted by Colorado Access staff. The QI program included mechanisms for comprehensive monitoring of the quality and appropriateness of services, including over- and underutilization, grievances and appeals, and **SMCN** enrollment information.

Colorado Access adopted CHP+ clinical practice guidelines (CPGs) for the required topic areas and met the requirements for development, dissemination, and application to other Colorado Access processes. Member and provider communications, however, did not clearly address CPGs. HSAG recommended that Colorado Access consider updating the **SMCN** member handbook and the **SMCN** provider manual to inform members and providers of the availability of CPGs and how to access or request them. Colorado Access had an integrated HIS that collected and processed member, provider, and service data from multiple databases to support the QI program. Colorado Access implemented mechanisms to verify the accuracy and completeness of data received from providers.

Staff explained that recent modifications to the **SMCN** contract will result in significantly fewer long-term members in the plan, with the exception of CHP+ Prenatal Care Program members. The short-term transitional enrollment of most members may impact the future approach to conducting QI activities for **SMCN** members. Colorado Access also expressed concern that a recent CHP+/**SMCN** eligibility and enrollment issue at the State will impact future member satisfaction measures, as well as Healthcare Effectiveness Data and Information Set (HEDIS[®])²⁻¹ measures.

²⁻¹ HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

Appendix A. **Compliance Monitoring Tool**
for **State Managed Care Network**

The completed compliance monitoring tool follows this cover page.



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard III—Coordination and Continuity of Care	
Requirement	Evidence as Submitted by the Health Plan
<p>1. The Contractor has a mechanism to ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member.</p> <p align="right"><i>42CFR438.208(b)(1)</i></p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • CCS305 – Care Coordination (<i>all</i>) • CCS306 – Delivering Continuity and Transition of Care for Members; <i>Sections II.a, II.c, III.A</i> • CCS310 – Access to Primary and Specialty Care; <i>Sections I, II, III.A</i> • CHP Provider Manual; <i>pp. 3-4 Primary Care Provider Responsibilities, pg. 45 Continuity of Care and Transition of Care for Existing Members – Primary Care Provider</i> • SMCN Member Benefits Booklet; <i>pp. 11, pp.21-22</i> <p>Description of Process: CCS 310 – Access to Primary and Specialty Care outlines the following standards (page 4, Sect I):</p> <ul style="list-style-type: none"> A. Colorado Access will allow, to the extent possible and appropriate, each member’s selection of a PCP for AA, CHP+ and SMCN. B. If a member does not select a PCP, Colorado Access shall assign the member to a PCP and notify the member, by telephone or in writing, of his/her PCP’s name, location, and office telephone number. C. The PCP will be responsible for providing all but inpatient, specialty and emergency services for his/her assigned members. <p>Member Benefits booklet (pg 11) identifies the following process to our members:</p> <ul style="list-style-type: none"> • If you do not choose an in-network PCP, you will be assigned to a PCP in your area. If you do not want to see the PCP we choose for you, please call Customer Service. <p>The PCP designation is listed on the members ID card, which is delivered to the member’s residence following enrollment into the health plan.</p>
<p>Findings: The Access to Primary and Specialty Care policy stated that the member is allowed to select a primary care physician (PCP). If the member does not select a PCP, Colorado Access assigns the member to a PCP and notifies the member of the assigned PCP’s name, location, and telephone number. The policy stated that the assigned PCP is the member’s medical home, responsible for coordinating specialty referrals and maintaining continuity of care.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard III—Coordination and Continuity of Care	
Requirement	Evidence as Submitted by the Health Plan
<p>The CHP+ Provider Manual included “coordinating healthcare services for members” in the list of PCP responsibilities and informed providers of the process for assigning a member to a PCP. The State Managed Care Network (SMCN) Member Benefits Booklet informed members of the need to select a PCP from the provider directory, available on request from Member Services or on the Colorado Access Web site, and that Colorado Access would assign a PCP and inform the member if no PCP is chosen. The Member Benefits Booklet described the role of the PCP in coordinating and making referrals for covered services for the member.</p> <p>During the on-site interview, Colorado Access presented a care coordination case for a 26-year-old female with a high-risk pregnancy, hemophilia, and a history of premature labor. The case was initially identified through claims data as a member with a high-risk diagnosis who did not have an assigned PCP. Colorado Access assisted the member with obtaining an appropriate obstetrics PCP and referred the member to the Colorado Access Healthy Moms, Healthy Babies program coordinator for care management services.</p>	
<p>2. The Contractor coordinates services furnished to the member by the Contractor with the services the member receives from any other MCO or PIHP.</p> <p style="text-align: right;"><i>42CFR438.208(b)(2)</i></p>	<p>Documents Submitted/Location Within Documents</p> <ul style="list-style-type: none"> • CCS305 – Care Coordination; Section I, Section III.C.7 • CCS306 – Delivering Continuity and Transition of Care for Members; Section I.A.2, III • QM302 – Review of Provider Medical Records; Section I.D • QM302b - Clinical Record Requirements Guideline • CHP+ Provider Manual; Section V – pp. 22-23 • SMCN Member Benefits Booklet; Section 9 – pp. 111-114 <p>Description of Process:</p> <p>CCS305 Care Coordination Policy - Colorado Access Care Coordination policy (CCS305) outlines our care coordination program. The CCS305 policy statement (page 2) reads:</p> <p style="padding-left: 20px;">Through Care Coordination efforts, Colorado Access will develop and maintain means to identify, screen, assess and assist in the management of members with complex physical, mental, and cultural healthcare needs. Colorado Access’ efforts will effectively coordinate care with multiple providers, human service agencies, and payers, on behalf of the member. The activities focus on coordinating provision of services, promoting and assuring service accessibility, with attention to the individual needs, continuity of care, comprehensive and coordinated service delivery, cultural competence and fiscal and professional accountability.</p>



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard III—Coordination and Continuity of Care	
Requirement	Evidence as Submitted by the Health Plan
	<p>CCS 305 policy (Sect III.C.7) also states that Colorado Access will:</p> <ul style="list-style-type: none"> • Coordinate services for the member that are funded by multiple payment sources.
<p>Findings: The Care Coordination policy stated that Colorado Access will coordinate care with multiple providers, human service agencies, and payors, on behalf of the member, including coordinating services that are funded by multiple pay sources. The Delivering Continuity and Transition of Care for Members policy stated that, when a member chooses to enroll in another health care organization, Colorado Access will disclose the member’s relevant health information to the subsequent health care organization in order to ensure continuity of care. During the on-site interview, staff confirmed that for members transitioning into or out of the health plan, Colorado Access coordinates with other managed care organizations to ensure continuity of care for members with special health care needs. Staff also stated that SMCN eligibility requirements preclude the member’s simultaneous enrollment in more than one managed care organization.</p>	
<p>3. The Contractor shares with other health care organizations serving the member with special health care needs, the results of its identification and assessment of that member’s needs, to prevent duplication of those activities.</p> <p align="right"><i>42CFR438.208(b)(3)</i></p>	<p>Documents Submitted/Location Within Documents</p> <ul style="list-style-type: none"> • CCS305 – Care Coordination; page 2, Sect I.G, Sect I.H, Section III.C.2 • CCS306-Delivering Continuity and Transition of Care for Members; Section III.A.C <p>Description of Process: Colorado Access Care Managers, Service Coordinators, and Peer Specialists routinely communicate their activities to providers and others involved in the member’s care. This activity is implicit in the definition of Care Coordination (CCS305, page 2). One of the stated goals of our care coordination program is to “to facilitate communication and coordination among providers, caregivers, and stakeholders” (CCS305, I.G, pg 3). “To create efficiencies by decreasing the duplication of services” is another stated goal of the program (CCS305, I.H, pg 3). In addition, it is expected that care coordination interventions are “non-duplicative (CCS305, Section I.H., page 3 and III.C.2, pgs 4-5) and collaborative.</p> <p>Sect III.C.2 of CCS 305 policy also states that Colorado Access takes the following steps: Conducting coordination with the member, family, DCR, Authorized Representative, provider, and involved Colorado Access physical and/or mental health staff members on an ongoing basis in order to share assessment findings and to develop an agreed upon care plan. The care plan will address the member's needs so that care is collaborative, non-duplicative, and outcomes focused and allows the member to remain in the community. Where applicable, members will be offered support and education in self-care strategies and other measures that the member may take to promote healthy living.</p>



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard III—Coordination and Continuity of Care	
Requirement	Evidence as Submitted by the Health Plan
<p>Findings: The Care Coordination policy stated that care coordinators will communicate with family, providers, and staff members to share assessment findings and develop a plan of care in a non-duplicative collaborated manner. The goals of the care coordination program included facilitating communication among multiple entities to decrease duplication of services. During the on-site interview, staff stated that Colorado Access communicates the results of members' assessments and specific member needs with providers and organizations in the process of seeking services that are appropriate to meeting the special health care needs of members. During transition of the member into or out of the Plan, Colorado Access coordinates with other managed care organizations and initiates single case agreements as required to ensure continuity of care for members with special health care needs. Staff stated that, upon request, Colorado Access will send a printed copy of the care coordination plan to other providers participating in the member's health care but generally limits communication of the member's needs to the information pertinent to a particular service provider.</p>	
<p>4. The Contractor ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that they are applicable.</p> <p align="right"><i>42CFR438.208(b)(4)</i></p>	<p>Documents Submitted/Location Within Documents</p> <ul style="list-style-type: none"> • HIP201 – Protection of Member Individually Identifiable Health Information • HIP204 – Security of EPHI • CCS305 – Care Coordination; <i>Section III.C.6</i> • CHP+ Provider Manual; <i>pp.3-4, 7</i> <p>Description of Process:</p> <p>The sharing of member information for the purposes of continuity and coordination of care is handled in accordance with State and Federal laws and regulations outlined in Colorado Access Protection of Health Information policy (HIP201). In addition, Colorado Access Security of Electronic Protected Health Information policy (HIP204) outlines the policies for sharing electronic health information.</p> <p>Colorado Access Care Coordination policy (CCS305) states care coordination will work to ensure that member confidentiality is maintained, in accordance with 45 CFR Parts 160 and 164 and other applicable law and regulation, at all times when collaborating with both internal and external parties, as well as assuring that all confidential member information is maintained in an orderly fashion within the member's file (Section III.C.6., page 5).</p> <p>The CHP+ Provider Manual (pages 3-4, 7) outlines member privacy requirements.</p> <p>These policies and procedures pertain to all activities undertaken by Colorado Access staff.</p>



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard III—Coordination and Continuity of Care	
Requirement	Evidence as Submitted by the Health Plan
<p>Findings: The Protection of Health Information policy stated that all employees, providers, Board of Directors, and other entities affiliated with Colorado Access may not use or disclose members’ protected health information (PHI) except for treatment, payment, and operations; and they must obtain the member’s written consent for other uses. The policy outlined processes for ensuring that member privacy is maintained, which included confidentiality agreements, provider and vendor contract requirements, staff and provider training, limited access to PHI based on the need to know for specific job functions, and verification of identity and authority of persons receiving PHI. The Care Coordination policy stated that care coordinators will ensure that confidentiality of member information is maintained when collaborating with both internal and external parties. The CHP+ Provider Manual informed providers that Colorado Access maintains confidentiality of member information in compliance with HIPAA standards, and that providers must be aware of expectations regarding privacy and confidentiality of member information.</p>	
<p>5. The Contractor implements mechanisms to assess each member identified by the State to the Contractor as having special health care needs, in order to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals.</p> <p align="right"><i>42CFR438.208(c)(2)</i></p>	<p>Documents Submitted/Location Within Documents</p> <ul style="list-style-type: none"> • CCS305 – Care Coordination; <i>Section II</i> • CCS306 – Delivering Continuity and Transition of Care for Members; <i>Section II</i> • CHP+ Provider Manual; <i>pp. 8-9, 12, 45</i> • Health Risk Assessment (HRA) <ul style="list-style-type: none"> • Process Guideline • HRA questionnaire <p>Description of Process: During CY2012, Health Risk Assessments were sent to all new members and included in the New Member Packets. We have altered and updated our process as outlined in the HRA Process Guideline document which explains in detail how Colorado Access will meet the standard beginning January 1, 2013.</p> <p>CCS 305 – Care Coordination policy identifies the following as needed screening process (Section III.B)</p> <ul style="list-style-type: none"> • Colorado Access has processes specific to each line of business to identify and screen members for specific services and/or health care needs. Members with complex or serious physical, cognitive, social and mental healthcare needs may be referred for Care Coordination as indicated for individualized assessment, care planning, developing interventions and providing follow-up based on the needs identified in the assessment and thereafter.



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard III—Coordination and Continuity of Care	
Requirement	Evidence as Submitted by the Health Plan
Findings:	<p>The Health Risk Assessment (HRA) questionnaire, distributed to members on enrollment, collected information to identify a child’s special health care needs, such as disabilities, mental health needs, pregnancy, asthma, or substance abuse problems. The HRA Process Guideline document outlined the specific procedures for documenting the HRA in the Altruista case management system and referring to Care Management for follow-up. During the on-site interview, staff stated that Colorado Access performs two outreach calls to members who do not respond to the HRA mailing, and that Colorado Access uses interactive voice response (IVR) technology to assist in outreach efforts. Pregnant members and members with asthma are especially targeted to receive HRA follow-up efforts.</p> <p>The Care Coordination policy stated that members identified as needing care management services will receive an in-depth assessment of physical, behavioral, psychosocial, and environmental status to prioritize the member’s needs. The Delivering Continuity and Transition of Care for Members policy stated that staff would conduct an assessment of needs for new members needing assistance with transition or continuity of care. The SMCN Provider Manual informed providers that Colorado Access would administer a health risk assessment and connect each member with appropriate care management or special health care programs (e.g., Healthy Moms, Healthy Babies). During the on-site interview, staff stated that the dynamic of transitional enrollment for most SMCN members resulted in the referral of very few members for case management, with the exception of women enrolled in the pregnancy program.</p> <p>During the on-site interview, Colorado Access presented a case for a 26-year-old female with a high-risk pregnancy, hemophilia, and a history of premature labor. The case was identified through claims data as a member with a high-risk diagnosis. Staff stated that Colorado Access performed an initial assessment after enrollment, identified that the member was pregnant, and referred the member to the Healthy Moms, Healthy Babies case management program. The case presentation demonstrated that the health coach (a registered nurse) performed a comprehensive high-risk pregnancy assessment on admission to the program. Staff stated that a postpartum assessment and newborn assessment would be performed after delivery.</p>



