COLORADO
Department of Health Care Policy & Financing

Fiscal Year 2017–2018 Site Review Report

for

Denver Health Medicaid Choice and Denver Health Medical Plan

January 2018

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

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

In order to allow for implementation of new federal managed care regulations published May 2016, the Department determined that the review period for FY 2017–2018 was July 1, 2017, through December 31, 2017. This report documents results of the FY 2017–2018 site review activities for **Denver Health Medicaid Choice** (**DHMC**) and **Denver Health Medical Plan** (**DHMP**), Denver Health's CHP+ health plan. Although the two lines of business were reviewed concurrently with results reported in this combined compliance monitoring report, the results for the CHP+ and Medicaid managed care lines of business are presented separately. For each of the four standard areas reviewed this year, this section contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 2 describes the background and methodology used for the 2017–2018 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the 2016–2017 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the appeals and grievances 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 2017–2018 and the required template for doing so. Appendix E contains a detailed description of HSAG's site review activities consistent with the Centers for Medicare & Medicaid Services (CMS) final protocol.

Summary of Results

Based on conclusions drawn from the review activities, HSAG assigned each Medicaid requirement in the compliance monitoring tool a score of *Met, Partially Met, Not Met,* or *Not Applicable.* Revisions to federal Medicaid managed care regulations published May 6, 2016, are not applicable to CHIP until July 1, 2018; therefore, HSAG assigned each **revised** federal requirement a score of *Met* or *Not Scored* for CHP+. HSAG assigned required actions for any requirement within the compliance monitoring tool receiving a score of *Partially Met* or *Not Met.* HSAG identified recommendations for those CHP+ requirements that do not become effective until July 2018.

Medicaid Results

Table 1-1 presents the scores for **DHMC** for each of the standards. Findings for requirements receiving a score of *Met* are summarized in this section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* follow in Appendix A—Compliance Monitoring Tool.

Table 1-1—Summary of Medicaid Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
V. Member Information	25	13	9	4	0	12	69%
VI. Grievance System	35	35	30	2	3	0	86%
VII. Provider Participation and Program Integrity	16	15	12	1	2	1	80%
IX. Subcontracts and Delegation	4	4	0	2	2	0	0%
Totals	**80**	**67**	**51**	**9**	**7**	**13**	**76%**

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

Table 1-2 presents the scores for **DHMC** for the record reviews. Details of the findings for the record reviews are in Appendix B—Record Review Tools.

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

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Appeals	24	24	20	4	0	83%
Grievances	42	29	29	0	13	100%
Totals	**66**	**53**	**49**	**4**	**13**	**92%**

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

CHP+ Results

Table 1-3 presents the scores for **DHMP** for each of the standards. Findings for requirements receiving a score of *Met* are summarized in this section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* follow in Appendix A—Compliance Monitoring Tool.

Table 1-3—Summary of CHP+ Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
V. Member Information	24	12	10	2	0	12	83%
VI. Grievance System	35	22	20	1	1	13	91%
VII. Provider Participation and Program Integrity	16	14	11	1	2	2	79%
IX. Subcontracts and Delegation	4	0	0	0	0	4	NA
Totals	**79**	**48**	**41**	**4**	**3**	**31**	**85%**

Note: While the scoring of evidence related to individual, new federal requirements in the tool may indicate *Met* or *Not Scored*, all new requirements were scored *Not Applicable* in the total results; new federal requirements do not apply to CHP+ until July 1, 2018.

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

Table 1-4 presents the scores for **DHMP** for the record reviews. Details of the findings for the record reviews are in Appendix B—Record Review Tools.

Table 1-4—Summary of CHP+ Scores for the Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Appeals	6	6	5	1	0	83%
Grievances	NA	NA	NA	NA	NA	NA
Totals	**6**	**6**	**5**	**1**	**0**	**83%**

DHMP reported no grievances during the review period.

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

Standard V—Member Information

The following sections summarize the findings applicable to both CHP+ and Medicaid managed care. Any notable differences in compliance between the CHP+ and Medicaid lines of business are identified.

Summary of Strengths and Findings as Evidence of Compliance

DHMC/P welcomed new Medicaid and CHP+ members with new-member orientation videos (available on its website in English and Spanish), monthly face-to-face new orientation meetings, and member handbooks. These videos, meetings, and handbooks helped explain the benefits and requirements of each plan. The **DHMC** and **DHMP** member handbooks (as well as other member materials such as newsletters, notices of adverse benefit determinations, and grievance and appeal resolution letters) clearly stated that information is available in Spanish, that interpreter services and auxiliary aids (including American Sign Language and TTY/TDY) are available free of charge, and how to access these services.

DHMC/P's policies and procedures thoroughly address the availability of interpreter services and auxiliary aids and include how **DHMC/P** ensures that members know to access those services. The Evaluating Member's Non-English Language Needs policy stated that all written materials must be written at the 6th grade reading level. The Creation, Review, and Readability of Member Materials policy described the process for checking the reading level of all member communications. **DHMC/P**'s policies also stated requiring that subcontractors responsible for translating written materials ensure 6th grade reading level.

DHMC/P posted the CHP+ and Medicaid formularies on the **DHMC** and **DHMP** websites in a machine-readable file (Adobe identified no accessibility errors). The formulary states that printed copies are available by calling member services. **DHMC/P**'s Member Newsletter Content Requirements policy described the process for ensuring that members receive written notice of any change (that the State defines as "significant") at least 30 days before the intended effective date of the change and stated that the member newsletter serves as written notification.

The CHP+ member handbook described the amount, duration, and scope of benefits available; procedures for choosing a provider, obtaining benefits (in- and out-of-network), and obtaining referrals; member rights; processes for filing a grievance, appeal, and State fair hearing—and the availability of assistance in doing so; what constitutes an emergency medical condition; how and where to obtain emergency and after-hour services; how to report suspected fraud or abuse; and how to exercise an advance directive.

DHMC/P's Required Provider Directory Information policy stated that provider directories must be updated at least monthly and available in paper copy. The policy also delineated the information that must be included. The CHP+ and Medicaid provider directories listed the names, location, telephone number, and linguistic capabilities of contracted providers. The directories described accommodations available for persons with physical disabilities (including those members deaf, hard of hearing, and blind) and how to request these services.

Summary of Findings Resulting in Opportunities for Improvement

The CHP+ and Medicaid member handbooks stated, "The emergency provider may perform a medical screening to decide if your condition is an emergency. If your condition is not an emergency based on the judgement of a prudent layperson, **DHMC** will not pay for any more emergency services after the screening." HSAG suggested that this language may dissuade members from seeking emergency care and suggested that **DHMC/P** remove it from both handbooks.

Also, the Medicaid member handbook stated, "DHMC will pay for emergency services even if they include mental health services. The mental health services will only be covered if they aren't the primary diagnosis (the reason for your visit) when receiving emergency services." This statement, as written, can be interpreted to mean that emergency mental health services are not covered. While emergency mental health services are not paid for by **DHMC/P**, they are covered benefits. HSAG strongly suggested that **DHMC/P** remove this statement from its Medicaid member handbook or add language to clarify that mental health emergencies are paid for by the behavioral health organization (BHO).

Summary of Required Actions

DHMC/P's Creation, Review, and Readability of Member Materials policy required that member materials be written in a font size no smaller than 12 points, be available in alternative formats and through provision of auxiliary aids and services, and include taglines in large print (18 point) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service number. While most member materials reviewed complied with these requirements, some documents (e.g., member complaint and appeal form, member newsletters, and some letters related to appeal and grievance processes) were missing the large-print tag line. **DHMC/P** must ensure that all critical member communications include the large-print tag line informing members how to request auxiliary aids and services.

HSAG used the Adobe Acrobat Pro accessibility checker to test the CHP+ and Medicaid member handbooks, provider directories, winter 2017 newsletter, and Medicaid Member Complaint and Appeal form. The Adobe checker noted several accessibility errors related to each document. Additionally, WAVE Web Accessibility Evaluation Tool identified several issues with the **DHMC** and **DHMP** websites. **DHMC/P** must develop a process to ensure that all information available on its websites is readily accessible (i.e., complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines). HSAG also suggested that **DHMC/P** state on its website that information is available in paper form without charge upon request.

The provider directories failed to designate which providers had completed cultural competency training. Additionally, while **DHMC/P** described numerous resources available to accommodate persons with physical disabilities, it failed to designate locations that have accessible medical diagnostic equipment (e.g., height-adjustable examination tables, weight scales, mammography equipment, x-ray machines). **DHMC/P** must revise its provider directory to designate which providers have completed

cultural competency training and identify office locations that have accessible medical diagnostic equipment. **DHMC/P** should also update applicable policies and procedures that list required content of the provider directories to include these items.

The CHP+ member handbook included inaccurate time frames for filing grievances and appeals and incorrectly stated that members may request State fair hearings before completing the health plan appeals process. **DHMC/P** must revise its CHP+ member handbook to include accurate time frames for filing grievances (any time) and appeals (60 days after the notice of adverse benefit determination). The handbook must also clarify that members must complete the **DHMC/P** appeals process before requesting a State fair hearing. HSAG also suggested that **DHMC/P** clarify that continuation of benefits applies only to services that **DHMC/P** terminates, suspends, or reduces.

The Department assumed responsibility for the development and distribution of the Health First Colorado Member Handbook, thereby waiving the member handbook requirements for contracted Medicaid health plans. However, **DHMC/P** opted to continue producing and distributing a Medicaid member handbook to ensure communication of information specific to **DHMC/P** members. The required actions related to the CHP+ member handbook (described in the previous paragraph) also apply to the **DHMC/P** Medicaid member handbook.

The CHP+ member handbook described instances in which a member may be required to pay for services. The handbook also described wraparound benefits; however, it included no information about how to access these services or where to learn more about them. **DHMC/P** must revise its member handbook to inform members how to access benefits available under the State plan but not covered by the **DHMC/P** CHP+ managed care contract. (These requirements were accurately addressed in the Medicaid member handbook.)

Standard VI—Grievance System

The following sections summarize the findings applicable to both CHP+ and Medicaid managed care. Any notable differences in compliance between the CHP+ and Medicaid lines of business are identified.

Summary of Strengths and Findings as Evidence of Compliance

DHMC/P's grievance system included policies and procedures that addressed State and federal requirements pertaining to member grievance, appeal, and State fair hearing processes. The documented procedures within the Appeals Process and Grievance Process policies reflected current Code of Federal Regulations (CFR) Part 438—Managed Care processing requirements and time frames for receiving, acknowledging, and resolving grievances and appeals and adhered to member notice requirements. **DHMC/P** had provisions in place for members or their authorized representatives to request State fair hearings. Additionally, **DHMC/P** demonstrated an effective health information system for documenting and tracking information related to the grievance system.

While concerns that **DHMC/P** was not tracking all member complaints as required were noted, the on-site record review demonstrated that documented **DHMC** member grievances were compliant with State and federal processing and resolution requirements and that member notices included appropriate content, were easy to understand, and were mailed to members timely. Additionally, through the on-site record review, HSAG confirmed that **DHMC/P** reviewed and resolved appeals timely.

Summary of Findings Resulting in Opportunities for Improvement

DHMC/P had established processes and procedures for the grievance system; however, the Appeals Process and Grievance Process policies contained discrepancies in information throughout each. For example, attachments in both referenced policies contained outdated letter templates inconsistent with the "Procedures" section of the policies and not compliant with federal and State requirements. **DHMC/P** should ensure that all documents, including policies and procedures, are thoroughly reviewed to ensure consistency in language and documented processes and to reflect current federal and State managed care requirements.

Through the on-site file reviews, HSAG confirmed that few grievances were being received and processed through **DHMC/P**. From July 2016 through October 2016 **DHMC** reported seven grievances; no grievances were reported by **DHMP**. **DHMC/P** should confirm that all complaints of dissatisfaction are being tracked as grievances, including any complaints received through departments other than through the Member Services and Appeals and Grievances teams, to ensure that all grievances are being handled in accordance with State and federal requirements, including those documented under 42 CFR Subpart F. **DHMC/P** should conduct organizational-wide training on the requirements of a grievance system, including how to report grievances to the Appeals and Grievances team. Additionally, it is important that staff know how to differentiate between what constitutes an appeal versus a grievance. During the on-site file review, HSAG determined that 50 percent of Medicaid appeals reported by **DHMC** were inaccurately tracked as appeals and should have been processed as grievances.

Although CHP+ is not required to be compliant with the updated federal managed care requirements until July 1, 2018, the health plan's grievance system, including documented processes and procedures, was applicable to both Medicaid and CHP+. To ensure compliance with requirements, **DHMC/P** should update all policies and procedures, including all appendices and attachments, in compliance with the Medicaid managed care requirements and all associated State and program contract requirements. Additionally, written notice of appeal resolution letters and policies and procedures related to appeal resolution should be updated to contain accurate information about when a member or a designated representative may request a State fair hearing.

Summary of Required Actions

DHMC/P submitted processes and procedures related to the grievance system; however, HSAG noted concerns with both the Grievance Process policy and the Appeals Process policy. First, while both had implementation effective dates of July 1, 2017, these policies were not signed by staff with approval authority until November 10, 2017. The Grievance Process policy emphasized that the purpose of the

policy was for the Grievance and Appeal Department to follow established Company grievance processes but did not include other Company staff members' accountability for handling grievances. Additionally, while the Appeals Process policy indicated "the Company maintains a standard and an expedited appeals process, which consists of only one level of appeal," the Appeals Process policy under Attachment 6—Appeal Investigation Worksheet included information regarding the 2nd-level appeals process. For Medicaid programs, managed care plans are prohibited from having more than one level of appeal for members. This policy is applicable to Medicaid programs; therefore, the attachments must clearly demonstrate the requirements for Medicaid appeals. Additionally, both the Grievance Process and Appeals Process policies included attachments that did not comply with current requirements. Finally, through the file reviews, **DHMC** demonstrated inaccuracies in the processing of appeals. Five of 10 appeal cases reviewed were deemed grievances and should have followed grievance timelines and requirements for resolution. Additionally, few grievances were tracked by **DHMC**, which indicated potential issues with reporting and subsequent tracking of member-reported complaints. To ensure that **DHMC** has a grievance and appeal system in place to handle appeals of adverse benefit determination and grievances as well as having processes to collect and track information about such, **DHMC** must update its grievance system policies and procedures, including all appendices and attachments, with language in compliance with the Medicaid managed care rule and all associated State and program contract requirements. Additionally, **DHMC** must ensure that all staff are aware of and have mechanisms in place for appropriately managing appeals and grievances; and policies and procedures must be updated timely to stay current with all federal, State, and program rule changes.

DHMC's policies and letters related to the appeals process, including the timeline for filing an appeal, must allow 60 calendar days from the date of an adverse benefit determination for a member to file an appeal with **DHMC/P**.

Appeal resolution letters reviewed during the on-site file reviews demonstrated that content within member resolution letters was not consistently written for easy comprehension. Specifically, one of the four Medicaid appeals and the single CHP+ appeal reviewed were not written in manners that would be easily understood by members. **DHMC/P** must ensure that written notices of appeal resolutions are in formats and language that may be easily understood by members.

DHMC/P must have mechanisms in place to ensure that members go through the appeals process prior to asking for a State fair hearing. During the on-site record review, instances (three of four cases) were noted in which inaccurate information was provided to members in the appeal resolution letter and accompanying attachments; errors involved State fair hearing timelines and when a hearing could be requested. **DHMC/P** must ensure that written notice of appeal resolution letters as well as policies and procedures related to appeal resolution contain accurate information about when a member or a designated representative may request a State fair hearing.

While **DHMC/P**'s Appeals Process policy stated that a Department-approved description of the appeal and State fair hearing procedures and time frames were provided to all providers and subcontractors at the time that the providers/subcontractors entered into contracts, the **DHMC/P** provided no documentation to support that this process was being implemented. **DHMC/P** must have mechanisms in

place to ensure that all providers and subcontractors are provided with information about the grievance, appeal, and fair hearing system upon entering into contracts with **DHMC/P**.

Standard VII—Provider Participation and Program Integrity

The following sections summarize the findings applicable to both CHP+ and Medicaid managed care. Any notable differences in compliance between the CHP+ and Medicaid lines of business are identified.

Summary of Strengths and Findings as Evidence of Compliance

DHMC/P demonstrated adequate mechanisms, including detailed policies and procedures, to support the appropriate retention and selection of healthcare providers. **DHMC/P** also exhibited a documented process for complying with the State's credentialing and recredentialing requirements. Additionally, **DHMC/P** had a robust monitoring and tracking system for ensuring that no employees, providers, consultants, subcontractors, board of directors, or other applicable individuals and entities were excluded from participating in the Medicaid program.

DHMC/P's corporate compliance program document was detailed and described the components of an effective compliance program, including effective lines of communication between the designated compliance officer and **DHMC/P**'s employees and members for reporting suspected noncompliance and fraud, waste, and/or abuse. **DHMC/P**'s compliance program included documented processes and procedures for detecting fraud, waste, and abuse; and staff were designated to review, investigate, and respond to allegations of fraud and instances of noncompliance. Additionally, **DHMC/P** demonstrated efforts to ensure an effective compliance program through a documented workplan, which included auditing and monitoring activities. Training documents and compliance-related newsletters presented during the on-site review confirmed that **DHMC/P** adequately trained its staff on how to report suspected noncompliance and kept employees informed of compliance-related activities occurring within the organization. **DHMC/P** also demonstrated a centralized repository containing approved policies and procedures and readily accessible to all **DHMC/P** employees.

Summary of Findings Resulting in Opportunities for Improvement

DHMC/P presented several compliance program documents to demonstrate an effective compliance program; however, these documents did not always contain information complying with requirements of the Medicaid program. In many instances, documents appeared to have been written for other lines of business. For example, the contract with the Department includes specific time frames for reporting suspected fraud and abuse. The fraud and prevention plan submitted as evidence was a comprehensive document, but timelines for reporting suspected fraud or abuse did not align with the Department's requirements. **DHMC/P** should ensure that all compliance-related policies and procedures, anti-fraud plans, and compliance plan documents used for the Medicaid program meet federal, State, and Medicaid program requirements.