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard III—Coordination and Continuity of Care	
Requirement	Evidence as Submitted by the Health Plan
<p>6. If the State requires treatment plans for members with special health care needs (SHCN), the Contractor develops treatment plans for members with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring. The treatment plan must be:</p> <ul style="list-style-type: none"> ◆ Developed by the member’s primary care provider with member participation, and in consultation with any specialists caring for the member. ◆ Approved by the Contractor in a timely manner (if required by the Contractor). ◆ In accord with any applicable State quality assurance and utilization review standards. <p align="right"><i>42CFR438.208(c)(3)</i></p>	<p>Documents Submitted/Location Within Documents</p> <ul style="list-style-type: none"> • Care Management Desktop Procedure • CCS305 – Care Coordination; <i>pp. 3-5</i> • CCS306 – Delivering Continuity and Transition of Care for Members; <i>Sections II, III</i> • CHP+ Provider Manual; <i>pp. 12, 34-36, 42</i> <p>Description of Process: Colorado Access policy CCS 305 (page 3-5) defines Special Health Care Needs as well as explain the processes which are in place to capture the needs of these individuals and ensure an accurate course of treatment.</p>
<p>Findings: The Delivering Continuity and Transition of Care for Members policy addressed the identification of members with special health care needs who need an ongoing course of treatment, and the policy described mechanisms for assessing the member’s needs and maintaining continuity of the treatment plan for members transitioning into the SMCN. The Care Coordination policy outlined the process for care plan development based on the member’s assessed needs. Colorado Access assigned members to various risk levels to guide the intensity of care coordination services. The policy defined multiple types of appropriate care plan service interventions. The policy stated that members/families must be involved in the development and implementation of the treatment plan. The SMCN Provider Manual stated that the provider has a responsibility to maintain a treatment plan consistent with the member’s diagnoses. The SMCN Provider Manual outlined the member medical record requirements, which did not include a requirement that the member participate in the development of the treatment plan.</p> <p>The on-site care coordination case presentation documented that Colorado Access developed a care plan and follow-up plan with the member; assisted the member with obtaining an appropriate obstetrics primary care provider; coordinated services with the member, physician, hospital, and pharmacy; and maintained frequent contact with the member concerning the member’s medical and anticipated social support needs. The care plan and progress notes were documented in the Altruista case management system.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard III—Coordination and Continuity of Care	
Requirement	Evidence as Submitted by the Health Plan
<p>7. For members with special health care needs, the Contractor has a mechanism in place to allow members to directly access a specialist, as appropriate to the member’s condition and identified needs.</p> <p align="right"><i>42CFR438.208(c)(4)</i></p>	<p>Documents Submitted/Location Within Documents</p> <ul style="list-style-type: none"> • CCS305 – Care Coordination; <i>pp. 4</i> • CCS306 – Delivering Continuity and Transition of Care for Members; <i>Section II.G</i> • CCS307 – Utilization Review Determinations; <i>Section II.A.4.a</i> • CCS310 – Access to Primary and Specialty Care; <i>Section II.D, III.A</i> • PNS202 – Selection and Retention of Providers; <i>Section I.C.3</i> • SMCN Member Benefits Booklet; <i>pp. 9, 19, 43</i> <p>Description of Process: CCS 305 Care Coordination policy identifies the following process (pg 4):</p> <p>B. Screening and Assessment of Member Needs</p> <ol style="list-style-type: none"> 1. Colorado Access has processes specific to each line of business to identify and screen members for specific services and/or health care needs. 2. Members with complex or serious physical, cognitive, social and mental healthcare needs may be referred for Care Coordination as indicated for individualized assessment, care planning, developing interventions and providing follow-up based on the needs identified in the assessment and thereafter. <p>Colorado Access CCS307 policy states that (<i>Section II.A.4.a</i>): In any case where Colorado Access has no participating providers or there exists a need beyond the scope of participating specialty services, UR staff will work with the primary care provider or behavioral health provider to arrange for a referral to a provider with the necessary expertise to ensure that the member has access to the covered benefit.</p>
<p>Findings: The Access to Primary and Specialty Care policy defined numerous circumstances when members may have direct access to specialists, which included standing referrals for members with special health care needs, as well as family planning and women’s health services, second opinions, and vision services. The Delivering Continuity and Transition of Care for Members policy stated that Colorado Access will allow new members with special health care needs direct access to appropriate specialty care when transitioning into the health plan. Colorado Access also submitted policies that stated that Colorado Access will assist members to obtain out-of-network access to specialists when needed services are not available in network. The SMCN</p>	



Appendix A. **Colorado Department of Health Care Policy and Financing**
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard III—Coordination and Continuity of Care

Requirement	Evidence as Submitted by the Health Plan
Provider Manual encouraged PCPs to assist members with referrals to specialists and informed providers that authorization for access to in-network specialists is not required. The SMCN Member Benefits Booklet informed members that they do not need a referral to an in-network OB/GYN or for family planning services. The booklet did not inform members that members with special health care needs may have direct access to a specialist.	

Standard III Recommendations:
HSAG recommended that Colorado Access consider mechanisms to clearly document the member’s agreement to the care coordination plan in the Altruista case management file and to inform providers of the requirement to involve the member/family in the development of the treatment plan.

HSAG recommended that Colorado Access clarify member materials to communicate that members with special health care needs are allowed direct access to specialists.



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard IV—Member Rights and Protections	
Requirement	Evidence as Submitted by the Health Plan
<p>1. The Contractor has written policies regarding member rights.</p> <p align="right"><i>42CFR438.100(a)(1)</i></p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> CS212-Member Rights and Responsibilities, Section I (pg 2) <p>Description of Process: Policy CS212 states that Colorado Access will establish and maintain written policies and procedures for treating members in a manner that is consistent with federal and state law, rules and regulations, and contract requirements (Section I, pg 2).</p>
<p>Findings: The SMCN had several polices in place that addressed member rights and protections in accordance with federal health care regulations. The Member Rights and Responsibilities policy described how member rights and responsibilities are communicated to providers, members, and SMCN employees. The Nondiscrimination policy defined the health plan’s responsibility to protect member rights and to take necessary action to address any allegations of discrimination. In addition, the Protection of Member Individually Identifiable Health Information policy described the SMCN’s role in protecting member confidentiality, including safeguarding members’ PHI.</p>	
<p>2. The Contractor ensures that its staff and affiliated network providers take member rights into account when furnishing services to members.</p> <p align="right"><i>42CFR 438.100(a)(2)</i></p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> CS212- Member Rights and Responsibilities policy, Sections III - IV (pg 2) Provider Manual, page 8-9 Grievance, Appeals, Denials Reporting Desktop Procedure- draft version Grievance Reports FY13 Q1 Report – in folder, Quality dept Appeals Reports FY13 Q1 Report – in folder, Quality dept <p>Description of Process: CS212 Policy - states that “Colorado Access will communicate member rights and responsibilities to members, Colorado Access employees and providers according to applicable federal and state laws, rules and regulations and contract requirements. Distribution channels include, but are not limited to, member handbooks, provider manuals, new provider orientation, provider and member bulletins, company website, newsletters, member complaint and appeal procedures, the Notice of Privacy Practices, and Evidence of Coverage documents”. (Section III)</p> <p>CS212 also states that “Colorado Access provider contracts require provider compliance with all applicable federal and state laws, their implementing regulations, and Colorado</p>



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard IV—Member Rights and Protections	
Requirement	Evidence as Submitted by the Health Plan
	<p>Access policies and procedures, including member rights as identified herein and the requirement to take those rights into account when providing services to members”. (Section IV)</p> <p>Provider Manual - Providers are informed within the Provider Manual that Members have certain rights that they must be aware of (pgs 8-9).</p> <p>Quarterly grievance and appeals report track concerns related to member rights and are addressed. No such member rights concerns were noted in the FY13 for the Q1 report. Q2 report will be completed per the reporting time cycle and available upon request during the on-site audit.</p>
<p>Findings: The SMCN Provider Manual included a complete list of CHP+ member rights. The SMCN provided grievances and appeals reports for July–September that illustrated the health plan had the ability to track and trend grievances related to member rights and protections, and follow up with members to strive for satisfactory resolution. Compliance training addressed member rights related to HIPAA regulations. During the on-site interview, SMCN staff reported that internal staff members were required to attend orientation at the time of hire that included information about member rights. Staff members were also required to participate in annual compliance training that included member rights information. Customer service staff members attended additional annual training regarding member rights and completed a related quiz each year. The schedule for provider training was available on the Web site. Staff members reported that Cultural Competency training for providers was scheduled as needed or requested.</p>	
<p>3. The Contractor’s policies include the following specified rights, and the Contractor ensures that each member has the right to:</p> <ul style="list-style-type: none"> ◆ Receive information in accordance with information requirements (42CFR438.10). ◆ Be treated with respect and with due consideration for his or her dignity and privacy. ◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member’s condition and ability to understand. ◆ Participate in decisions regarding his or her health care, including the right to refuse treatment. ◆ Be free from any form of restraint or seclusion used 	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • CS212 – Member Rights and Responsibilities Policy • Member Handbook - Member Rights and Responsibilities Sections (pgs 16-17) • Provider Manual – Member Rights and Responsibilities Section (pgs 8-9) • Grievance Report – FY13 Q1 • Grievance, Appeals, Denials Reporting Desktop Procedure – draft version • Appeals Report -FY13 Q1 <p>Description of Process: Each new Member receives a new member packet mailing, which includes the CHP Member Handbook. This handbook outlines the members rights and responsibilities on pg 16-17.</p>



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard IV—Member Rights and Protections	
Requirement	Evidence as Submitted by the Health Plan
<p>as a means of coercion, discipline, convenience, or retaliation.</p> <ul style="list-style-type: none"> ◆ Request and receive a copy of his or her medical records and request that they be amended or corrected. ◆ Be furnished health care services in accordance with requirements for access and quality of services (42CFR438.206 and 42CFR438.210). <p align="right"><i>42CFR438.100(b)(2) and (3)</i></p>	<p>Member rights are outline on page 8-9 of the CHP Provider Manual.</p> <p>Quarterly grievance and appeals report track concerns related to member rights and are addressed. No such member rights concerns were noted in the FY13 for the Q1 report. Q2 report will be completed per the reporting time cycle and available upon request during the on-site audit.</p>
<p>Findings: The SMCN Member Benefits Booklet, distributed to each member at the time of enrollment and available on the Colorado Access Web site, included the list of member rights and included all those required in 42CFR438.100(b)(2)&(3). The provider manual also included the list of member rights. During the on-site interview, Colorado Access/SMCN staff members reported that the health plan was developing a focus group program for the CHP+ population. The first focus group topic was emergency room (ER) utilization and participants invited were high ER utilizers. Colorado Access staff members discussed plans to develop future focus groups with additional topics that could include member rights topics.</p>	
<p>4. The Contractor ensures that each member is free to exercise his or her rights and that exercising those rights does not adversely affect the way the Contractor treats the member.</p> <p align="right"><i>42CFR438.100(c)</i></p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • Member Handbook - page 16 • Grievance, Appeals, Denials Reporting Desktop Procedure- draft version • Provider Manual – page 8 • Grievance Report – FY13 Q1 • Appeals Report -FY13 Q1 <p>Description of Process: CHP Members have the right to file a grievance about their care without retaliation. Member rights listed within the Member Handbook and in the Provider Manual states that this is a Member right.</p> <p>The CHP Member Handbook (pg 16) informs members that As a member, you have the right to exercise these rights without fear of retaliation, below are several of the outlined rights:</p>



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard IV—Member Rights and Protections	
Requirement	Evidence as Submitted by the Health Plan
	<ul style="list-style-type: none"> • Be treated respectfully and with consideration. Be free from any form of restraint or seclusion used as a means of convincing you to do something you may not want to do. • Express any concerns and complaints about care and services provided so that CHP+ State Managed Care Network can investigate and take appropriate action. • File a complaint or appeal a decision with the CHP+ State Managed Care Network as outlined in the section without fear of retaliation. <p>CHP ensures that Members are free to exercise their rights without retaliation by monitoring issues that may arise through the grievance process as outlined in the Grievance, Appeals and Denials desktop document.</p>
<p>Findings: The list of member rights included in the SMCN Benefits Booklet and the SMCN provider manual included the member’s right to express any complaints and concerns about services received. The benefits booklet and the provider manual also informed members and providers of the right to file a complaint or appeal a decision without fear of retaliation. In addition, the SMCN’s Nondiscrimination policy stated that Colorado Access/SMCN will not tolerate retaliation of any kind.</p>	
<p>5. The Contractor complies with any other federal and State laws that pertain to member rights including Title VI of the Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act, and titles II and III of the Americans with Disabilities Act and other laws regarding privacy and confidentiality.</p> <p align="right"><i>42CFR438.100(d)</i></p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • ADM205-Nondiscrimination <p>Description of Process: Colorado Access policy ADM205 outlines our nondiscrimination policy and adherence to applicable Stated and Federal laws.</p>
<p>Findings: The Nondiscrimination policy mandated compliance with all State and federal laws and prohibited discrimination based on race, color, national origin, sex, religion, creed, sexual orientation, age, or mental or physical disability. The Protection of Member Individually Identifiable Health Information policy addressed the protection of member privacy and confidentiality, including safeguarding member PHI. In addition, the requirement to comply with federal and State laws was included in both the provider manual and in provider contracts.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard IV—Member Rights and Protections	
Requirement	Evidence as Submitted by the Health Plan
<p>6. The Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable.</p> <p align="right"><i>42CFR438.224</i></p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> HIP201-Protection of Health Information <p>Description of Process: All Colorado Access employees complete HIPAA training at orientation and an annual HIPAA General Awareness Training. Documentation of employee completion of HIPAA training can be provided if requested during the site review</p> <p>Each employee also signs a confidentiality agreement upon hire and annually thereafter. Documentation can be provided it requested, during the site review.</p>
<p>Findings: SMCN had a comprehensive Protection of Individually Identifiable Health Information policy that addressed the use and disclosure of member information, the processing of requests from members to access information, and the handling of member complaints regarding HIPAA-related issues. Staff reported that all employees were required to complete HIPAA training as part of their new hire orientation and to attend a HIPAA General Awareness training each year. Colorado Access employees were also required to sign an annual confidentiality statement stating that they would protect member PHI. During the on-site interview, SMCN staff described electronic password protection for files and computers, locked file cabinets and rooms, encryption of files before sending externally, and access to records based of job tasks and need for the information.</p>	

Standard IV Recommendations:
 While member rights information was available in the SMCN benefits booklet found on the Web site, there were no member rights reminders on the Web site or evidence that provider training includes member rights information. The SMCN may want to consider placing member rights information under the provider tab on the Web site, including brief member rights information as part of the provider overview training, or including topic-specific rights information in the provider bulletin periodically.