Summary of Required Actions

DHMC/P was unable to demonstrate a documented process for promptly reporting to the Department all overpayments identified or recovered, specifying which overpayments are due to potential fraud. Additionally, during the interview session, staff members indicated that they were only aware of overpayments occurring when a provider submitted an overpayment check. While **DHMC/P** has contracted with a vendor to conduct future screenings of all provider claims for potential fraud, waste, or abuse, including suspected instances of up-coding, unbundling of services, services billed for but never rendered, and inflated bills for services and goods, DMHC/P could not demonstrate a current process for identifying, investigating, and reporting these types of issues during the period under review. Additionally, **DHMC/P** was unable to demonstrate documented processes for notifying the Department about changes in a network provider's circumstances that could affect the provider's eligibility to participate in the managed care program, including termination of the provider agreement. **DHMC/P** must have mechanisms in place for promptly reporting all overpayments identified or recovered due to potential fraud; screening all provider claims for potential fraud, waste, or abuse; and notifying the Department about changes in a network provider's circumstances that could affect the provider's eligibility to participate in the Medicaid managed care program.

DHMC/P was unable to demonstrate evidence of compliance with providing the Department with written disclosures of any prohibited affiliations as defined in 438.610, written disclosure of ownership and control as defined in 455.104, or mechanisms for identifying within 60 calendar days any capitation payments or other payments more than the amounts specified in the contract. Additionally, **DHMC/P** could not demonstrate mechanisms for ensuring that providers were aware of their obligations to report prohibited affiliations, disclose ownership and control, and report payments made for more than amounts specified in the contract. **DHMC/P** must have documented procedures for notifying the Department of the following:

- Written disclosure of any prohibited affiliation (as defined in 438.610)
- Written disclosure of ownership and control (as defined in 455.104)
- Identification within 60 calendar days of any capitation payments or other payments made for more than the amounts specified in the contract

DHMC/P was unable to demonstrate that its network providers were made aware of the requirement to report overpayments and the process for reporting overpayments. Additionally, no evidence was presented to support that the Department was notified annually of any recoveries of overpayments. **DHMC/P** must have mechanisms in place for ensuring that network providers report to **DHMC/P** when they have received an overpayment, return the overpayment to **DHMC/P** within 60 calendar days of its identification as such, and notify **DHMC/P** in writing of the reason for the overpayment. **DHMC/P** must also report annually to the Department recoveries of overpayments.

Standard IX—Subcontracts and Delegation

The following sections summarize the findings applicable to both CHP+ and Medicaid managed care. Any notable differences in compliance between the CHP+ and Medicaid lines of business are identified.

Summary of Strengths and Findings as Evidence of Compliance

DHMC/P's Subcontractor/Delegated Entity First Tier, Downstream & Related Entity (FDR) Compliance Guide (dated 2016) and its Subcontractor Management and Oversight Program (no date) documents stated that **DHMC/P** maintained ultimate responsibility for all delegated activities. The documents described the process for pre-delegation review of all potential subcontractors to ensure the subcontractor's ability to perform the activities to be delegated. The documents also required that **DHMC/P** management staff members perform, at least annually, a reassessment to ensure that the subcontractor maintains its ability to fulfill contractual obligations and to meet all applicable federal and State laws and regulations. **DHMC/P**'s policies required ongoing review of compliance with contractual requirements, prompt response to identified deficiencies, and "periodic" reporting of each subcontractor's performance to the Compliance Committee.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to subcontracts and delegation.

Summary of Required Actions

While **DHMC/P** provided evidence of having written procedures for pre-delegation review, ongoing monitoring, and implementing corrective actions to address identified deficiencies, staff members were unable to demonstrate that these processes had been implemented for all subcontractors. At the time of the site review, **DHMC/P** staff described a recent initiative to: reconcile its list of subcontractors, identify staff members responsible for oversight, and track ongoing and formal monitoring of each delegate. **DHMC/P** must subject all potential subcontractors to a pre-delegation assessment to ensure that the organization is qualified and capable of performing the tasks to be delegated. **DHMC/P** must also ensure ongoing and formal monitoring of every subcontractor and require corrective actions to mitigate any identified deficiencies or areas of improvement.

DHMC/P's written contract with MedImpact Healthcare Systems, Inc. (MedImpact) contract included the required provisions; however, **DHMC/P** was unable to demonstrate that it held written agreements with all subcontracted providers. **DHMC/P** must have, with every subcontractor, a written agreement that includes:

- Delegated activities and related reporting responsibilities.
- Remedies for instances for which the State or **DHMC/P** determines that the subcontractor fails to meet performance standards.

- Required compliance with all applicable Medicaid laws and regulations, including applicable sub-regulatory guidance and contract provisions.
- The right of State, CMS, the U.S. Department of Health and Human Services (HHS) Inspector General, Comptroller General, or designees to audit, evaluate, and inspect records related to any aspect of services and activities performed, as delineated in 42 CFR 438.230(c)(3).

These agreements must be signed to indicate that the subcontractor agrees to perform the delegated activities and agrees to comply with the requirements.

2. Overview and Background

Overview of FY 2017–2018 Compliance Monitoring Activities

For the fiscal year (FY) 2017–2018 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation. Compliance with applicable federal managed care regulations and managed care contract requirements was evaluated through review of all four standards.

Compliance Monitoring Site Review Methodology

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

HSAG also reviewed a sample of the health plan's administrative records related to Medicaid appeals and grievances to evaluate implementation of federal healthcare regulations and managed care contract requirements as specified in 42 CFR 438 Subpart F and 10 CCR 2505-10, Section 8.209. Additionally, HSAG reviewed a sample of the health plan's administrative records related to CHP+ appeals and grievances to evaluate implementation of managed care contract requirements for processing grievances and appeals. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records—to the extent available—for each of Medicaid and CHP+. Using a random sampling technique, HSAG selected the samples from all applicable Medicaid and CHP+ appeals and grievances that occurred between July 1, 2017, and December 31, 2017. For the record review, the health plan received a score of *M* (met), *NM* (not met), or *NA* (not applicable) for each required element. Results of record reviews were considered in the review of applicable requirements in Standard VI—Grievance System. HSAG also separately calculated a grievances record review score, an appeals record review score, and an overall record review score for **DHMC** and **DHMP**.

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),*

Version 2.0, September 2012.[2-1] Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The four standards chosen for the FY 2017–2018 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement.

Objective of the Site Review

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

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

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Sep 26, 2017.

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

FY 2016–2017 Corrective Action Methodology

As a follow-up to the FY 2016–2017 site review, each health plan that received one or more *Partially Met* or *Not Met* scores was required to submit a corrective action plan (CAP) to the Department addressing those requirements found not to be fully compliant. If applicable, the health plan was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the health plan and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **DHMC** and **DHMP** until they completed each of the required actions from the FY 2016–2017 compliance monitoring site review.

Summary of FY 2016–2017 Required Actions

For the FY 2016–2017 site review, HSAG reviewed for **DHMC** and **DHMP** Standard I—Coverage and Authorization of Services and Standard II—Access and Availability; HSAG reviewed for **DHMC** only Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services.

DHMP was required to implement mechanisms to ensure that, for claims denials for out-of-network services, a written notice of action (NOA) to the member is generated and that NOAs are always mailed for denials of payment at the time of any actions affecting such claims. Furthermore, HSAG suggested that **DHMP** consider implementing processes which strengthen the relationship between the claims adjudication and utilization management departments to ensure that out-of-network services are reviewed for potential authorization determinations.

DHMC was required both to ensure that actual requesting providers are consulted when necessary to obtain information needed for making authorization decisions and to develop mechanisms to ensure that reasons for denials entered into member NOA letters are written in language that is easy for members to understand. **DHMC** also had five required actions related to enhancing provider communications and EPSDT-related policies and procedures, to more fully address the requirements of the EPSDT program.

Additionally, both **DHMC** and **DHMP** were required to continue expanding the provider network until they maintain a sufficient number of providers to ensure adequate access to all services covered under the contract.

Summary of Corrective Action(s)/Document Review

DHMC/P submitted its proposed plan of corrective actions in May 2017. HSAG and the Department reviewed and approved the proposed plan. **DHMC/P** was allowed until November 30, 2017, to submit evidence of having implemented its corrective actions. HSAG completed this 2017–2018 compliance monitoring report prior to receiving and processing **DHMC/P**'s 2016–2017 CAP submission and is unable to comment on the completeness of the corrective actions.

Summary of Continued Required Action(s)

HSAG will review **DHMC/P**'s CAP submission with the Department when received and work with **DHMC/P** to ensure full implementation of all corrective actions.

Appendix A. Compliance Monitoring Tool

The completed compliance monitoring tool follows this cover page.

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor provides all required member information to members in a manner and format that may be easily understood **and is readily accessible by members.** *(Note: Readily accessible means electronic information which complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines.)* *42 CFR 438.10(b)(1)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—2.5.6.3.5, 2.5.6.3.13, 3.1.1.4.2	• Q1_MCD_HB_Literacy –page 1, column 1 • Q1_CHP_HB_Literacy – page 1, column 1 • MCD Provider Directory – Entire Document • CHP+ Provider Directory – Entire Document • Q1_DHMP Readability Log2017- "Health Literacy Advisor Results" • Q1_Braille Invoice 4-2017 – All • Q1_ MCD_CHP_GVT06 –highlighted section Description: The Member Handbook explains to members that written information is available in other forms such as braille, large fonts, audiotapes, sign language, and more. The Q1_MCD_HB_Literacy & Q1_CHP+HB_Literacy show that the documents were ran through readability software to determine the readability level. The stamp on the right column show that these documents meet 6th grade reading level. Q1_MCD_CHP_GVT06.09, *Readability of Member Materials*, explains to DHMC employees the process for ensuring the Member materials are, to the extent possible, 6th grade reading level or below. Q1_DHMP Readability Log2017 is a master spreadsheet of written DHMC member materials. Member materials are given form numbers for tracking, and are assessed by Special Microsoft Word software (as explained in MCD_CHP_GVT06.v.09) for readability levels. As seen in column 1 of the spreadsheet, readability results are	**CHP+:** ☒ Met ☐ Not Scored **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	"stamped" into the Master file to indicate the reading level of each member material. Q1_Braille Invoice 4-2017 is an invoice from Braille Works, a company that creates a Braille insert for the front of the member handbook to show we offer the handbook in braille upon request. We order the insert in bulk, so the invoice is from April when the last bulk order was purchased.	
2. The Contractor has in place a mechanism to help members understand the requirements and benefits of the plan. *42 CFR 438.10(c)(7)* CHP+ Contract: Exhibit B—6.3.1.15 Medicaid Contract: Exhibit F—(1) and (2)	• CHP Member Handbook – page 5, "Come Meet Your DHMC Health Plan Team" • MCD Member Handbook – page 5, "Come Meet Your DHMC Health Plan Team" • Q2_EnglishVideo (https://www.youtube.com/watch?v=5VWerE2_A_M in English) and Q2_Spanish Video (https://www.youtube.com/watch?v=GgHhodZk3SA in Spanish) Description: The Member Handbook informs members of the monthly orientation for new and existing DHMP members to learn more about the requirements and benefits of DHMP. The DHMP New Member Orientation video is on the Denver Health Website in English and Spanish and helps members understand their responsibilities and benefits under the DHMP.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. **For consistency in the information provided to members, the Contractor uses the following as developed by the State:** • **Definitions for managed care terminology, including appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care.** • **Model member handbooks and member notices.** *42 CFR 438.10(c)(4)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—1.1.1, Exhibit D, and Exhibit F	• Q3_MCD_HB_Termonology • Q3_CHP_HB_Termonology • Q5_currentbenefitdenial • Q5_ModelNoticeofDetermination • Q5_Currentneccesarydenial Description: The DHMC Member Handbooks include a terminology page defining the required terms and definitions set out by the HCPF member handbook (model handbook), the contracts, and the federal government glossary website. Each terminology is footnoted to indicate where the definition came from. Q5_currentbenefitdenial letter and Q5_Currentnecessarydenial letter demonstrate the letters launching 11/1/2017 (due date set by the state) with the language/ format to mirror the model letter (Q5_modelnoticedetermination).	**CHP+:** ☐ Met ☒ Not Scored **Medicaid:** ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
Findings: HSAG is aware and the Department acknowledges that, for the 2017–2018 compliance review period, the State has not completed nor communicated to health plan contractors a consensus list of managed care definitions to be used in information provided to members. HSAG has therefore scored this element as *Not Applicable.* HSAG recommends that all Contractors maintain awareness of this requirement and, when received, incorporate State-defined managed care definitions into all applicable member communications, as directed by the Department.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • Written materials must use easily understood language and format. *42 CFR 438.10(d)(3) and (d)(6)(i)* CHP+ Contract: Exhibit B—10.8.2.5 Medicaid Contract: Exhibit A—2.3.2.1.8, 2.5.6.3.5, 2.5.6.3.12–13, 3.1.1.3.7	• Q4_CHP_HB_NonPrevelantEnglish • Q4_MD_HB_NonPrevelantEnglish • Q4_MCD_CHP_GVT10 v. 12 – highlighted sections • Q4_LiaisonMultilangual Services, Inc. fully executed Business Associate Agreement • Q4_DHMP Liaison Multilingual Services Inc. General Contract Signed • Q4_Multilangual_Invoice Description: Q4_CHP_HB_NonPrevelantEnglish and Q4_MD_HB_NonPrevelantEnglish explains to members that written information is available to them in different languages, and that members should call Member Services to request written information in a different language. The MCD_CHP_GVT10 v. 12 Policy & Procedure, *Evaluating Member's Non-English Language Needs for Language Translation Services*, outlines the process in which DHMC evaluates the language needs for non-English speaking members and the readability of Company member materials. Q4_LiasonMultilangual Services and Q4_DHMP Liaison Multilingual Services Inc represent the contracts and agreements we have in place with Liaison MultiLangual to help Denver Health execute member documents into non-Prevalent English. The Q4_Multilangual_Invoice showing that we pay them to help us translate everything, even letters.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. **Written materials that are critical to obtaining services include: provider directories, member handbooks, appeal and grievance notices, and denial and termination notices.** **All written materials for members must:** • **Use a font size no smaller than 12 point.** • Be available in alternative formats **and through provision of auxiliary aids and service** that takes into consideration the special needs of members **with disabilities** or limited English proficiency. • **Include taglines in large print (18 point) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service number, and availability of materials in alternative formats.** *42 CFR 438.10(d)(3) and (d)(6)(ii–iv)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—2.5.6.3.5, 2.5.6.3.7, 2.5.6.3.12-13, 3.1.1.4.4, 3.1.2.1.7	• Q5_CHP_HB_Final • Q5_MD_HB_Final • MCD Provider Directory • CHP Provider Directory • Q5_AppealandGrievance_LetterAttachment • Q5_ NoABD Dynamic Text Fields_StateModel • Q5_NoABD Policy Transmittal • Q5_ModelNoticeofDetermination • Q5_currenttaglines • Q5_Currentattachment • Q5_currentbenefitdenial • Q5_Currentneccesarydenial • Q5_NovemberAttachment • Q5_Novemnerbenefitdenial • Q5_NovemberMedicallyNecessaryDenial Description: Q5_CHP_HB_Final and Q5_MD_HB_Final shows the required font size (12 point) and that the information is available in other languages, formats, audio, and interpreted for members. The handbook also demonstrated all taglines and Spanish translation describing how to request auxiliary aids and services. The MCD Provider Directory and CHP Provider Directory follow the same requirements Q5_NoABD Policy Transmittal is the note from the Contract Manager at HCPF stating on 9/1/2017 all Managed Care	**CHP+:** ☐ Met ☒ Not Scored **Medicaid:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Organizations and Behavioral Care Organizations will be required to use the standard Adverse Benefit Determination notice developed by the Department (State) by 11/1/2017. Q5_ModelNoticeofDetermination and Q5_NoABD Dynamic Text Fields_StateModel represent the model sent by HCPF on 9/1/2017. Q5_currenttaglines and Q5_current attachment are the extra documents sent with every denial, but in November they will be combined to one attachment, Q5_NovemberAttachment. Q5_currentbenefitdenial is currently the denial for prescription benefits, and Q5_currentnecessarydenial is the current prescription denial for medically necessary. Q5_Novemberbenefitdenial and Q5_NovemberMedicallyNecessaryDenial is the new formatted letters that start 11/1/2017 to meet the state's model letter.	
Findings: DHMC/P's Creation, Review, and Readability of Member Materials policy required that member materials be written in a font size no smaller than 12 points, be available in alternative formats and through provision of auxiliary aids and services, and include taglines in large print (18 point) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service number. While most member materials reviewed complied with these requirements, some documents (e.g., member complaint and appeal form, template letter to notify members about terminated providers) were missing the large-print tag line.		
CHP+ Recommendations: DHMP must ensure that all critical member communications include the large-print tag line informing members how to request auxiliary aids and services.		
Medicaid Required Actions: DHMC must ensure that all critical member communications include the large-print tag line informing members how to request auxiliary aids and services.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. **If the Contractor makes information available electronically—Information provided electronically must meet the following requirements:** • **The format is readily accessible (see definition of readily accessible above).** • **The information is placed in a Web site location that is prominent and readily accessible.** • **The information can be electronically retained and printed.** • **The information complies with content and language requirements.** • **The member is informed that the information is available in paper form without charge upon request, and is provided within 5 business days.** *42 CFR 438.10(c)(6)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—3.1.1.4.2	• CHP: http://www.denverhealthmedicalplan.org/chp-handout-english or http://www.denverhealthmedicalplan.org/chp-handout-spanish • Q6_MCDHB_Link • Q6_CHPHB_Link_Screenshot • Q6_MCDHB_Link_Screenshot Description: Q6_MCDHB_Link and CHP website links allows you to access the Member Information and to view the PDF file of the handbook, allowing the member to easily save or print their own copy of the handbook. The Q6_CHPHB_Link_Screenshot and Q6_MCDHB_Link_Screenshot points out where you can click to access the information, that is readily accessible and prominent for a member. The information on the pdf complied with the content and language requirements set out by 42 CFR 438.10 (c)(6). It is noted that the member information is available per the members request, and will be issued within 5 business days.	**CHP+:** ☐ Met ☒ Not Scored **Medicaid:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The forms and documents on the DHMC/P website were placed in prominent locations, could be electronically retained and printed, and complied with content and language requirements. The member handbook and provider directory inform members that the documents are available in hard copy, free of charge, and within 5 days—including a telephone number members may call to get a copy. HSAG used the Adobe Acrobat Pro accessibility checker to test the CHP+ and Medicaid member handbooks, provider directories, winter 2017 newsletter, and Medicaid Member Complaint and Appeal form. The Adobe checker noted several accessibility errors related to each document. Additionally, WAVE Web Accessibility Evaluation Tool identified several issues with the Denver Health Medicaid Choice and Denver Health Medical Plan websites.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