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence Submitted by the Health Plan
<p>1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members.</p> <p>NCQA CR1</p>	<p>Documentation Submitted:</p> <ul style="list-style-type: none"> • CR301-Provider Credentialing and Recredentialing, All • CR302-Office Site Visit for Provider Credentialing, All • CMP206-Sanction, Exclusion, Prohibited Affiliation, and Opt-Out Screening, All • CR307- Credentialing and Recredentialing Provider Review Classification, All • CR312-Provider Rights, All • CR213-Adverse Actions and Hearing and Appeals Process for Providers, All • CR318-Ongoing Monitoring of Provider Sanctions, Grievances, and Occurrences of Adverse Actions, All • PNS202-Selection and Retention of Providers, All • ADM223 Delegation, All <p>Process Description:</p> <p>Credentialing functions are the responsibility of the Director of Provider Contracting. Credentialing staff consist of the Manager of Contract Systems and a Credentialing Program Coordinator.</p> <p>Colorado Access maintains a credentialing committee consisting of physicians from within our network and chaired by a Colorado Access Medical Director. Minutes will be made available upon request during the site review.</p> <p>All Colorado Access credentialing and recredentialing policies and procedures adhere to NCQA Standards and Guidelines for Credentialing and Recredentialing.</p>
<p>Findings:</p> <p>Colorado Access, a health plan with several product lines, performed the credentialing and recredentialing processes for its SMCN line of business. The Practitioner Credentialing and Recredentialing policy provided an overview of Colorado Access’ credentialing and recredentialing processes, referring to other pertinent policies for specific details. Processes reviewed on-site were consistent with the policies and provided evidence of Colorado Access’ well-defined credentialing and recredentialing processes.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard VIII—Credentialing and Recredentialing	
Requirement	Evidence Submitted by the Health Plan
<p>2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify:</p> <p>2.A. The types of practitioners to credential and recredential. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. (Examples include doctors of medicine [MDs], doctors of osteopathy [DOs], podiatrists, and each type of behavioral health provider.)</p> <p align="right"><i>42CFR438.214(a)</i></p> <p>NCQA CR1—Element A1</p>	<p>Documentation Submitted:</p> <ul style="list-style-type: none"> • CR301-Provider Credentialing and Recredentialing, Section I (pg3) • Credentialing Committee Minutes (available onsite for review) <p>Process Description:</p> <p>Colorado Access policy CR301 outlines the company’s credentialing practices. Practitioners are credentialed following current NCQA standards. The policies listed in Requirement #1 support the credentialing and recredentialing process. Colorado Access uses the CDPHE Colorado Health Care Professional Credential Application. This common State approved application specifies the types of practitioners to be credentialed.</p> <p>CR301, Section I, specifies the types of practitioners credentialed by Colorado Access (p 3-4).</p>
<p>Findings:</p> <p>The Practitioner Credentialing and Recredentialing policy described each type of practitioner subject to Colorado Access’ credentialing processes. Practitioners credentialed and recredentialled by Colorado Access included medical doctors, doctors of osteopathy, podiatrists, chiropractors, doctors of dental science, psychologists, psychiatrists, social workers, nurses, and counseling professionals (including family therapists and licensed professional counselors). The SMCN provider directory provided evidence that Colorado Access maintained a robust selection of practitioners that included both primary care and specialty practitioners.</p>	
<p>2.B. The verification sources used.</p> <p>NCQA CR1—Element A2</p>	<p>Documentation:</p> <ul style="list-style-type: none"> • CR301-Provider Credentialing and Recredentialing, Section XV (pgs 11-15) <p>Process Description:</p> <p>The CR301 section noted above specifies the verification sources used for credentialing and recredentialing. If requested, credentialing staff can produce examples of practitioner credentialing file applications as evidence of the verification sources used.</p>
<p>Findings:</p> <p>The Practitioner Credentialing and Recredentialing policy described the acceptable primary sources used for verifying licensure, education and training, Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certification, board certification, and malpractice coverage.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard VIII—Credentialing and Recredentialing	
Requirement	Evidence Submitted by the Health Plan
<p>2.C. The criteria for credentialing and recredentialing.</p> <p>NCQA CR1—Element A3</p>	<p>Documentation:</p> <ul style="list-style-type: none"> • CR301-Provider Credentialing and Recredentialing, Section VIII, pgs. 6-7 • CR307-Credentialing and Recredentialing Provider Review Classification, All • Provider Manual (pg 5) <p>Process Description: CR301, Section VIII (p6-7) and CR307 outline the criteria used for Credentialing (p59-60). If requested, credentialing staff can produce examples of practitioner credentialing file applications as evidence of the criteria used.</p>
<p>Findings: The Practitioner Credentialing and Recredentialing policy described the criteria for network participation, which applied to all practitioners under the scope of Colorado Access’ credentialing program. The Credentialing/Recredentialing Practitioner Review Classification and Credentials Committee Determination Process policy (Practitioner Review Classification policy) described the specific criteria for files meeting the standard for clean files and those that are submitted to the Colorado Access Credentials Committee for review. The SMCN Provider Manual informed providers of the criteria for acceptance into and continued participation in Colorado Access’ provider network.</p>	
<p>2.D. The process for making credentialing and recredentialing decisions.</p> <p>NCQA CR1—Element A4</p>	<p>Documentation:</p> <ul style="list-style-type: none"> • CR307-Credentialing and Recredentialing Provider Review Classification, All • CR301-Provider Credentialing and Recredentialing, Section IX (pgs 7-8), and Section XVI (pg 15-16) <p>Process Description: Colorado Access policy CR307 outlines the process for making credentialing and recredentialing decisions. CR301 also speaks generally to the credentialing decision making process.</p> <p>If requested, credentialing staff can produce Credentialing Committee minutes as evidence of the decision making process.</p>
<p>Findings: The Practitioner Credentialing and Recredentialing policy described the Colorado Access Credentials Committee and its processes for reviewing practitioner applications and making credentialing and recredentialing decisions. The Practitioner Review Classification policy described the process and criteria for files that may go directly to the medical director for review.</p>	

Standard VIII—Credentialing and Recredentialing	
Requirement	Evidence Submitted by the Health Plan
<p>2.E. The process for managing credentialing/ recredentialing files that meet the Contractor’s established criteria.</p> <p>NCQA CR1—Element A5</p>	<p>Documentation Submitted:</p> <ul style="list-style-type: none"> • CR301-Provider Credentialing and Recredentialing, Section VIII (pg 6) <p>Process Description:</p> <p>CR301 specifies how records are maintained by credentialing staff (p6).</p> <p>Credentialing files are maintained using the Apogee Managed Care Credentialing System (Morrisey Associates, Inc.). Prior to November 2009, we used the MSO product from Morrisey. Apogee software is a web-based comprehensive membership management system.</p> <p>During the site review, Credentialing staff can demonstrate this product if requested. Reviewers are welcome to visit the credentialing area where physical files are stored.</p>
<p>Findings:</p> <p>The Practitioner Credentialing and Recredentialing policy described the process for the credentialing program coordinator to review credentialing files for completeness and timeliness and for forwarding the file to the chief medical officer or the associate medical director for review. The Practitioner Review Classification policy described which files may be reviewed by the chief medical officer or the associate medical director physician designee, and which files are sent to the Credentials Committee for review. The policy stated that the Credentials Committee may also review any file designated as “meeting criteria.” The Credentials Committee meeting minutes provided evidence that the Credentials Committee reviewed credentialing and recredentialing files as well as the list of providers who were approved by the medical director when providers met, without exception, all of the credentialing criteria.</p>	
<p>2.F. The process for delegating credentialing or recredentialing (if applicable).</p> <p>NCQA CR1—Element A6</p>	<p>Documentation:</p> <ul style="list-style-type: none"> • CR301-Provider Credentialing and Recredentialing, Sections VI (pg 5), VIII (pg 6-7) • Provider Manual (pg 5-6) <p>Process Description:</p> <p>The process for delegating credentialing and recredentialing is specified in CR301 ssections VI (pg 5)and VIII (p6-7). Currently, Colorado Access delegates credentialing and recredentialing to three entities: Denver Health, National Jewish, and University Physicians. These agreements are included in the “Delegation Agreements” folder. All three include CHP credentialed providers.</p> <p>The delegation of credentialing is also mentioned in the Provider Manual (pg 5-6).</p>

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence Submitted by the Health Plan
<p>Findings: SMCN staff members reported that Colorado Access delegated credentialing to Denver Health and Hospital Authority, National Jewish Health, and University Physicians, Incorporated, for those providers. Colorado Access staff stated that each delegate maintained a network of physicians who had an independent relationship with Colorado Access for provision of services to SMCN members. The Practitioner Credentialing and Recredentialing policy described the processes for delegation, which included completion of a predelegation audit and Colorado Access’ approval of the delegated entity’s credentialing policies and procedures as well as subsequent oversight processes.</p>	
<p>2.G. The process for ensuring that credentialing and recredentialing are conducted in a non-discriminatory manner, (i.e., must describe the steps the Contractor takes to ensure that it does not make credentialing and recredentialing decisions based solely on an applicant’s race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes).</p> <p>NCQA CR1—Element A7</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • CR301-Provider Credentialing and Recredentialing, Section III (pgs 4-5) • Provider Manual (pg 6) <p>Process Description: The process for ensuring that credentialing and recredentialing are conducted in a non-discriminatory manner is specified in CR301 section III (p4-5). The CHP provider Manual also describes non-discrimination on page 60. If requested, the Credentials Committee signatures on the Non-Discrimination Acknowledgment can be made available during the site review.</p>
<p>Findings: The Practitioner Credentialing and Recredentialing policy stated that Colorado Access does not make credentialing and recredentialing decisions based solely on ethnic/national identity, gender, age, sexual orientation, type of practice, or types of patients the practitioner may specialize in treating. The policy also stated that Colorado Access will not discriminate—in terms of participation, reimbursement, or indemnification—against any health care professional who is acting within the scope of his or her license or certification under State law solely on the basis of that license or certification. In addition, the policy described the Credentials Committee process and described how the committee, the chief medical officer, and the associate medical director designee applied the criteria in the credentialing policies to each file prepared and reviewed for credentialing and recredentialing. The policy stated that all participating Credentials Committee members sign an acknowledgment form stating that they do not discriminate when making credentialing and recredentialing decisions. Signed nondiscrimination forms for committee members were reviewed on-site. The SMCN Provider Manual informed providers of Colorado Access’ policy not to discriminate during the credentialing and recredentialing processes. During the on-site interview, staff members reported that if complaints were received, the medical director would review the case. While Colorado Access had appropriate methods to prevent discrimination, there were no methods in place for monitoring to ensure nondiscriminatory credentialing practices, as required by National Committee for Quality Assurance (NCQA).</p>	



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard VIII—Credentialing and Recredentialing	
Requirement	Evidence Submitted by the Health Plan
<p>2.H. The process for notifying practitioners if information obtained during the Contractor’s credentialing/recredentialing process varies substantially from the information they provided to the Contractor.</p> <p>NCQA CR1—Element A8</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • CR301-Provider Credentialing and Recredentialing, Section V (pg 5) • CR312-Provider Rights, Section II.B (pg 3) • Colorado Health Care Professional Credentials Application (pg 23) • Provider Manual (pg 5) <p>Process Description:</p> <p>Colorado Access policy CR301 states, “Practitioners have the right to review the information submitted in support of the credentialing application; be notified during the credentialing process if information obtained varies substantially from practitioner’s information; correct any erroneous information submitted as a part of the credentialing process; and be informed, upon request, of the status of their credentialing or recredentialing application (Section V, pg 5).”</p> <p>Colorado Access policy CR312 details the rights afforded practitioners in the credentialing process (Section II.B, pg 3).</p> <p>The CHP Provider Manual on page 5 states; “To the extent permitted by law, the applicant has the right to review information obtained by Colorado Access to evaluate their credentialing application. Colorado Access is not required to allow applicants to review references, recommendations, or other information that is peer-review protected. Colorado Access is not required to reveal the source of information when the information is obtained to meet credentialing verification requirements, if disclosure is prohibited by law. In the event that credentialing information obtained from other sources varies substantially from that provided by the applicant, the Credentialing Department will notify the applicant of the process to correct erroneous information submitted by another party.</p>
<p>Findings:</p> <p>The Practitioner Credentialing and Recredentialing policy stated that if an application contained information that varied substantially from the information acquired during the credentialing process, the practitioner would be given the opportunity to correct the information and/or explain the discrepancy. Providers were notified in the credentialing application that they would be notified if information received during the credentialing process varied from the information provided by the applicant and that the applicant had the right to correct any erroneous information. The Practitioner Rights policy stated that such notification would occur in writing using a standard form.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard VIII—Credentialing and Recredentialing	
Requirement	Evidence Submitted by the Health Plan
<p>2.I. The process for ensuring that practitioners are notified of credentialing and recredentialing decisions within 60 calendar days of the committee’s decision.</p> <p>NCQA CR1—Element A9</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • CR301-Provider Credentialing and Recredentialing, Section XVII (pg 16) <p>Process Description: Colorado Access policy CR301 states, “Providers undergoing initial credentialing are notified in writing within ten (10) business days of the Senior Medical Director weekly reviews and Credentials Committee decisions.” (Section XVII).</p>
<p>Findings: The Practitioner Credentialing and Recredentialing policy stated that practitioners undergoing initial credentialing are notified in writing within 60 calendar days of the committee’s credentialing decision. On-site review of credentialing and recredentialing files demonstrated that notification was typically provided within the same week of the decision.</p>	
<p>2.J. The medical director’s or other designated physician’s direct responsibility and participation in the credentialing/ recredentialing program.</p> <p>NCQA CR1—Element A10</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • CR301-Provider Credentialing and Recredentialing, Section IV (pg 5) and IX (pgs 7-8). <p>Process Description: Colorado Access policy CR301 requires Medical Director responsibility for the credentialing program (Section IV p5 and IX p7-8 and). Credentialing Committee minutes (available during site review) are evidence that the Chief Medical Officer, or other Associate Medical Director designee, chairs the committee.</p>
<p>Findings: The Practitioner Credentialing and Recredentialing policy stated that the chief medical officer or the associate medical director designee is responsible for clinical aspects of the credentialing program and serves as chair of the Credentials Committee. The policy also stated that the chief medical officer or the associate medical director (designee) is authorized to approve practitioners who meet criteria for participation. The Credentials Committee meeting minutes reviewed on-site provided evidence of the medical director’s involvement and participation in the committee. During the on-site interview, SMCN staff confirmed that the credentialing date for clean files is the medical director sign-off date; and for the files reviewed by the Credentials Committee, it is the committee date.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard VIII—Credentialing and Recredentialing	
Requirement	Evidence Submitted by the Health Plan
<p>2.K. The process for ensuring the confidentiality of all information obtained in the credentialing/ recredentialing process, except as otherwise provided by law.</p> <p>NCQA CR1—Element A11</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> CR301-Provider Credentialing and Recredentialing, Section VII (pg 6) <p>Process Description: Colorado Access policy CR301 (Sections noted above) specifies the process for ensuring the confidentiality of all credentialing information (p6).</p> <p>Confidentiality statements signed by the Credentials Committee can be produced upon request during the site review.</p>
<p>Findings: The Practitioner Credentialing and Recredentialing policy described the processes and procedures used for ensuring the confidentiality of information obtained during the credentialing and recredentialing processes. Processes included signed confidentiality statements by staff with access to credentialing and recredentialing materials, locked file cabinets for storage of hard copy files, shredding of copied materials, and password protection security of electronic files.</p>	
<p>2.L. The process for ensuring that listings in provider directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty.</p> <p>NCQA CR1—Element A12</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> CR301-Provider Credentialing and Recredentialing, Section XVIII (pg 16-17) <p>Process Description: Colorado Access policy CR301 specifies the process for listing practitioner information in provider directories.</p> <p>CR301 Section XVIII states; “Colorado Access verifies that the information pertaining to credentialed providers that is contained in member materials including provider directories is consistent with the information obtained during credentialing by conducting audits, at least annually. Examples of elements audited may include verification of the provider’s name, education, training, certification, and specialty (p16).”</p>
<p>Findings: The Practitioner Credentialing and Recredentialing policy described annual audits for accuracy of the provider directory information. SMCN staff stated that the claims system was used to query provider contact information, which was verified against the information contained in the credentialing database. Staff also stated that the online searchable database is updated within days of a change to the database. Hard copies used for mailings are printed annually by the vendor used for eligibility mailings.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard VIII—Credentialing and Recredentialing	
Requirement	Evidence Submitted by the Health Plan
<p>2.M. The right of practitioners to review information submitted to support their credentialing or recredentialing application, upon request.</p> <p>NCQA CR1—Element B1</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • CR301-Provider Credentialing and Recredentialing, Section V (pg 5) • CR312-Provider Rights, All • Colorado Health Care Professional Credentials Application (#12, pg 23) • Provider Manual (pg 5) <p>Process Description:</p> <p>Colorado Access policy CR301 states, “Providers have the right to review the information submitted in support of the credentialing application. Providers will be notified during the credentialing process if information obtained varies substantially from provider’s information. Providers have the right to correct any erroneous information submitted as a part of the credentialing process, provide missing information during the verification process, and be informed, upon request, of the status of their credentialing or recredentialing application.” (Section V).</p> <p>Colorado Access policy CR312 specifies the process practitioners need to follow to obtain information related to their credentialing application.</p> <p>The CO Health Care Professional Credentials Application used by Colorado Access informs practitioners of their right to review information submitted in support of their application(p23).</p> <p>Practitioners are also informed of this right within the Provider Manual (pg 5).</p>
<p>Findings:</p> <p>The Practitioner Credentialing and Recredentialing policy included the provision that practitioner applicants have the right to review information submitted in support of their credentialing/recredentialing application. The Practitioner Rights policy described Colorado Access’ processes for allowing practitioners to access their information. Providers were informed of this right in the credentialing application and in the provider manual.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard VIII—Credentialing and Recredentialing	
Requirement	Evidence Submitted by the Health Plan
<p>2.N. The right of practitioners to correct erroneous information.</p> <p>NCQA CR1—Element B2</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> CR301-Provider Credentialing and Recredentialing, Section V (pg 5) CR312-Provider Rights, Section II (pg 3) Colorado Health Care Professional Credentials Application (pg. 23) Provider Manual (pg 5) <p>Process Description:</p> <p>Colorado Access policy CR301 states, “Practitioners have the right to ... correct any erroneous information submitted as a part of the credentialing process” (Section V, pg5).</p> <p>Colorado Access policy CR312 specifies the process practitioner’s should follow to request that information within their application be corrected (Section II, pg 3).</p>
<p>Findings:</p> <p>The Practitioner Credentialing and Recredentialing policy included the provision that practitioners have the right to correct any erroneous information obtained during the credentialing/recredentialing process. The Practitioner Rights policy described Colorado Access’ processes for correcting erroneous information. The policy included the link to find a correction form online.</p>	
<p>2.O. The right of practitioners, upon request, to receive the status of their application.</p> <p>NCQA CR1—Element B3</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> CR301-Provider Credentialing and Recredentialing, Section V (pg 5) CR312-Provider Rights, Section III (pg 3) Colorado Health Care Professional Credentials Application (#12, pg 23) Provider Manual (pg 5-6) <p>Process Description:</p> <p>Colorado Access policy CR301 states, “Practitioners have the right to ... be informed, upon request, of the status of their credentialing or recredentialing application” (Section V, pg 5).</p> <p>Colorado Access policy CR312 specifies the process practitioner’s should follow to request the status of their application (Section III, pg 3).</p> <p>Practitioners are informed of this right within the CO Health Care Professional Credentials Application (#12, pg 23).</p> <p>The Provider Manual also informs providers of this right (pg 5-6).</p>

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence Submitted by the Health Plan
<p>Findings:</p>	
<p>The Practitioner Credentialing and Recredentialing policy included the practitioner’s right to receive the status of his/her credentialing application, upon request. The Practitioner Rights policy described Colorado Access’ processes for informing practitioners of their application status, upon request. Providers were notified of this right in the credentialing application and in the provider manual.</p>	
<p>2.P. The right of applicants to receive notification of their rights under the credentialing program.</p> <p>NCQA CR1—Element B4</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • CR312-Provider Rights, Section IV (pg 3) • Colorado Health Care Professional Credentials Application (Schedule A, pgs 22-23) • Provider Manual (pg 5-6) <p>Process Description:</p> <p>Colorado Access policy CR312 states, “Practitioners are notified of these rights by the Provider Manual and on Schedule A of the Colorado Health Professional Credentials Application” (Section IV, pg 4).</p> <p>Practitioners are notified of their rights when they sign Schedule A of the CO Health Care Professional Credentials Application.</p> <p>Providers are also notified of their rights within the Provider Manual (pg 5-6). This document is readily available on our website at http://www.coaccess.com/chp-state-managed-care-network-smcn-provider-information</p>
<p>Findings:</p>	
<p>The Practitioner Rights policy stated that providers are notified of their rights via the provider manual and in the credentialing application. The credentialing application and the provider manual included each of the applicant rights.</p>	
<p>2.Q. How the Contractor accomplishes ongoing monitoring of practitioner sanctions, complaints, and adverse events between recredentialing cycles including:</p> <ul style="list-style-type: none"> ◆ Collecting and reviewing Medicare and Medicaid sanctions. ◆ Collecting and reviewing sanctions or limitations on licensure. ◆ Collecting and reviewing complaints. 	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • CR301-Provider Credentialing and Recredentialing, Section XI (pg 9) • CR318-Ongoing Monitoring of Provider Sanctions, Grievances, and Occurrences of Adverse Events, All • QM201-Investigation of Potential Clinical Quality of Care Grievances and Concerns, All <p>Process Description:</p> <p>Colorado Access policy CR301 states, “Colorado Access conducts ongoing monitoring of practitioners contracted to participate in the Colorado Access networks that fall within the scope</p>

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence Submitted by the Health Plan
<ul style="list-style-type: none"> ◆ Collecting and reviewing information from identified adverse events. ◆ Implementing appropriate interventions when it identified instances of poor quality related to the above. <p>NCQA CR9—Element A</p>	<p>of credentialing activities and will take appropriate action based on the findings. The ongoing monitoring activities conducted between recredentialing cycles will include Medicare and Medicaid sanctions or exclusions, practitioners who opt-out of Medicare, Colorado State licensing sanctions or limitations on licensure, and practitioner-specific member grievances, and occurrences of adverse events ” (Section XI p9) .</p> <p>Colorado Access policy CR318 outlines the specific monitoring activities referred to in CR301, Section XI.</p> <ul style="list-style-type: none"> • On a monthly basis, credentialing staff check the OIG exclusion database (CR318: Section II.A.1, pg 3) • Prior to each credentialing committee meeting, credentialing staff check the DORA Registrations Online Disciplinary report for all credentialed providers (CR318: Section II.B.1-2, pg 3). • Member quality of care concerns of adverse events are reviewed by a Medical Director. If warranted, cases are referred to the credentials committee for review (CR318: Section II.C, pg 4). This process is specified within QM201 Section I.E-G. The summary report prepared by Quality Management will be available upon request.

Findings:

The Practitioner Credentialing and Recredentialing policy stated that ongoing monitoring activities between credentialing cycles included review for Medicare/Medicaid sanctions, Colorado State licensure sanctions, review of practitioner-specific member grievances, and occurrences of adverse events. The Ongoing Monitoring of Sanctions, Grievances, and Occurrences of Adverse Events policy (Ongoing Monitoring policy) stated that monitoring for State and Medicare/Medicaid sanctions occurred monthly. The Ongoing Monitoring policy also stated that if a provider had been disciplined, Colorado Access monitored compliance with the corrective actions. The Investigation of Potential Clinical Quality of Care (QOC) Grievances and Referrals policy described the processes for peer review and Colorado Access’ response when practitioners were determined to have QOC issues. The Sanction Monitoring Report, which was presented each month to the Credentials Committee, provided evidence that the health plan regularly monitored practitioner sanctions, licensure issues, Office of Inspector General (OIG) sanctions, and other adverse events for practitioners in the network and presented the information to the Credentials Committee for review. On-site review of the Credentials Committee meeting minutes provided evidence that the Sanction Monitoring Report was presented to and reviewed by the committee. On-site, the SMCN provided evidence on monthly searches for sanctions using the appropriate online databases and crosschecks to determine if SMCN providers were on the list.



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard VIII—Credentialing and Recredentialing	
Requirement	Evidence Submitted by the Health Plan
<p>2.R. The range of actions available to the Contractor against the practitioner (for quality reasons).</p> <p>NCQA CR10—Element A1</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • CR213-Adverse Actions and Hearing and Appeals Process for Providers, All • CR318-Ongoing Monitoring of Providers Sanctions, Grievances, and Occurrences of Adverse Events, Section III (pgs 4-5) <p>Process Description: Colorado Access policy CR213 outlines the action available to CHP if a provider does not meet quality standards.</p> <p>Colorado Access policy CR318 also outlines the actions available to the credentialing committee (Section III, pgs 4-5).</p>
<p>Findings: The Adverse Actions and Hearing and Appeal Process for Practitioners policy (Adverse Actions policy) described the range of actions available to SMCN in response to an administrative action or a peer review action taken against a practitioner. Actions included imposition of a corrective action plan or reduction, suspension, or termination of the practitioner’s network participation. The Credentials Committee meeting minutes provided evidence that the committee pended or denied credentialing to providers who did not meet the credentialing criteria for quality reasons.</p>	
<p>2.S. If the Contractor has taken action against a practitioner for quality reasons, the Contractor reports the action to the appropriate authorities (including State licensing agencies for each practitioner type and the National Practitioner Data Bank [NPDB]).</p> <p>NCQA CR10—Element A2 and B</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • CR213-Adverse Actions and Hearing and Appeals Process for Providers, Section III (pg 6-7) <p>Process Description: Colorado Access policy CR213 specifies the procedures to be followed when Colorado Access takes an action against a practitioner for quality reasons (Section IV, pgs 7-8).</p>
<p>Findings: The Adverse Actions policy described Colorado Access’ processes for reporting adverse actions to the appropriate agency, including the applicable State licensing board, the National Practitioners Data Bank (NPDB), and the Healthcare Integrity and Protection Data Bank (HIPDB), as applicable. SMCN staff stated that medical director approval is obtained prior to notification of authorities.</p>	

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence Submitted by the Health Plan
<p>2.T. A well-defined appeal process for instances in which the Contractor chooses to alter the conditions of a practitioner’s participation based on issues of quality of care or service which includes:</p> <ul style="list-style-type: none"> ◆ Providing written notification indicating that a professional review action has been brought against the practitioner, reasons for the action, and a summary of the appeal rights and process. ◆ Allowing the practitioner to request a hearing and the specific time period for submitting the request. ◆ Allowing at least 30 days after the notification for the practitioner to request a hearing. ◆ Allowing the practitioner to be represented by an attorney or another person of the practitioner’s choice. ◆ Appointing a hearing officer or panel of the individuals to review the appeal. ◆ Providing written notification of the appeal decision that contains the specific reasons for the decision. <p>NCQA CR10—Element A3and C</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • CR213-Adverse Actions and Hearing and Appeals Process for Providers, Section I.A, Section II.C (pg 5), Section II.E, Section III.D, Attachment C (pgs 10-16), Attachment D • Provider Manual (pg 31-34) <p>Process Description:</p> <p>CR213 Section I.A states, “For actions involving quality of care, professional competence and/or conduct, the Provider will be notified by certified mail within five (5) business days of the decision set forth in Section II below. (p5)” CR213 Section II.C describes the minimum contents of the written notice (5-6).</p> <p>CR213 Section II.C indicates as part of the written notification that a practitioner can request a hearing within 30 days of written notice.</p> <p>CR213 Section II.E states that practitioner has 30 days to request a hearing (p6).</p> <p>CR213 Attachment D states that practitioner can be represented by an attorney or any person of the practitioner’s choice (p30).</p> <p>CR213 Attachment A III.F&G describe how a hearing panel and hearing officer are appointed (p13).</p> <p>CR213 Section III.D states; “The Appeal Panel may render its decision orally at the close of the Appeal Hearing. Within thirty (30) calendar days after rendering an oral decision, or within thirty (30) calendar days after the close of the Appeal Hearing if no oral decision has been rendered, the Appeal Hearing Panel shall issue a decision which shall be accompanied by a written report that contains findings of fact and conclusions that articulate the connection between the evidence produced at the Appeal Hearing and the decision rendered. The written decision and report shall be delivered to Colorado Access and the Provider within ten (10) business days.”</p>

Findings:
 The Adverse Actions policy described the practitioner appeal and hearing processes. Practitioners were notified of the appeal and hearing processes in the Provider Manual.