CHP+ Recommendations: DHMP must develop a process to ensure that all information available on its websites is readily accessible (i.e., complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines). HSAG also suggested that DHMP state on its website that information is available in paper form upon request without charge.		
Medicaid Required Actions: DHMC must develop a process to ensure that all information available on its websites is readily accessible (i.e., complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines). HSAG also suggested that DHMC state on its website that information is available in paper form without charge upon request.		
7. **The Contractor makes available to members in electronic or paper form information about its formulary:** • **Which medications are covered (both generic and name brand).** • **What tier each medication is on.** • **Formulary drug list must be available on the Contractor's Web site in a machine readable file and format.** *42 CFR 438.10(i)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—2.4.4.5.2.1	• Q7_MCD_CHP_Formulary_Link_Document • Q7_Medicaid.CHP Formulary Description: On the Denver Health Medicaid website, the member can view the entire list of prescriptions offered by the plan, what tier it is on, and the requirements/limits of the prescribed drug. The list is in a format that is machine readable.	**CHP+:** ☒ Met ☐ Not Scored **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor makes interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and how to access them. *42 CFR 438.10(d)(4) and (d)(5)* CHP+ Contract: Exhibit B—7.5, 14.1.3.4, 14.1.7.4–6 Medicaid Contract: Exhibit A—3.1.1.3.7	• Q4_CHP_HB_NonPrevelantEnglish • Q4_MD_HB_NonPrevelant English • MCD Provider Directory • CHP Provider Directory • Q8_DHHA_Language Line Services Agreement_Amendment • Q8_DHHA_Language Line Services American Master Agreement • Q8_P-2.100 – Process, highlighted • Q4_MCD_CHP_GVT10v.12 Description: Q4_CHP_HB_NonPrevelant English and Q4_MD_HB_NonPrevelantEnglish explains to members in the member handbook that oral interpretation services are available free of charge, and instructs members to request interpretation services through Member Services. In the Provider Directory, members are also made aware of the free-of-charge interpreter services available to them through DHMC. Q8_P-2.100, *Interpreter and Translation Services and Auxiliary Communication Devices,* explains the process of providing interpreter services to members who access such services at the clinic or hospital from Denver Health & Hospital Authority (DHHA). Policy MCD_CHP_GVT10 v. 12 explains how DHHA evaluating language needs for non-English speaking members. Q8_DHHA_Language Line Services Agreement_Amendment is an agreement with	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Language Line and has an auto renewal for year to year service unless cancelled no less than 90 days prior to the expiration of the current term. Q8_DHHA_Language Line Services American Master Agreement is another agreement set up have auto renew contracts for 1 year, unless either party provides written cancellation at least 90 days prior to expiration of the 10 current 1 year contract. Denver Health and Hospital Authority used the Language Line service to help in aiding service to all members who speak non-English and non-Spanish language.	
9. **Interpretation services includes oral interpretation and use of auxiliary aids such as TTY/TDY and American Sign Language.** • The Contractor notifies members that **auxiliary aids and services are available upon request and at no cost for members with disabilities**, and how to access them. *42 CFR 438.10(d)(4) and (d)(5)* CHP+ Contract: N/A Medicaid Contract: Exhibit F—28	• Q4_CHP_HB_NonPrevelantEnglish • Q4_MCD_HB_NonPrevelantEnglish • CHP+ Provider Directory • MCD Provider Directory • Q8_DHHA_Language Line Services Agreement_Amendment • Q8_DHHA_Language Line Services American Master Agreement Description: Q4_CHP_HB_NonPrevelantEnglish and Q4_MCD_HB_NonPrevelantEnlgish indicate where the member handbook mentions Interpretation services are available to a member at no cost and where they are able to access them. CHP+ Provider Directory and MCD Provider Directory indicate that the information can be accessed by oral interpretation or with auxiliary aids and	**CHP+:** ☒ Met ☐ Not Scored **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	services per member request, free of charge. Q8_DHHA_Language Line Services Agreement_Amendment and Q8_DHHA_Language Line Services American Master Agreement is a service Denver Health and Hospital Authority has to help communicate to members when another language is needed.	
10. **The Contractor provides each member with a member handbook within a reasonable time after receiving notification of the member's enrollment.** *Note: The State generally defines "a reasonable time" as 30 days.* *42 CFR 438.10(g)(1)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—3.1.1.3.6	• Q10 Reasonable Time CHP Handbook Report Sept-2017 • Q10 Reasonable Time Medicaid Handbook Report Sept-2017 Description: These reports show the date the new request was processed and the date it was shipped to the member from Clarity for the month of September. We track both Medicaid and CHP+ to verify members are receiving their handbook within a reasonable time after Denver Health receives notification of the member's enrollment.	**CHP+:** ☒ Met ☐ Not Scored **Medicaid:** ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
11. The Contractor gives members written notice of any significant change (as defined by the State) in the information required at 438.10(g) at least 30 days before the intended effective date of the change. *42 CFR 438.10(g)(4)* CHP+ Contract: Exhibit B—14.1.3.13 Medicaid Contract: Exhibit A—3.1.1.4.3	• Q11_MCDHB-Significant Change • Q11_CHPHB- Significant Change • Q11_ MCD_CHP_GVT05v.10.pdf –highlighted Description: The Member Handbook explains to members that they will be informed of any significant changes to certain information (outlines in Handbook), in writing and at least 30 days prior to the effective date of change. The MCD_CHP_GVT05v.10 informs the DHMC employee of the required written notice that must be sent to	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	members at least 30 days prior to the effective date of change agreed upon Government Products and Marketing Departments.	
12. The Contractor makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. *42 CFR 438.10(f)(1)* CHP+ Contract: Exhibit B—7.12.2, 14.1.8.1 Medicaid Contract: Exhibit A—3.2.9.2	• Q12_MBR06v.04 –highlighted Description: Q12_MBR06v.04 explains the members affected by the termination of a practitioner or practice group in general, family and internal medicine or pediatrics, has ten days from the date of notice to run a report and then 5 business days to print and send termination letters from the members listed on the query. This would mean that DHMP uses the good faith effort to notify a member within the 15 days. Attached in the policy are the template letters used by Member Services to notify the member about the provider.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. The Contractor makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals**, pharmacies, and behavioral health providers, and long-term services and supports (LTSS) providers:** • The provider's name and **group affiliation**, street address(es), telephone number(s), **Web site URL, specialty (as appropriate),** and whether the providers will accept new members. • **The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the**	• Q12_CHPHB_WhereYouCanGetCare • Q12_MCDHBK_WhereYouCanGetCare • CHP+ Provider Directory –How To Get Care • MCD Provider Directory – How to Get Care • Q13_GV01v.01 – highlighted section • Q13_MCD_CHP_GVT11v.03 – highlighted section • Denver Health Medicaid Choice_CHP Pharmacy Directory_10.2017 • Q13_GVT06v.10 – highlighted section Directions:	**CHP+:** ☐ Met ☒ Not Scored **Medicaid:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
provider or provider's office, and whether the provider has completed cultural competency training. • **Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment.** *(Note: Information included in a paper provider directory must be updated at least monthly, and electronic provider directories must be updated no later than 30 calendar days after the Contractor receives updated provider information.)* *42 CFR 438.10(h)(1–3)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—3.1.1.3.2–3	The Member Handbook informs the member that all necessary information about contracted providers can be found in the Provider Directory. The Member Handbook also explains that members may see any DHMC provider in network, subject to Specialist referral requirements. The Provider Directory informs the member of names, locations, telephone numbers, and languages spoken by providers in the DHMC network. The Provider Directory also explains that Members may see any DHMC providers, subject to Specialists referral requirements. Q13_MCD_CHP_GVT11v03 states that Denver Health will inform members how to obtain information regarding the Company's participating providers who serve members. GV01v.01 demonstrates the requirements of the Provider Directory and the information that is required to be available to the member. Denver Health Medicaid Choice_CHP Pharmacy Directory_10.2017 is the full list of Pharmacies within Colorado that gets updated on a monthly basis to assist members in locating a pharmacy. Q13_GVT06v.10 states Denver Health's policy to include content requirements in the provider directory.	