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard VIII—Credentialing and Recredentialing	
Requirement	Evidence Submitted by the Health Plan
<p>2.U. Making the appeal process known to practitioners.</p> <p>NCQA CR10—Element A4</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • CR213-Adverse Actions and Hearing and Appeals Process for Providers, Attachment A (pg 10) • Provider Manual, Section XI (pg 31-34) <p>Process Description:</p> <p>Practitioners are notified of the appeal process in the Practitioner Termination for Professional Review Action letter (CR213, Attachment A p11).</p> <p>Practitioners are also made aware of the credentialing appeal process within the Provider Manual (pg 31-34)</p>
<p>Findings:</p> <p>The Adverse Actions policy included a template letter that informed practitioners of the actions the SMCN took, the reasons for the actions, and the practitioner’s right to request a hearing.</p>	
<p>3. The Contractor designates a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions. The committee includes representation from a range of participating practitioners.</p> <p>NCQA CR2—Element A</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • CR301-Provider Credentialing and Recredentialing, Section IX (pgs 7-8) • Credentialing Committee Roster 2012 <p>Process Description:</p> <ul style="list-style-type: none"> • Colorado Access policy CR301 designates the existence of a credentialing committee (Section IX, pgs 7-8). This committee consists of participating network providers from all Colorado Access lines of business. The credentialing committee roster is included.
<p>Findings:</p> <p>The Practitioner Credentialing and Recredentialing policy described the Colorado Access Credentials Committee and its responsibilities. The Credentials Committee roster listed the committee’s membership, which consisted of a range of practicing physicians including a psychologist and medical doctors from several disciplines.</p>	

Standard VIII—Credentialing and Recredentialing	
Requirement	Evidence Submitted by the Health Plan
<p>4. The Contractor provides evidence of the following:</p> <ul style="list-style-type: none"> ◆ Credentialing committee review of credentials for practitioners who do not meet established thresholds. ◆ Medical director or equally qualified individual review and approval of clean files. <p>NCQA CR2—Element B</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • CR301-Provider Credentialing and Recredentialing, Section IX (pgs 7-8) • CR307-Credentialing and Recredentialing Provider Review Classification, Section I.B.1- 2 (pg 3) <p>Process Description:</p> <p>Colorado Access policy CR301 stipulates that the credentialing committee will review, at a minimum, the status of practitioners who do not meet established credentialing criteria (Section IX, pg 7).</p> <p>Colorado Access policy CR307 specifies the process for reviewing practitioners who do not meet minimum standards and for review and approval of files by the Medical Director (Section I.B.1-2, pgs 2-3).</p>
<p>Findings:</p> <p>The Practitioner Review Classification policy described the criteria for applicants who met the criteria for clean files that may be reviewed by the chief medical officer, and for those files that must be reviewed by the committee. The Credentials Committee meeting minutes provided evidence that the Credentials Committee reviewed all files that did not cleanly meet the credentialing criteria.</p>	

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence Submitted by the Health Plan
<p>5. The Contractor conducts timely verification (at credentialing) of information, using primary sources, to ensure that practitioners have the legal authority and relevant training and experience to provide quality care. Verification is within the prescribed time limits and includes:</p> <ul style="list-style-type: none"> ◆ A current, valid license to practice (verification time limit = 180 calendar days). ◆ A valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (effective at the time of the credentialing decision). ◆ Education and training, including board certification, if applicable (verification of the highest of graduation from medical/ professional school, residency, or board certification [board certification time limit = 180 calendar days]). ◆ Work history (verification time limit = 365 calendar days) (non-primary verification—most recent 5 years). ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (verification time limit = 180 calendar days). <p>NCQA CR3—Elements A and B</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • CR301-Provider Credentialing and Recredentialing, Section VIII (pgs 6-7) and XIV (pgs 10-15) <p>Process Description:</p> <p>Colorado Access policy CR301 outlines the use of primary source verification and the deadlines for this verification to occur (Sections VIII, pgs 6-7 and XIV, pgs 9-13).</p>

Findings:
 The Practitioner Credentialing and Recredentialing policy described the processes for primary source verification and for the time limits for verifying each element at the primary source, all of which were NCQA-compliant.

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence Submitted by the Health Plan
<p>6. Practitioners complete an application for network participation (at initial credentialing and recredentialing) that includes a current and signed attestation and addresses the following:</p> <ul style="list-style-type: none"> ◆ Reasons for inability to perform the essential functions of the position, with or without accommodation. ◆ Lack of present illegal drug use. ◆ History of loss of license and felony convictions. ◆ History of loss or limitation of privileges or disciplinary actions. ◆ Current malpractice/professional liability insurance coverage (minimums = physician—.5mil/1.5mil; facility—.5mil/3mil). ◆ The correctness and completeness of the application. <p>NCQA CR4—Element A NCQA CR7—Element C C.R.S.—13-64-301-302</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • CR301-Provider Credentialing and Recredentialing, Section X (pgs 8-9) • Colorado Health Care Professional Credentials Application (pgs 19-21, 24-26) <p>Process Description: Colorado Access policy CR301 requires that all credentialing and recredentialing applications must include a current and signed attestation that includes the bullets listed to the left (Section X, pg 9).</p> <p>The CO Health Care Professional Credentials Application requires practitioners to attest to these requirements (pgs 19-21, 24-26).</p>

Findings:
 The Practitioner Credentialing and Recredentialing policy stated that Colorado Access requires all practitioners to complete the Colorado Health Care Professional Credentials Application. The application included each of the required attestations. On-site review of 10 credentialing and 10 recredentialing files provided evidence that each file contained a completed and signed application and attestation from the provider.



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence Submitted by the Health Plan
<p>7. The Contractor verifies the following sanction activities for initial credentialing and recredentialing:</p> <ul style="list-style-type: none"> ◆ State sanctions, restrictions on licensure, or limitations on scope of practice. ◆ Medicare and Medicaid sanctions. <p align="right"><i>42CFR438.610(b)(3)</i></p> <p>NCQA CR5—Element A NCQA CR7—Element D</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • CR301-Practitioner Credentialing and Recredentialing, Section XI (pg 9), XIV.A (pg 10), XV.H (pg 14) <p>Process Description: Colorado Access policy CR301 requires that Colorado Access receive information on practitioner sanction before making a credentialing decision. This includes State and CMS sanctions. See specific sections noted above.</p>
<p>Findings: The Practitioner Credentialing and Recredentialing policy stated that in support of credentialing or recredentialing applications, State licensure sanctions and Medicare/Medicaid sanctions are researched using the required databases. On-site review of credentialing and recredentialing files confirmed review for sanctions at credentialing and recredentialing.</p>	
<p>8. The Contractor has a process to ensure that the offices of all practitioners meet its office-site standards. The organization sets standards and performance thresholds for:</p> <ul style="list-style-type: none"> ◆ Physical accessibility. ◆ Physical appearance. ◆ Adequacy of waiting and examining room space. ◆ Adequacy of treatment record-keeping. <p>NCQA CR6—Element A</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • CR301-Provider Credentialing and Recredentialing, Section VIII (pg 7), XV.I (pg 15) • CR302-Office Site Visit for Providers Credentialing, All <p>Process Description: Colorado Access policy CR301 specifies that a site visit will occur if a complaint is received related to the physical accessibility, appearance, or adequacy of waiting room or examining room space.</p> <p>If a site visit is required, Colorado Access policy CR302 outlines the process for practitioner site visits. Section II.A outlines what items will be assessed in a site visit (p2-3).</p>
<p>Findings: The Office Site Visit for Provider Credentialing policy delineated Colorado Access’ criteria for office site visits. The policy stated that an office site assessment will assess physical appearance, physical accessibility, appointment availability, and the adequacy of waiting room and exam/treatment room space. The policy also stated that the office site visit included assessment of medical record-keeping practices, including practices for confidentiality, file organization, and documentation. The site visit form, attached to the policy, included the specific requirements for each standard, which included a review for all the NCQA standards. Providers were informed of the site review standards via the provider manual. During the on-site interview, SMCN staff members reported that there had been no site visits based on office site quality during the review period.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence Submitted by the Health Plan
<p>9. The Contractor implements appropriate interventions by:</p> <ul style="list-style-type: none"> ◆ Conducting site visits of offices about which it has received member complaints. ◆ Instituting actions to improve offices that do not meet thresholds. ◆ Evaluating effectiveness of the actions at least every six months, until deficient offices meet the thresholds. ◆ Continually monitoring member complaints for all practitioner sites and performing a site visit within 60 days of determining a complaint threshold was met. ◆ Documenting follow-up visits for offices that had subsequent deficiencies. <p>NCQA CR6—Element B</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • CR302-Office Site Visit for Provider Credentialing, All <p>Process Description:</p> <p>Colorado Access policy CR302 outlines the process for practitioners site visits based on a member complaint.</p> <p>CR302 Section I describes how Colorado Access will conduct site visits when member complaints are received (p2)</p> <p>CR302 Section V.A&B describes actions that will be taken to improve offices that do not meet thresholds (p3).</p> <p>Section V.A also indicates that follow up site visits will occur every six months until the office meets the threshold (p3).</p> <p>Section VI describes how follow up visits are documented (p3).</p>

Findings:

The Office Site Visit for Practitioner Credentialing policy included the process for determining office sites that require an office site visit. The policy contained the provision that two or more complaints or one Level 3 complaint (safety issue as defined by the Occupational Safety and Health Administration [OSHA]) in a 12-month period would trigger a site visit. The Colorado Access thresholds for what triggers a site visit were compliant with NCQA guidelines.

The Office Site Visit for Practitioner Credentialing policy also stated that if an office did not meet Colorado Access’ threshold for acceptability, a corrective action plan would be developed and a follow-up site visit would be scheduled every six months until the performance standards were met. The Colorado Access Investigation of Potential Clinical and QOC Grievances and Referrals policy described Colorado Access’ process for referring Level 3 complaints to the Credentials Committee for review and follow-up. The policy also stated that if the circumstances of the QOC incident precluded waiting for the next scheduled Credentials Committee meeting, the quality management department would notify the appropriate SMCN medical director or physician designee for immediate action. The policy also described the actions Colorado Access would take for a Level 3 incident (most serious), which included requesting a corrective action plan from the involved provider or practitioner or termination of the provider.



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence Submitted by the Health Plan
<p>10. The Contractor formally recredentials its practitioners (at least every 36 months) through information verified from primary sources. The information is within the prescribed time limits and includes:</p> <ul style="list-style-type: none"> ◆ A current, valid license to practice (verification time limit = 180 calendar days). ◆ A valid DEA or CDS certificate (effective at the time of recredentialing). ◆ Board certification (verification time limit = 180 calendar days). ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (verification time limit = 180 calendar days). <p>NCQA CR7—Elements A and B NCQA CR8—Element A</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • CR301-Provider Credentialing and Recredentialing, Section IX (pg 8) Section VIII (pgs 6), Section XIV (pgs 11) • Provider Manual (pg 28) <p>Process Description: Colorado Access policy CR301 specifies that practitioners are recredentialled at least every 36 months (Section IX, pg 8). This policy also outlines the information the recredentialing process must include (Section VIII, pgs 6 and XIV, pg 11).</p>
<p>Findings: The Practitioner Credentialing and Recredentialing policy stated that practitioners were recredentialled every 36 months and described the verification criteria required for recredentialing, which met NCQA requirements. Providers were informed in the provider manual that recredentialing occurred every three years. The recredentialing files reviewed on-site provided evidence that the above information was validated at the primary source and that recredentialing occurred every three years.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard VIII—Credentialing and Recredentialing	
Requirement	Evidence Submitted by the Health Plan
<p>11. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of (organizational) providers with which it contracts, which include:</p> <p>11.A. The Contractor confirms that the provider is in good standing with State and federal regulatory bodies.</p> <p>NCQA CR11—Element A1</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • CR305-Organizational Provider Credentialing, Section IV (pgs 4) • Credentials Committee Roster 2012 <p>Process Description: Colorado Access policy CR305 outlines the process for the initial and ongoing assessment of organizational providers. The Organizational Provider Credentialing meets monthly and is staffed by Colorado Access clinical staff (see Credentialing Committee Roster 2012). Minutes will be available for review during the site visit.</p> <p>CR305 specifies that Colorado Access will ensure all organizational providers are in good standing with State and Federal regulatory bodies (Section IV, pg 4-5).</p>
<p>Findings: The Organizational Provider Credentialing policy included the procedures for assessment of organizational providers with which Colorado Access contracts. The procedures included the process for obtaining applicable State licenses or certifications, and evidence of eligibility to participate in federal health care programs, as evidenced by the federal OIG database query. Review of five organizational provider records on-site demonstrated that Colorado Access followed its procedures regarding assessment of organizational provider files.</p>	
<p>11.B. The Contractor confirms that the provider has been reviewed and approved by an accrediting body.</p> <p>NCQA CR11—Element A2</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • CR305-Organizational Provider Credentialing, Section IV (pgs 4), Section V (Pgs 7) • Provider Manual (pgs 28-29) <p>Process Description: Colorado Access policy CR305 specifies that Colorado Access confirms that each organizational provider has been reviewed and approved by an accrediting body (Section IV and V, pgs 4-9).</p>
<p>Findings: The Organizational Provider Credentialing policy included the process for obtaining a copy of any applicable accreditation certificates when contracting with and assessing organizational providers. The on-site review of organizational provider files provided evidence that the health plan collected accreditation information and certificates from organizational providers that were accredited.</p>	



*Appendix A. Colorado Department of Health Care Policy and Financing
 FY 2012–2013 Compliance Monitoring Tool
 for State Managed Care Network*

Standard VIII—Credentialing and Recredentialing	
Requirement	Evidence Submitted by the Health Plan
<p>11.C. The Contractor conducts an on-site quality assessment if there is no accreditation status.</p> <p>NCQA CR11—Element A3</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • CR305-Organizational Provider Credentialing, Section VII.E (pg 12) <p>Process Description: Colorado Access policy CR305 specifies that Colorado Access will conduct an on-site assessment if the organization does not have accreditation status (Section VII.E, pg 12).</p>
<p>Findings: The Organizational Provider Credentialing policy stated that nonaccredited facilities were subject to an on-site assessment by Colorado Access. Colorado Access provided an on-site assessment form for use for non-accredited facilities not surveyed by the <u>Division of Behavioral Health (DBH)</u> or the Colorado Department of Public Health and Environment (CDPHE).</p>	
<p>11.D. The Contractor confirms at least every three years that the organizational provider continues to be in good standing with State and federal regulatory bodies, and if applicable, is reviewed and approved by an accrediting body. The Contractor conducts a site visit every three years if the organizational provider has no accreditation status.</p> <p>NCQA CR11—Element A</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • CR305-Organizational Provider Credentialing, Section II (pg 3), and VII.D (pg 11) <p>Process Description: Colorado Access policy CR305 states, “Colorado Access conducts a pre-contractual assessment and re-assessment at least every three years.</p> <p>Reassessment includes confirmation that the organizational provider remains in good standing with State and Federal regulatory bodies. If not approved by an accrediting body, provisions for site review follow the same initial assessment procedures at reassessment (Section VII.D, pgs 11).</p>
<p>Findings: The Organizational Provider Credentialing policy contained the procedures for reassessment of organizational providers every three years, which included verifying that the provider was in good standing with State and federal regulatory agencies and whether it was accredited, and performing site visits for organizations not accredited. On-site review of five organizational provider files demonstrated that providers were reassessed every three years.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard VIII—Credentialing and Recredentialing	
Requirement	Evidence Submitted by the Health Plan
<p>11.E. The Contractor’s policies list the accrediting bodies the Contractor accepts for each type of organizational provider. (If the Contractor only contracts with organizational providers that are accredited, the Contractor must have a written policy that states it does not contract with nonaccredited facilities.)</p> <p>NCQA CR11—Element A</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • CR305-Organizational Provider Credentialing, Section IV (pgs 4), V (pgs 6), and VII. E (pg10) <p>Process Description:</p> <ul style="list-style-type: none"> • Colorado Access policy CR305 (Section IV) specifies the Criteria and Verification Requirements used to evaluate organizational providers during initial credentialing and recredentialing and the verification requirements associated with each follow. • In the case of non-accredited organizational provider(s), Colorado Access will utilize the CMS site survey conducted by the Colorado Department of Public Health and Environment (CDHPE), the DMH site review conducted on behalf of the Department of Human Services (DHS) or the Alcohol and Drug Abuse Division (ADAD) Site Inspection in lieu conducting a site visit. <p>Colorado Access requires each organizational provider be accredited by one of the accreditation bodies listed in the CR 305 policy, Sct V. In lieu of accreditation, Colorado Access will accept the CMS site survey conducted by CDHPE, the DMH site review or the DBH Site Inspection Report, as applicable. If the organizational provider is not accredited by an entity recognized by Colorado Access or not subject to site reviews conducted by CMS, DMH or DBH, Colorado Access will perform a site visit.</p>
<p>Findings:</p> <p>The Organizational Provider Credentialing policy listed numerous appropriate accrediting bodies Colorado Access would accept. On-site review of organizational provider records included two facilities accredited by The Joint Commission.</p>	