Findings:
DHMC/P's Required Provider Directory Information policy stated that provider directories must be updated at least monthly and available in paper copy, and delineated the information that must be included. The CHP+ and Medicaid provider directories listed the names, location, telephone number, and linguistic capabilities of contracted providers. The directories described accommodations available for persons with physical disabilities (including deaf, hard of hearing, and blind) and how to request these services. The provider directories failed to designate which providers had completed cultural competency training. Additionally, while DHMC/P described numerous resources available to accommodate person with physical disabilities, it failed to designate locations with accessible medical diagnostic equipment (e.g., height-adjustable examination tables, weight scales, mammography equipment, x-ray machines).

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
CHP+ Recommendations: DHMP must revise its provider directory to designate which providers have completed cultural competency training and identify office locations with accessible medical diagnostic equipment. DHMP should also update applicable policies and procedures that list required content of the provider directories to include these items.		
Medicaid Required Actions: DHMC must revise its provider directory to designate which providers have completed cultural competency training and identify office locations that have accessible medical diagnostic equipment. DHMC should also update applicable policies and procedures that list required content of the provider directories to include these items.		
14. **Provider directories are made available on the Contractor's web site in a machine readable file and format.** *42 CFR 438.10(h)(4)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—3.1.1.3.4	• CHP: http://www.denverhealthmedicalplan.org/chp-provider-directory • MCD: http://www.denverhealthmedicaid.org/find-doctor The links above will take you to the website where the user is able to open, save, and print a PDF copy of the most recent provider directory.	**CHP+:** ☒ Met ☐ Not Scored **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The CHP+ and Medicaid provider directories were available on the website in a downloadable format. The Adobe Acrobat Pro accessibility checker identified issues with each directory which could impede and/or prohibit machine readability.		
CHP+ Recommendations: DHMP should resolve accessibility issues as soon as possible and implement ongoing monitoring to ensure that updated versions maintain a machine-readable format.		
Medicaid Required Actions: DHMC must resolve accessibility issues as soon as possible and implement ongoing monitoring to ensure that updated versions maintain a machine-readable format.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. **Medicaid Only--** For any information provided to members by the Contractor, the Contractor ensures that information is consistent with federal requirements in 42 CFR 438.10. *42 CFR 438.10 (b)*	• Q15_MCD_HB • Q15_MCD_CHP_GVT11_v.03–highlighted Description: Q15_MCDHB_page 14 explains in the member handbook the members rights in a clean bullet point that allows the member to know exactly what rights they have. Q15_MCD_CHP_GVT11_v.03 explains on page 2 the procedures and content at a minimum in accordance with 42 CFR 438.100.	**Medicaid:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The Department assumed responsibility for the development and distribution of the Health First Colorado Member Handbook, thereby waiving the member handbook requirements for contracted Medicaid managed care plans. However, DHMC opted to continue producing and distributing a Medicaid member handbook to ensure communication of information specific to DHMC members. The Denver Health Medicaid member handbook included inaccurate time frames for filing grievances and appeals and incorrectly stated that members may request State fair hearings before completing the health plan appeals process.		
Required Actions: DHMC must revise its Medicaid member handbook to include accurate time frames for filing grievances (any time) and appeals (60 days after the notice of adverse benefit determination). The handbook must also clarify that members must exhaust the DHMC appeals process before requesting a State fair hearing. HSAG also suggested that DHMC clarify that continuation of benefits applies only to services that DHMC terminates, suspends, or reduces.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The member handbook provided to members following enrollment includes: • The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled. • Procedures for obtaining benefits, including authorization requirements and/or referrals for specialty care and for other benefits not furnished by the member's primary care provider. • Any restrictions on the member's freedom of choice among network providers. • In the case of a counseling or referral service that the Contractor does not cover due to moral or religious objections, the Contractor informs the member that the service is not covered and how the member can obtain information from the State about how to access such services. *42 CFR 438.10(g)(2)(iii, iv, vi) and (g)(ii)(A-B)* CHP+ Contract: Exhibit B—14.1.3.13.1–3, 14.1.3.14.4 and Exhibit K—1.1.4.1–3, 1.1.7, 1.1.16.3.11, 1.1.28 Medicaid Contract: Exhibit A—3.1.1.3.6, 2.4.1.5, 3.1.1.4.3.8 and Exhibit F—2, 3, 14, 31	• Q16_CHP_HB-Care • Q16_CHPHB-Specialist • Q16_MCDHB-Care • Q16_MCDHB-Specialist • Member Handbook – "When Can You Get Care" • Q16_MCD_CHP_GVT11v.03 Description: Q16_CHP_HB-Specialist and Q16_MCDHB-Specialist explains to the member a wide variety of benefits offered to them such as, "How To Get Care" including emergency care, urgent care, post-stabilization care, Preventative Care, Making an Appointment, Pharmacy/Prescriptions. It also includes "How To Get Care When You Are Away From Home" including seeing an OB/GYN, Prescriptions when you are away from home, Newborn Care, Pregnancy Care, WIC-Women, Infants, and Children's Food Program. As well as, "Children's Health Care" including Early Intervention Services, Childhood and Adolescent Immunizations, Pediatric and Adolescent Immunizations. Including, "Special Health Care Programs" like health coaching, Special Health for New Members with Special Needs, Case Management, Utilization Management, and Medical Necessary Services. With other additions such as "DHMP Benefits" and "Extra Services". Q16_CHPHB-Care and Q16_MCDHB – Care include "How Your Plan Works" talking about getting an approval or referral to see a specialist. Both MCD and CHP+ Handbooks	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	include "When Can You Get Care" which shows a map representing all Denver Health locations that members can visit for their health needs. Q16_MCD_CHP_GVT11v.03 states the procedures as a minimum, the member handbook must contain covered services and any additional benefits and services offered by the contractor, including, the amount, duration, and scope of covered services available and procedures for obtaining covered services, including authorization requirements.	
17. The member handbook provided to members following enrollment includes: • The extent to which and how members may obtain benefits, including family planning services, from out-of-network providers. **This includes an explanation that the Contractor cannot require the member to obtain a referral before choosing family planning provider.** • **The process of selecting and changing the member's primary care provider.** *42 CFR 438.10(g)(2)(vii, x)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—3.1.1.3.6, 3.1.1.4.3.3, Exhibit D—Covered Services, and Exhibit F—10	• Q17_CHPHB • Q17_MCDHB • Q17_MCD_CHP_GVT11_v.03 –highlighted Description: In Q17_CHPHB and Q17_MCDHB it talks about "Choosing or Changing your DHMP PCP" and "Family Planning". Family Planning explains that once you have selected a family planning health provider, whether the provider or his or her PCP or an OB/GYN provider. The member should continue to see that provider to ensure a better chance of receiving good care. In Choosing or Changing your DHMC PCP it explains that the member how to select a PCP or Provider and that they have the right to change PCP or Provider at any time. Q17_MCD_CHP_GVT11_v.03 states at a minimum the member material must include the extent to which, and how, members may obtain benefits, including family planning services, from out-of-network providers.	**CHP+:** ☒ Met ☐ Not Scored **Medicaid:** ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. The member handbook provided to members following enrollment includes the following member rights and protections as specified in 42 CFR 438.100. Members have the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for his or her dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding his or her health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. • Request and receive a copy of his or her medical records, and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for access, coverage, and coordination of medically necessary services. • Freely exercise his or her rights, and the exercising of those rights will not adversely affect the way the Contractor, its network providers, or the State agency treats the member.	• Q18_CHP_HB_YourRights • Q18_MCDHB_YourRights • MCD_CHP_GVT02 v.7 - highlighted Description: Q18_CHP_HB_YourRights and Q18_MCDHB_YourRights include a full list of the member's rights and responsibilities. MCD_CHP_GVT02v.07, *Member Rights and Responsibilities*, outlines for DHMC employees the rights and responsibilities for members.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.10(g)(2)(ix) CHP+ Contract: Exhibit B—14.1.3.6.1 and Exhibit K—1.1.2 Medicaid Contract: Exhibit A—3.1.1.3.6, 3.1.1.1.2–7 and Exhibit F—1		
19. The member handbook provided to members following enrollment includes the following information regarding the grievance, appeal, and fair hearing procedures and timeframes: • The right to file grievances and appeals. • The requirements and timeframes for filing a grievance or appeal. • The right to a request a State fair hearing after the Contractor has made a determination on a member's appeal which is adverse to the member. • The availability of assistance in the filing process. • The fact that, when requested by the member: – Benefits that the Contractor seeks to reduce or terminate will continue if the member file an appeal or a request for State fair hearing is filed within the time frames specified for filing. – If benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal or State fair hearing is pending if the final decision is adverse to the member. *42 CFR 438.10(g)(2)(xi)*	• Q19_CHPHB_GrievanceandAppeal • Q19_MCDHB_ GrievanceandAppeal • Q19_MCD_CHP_GVT11v.02- highlighted Description: Q19_CHPHB_ GrievanceandAppeal and Q19_MCDHB_ GrievanceandAppeal indicate what a grievance, appeal, and state fair hearing is. It explains the timeframes and requirements of all entities involved. The handbooks mention who can file a grievance, appeal or state hearing and how a member can get assistance. Q19_MCD_CHP_GVT11v.02 indicate the requirement to provide members the informal and formal procedures and timeframes to voice a complaint, file a grievance or obtain a Fair Hearing related to coverage, benefits, or any aspect of the member's relationships to the company through both the internal grievance process and the HCPF or state's external process. Denver Health includes to members the requirement and timeframes for filing, availability of assistance in filing, and toll-free number the member can use to file. The member is notified benefits continue if the member files an appeal or request for a State fair hearing within the timeframes of filing, the member may be required to pay costs of services	**CHP+:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
CHP+ Contract: Exhibit B—1.1.16.6, 1.1.16.6.1, 1.1.16.6.3 Medicaid Contract: Exhibit A—3.1.1.3.6 and Exhibit F—13	while the appeal or State fair hearing is pending if the decision is adverse to the member. In all, the member is notified of their rights, the process, and the timeframes of an appeal, grievance, or State fair hearing.	
Findings: The CHP+ handbook included members' rights and processes to file a grievance, appeal, or State fair hearing; informed members that its Member Services staff is available to assist with the filing process; included the circumstances under which a member may request continuation of benefits; and expressed circumstances under which the member would have to pay for services continued during an appeal and/or State fair hearing. The CHP+ handbook included inaccurate time frames for filing grievances and appeals and incorrectly stated that members may request State fair hearings before completing the health plan appeals process.		
Required Actions: DHMP must revise its CHP+ member handbook to include accurate time frames for filing grievances (any time) and appeals (60 days after the notice of adverse benefit determination). The handbook must also clarify that members must exhaust the DHMP appeals process before requesting a State fair hearing. HSAG also suggested that Denver Health clarify that continuation of benefits applies only to services that DHMP terminates, suspends, or reduces.		
20. The member handbook provided to members following enrollment includes the extent to which and how after-hours and emergency coverage are provided, including: • What constitutes an emergency medical condition and emergency services. • The fact that prior-authorization is not required for emergency services. • The fact that the member has the right to use any hospital or other setting for emergency care. *42 CFR 438.10(g)(2)(v)*	• Q20_CHPHB- how to get care • Q20_MCDHB- how to get care • Q20_MCD_CHP_GVT11_v.03 – pages 3-4, highlighted Description: In Q20_CHP_HB- how to get care and Q20_MCDHB- how to get care indicate emergency and urgent hours, and what a member should do. Prior authorization is not needed in cases of emergencies. If a member is unsure if they should go to an emergency room/urgent care they can call the 24/7 NurseLine.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
CHP+ Contract: Exhibit K—1.1.10.1, 1.1.10.1.1–2, 1.1.10.1.5 Medicaid Contract: Exhibit A—3.1.1.3.6, 3.1.1.4.3.4 and Exhibit F—7–9	Q20_MCD_CHP_GVT11_v.03 mentions Denver Health's policy and procedure to notify members of the appropriate use of and obtaining after hours care and emergency care within the service area. Members are notified they do not need a prior authorization for a true emergency service.	
21. The member handbook provided to members following enrollment includes: • That cost-sharing, if any, is imposed under the State plan. • How and where to access any benefits that are available under the State plan but not covered under the CHP+ managed care contract. • How transportation is provided. *42 CFR 438.10(g)(2)(ii, viii)* CHP+ Contract: Exhibit K—1.1.3 Medicaid Contract: Exhibit A—3.1.1.3.6, 3.1.1.4.3.7, 2.4.4.9.1 and Exhibit F—18, 19, and 32	• Q21_CHPHB • Q21_MCDHB_Transportation&WrapAround • Q15_MCD_CHP_GVT11v.03 - highlighted Description: Q21_CHPHB explains the services provided to a member by the State. Transportation is not an included benefit of CHP+ and is not mentioned in the book. Q21_MCDHB_Transportation&WrapAround indicated the benefits and use of Transportation and Wrap Around Benefits. The member handbook explains what benefits a member has and how they are used. Q15_MCD_CHP_GVT11v.03 policy and procedure states at a minimum the member handbook contains the following information, cost sharing if any.	**CHP+:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
Findings: The CHP+ handbook described instances in which a member may be required to pay for services. The handbook also described wraparound benefits; however, it included no information about how to access these services or where to learn more about them.		
Required Actions: DHMP must revise its member handbook to inform members how to access benefits available under the State plan but not covered by the DHMP CHP+ managed care contract.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
22. The member handbook provided to members following enrollment includes: • **The toll-free telephone number for member services, medical management, and any other unit providing services directly to members.** • **Information on how to report suspected fraud or abuse.** • **How to access auxiliary aids and services, including information in alternative formats or languages.** *42 CFR 438.10(g)(2)(xiii, xiv, xv)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—3.1.1.3.6 and Exhibit F—28–30	• Q22_CHPHB_ProtectYourself • Q22_MCDHB_ProtectYourself • MCD_Important Numbers • CHP+_Important Numbers Description: Q22_CHPHB_ProtectYourself and Q22_MCDHB_ProtectYourself is explained in the member handbook, and how they should contact compliance. CHP+ Important Numbers and MCD_Important Numbers are at the front of the member handbook and represent all frequently used phone numbers, or phone numbers that would be needed in an emergency. The Important Phone Numbers shows the phone number for member services, medical management, and other important units. Above the important Information page, the table of contents explains how to request auxiliary aids and services, or to request information in another language.	**CHP+:** ☒ Met ☐ Not Scored **Medicaid:** ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
23. The member handbook provided to members following enrollment includes **how to exercise** an advance directive as required in 438.3 (j): • The member's right under the State law to make decisions regarding medical care and to formulate advance directives, including the right to accept or refuse medical or surgical treatment. • The Contractor's policies and procedures respecting implementation of advance directives, with a clear statement of limitation if the Contractor cannot	• Q23_CHPHB_AdvanceDirectives • Q23_MCDHB_AdvanceDirectives • Q23_MCD_CHP+GVT12v.08 Description: Q23_CHPHB_AdvanceDirectives and Q23_MCDHB_Advanve Directives explains what an advance directive is. Q23_MCD_CHP+GVT12v.08 Policy and Procedure explains the Advance Medical	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
implement an advance directive as a matter of conscience. • Instructions that complaints concerning noncompliance with advance directives requirements may be filed with the Colorado Department of Public Health and Environment. *42 CFR 438.10(g)(2)(xii)* CHP+ Contract: Exhibit B—14.1.1.2.7, 14.1.1.2.7.1, 14.1.9 Medicaid Contract: Exhibit A—3.1.1.3.6, 3.1.1.1.8 and Exhibit F—21	Directives explains how members can exercise advance directives per 438.3(j).	
24. **The Contractor provides member information by any of:** • **Mailing a printed copy of the information to the member's mailing address.** • **Providing the information by email after obtaining the member's agreement to receive the information by email.** • **Posting the information on the web site of the MCO and advises the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost.**	• Q10 Reasonable Time CHP Handbook Report Sept-2017 • Q10 Reasonable Time Medicaid Handbook Report Sept-2017 • Handbook – indicating handbook is online • Hyperlink and screenshot showing you may ask for a paper copy of Member Handbook Description: The Q10 Reasonable Time CHP Handbook Report Sept-2017 and Q10 Reasonable Time Medicaid Handbook Report Set-2017 show that a book was sent out for a new member. The handbook shows how Denver Health will accommodate with disabilities "Special Health for New Members with Special Needs", Material is available in Non-prevalent English, TTY/TDD, and interpretation.	**CHP+:** ☒ Met ☐ Not Scored **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• **Providing the information by any other method that can reasonably be expected to result in the member receiving that information.** *42 CFR 438.10(g)(3)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—3.1.1.3.6.1	The link shows how online it states a member may request for a paper copy be sent to them.	
25. The Contractor must make available to members, upon request, any physician incentive plans in place. *42 CFR 438.10(f)(3)* CHP+ Contract: (Not found) Medicaid Contract: Exhibit A—3.2.4.2 and Exhibit F—13(d)(2)	• Q25_CHPHB_PhysicianIncentivePlan • Q25_MCDHB_PhysicianIncentivePlan • Q25_MCD_CHP_GVT11v.03 –highlighted Description: While DHMC does not utilize a Physician Incentive Plan, members are made aware of Physician Incentive Plans in the Member Handbook and are instructed to call Member Services if they would like more information about Physician Incentive Plans. Q25_MCD_CHP_GVT11v.03 Policy and Procedure states that Denver Health will provide Medicaid Choice Members Only about Physician Incentive plans that are available upon request.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Note: While the scoring of evidence related to individual, new federal requirements in the tool may indicate *Met* or *Not Scored*, all new requirements were scored *Not Applicable* in the total results; new federal requirements do not apply to CHP+ until July 1, 2018.