Standard VIII—Credentialing and Recredentialing	
Requirement	Evidence Submitted by the Health Plan
<p>12. The Contractor has a selection process and assessment criteria for each type of nonaccredited organizational provider with which the Contractor contracts.</p> <p>NCQA CR11—Element A</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> CR305-Organizational Provider Credentialing, Section IV (pgs 4), V (pgs 7), and VII. E (pg 12) <p>Process Description: Colorado Access policy CR305 specifies the selection process and assessment criteria for each type of nonaccredited organizational provider.</p> <ul style="list-style-type: none"> In the case of non-accredited organizational provider(s), Colorado Access will utilize the CMS site survey conducted by the Colorado Department of Public Health and Environment (CDHPE), the DMH site review conducted on behalf of the Department of Human Services (DHS) or the Division of Behavioral Health (DBH) Site Inspection in lieu conducting a site visit. If the organizational provider has not undergone a site visit by one of the above, Colorado Access will perform a site visit.
<p>Findings: The Facility Site Assessment form included a review of appointment availability, credentialing/recredentialing policies and practices, various aspects of clinical operations, safety policies and practices, office/site appearance, treatment record-keeping practices, confidentiality procedures, and medication safety practices. Colorado Access/SMCN had a specific form for each type of organizational provider.</p>	
<p>13. Site visits for nonaccredited facilities include a process for ensuring that the provider credentials its practitioners.</p> <p>NCQA CR11—Element A</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> CR305-Organizational Provider Credentialing, Section VII E (pg 12) <p>Process Description: Colorado Access policy CR305 organizational site review survey procedures confirm that nonaccredited facilities include a process for ensuring that the provider credentials its practitioners.</p>
<p>Findings: The Organizational Provider Assessment policy stated that the site visit for nonaccredited facilities included a review of staff hiring and credentialing processes. Review of organizational provider files on-site demonstrated that Colorado Access followed its policies for ensuring that nonaccredited facilities credential their practitioners.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard VIII—Credentialing and Recredentialing	
Requirement	Evidence Submitted by the Health Plan
<p>14. If the Contractor chooses to substitute a CMS or State review in lieu of the required site visit, the Contractor must obtain the report from the organizational provider to verify that the review has been performed and that the report meets its standards. (CMS or State review or certification does not serve as accreditation of an institution.) A letter from CMS or the applicable State agency which shows that the facility was reviewed and indicates that it passed inspection is acceptable in lieu of the survey report if the organization reviewed and approved the CMS or State criteria as meeting the organization's standard.</p> <p>NCQA CR11—Element A</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • CR305-Organizational Provider Credentialing, Section IV (pgs 4), V (pgs 7), and VII. E (pg 12) <p>Process Description: Colorado Access policy CR305 outlines the requirements and terms for substituting a CMS or state review for the required site visit. The policy explains that if the organizational provider is not accredited or is accredited by an entity not recognized by Colorado Access, receipt of a copy of the report (survey), letter sent to the organizational provider from CMS, DMH or DBH that shows that the facility was reviewed and passed inspection.</p>
<p>Findings: On-site review of organizational provider files demonstrated that Colorado Access obtained DBH and CDPHE survey reports for nonaccredited facilities surveyed by these State departments. Review of Credentials Committee meeting minutes demonstrated that the committee reviewed the applicable State survey during the organization’s reassessment/recredentialing process.</p>	
<p>15. The Contractor’s organizational provider assessment policies and process include assessment of at least the following medical providers:</p> <ul style="list-style-type: none"> ◆ Hospitals. ◆ Home health agencies. ◆ Skilled nursing facilities. ◆ Free-standing surgical centers. <p>NCQA CR11—Element B</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • CR305-Organizational Provider Credentialing, Section I. A, B, C (pgs 2-3) <p>Process Description: Per policy CR305 Colorado Access will conduct a pre-contractual credentialing of Physical and Behavioral health organizational providers for all lines of business. A full list is outlined in policy CR 305.</p>



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard VIII—Credentialing and Recredentialing	
Requirement	Evidence Submitted by the Health Plan
<p>Findings: The Organizational Provider Assessment policy stated that Colorado Access’ organizational providers may include community mental health centers (CMHCs), hospitals, home health agencies, skilled nursing facilities, and other types of facilities. The provider directory provided evidence that the SMCN contracted with these types of facilities. On-site record review included files for one hospital, two home health agencies, and one federally qualified health center (FQHC).</p>	
<p>16. The Contractor’s organizational provider assessment policies and process include assessment of at least the following behavioral health and substance abuse settings:</p> <ul style="list-style-type: none"> ◆ Inpatient. ◆ Residential. ◆ Ambulatory. <p>NCQA CR11—Element C</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • CR305-Organizational Provider Credentialing, Section I. B (pg 2) <p>Process Description: Colorado Access policy CR 305 outlines the list of medical and behavioral health providers for which pre-contractual credentialing will be performed on, for all lines of business. A full list is outlined in policy CR 305.</p>
<p>Findings: The Organizational Provider Assessment policy stated that Colorado Access’ organizational providers may include CMHCs, hospitals, residential treatment facilities, rehabilitation facilities, and other types of facilities. The provider directory provided evidence that the SMCN contracted with inpatient facilities, residential treatment facilities, and ambulatory facilities. On-site record review included one file for a CMHC.</p>	
<p>17. The Contractor has documentation that it has assessed contracted medical health care (organizational) providers.</p> <p>NCQA CR11—Element D</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • CR305-Organizational Provider Credentialing, Section I. A, B, C (pgs 2-3) <p>Process Description: Colorado Access policy CR305 explains the Scope of Credentialing Activities, including medical health care providers (Section I, A-C).</p>
<p>Findings: On-site review of organization-specific files demonstrated that Colorado Access documented assessment and reassessment activities for organizational providers with which it contracts.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard VIII—Credentialing and Recredentialing	
Requirement	Evidence Submitted by the Health Plan
<p>18. If the Contractor delegates any NCQA-required credentialing activities, there is evidence of oversight of the delegated activities.</p> <p>NCQA CR12</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • ADM223-Delegation, All • Executive Summaries for: (located in the Executive Summary and Audit Results uploaded folder) <ul style="list-style-type: none"> ○ Boulder Valley IPA ○ Denver Health and Hospital Authority ○ University Physician Inc ○ Northern Colorado IPA ○ National Jewish Health <p>Process Description: Per policy ADM 223, Colorado Access will establish and maintain a pre-Delegation assessment process for Contractors with which Colorado Access desires Delegation and a process to accomplish Delegation oversight of Contractors awarded Delegation.</p>
<p>Findings: The Delegation policy described ongoing monitoring and annual audit processes for oversight of delegates. SMCN staff provided audit reports for each delegate that demonstrated Colorado Access conducted an on-site annual audit for each credentialing delegate. The Centura Health Audit was a predelegation audit completed in July 2012, and all others were annual audits, also completed within 2012. On-site review of Credentials Committee meeting minutes demonstrated that the committee reviewed periodic reports of credentialing activities from each delegate.</p>	
<p>19. The Contractor has a written delegation document with the delegate that:</p> <ul style="list-style-type: none"> ◆ Is mutually agreed upon. ◆ Describes the responsibilities of the Contractor and the delegated entity. ◆ Describes the delegated activities. ◆ Requires at least semiannual reporting by the delegated entity to the Contractor. ◆ Describes the process by which the Contractor evaluates the delegated entity’s performance. ◆ Describes the remedies available to the Contractor (including revocation of the 	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • Delegation Agreements for: (located in the Delegation Agreements uploaded folder) <ul style="list-style-type: none"> ○ Boulder Valley IPA ○ Denver Health and Hospital Authority ○ University Physician Inc ○ Northern Colorado IPA ○ National Jewish Health • Delegation Agreement template (located in the Delegation Agreements uploaded folder) <p>Process Description:</p> <ul style="list-style-type: none"> • Each credentialing delegation agreement: <ul style="list-style-type: none"> ○ Is mutually agreed upon ○ Describes the responsibilities of the Contractor and the delegated entity



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard VIII—Credentialing and Recredentialing	
Requirement	Evidence Submitted by the Health Plan
<p>contract) if the delegate does not fulfill its obligations.</p> <p>NCQA CR12—Element A</p>	<ul style="list-style-type: none"> ○ Describes the delegated activities ○ Requires at least semiannual reporting to the Contractor ○ Describes the process by which the Contractor evaluates the delegated entity’s performance ○ Describes the remedies available to the Contractor if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement
<p>Findings: SMCN provided signed Credentialing Delegation Agreements with Northern Colorado Individual Practice Association (IPA), Centura Health, Denver Health and Hospital Authority, University Physicians Incorporated, Boulder Valley IPA, and National Jewish Health. The delegation agreements described delegated activities and responsibilities for both parties, described reporting requirements, and specified how Colorado Access will monitor the delegate’s performance of credentialing activities. The agreement specified several reports required monthly or annually, as appropriate. The agreement also provided for remedies if the delegate’s performance is not adequate.</p>	
<p>20. If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes:</p> <ul style="list-style-type: none"> ◆ A list of allowed use of PHI. ◆ A description of delegate safeguards to protect the information from inappropriate use or further disclosure. ◆ A stipulation that the delegate will ensure that subdelegates have similar safeguards. ◆ A stipulation that the delegate will provide members with access to their PHI. ◆ A stipulation that the delegate will inform the Contractor if inappropriate uses of the information occur. ◆ A stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends. <p>NCQA CR12—Element B</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> ● ADM223-Delegation, Section I.L (pg 4) ● HIP203 Business Associate Agreement <p>Process Description: Each credentialing delegation agreement includes:</p> <ul style="list-style-type: none"> ● Includes a list of allowed uses of PHI ● Includes a description of delegate safeguards to protect the information (PHI) from inappropriate uses ● Includes a stipulation that the delegate will ensure that subdelegates have similar safeguards ● Includes a stipulation that the delegate will provide individuals with access to their PHI ● Includes a stipulation that the delegate will inform the Contractor if inappropriate use of the information (PHI) occur ● Includes a stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard VIII—Credentialing and Recredentialing	
Requirement	Evidence Submitted by the Health Plan
<p>Findings: The Business Associate Agreement included the required HIPAA-compliant provisions. During the on-site interview, SMCN staff confirmed that Colorado Access had a Business Associate Agreement with each delegate.</p>	
<p>21. The Contractor retains the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision making. This right is reflected in the delegation agreement.</p> <p>NCQA CR12—Element C</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • Delegation Agreement Template, Section B.2 (pg 4) • Delegation Agreements – located in the Delegation Agreements uploaded folder <p>Process Description: The delegation agreement Includes a stipulation that the Contractor has the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision-making.</p>
<p>Findings: Each of the delegation agreements included the provision that Colorado Access retains the right to approve, suspend, and terminate individual practitioners and providers. During the on-site interview, staff members confirmed that ongoing monitoring for sanctions includes practitioners credentialed by delegates. In addition, the Credentials Committee reviewed credentialing reports by delegates. If sanctions or other concerns are discovered, the process would be to alert the delegate and begin appropriate Colorado Access committee review procedures to determine the appropriate action.</p>	
<p>22. For delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity before the delegation document was signed.</p> <p>NCQA CR12—Element D</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • 2012 Centura Health Physician Group Pre-Delegation Documents <p>Process Description: Colorado Access evaluated the delegate capacity, as identified in the uploaded pre-delegation documents, prior to signing the contract with Centura Health Physician Group.</p>
<p>Findings: SMCN staff provided the completed Pre-Delegation Audit report for Centura Health Group, completed in July 2012, and delegation agreement with Centura signed in October 2012.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard VIII—Credentialing and Recredentialing	
Requirement	Evidence Submitted by the Health Plan
<p>23. For delegation agreements in effect 12 months or longer, the Contractor audits credentialing files against NCQA standards for each year that the delegation has been in effect.</p> <p>NCQA CR12—Element E</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • 2012 Boulder Valley IPA Audit Results • 2012 Denver Health and Hospital Authority Audit Results • 2012 University Physician Inc. Audit Results • 2012 Northern Colorado IPA Audit Results • 2012 National Jewish Health Audit Results <p>Process Description: Colorado Access has performed an audit for each of above listed facilities, whose delegation agreements have been in the effect longer than 12 months. The audit results for each have been uploaded to the Executive Summary and Audit Results folder.</p>
<p>Findings: Audit reports submitted for each delegate demonstrated that Colorado Access’ audit included a file review for compliance with NCQA standards.</p>	
<p>24. For delegation arrangements in effect 12 months or longer, the Contractor performs an annual substantive evaluation of delegated activities against NCQA standards and organization expectations.</p> <p>NCQA CR12—Element F</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • 2012 Boulder Valley IPA Audit Results • 2012 Denver Health and Hospital Authority Audit Results • 2012 University Physician Inc. Audit Results • 2012 Northern Colorado IPA Audit Results • 2012 National Jewish Health Audit Results <p>Process Description: Colorado Access has performed an audit for each of above listed facilities, whose delegation agreements have been in the effect longer than 12 months. The annual evaluation performs a comparison of NCQA standards against those of Colorado Access. The audit results for each have been uploaded to the Executive Summary and Audit Results folder.</p>
<p>Findings: Audit Reports submitted for each delegate demonstrated that Colorado Access conducted a review of policies and procedures and reviewed for compliance with NCQA standards.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard VIII—Credentialing and Recredentialing	
Requirement	Evidence Submitted by the Health Plan
<p>25. For delegation arrangements in effect 12 months or longer, the Contractor evaluates regular reports (at least semiannually).</p> <p>NCQA CR12—Element G</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • Boulder Valley IPA • Denver Health and Hospital Authority • University Physician Inc • Northern Colorado IPA • National Jewish Health <p>Process Description:</p> <p>Colorado Access Credentialing staff receives monthly report from each organization delegated credentialing. These reports can be produced during the site visit if requested.</p>
<p>Findings:</p> <p>Review of Credentials Committee meeting minutes demonstrated that Colorado Access reviewed periodic reports of credentialing activities performed by each delegate. The frequency of reports varied based on the volume of credentialing activity, but all reports were reviewed at least semiannually.</p>	
<p>26. The Contractor identifies and follows up on opportunities for improvement, if applicable.</p> <p>NCQA CR12—Element H</p>	<p>Documents Submitted/Location Within Documents:</p> <ul style="list-style-type: none"> • 2012 Boulder Valley IPA Audit Results • 2012 Denver Health and Hospital Authority Audit Results • 2012 University Physician Inc. Audit Results • 2012 Northern Colorado IPA Audit Results • 2012 National Jewish Health Audit Results <p>Process Description:</p> <p>Colorado Access performs annual audits, per the audit results explanation any opportunities for improvement are identified and documented in the Recommendations for Improvement section as well as followed up on if applicable.</p> <p>Per the pre-delegation audit for Centura Health, the delegation recommendation was for Colorado Access to perform a 6-month delegation audit in order to assure the action plans listed in the audit results were implemented.</p>



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard VIII—Credentialing and Recredentialing

Requirement

Evidence Submitted by the Health Plan

Findings:

The Centura Pre-delegation audit report demonstrated that Colorado Access identified opportunities for improvement, and recommended corrective actions. Colorado Access accepted Centura for a six-month provisional period pending completion of corrective actions.

Standard VIII Recommendations:

HSAG recommended that Colorado Access develop processes for monitoring to ensure nondiscriminatory credentialing practices.



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard X—Quality Assessment and Performance Improvement	
Requirement	Evidence as Submitted by the Health Plan
<p>1. The Contractor has an ongoing Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members.</p> <p align="right"><i>42CFR438.240(a)</i></p>	<p>Documents Submitted/Location Within Documents:</p> <ol style="list-style-type: none"> 1. CY12 Colorado Access QAPI Program Description 2. CY12 MBQIC Minutes 3. CY12 QIC Minutes <p>Description of Process Colorado Access has an ongoing QAPI Program described in detail in the QAPI Program Description which is updated annually and approved by the Board of Directors. Activities are reported to the QIC (Quality Improvement Committee including multidisciplinary representation from all areas of the company) and MBQIC (external Quality Improvement Committee including members and providers) committees.</p>
<p>Findings: The Colorado Access Quality Improvement (QI) Program Description (applicable to all lines of business) defined the objectives and the organizational structure for the QI program. The Board of Directors had ultimate accountability for the program and designated the corporate-wide Quality Improvement Committee (QIC) as the oversight committee for the QI program. The Medical/Behavioral Quality Improvement Committee (MBQIC), a subcommittee of the QIC, was responsible for recommending strategies to monitor and improve the clinical quality of health care delivered to members. The description stated that results of activities and measures are analyzed and addressed through the implementation of action plans to improve performance or correct identified problems. Program components included analysis of accessibility, provider availability, clinical practice guidelines, care management, Healthcare Effectiveness Data and Information Set (HEDIS) clinical performance measures, member satisfaction, performance improvement projects (PIPs), grievances and appeals, utilization management, medication utilization, member education, and medical record documentation. The QI Program Description was updated and approved annually. Both the QIC meeting minutes and MBQIC meeting minutes documented review and approval of the QI Program Description. Meeting minutes also included discussions and recommendations related to QI findings and activities.</p> <p>During the on-site interview, staff stated that the imminent transition of the majority of SMCN members into the CHP+ health maintenance organization (HMO) may impact the future SMCN QI program. The SMCN population will consist of short-term transitioning members or women in the specialized pregnancy program. Staff stated that Colorado Access is awaiting contract revisions to determine the best strategies for future QI activities.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard X—Quality Assessment and Performance Improvement	
Requirement	Evidence as Submitted by the Health Plan
<p>2. The Contractor’s QAPI Program includes mechanisms to detect both underutilization and overutilization of services.</p> <p align="right"><i>42CFR438.240(b)(3)</i></p>	<p>Documents Submitted/Location Within Documents:</p> <ol style="list-style-type: none"> 1. CY12 COA QAPI Program Description-p 10-13 2. FY13 COA UM Program Description- p 15-18 3. FY13 COA Access to Care Plan-p 8 Sect. IV. A; p 9 Sect IV. D; p. 10 Sect. IV. G; p 13 Sect. V. A) 4. CCS307-Utilization Review Determinations 5. CCS302-Medical Criteria for Utilization Review 6. CHP+ SMCN Trend Report (Category of Service) 7. CHP+ SMCN Dashboard (Medical Trends) 8. CHP+ HEDIS 2012 QIC Report 9. CY12 Q3 CHP+ SMCN Pharmacy Report 10. Daily Census Report 12 10 12 NO PHI 11. CHC ER Report 12 06 12 NO PHI <p>Description of Process Colorado Access QAPI and UM Program has mechanisms to detect under and overutilization. The QAPI and UM Program Descriptions scope sections and Access to Care Plan outlines the various areas monitored including all levels of service. Colorado Access policies CCS307-Utilization Review Determination and CCS302-Medical Criteria for Utilization Review outline the UM review process which helps manage utilization. Various reports are reviewed by the QIC, Senior Staff Team, work groups and clinical/quality staff. These include reports at summary and patient detail levels including Category of Service, Medical Trends, HEDIS reporting, Pharmacy Utilization and Daily Inpatient and ER reports.</p>
<p>Findings: The QI Program Description and the Utilization Management (UM) Program Description stated that potential over- and underutilization is managed through UM Program authorizations, as well as the case management and disease management programs. Utilization is monitored through utilization trending reports and HEDIS measures. The QI Program Description also stated that medication utilization and cost profiles are monitored through the pharmacy program. Colorado Access submitted several sample reports used to monitor SMCN utilization, including HEDIS measures of underutilization, and a dashboard report of multiple measures of potential overutilization. During the on-site interview, staff stated that utilization and dashboard trending reports are reviewed by senior staff regularly, and a staff summary is presented to the QIC.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard X—Quality Assessment and Performance Improvement	
Requirement	Evidence as Submitted by the Health Plan
<p>3. The Contractor’s QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs.</p> <p align="right"><i>42CFR438.240(b)(4)</i></p>	<p>Documents Submitted/Location Within Documents:</p> <p>1. CY12 COA QAPI Program Description-p 10-13</p> <p>Description of Process</p> <p>Colorado Access has an ongoing QAPI Program which includes mechanisms to assess the quality and appropriateness of care furnished to members with special healthcare needs as described in detail in the QAPI Program Description.</p>
<p>Findings:</p> <p>The Colorado Access QI Program Description described a comprehensive approach to monitoring quality and appropriateness of care for all members, including SMCN members with special health care needs. The program description addressed the application of UM and other clinical practice guidelines (CPGs), and the assessment of quality of care through trending of performance measures (e.g., HEDIS), member satisfaction surveys, grievance and appeal data, quality of care concerns (QOCCs), clinical outcomes reporting, and PIPs. During the on-site interview, staff confirmed that QI activities applied to all SMCN members. Staff also described the process for conducting a health risk assessment of SMCN members to identify members for referral to specialized care management programs, such as management of asthma, the Healthy Moms, Healthy Babies program for high-risk pregnancy, and the emergency department diversion program for high users of emergency services.</p>	
<p>4. If the State requires, the Contractor has a process for evaluating the impact and effectiveness of the QAPI Program. The process includes a review of:</p> <ul style="list-style-type: none"> ◆ The Contractor’s performance on the standard measures on which it is required to report. ◆ The results of each performance improvement project. <p align="right"><i>42CFR438.240(e)(2)</i></p>	<p>This standard is not applicable as the state does not require a process for evaluating the impact of the QAPI program for the State Managed Care Network.</p>
<p>Findings:</p> <p>The Department determined that this requirement will not be included in the 2013 SMCN contract due to the anticipated short-term enrollment of the member population in the SMCN Plan.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard X—Quality Assessment and Performance Improvement

Requirement	Evidence as Submitted by the Health Plan
<p>5. The Contractor adopts practice guidelines that meet the following requirements:</p> <ul style="list-style-type: none"> ◆ Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. ◆ Consider the needs of the Contractor’s members. ◆ Are adopted in consultation with contracting health care professionals. ◆ Are reviewed and updated periodically as appropriate. <p align="right"><i>42CFR438.236(b)</i></p>	<p>Documents Submitted/Location Within Documents:</p> <ol style="list-style-type: none"> 1. QM311 Clinical Practice Guidelines-p 2 I 2. CY12 COA QAPI Program Description-p 10-11 last bullet 3. FY13 COA UM Program Description- p 16 B and C 4. MBQIC Minutes 03 06 12-p 2, #5 11 5. MBQIC Minutes 09 04 12- p 2, #4 6. MBQIC Minutes 11 06 12-p 4-5, #6 7. Guideline Track 2012-2013 <p>Description of Process</p> <p>Colorado Access ensures that practice guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field as stated in policy QM311. Most guidelines are adopted from HealthTeamWorks, Colorado’s consensus based clinical guideline task force. Topics that do not have HealthTeamWorks guidelines are adopted from reliable clinical sources based on research and oversight from internal medical directors and external contracting health care professionals through the MBQIC. Guidelines are tracked in the Guideline Track to ensure they are reviewed and updated periodically. MBQIC minutes demonstrate adoption in consultation with contracted providers and annual review.</p>

Findings:

The Clinical Practice Guidelines policy stated that Colorado Access would adopt CPGs that meet all of the criteria outlined in the requirement. The policy stated that guidelines are approved by the MBQIC, which was confirmed through MBQIC meeting minutes. The QI Work Plan and the Guidelines Tracking tool documented annual review of the Colorado Access’ CPGs. During the on-site interview, staff described that many of the CPGs originated from HealthTeamWorks, which publishes CPGs based on nationally recognized standards. A provider subcommittee reviews the proposed CPGs prior to approval by the MBQIC.



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard X—Quality Assessment and Performance Improvement	
Requirement	Evidence as Submitted by the Health Plan
<p>6. The Contractor disseminates the guidelines to all affected providers, and upon request, to members and potential members.</p> <p align="right"><i>42CFR438.236(c)</i></p>	<p>Documents Submitted/Location Within Documents:</p> <ol style="list-style-type: none"> 1. QM311 Clinical Practice Guidelines-p 3 V 2. CHP+ SMCN Provider Manual 3. CHP+ SMCN Provider Bulletin June 2012-p. 4-5 4. Provider Website Screenshot Guidelines-p 1 5. CHP+ SMCN Member Benefits Booklet- p 23-4 6. Member Website Screenshot Guidelines-p 1 <p>Description of Process</p> <p>As stated in QM311 Clinical Practice Guidelines, Colorado Access disseminates guidelines to providers, members, potential members, and the public. This is done through various mechanisms. The guidelines are posted to the Colorado Access website both in the member health and wellness and provider areas. Providers are also informed of updated guidelines through the Provider Bulletin. Providers and Members are also notified of guideline availability in the Provider Manual and Member Benefits Handbook.</p>
<p>Findings:</p> <p>The Clinical Practice Guidelines policy stated that guidelines would be disseminated to Colorado Access providers through the Colorado Access Web site, to members upon request, and to the public at no cost. The Preventive Health Services policy stated that Colorado Access develops and maintains preventive services guidelines that follow nationally accepted standards and are available to providers and members at no cost. Colorado Access submitted a sample SMCN Provider Bulletin that informed providers of the guidelines applicable to SMCN (listed) and informed providers that the guidelines are available on the Colorado Access Web site or on request. The Colorado Access provider Web site included all practice guidelines. The SMCN Provider Manual did not reference CPGs.</p> <p>The member tab on the Colorado Access Web site provided access to CPGs; however, HSAG staff noted that finding CPGs under the member tab of the Web site was not easy, and that the SMCN Member Benefits Handbook did not reference CPGs or provide direction about how to obtain them from the Web site.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard X—Quality Assessment and Performance Improvement	
Requirement	Evidence as Submitted by the Health Plan
<p>7. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.</p> <p align="right"><i>42CFR438.236(d)</i></p>	<p>Documents Submitted/Location Within Documents:</p> <ol style="list-style-type: none"> 1. QM311 Clinical Practice Guidelines-p 3 VI 2. QM308 Preventive Health Services-p 2-3 I.C and V 3. CCS307 Utilization Review Determinations 4. CCS 302 Medical Criteria for Utilization Review p 3 I A <p>Description of Process</p> <p>As stated in QM311 Clinical Practice Guidelines, Colorado Access ensures that decisions for utilization management, member education, coverage of services and other areas to which the guidelines apply are consistent with the guidelines. QM308 discusses assuring member education is aligned with guidelines and CCS 302 and CCS 307 discusses utilization management and coverage of services. As guidelines are reviewed annually at the MBQIC, discussions around benefits coverage for the services recommended are always integral to determining guideline approval.</p>
<p>Findings:</p> <p>The Clinical Practice Guidelines policy stated that Colorado Access will ensure that decisions regarding UM, member education, covered services, and other areas to which the clinical practice guidelines apply are consistent with adopted CPGs. The Preventive Health Services policy stated that Colorado Access maintains appropriate preventive services guidelines and that Colorado Access informed members regarding preventive health initiatives through member newsletters, member calls, and health education materials. Colorado Access submitted policies that confirmed UM decisions are based on nationally recognized InterQual guidelines.</p> <p>During the on-site interview, staff stated that CPGs are used to educate providers regarding performance measures, as a reference for case management decisions, and provide the basis for member education regarding disease management topics (e.g., asthma). Staff stated that CPGs are reviewed by QI staff, the medical director, and line of business managers to ensure consistency with other operational decisions; and a summary of recommendations is presented to the MBQIC during the annual approval process. Staff provided an example of a required modification to a national guideline based on inconsistency with covered member benefits.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard X—Quality Assessment and Performance Improvement	
Requirement	Evidence as Submitted by the Health Plan
<p>8. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data.</p> <p align="right"><i>42CFR438.242(a)</i></p>	<p>Documents Submitted/Location Within Documents:</p> <ol style="list-style-type: none"> 1. 2012 CoA QAPI Program Description-p 10 V A 2nd paragraph 2. IT Data Flow 3. FY13 Q1 Appeals Report 4. FY13 Q1 Grievance Report 5. FY13 Q1 Call Reporting 6. FY12 Q4 Denials Report 7. CHP+ HEDIS 2012 QIC 8. Monthly Membership Report November 2012 <p>Description of Process</p> <p>Colorado Access maintains a robust health information system that collects, integrates, reports and analyzes data as outlined in the QAPI Program Description. The IT Data Flow depicts many of the systems used to collect data and how it is integrated into the data warehouse for reporting. Reports are generated by Decision Support Services and various business owners. Data is analyzed and reported to the QIC regularly. Examples of reports and analysis include monthly membership reports; quarterly service monitoring such as grievances, appeals, denials and calls and the annual HEDIS report.</p>
<p>Findings:</p> <p>The IT Data Flow diagram provided an overview of multiple source systems for collecting and processing data related to claims from multiple provider systems (e.g., laboratory, pharmacy), eligibility, customer services, case management, and authorizations. All data are integrated and maintained in Colorado Access’ database, which provides reporting and electronic output to the Colorado Access Web site, operating departments, the Department, and other external recipients. Reporting can be customized online or through routine programmed reports. Colorado Access submitted numerous examples of reports used in the QAPI program that demonstrated integration of health information system (HIS) data.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard X—Quality Assessment and Performance Improvement	
Requirement	Evidence as Submitted by the Health Plan
<p>9. The Contractor’s health information system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of CHP+ eligibility.</p> <p align="right"><i>42CFR438.242(a)</i></p>	<p>Documents Submitted/Location Within Documents:</p> <ol style="list-style-type: none"> 1. 2012 CoA QAPI Program Description-p 10-13 Scope 2. CHP+ SMCN Trend Report (Category of Service) 3. CHP+ SMCN Dashboard (Medical Trends) 4. CHP+ HEDIS 2012 QIC Report 5. CY12 Q3 CHP+ SMCN Pharmacy Report 6. Daily Census Report 12 10 12 NO PHI 7. FY13 Q1 Appeals Report 8. FY13 Q1 Grievance Report 9. Monthly Membership Report November 2012 <p>Description of Process</p> <p>As stated in the QAPI Program Description, Colorado Access health information system provides information on areas including utilization, grievances, appeals and disenrollments. Examples of utilization information reporting include the Daily Census Inpatient Report, Monthly Category of Service and Medical Trends Dashboard, HEDIS measures and quarterly Pharmacy Reporting. The health information system also collects information on grievances and appeals as demonstrated in the quarterly grievance and appeals monitoring. Enrollment information is captured in the monthly membership report.</p>
<p>Findings:</p> <p>Staff stated that the Altruista Guiding Care software component of the HIS is used by Clinical Care Services, Case Management, Member Services, and other staff to document authorizations, grievances and appeals, care coordination, and other member-specific information. This system also has reporting and data analysis capabilities to support QI activities. The IT Data Flow diagram illustrated that Altruista is an integrated component of the system-wide HIS. Colorado Access submitted examples of HIS reports related to SMCN utilization of services, grievances and appeals, and enrollment trends. During the on-site interview, staff stated that disenrollment data from the State does not provide adequate information related to reasons for termination, but that most disenrollments in the SMCN program were due to transitioning of the member to a CHP+ HMO. Staff reported that there have been recent and significant issues with the State eligibility and enrollment process that have resulted in confusion among SMCN providers and members. Staff stated that Colorado Access anticipates this incident will result in high levels of member dissatisfaction with access to services in the upcoming Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and will also impact HEDIS results.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Compliance Monitoring Tool
for State Managed Care Network

Standard X—Quality Assessment and Performance Improvement

Requirement	Evidence as Submitted by the Health Plan
<p>10. The Contractor collects data on member and provider characteristics and on services furnished to members.</p> <p align="right"><i>42CFR438.242(b)(1)</i></p>	<p>Documents Submitted/Location Within Documents:</p> <ol style="list-style-type: none"> 1. 2012 CoA QAPI Program Description-p 10-13 Scope 2. Monthly Membership Report November 2012 3. FY13 Pediatric Routine Secret Shopper Report 4. FY13 Pediatric Non Urgent Secret Shopper Report 5. FY13 Q1 CHP+ SMCN Network Adequacy Medical and Behavioral 6. 2011 CHP+ CAHPS Summary 7. CHP+ HEDIS 2012 QIC 8. CHP+ SMCN Trend Report (Category of Service) 9. CHP+ SMCN Dashboard (Medical Trends) <p>Description of Process</p> <p>Colorado Access collects data on member and provider characteristics and services furnished to members as outlines in the QAPI Program Description scope. Examples of data on member characteristics include the monthly membership and CAHPS reporting. Examples of data on provider characteristics include the Secret Shopper access to care testing and quarterly network adequacy reports. Examples of data collected on services furnished to members include the CAHPS, HEDIS, Trend Report and Dashboards.</p>

Findings:
 Colorado Access submitted several examples of reports that demonstrated collection of data related to SMCN member characteristics, provider characteristics, and services furnished to members. During the on-site interview, staff explained that Colorado Access collects data on member characteristics from claims and enrollment databases, as well as updates from the customer service, care management, and utilization management systems. Colorado Access collects provider characteristics through the provider contracting and credentialing databases, and integrates provider characteristics into the claims payment system. Colorado Access collects data on services provided to members primarily through the claims database.

Standard X—Quality Assessment and Performance Improvement

Requirement	Evidence as Submitted by the Health Plan
<p>11. The Contractor’s health information system includes a mechanism to ensure that data received from providers are accurate and complete by:</p> <ul style="list-style-type: none"> ◆ Verifying the accuracy and timeliness of reported data. ◆ Screening the data for completeness, logic, and consistency. ◆ Collecting service information in standardized formats to the extent feasible and appropriate. <p align="right">42CFR438.242(b)(2)</p>	<p>Documentation:</p> <ul style="list-style-type: none"> • CHP Provider Manual • CHP Provider Website http://www.coaccess.com/chp-state-managed-care-network-smcn-provider-information • CLM301-Timing Filing and Prompt Payment of Claims • IT Data Flow <p>Process Description: CHP ensures that data received from its providers is accurate and complete through a variety of data quality checks and processes. The timeliness and accuracy of data is monitored through quarterly Claims timeliness and accuracy reporting. The CHP provider manual provides education on billing/submission guidelines to address timeliness (timely filing), required fields on claim forms, and only accepting standard claim forms or HIPAA compliant EDI files. Screening for data completeness, logic and consistency and collecting service information in standardized formats is outlined in the Claims Validation Report, the CHP Flat File Requirements, the DS Encounter Data QA Process and the ISCAT.</p>

Findings:
 The Colorado Access QI Program Description stated that Colorado Access is committed to ensuring the reliability and integrity of data through internal and external audit processes, which included all of the mechanisms specified in the requirement. The Claims Validation Report described the internal claims edit processes applied to encounter files and verification of claims information with medical record documentation. The Information Systems Capabilities Assessment Tool (ISCAT) demonstrated that Colorado Access receives all claims and encounter data in standardized formats. The IT Data Flow diagram illustrated that the PowerSTEPP claims transactional system applies automated edits to each claim for accuracy and completeness. The Timely Filing and Prompt Payment of Claims policy defined the time frames for timely submission of claims by providers. The SMCN Provider Manual and the Colorado Access provider Web site detailed provider responsibilities for timely filing of claims, use of standardized claims forms, and accuracy of coding and completion of fields in the claim form. The manual also described the process for correcting information on held or denied claims.

Standard X Recommendations:
 HSAG recommended that Colorado Access clarify the availability of CPGs under the member tab of the Web site and develop a mechanism to inform SMCN members of the availability of CPGs and how to access them. HSAG recommended that Colorado Access consider informing providers in the SMCN Provider Manual of the availability of CPGs and how to access them.

Appendix B. **Record Review Tools**
for **State Managed Care Program**

The completed record review tools follow this cover page.



Appendix B. Colorado Department of Health Care Policy and Financing
Recredentialing Record Review Tool
for State Managed Care Network

Review Period:	January 1, 2012–December 31, 2012
Date of Review:	February 12, 2013

Reviewer:	Rachel Henrichs
Participating Plan Staff Member:	Jennifer Rogers

SAMPLE	1		2		3		4		5		6		7		8		9		10					
	Provider ID#	Provider Type (MD, PhD, NP, PA, MSW, etc.)	Application/Attestation Date	Specialty	Last Credentialing/Recredentialing Date	Recredentialing Date (Committee/Medical Director Approval Date)	Item	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No			
005610	MD	3/9/11	OBGYN	6/3/09	4/21/11	Recredentialing Verification:																		
004858	MD	1/6/11	Internal Med	6/16/08	4/28/11	The contractor, using primary sources, verifies that the following are present:																		
006356	MD	10/26/11	Urology	3/12/09	3/22/12	◆ A current, valid license to practice (with verification that no State sanctions exist)	X		X		X		X		X		X		X					
012233	MD	10/17/11	OBGYN	2/18/09	12/15/11	◆ A valid DEA or CDS certificate (if applicable)	X		X		X		X		X		X		X					
013519	MD	2/14/11	Internal Med	5/14/08	4/1/11	◆ Credentials (i.e., verified board certification only if the practitioner states on the recredentialing application that there is new board certification since last credentialing/recredentialing date)	X		X		X		X		X		X			NA				
800378	MD	6/9/11	Otolaryngology	9/12/08	8/11/11	◆ Current malpractice insurance in the required amount (with history of professional liability claims)	X		X		X		X		X		X		X					
005122	MD	10/4/10	Gastro	3/14/08	2/18/11	◆ Verification that the provider has not been excluded from federal participation	X		X		X		X		X		X		X					
013479	DO	10/8/10	Family Med	12/9/07	12/9/10	◆ Signed application and attestation	X		X		X		X		X		X		X					
009766	MD	7/28/11	Pediatric	12/19/08	10/13/11	◆ The provider's recredentialing was completed within verification time limits (see specific verification element—180/365 days)	X		X		X		X		X		X		X					
011551	CNM	8/29/11	Midwife	12/10/08	10/13/11	◆ Recredentialing was completed within 36 months of last credentialing/recredentialing date	X		X		X		X		X		X		X					
Applicable Elements							8		8		8		8		8		8		8		7			
Point Score							8		8		8		8		8		8		8		8		7	
Percentage Score							100%		100%		100%		100%		100%		100%		100%		100%		100%	
Total Record Review Score							Total Applicable: 79					Total Point Score: 79					Total Percentage: 100%							

Notes:

Appendix C. **Site Review Participants**
for **State Managed Care Network**

Table C-1 lists the participants in the FY 2012–2013 site review of **SMCN**.

Table C-1—HSAG Reviewers and Health Plan Participants	
HSAG Review Team	Title
Barbara McConnell, MBA, OTR	Director, State & Corporate Services
Katherine Bartilotta, BSN	Project Manager
Rachel Henrichs	Project Coordinator
SMCN Participants	Title
Carrie Bandell	Director of Quality Management
Robert Bremer	Executive Director, Access Behavioral Care (ABC)
Laura Coleman	Director of Clinical Services
Rodonda DeLoach	Health Coach
Rich Duncan	Manager of CHP+ Care Management
Sandy Gahagan	Care Manager II
Bethany Himes	Executive Director, CHP+
John Kickhaefer	Operations Manager, ABC
Suzanne Kinney	Behavioral Health Quality Program Manager
Claudine McDonald	Director, Office of Member and Family Affairs
Suzanne Nelson	Care Manager II
Marina Osovskaya	CHP+ Program Specialist
Irina Pomirchy	CHP+ Senior Program Manager
Jennifer Rogers	Manager, Credentialing Program
Robin Walker	Care Manager II
Department Observers	Title
Teresa Craig	Contract Manager
Alan Kislowitz	Health Plan Manager
Russell Kennedy	Quality Compliance Specialist

Appendix D. Compliance Monitoring Review Activities for State Managed Care Network

The following table describes the activities performed throughout the compliance monitoring process. The activities listed below are consistent with CMS’ final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)*, February 11, 2003.

Table D-1—Compliance Monitoring Review Activities Performed	
For this step,	HSAG completed the following activities:
Activity 1:	Planned for Monitoring Activities
	<p>Before the compliance monitoring review:</p> <ul style="list-style-type: none"> ◆ HSAG and the Department held teleconferences to determine the content of the review. ◆ HSAG coordinated with the Department and the health plan to set the dates of the review. ◆ HSAG coordinated with the Department to determine timelines for the Department’s review and approval of the tool and report template and other review activities. ◆ HSAG staff attended Medical Quality Improvement Committee (MQIUC) meetings to discuss the FY 2012–2013 compliance monitoring review process and answer questions as needed. ◆ HSAG assigned staff to the review team. ◆ Prior to the review, HSAG representatives also responded to questions via telephone contact or e-mails related to federal managed care regulations, contract requirements, the request for documentation, and the site review process to ensure that the health plans were prepared for the compliance monitoring review.
Activity 2:	Obtained Background Information From the Department
	<ul style="list-style-type: none"> ◆ HSAG used the federal Medicaid managed care regulations, NCQA Credentialing and Recredentialing Standards and Guidelines, and the health plan’s managed care contract with the Department, to develop HSAG’s monitoring tool, on-site agenda, record review tools, and report template. ◆ HSAG submitted each of the above documents to the Department for its review and approval. ◆ HSAG submitted questions to the Department regarding State interpretation or implementation of specific Managed Care regulations or contract requirements. ◆ HSAG considered the Department responses when determining compliance and analyzing findings.
Activity 3:	Reviewed Documents
	<ul style="list-style-type: none"> ◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the health plan in writing of the desk review request via e-mail delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. ◆ Documents submitted for the desk review and during the on-site document review consisted of the completed desk review form, the compliance monitoring tool with the health plan’s section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials.

Table D-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
	<ul style="list-style-type: none"> ◆ The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.
Activity 4:	Conducted Interviews
	<ul style="list-style-type: none"> ◆ During the on-site portion of the review, HSAG met with the health plan’s key staff members to obtain a complete picture of the health plan’s compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan’s performance.
Activity 5:	Collected Accessory Information
	<ul style="list-style-type: none"> ◆ During the on-site portion of the review, HSAG collected and reviewed additional documents as needed. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were of a confidential or proprietary nature or were requested as a result of the pre-on-site document review.)
Activity 6:	Analyzed and Compiled Findings
	<ul style="list-style-type: none"> ◆ Following the on-site portion of the review, HSAG met with health plan staff to provide an overview of preliminary findings. ◆ HSAG used the FY 2012–2013 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. ◆ HSAG analyzed the findings. ◆ HSAG determined opportunities for improvement and recommendations based on the review findings.
Activity 7:	Reported Results to the Department
	<ul style="list-style-type: none"> ◆ HSAG completed the FY 2012–2013 Site Review Report. ◆ HSAG submitted the site review report to the health plan and the Department for review and comment. ◆ HSAG incorporated the health plan’s and Department’s comments, as applicable and finalized the report. ◆ HSAG distributed the final report to the health plan and the Department.