CHP+ Results for Standard V—Member Information							
Total	Met	=	10	X	1.00	=	10
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	12	X	NA	=	NA
Total Applicable		=	12	**Total Score**		=	10
				Total Score ÷ Total Applicable		=	83%

Medicaid Results for Standard V—Member Information							
Total	Met	=	9	X	1.00	=	9
	Partially Met	=	4	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	12	X	NA	=	NA
Total Applicable		=	13	**Total Score**		=	9
				Total Score ÷ Total Applicable		=	69%

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. **The Contractor has established internal grievance procedures under which members, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance. The Contractor must have a grievance and appeal system in place to handle appeals of an adverse benefit determination and grievances, as well as processes to collect and track information about them.** • **The Contractor may have only one level of appeal for members (or providers acting on their behalf).** • **A member may request a State fair hearing after receiving an appeal resolution notice from the Contractor that the adverse benefit determination has been upheld.** • **If the Contractor fails to adhere to required timeframes for processing appeals, the member is deemed to have exhausted the Contractor's appeal process and the member may initiate a State fair hearing.** *42 CFR 438.400(a)(3)* *42 CFR 438.402(a-c)* *42 CFR 438.400(b)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—3.1.2.1.1-2, 3.1.2.7.1-2 10 CCR 2505-10—8.209.3.A, 8.209.4.A.2.c, 8.208.4.N, 8.209.4.O	• MCD_CHP_CGA22 v.16 Grievance Process – Section I. Policy Statement, page 1 describes internal grievance procedures • MCD_CHP_CGA09 v.03 Appeals Process – Section I. Policy Statement, page 1, Section VI. Process, Item A. Data Systems and Documentation describes the establishment of an appeal process and how we collect and track information from initial logging of matter to resolution. • MCD_CHP_CGA09 v.03 Appeals Process, Item 3, How an Appeal Is Filed, page 4 describes only one level of appeal • MCD_CHP_CGA09 v.03 Appeals Process – Item M entitled State Fair Hearings describes when a member can request a state fair hearing after receiving an appeal resolution letter when an adverse benefit determination has been upheld. • MCD_CHP_CGA09 v.03 Appeals Process – Item F entitled Timeframes states that if the Company fails to adhere to required timeframes, the member is deemed to have exhausted the appeal process and may initiate a state fair hearing	**CHP+:** ☐ Met ☒ Not Scored **Medicaid:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: While DHMC/P submitted processes and procedures related to the grievance system, HSAG noted concerns with both the Grievance Process policy and the Appeals Process policy. First, while both had effective dates of July 1, 2017, these policies were not signed by staff with approval authority until November 10, 2017. The Grievance Process policy emphasized that the purpose of the policy was for the Grievance and Appeal Department to follow established Company grievance processes but did not include other Company staff members' accountability for handling grievances. The Grievance Process policy, Section VI(A), also indicated that the company had a data tracking system to log, process, track, and trend all member appeals. DHMC/P demonstrated the system used to maintain all written documentation, including the nature and substance of each grievance, receipt date, actions taken, any results, and resolution date. This language demonstrated inconsistencies in the policy; this policy was applicable only to the Grievance process. Additionally, while the Appeals Process policy indicated, "the Company maintains a standard and an expedited appeals process, which consists of only one level of appeal," the Appeals Process policy under Attachment 6—Appeal Investigation Worksheet included information regarding the 2nd-level appeals process. For Medicaid programs, managed care plans are prohibited from having more than one level of appeal for members. This policy is applicable to Medicaid programs; therefore, the attachments must clearly demonstrate the requirements for Medicaid appeals. Additionally, both the Grievance Process and Appeals Process policies included outdated attachments. DHMC/P must ensure that policies and procedures, including all attachments and appendices, include current requirements. Finally, through the file reviews, DHMC/P demonstrated inaccuracies in the processing of appeals. Five of 10 appeal cases reviewed were deemed grievances and should have followed grievance timelines and requirements for resolution. Additionally, few grievances were tracked by DHMC/P, which indicated potential issues with reporting and subsequent tracking of member-reported complaints.		
CHP+ Recommendations: DHMC/P should update policies and procedures, including all appendices and attachments, with language in compliance with the Medicaid managed care rule and all associated State and program contract requirements. Additionally, DHMC/P should ensure that all staff members are aware of and have mechanisms in place for appropriately managing appeals and grievances.		
Medicaid Required Actions: DHMC/P must update policies and procedures, including all appendices and attachments, with language in compliance with the Medicaid managed care rule and all associated State and program contract requirements. Additionally, DHMC/P must ensure that all staff members are aware of and have mechanisms in place for appropriately managing appeals and grievances. DHMC/P must also ensure that policies and procedures are updated timely in accordance with all federal, State, and program rule changes.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor defines **adverse benefit determination** as: • The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. • The reduction, suspension, or termination of a previously authorized service. • The denial, in whole, or in part, of payment for a service. • The failure to provide services in a timely manner, as defined by the state. • The failure to act within the time frames defined by the State for standard resolution of grievances and appeals. • For a resident of a rural area with only one managed care plan, the denial of a member's request to exercise his or her rights to obtain services outside of the network under the following circumstances: – The service or type of provider (in terms of training, expertise, and specialization) is not available within the network. – The provider is not part of the network, but is the main source of a service to the member—provided that: o The provider is given the opportunity to become a participating provider. o If the provider does not choose to join the network or does not meet the Contractor's	MCD_CHP_CGA09 v.03 Appeals Process – Section IV. Definitions, Item A. provides the definition of an adverse benefit determination.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
qualification requirements, the member will be given the opportunity to choose a participating provider and then will be transitioned to a participating provider within 60 days. *42 CFR 438.400(b)* *42 CFR 438.52(b)(2)(ii)* CHP+ Contract: Exhibit B—1.1.1 Medicaid Contract: Exhibit A—3.1.2.1.2 10 CCR 2505-10—8.209.2.A		
3. The Contractor also defines **adverse benefit determination** as: • **The denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other).** *42 CFR 438.400(b)* *42 CFR 438.52(b)(2)(ii)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—3.1.2.1.2 10 CCR 2505-10—8.209.2.A.7	Section IV. Definitions, Item A. sub item g. provides the definition of an adverse benefit determination and includes language regarding the denial of a member's request to dispute a member financial liability.	**CHP+:** ☒ Met ☐ Not Scored **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor defines "Appeal" as "a review by the Contractor of an **adverse benefit determination**." *42 CFR 438.400(b)* CHP+ Contract: Exhibit B—1.1.4 Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.4.1 10 CCR 2505-10—8.209.2.B	MCD_CHP_CGA09 v.03 Appeals Process – Section IV. Definitions, Item B. provides the definition of an appeal.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. The Contractor defines "grievance" as "an expression of dissatisfaction about any matter other than an **adverse benefit determination.**" Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights **regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision.** *42 CFR 438.400(b)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.2.1, 3.1.2.3.2.5.2 10 CCR 2505-10—8.209.2.D, 8.209.4.A.3.c.i	MCD_CHP_CGA22 v.16 Grievance Process, Section IV. Definitions, Item #D provides the definition of a grievance	**CHP+:** ☒ Met ☐ Not Scored **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor has provisions for who may file: • A member may file a grievance, a Contractor-level appeal, and may request a State fair hearing. • With the member's written consent, a provider or authorized representative may file a grievance, a Contractor-level appeal, and may request a State fair hearing on behalf of a member. *42 CFR 438.402(c)* CHP+ Contract: Exhibit B—14.1.4.5, 14.1.5.1 Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.4.1.1 10 CCR 2505-10—8.209.3.B.1, 8.209.3.B.2, 8.209.2.C	• MCD_CHP_CGA22 v.16 Grievance Process, Section VI Procedures, Item #B describes who may file a grievance. • MCD_CHP_CGA09 v.3 Appeal Process, Section VI Procedures, Item B entitled "Who May File an Appeal"	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
7. The Contractor accepts grievances orally or in writing. *42 CFR 438.402(c)(3)(i)* CHP+ Contract: Exhibit B—14.1.5.6 Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.2.2.3 10 CCR 2505-10—8.209.5.D	MCD_CHP_CGA22 v.16 Appeal Process, Section VI Procedures, Item C entitled "How an Appeal is Filed"	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. Members may file a grievance **at any time.** *42 CFR 438.402(c)(2)(i)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.2.3 10 CCR 2505-10—8.209.5.A	MCD_CHP_CGA22 v.16 Grievance Process, Section VI. Procedures, Item C states a member can file a grievance at any time.	**CHP+:** ☒ Met ☐ Not Scored **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor sends the member written acknowledgement of each grievance within two (2) working days of receipt. *42 CFR 438.406(b)(1)* CHP+ Contract: Exhibit B—14.1.5.5 Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.2.3 10 CCR 2505-10—8.209.5.A	MCD_CHP_CGA22 v.16 Grievance Process, Section VI. Procedures Item F "Acknowledgement of Grievance" states the timeframe for sending a written acknowledgement.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor must resolve each grievance and provide notice as expeditiously as the as the member's health condition requires, and **within 15 working days of when the member files the grievance.** • **Notice to the member must be in a format and language that may be easily understood by the member.** *42 CFR 438.408(a) and (b)(1) and (d)(1)* CHP+ Contract: Exhibit B—14.1.5.7, 14.1.5.9 Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.2.6, 3.1.1.3.7 10 CCR 2505-10—8.209.5.B	• MCD_CHP_CGA22 v.16 Grievance Process, Section VI. Procedures Item D describes the resolution timeframe. • Section I "Policy Statement" Item C describes the resolution letter is in a format and language that is easily understood.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11. The written notice of grievance resolution includes: • Results of the disposition/resolution process and the date it was completed. CHP+ Contract: Exhibit B—14.1.5.1.1 Medicaid Contract: Exhibit A—3.1.2.1.2 10 CCR 2505-10—8.209.5.G	MCD_CHP_CGA22 v.16 Grievance Process, Section VI. Procedures Item G describes the contents of the written notice.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, **auxiliary aids and services upon request**, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. *42 CFR 438.406(a)(1)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.1.7 10 CCR 2505-10—8.209.4.C	MCD_CHP_CGA22 v.16 Grievance Process, Section I. Policy Statement, Item B describes reasonable assistance given to the member by the Company.	**CHP+:** ☒ Met ☐ Not Scored **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who: • Were not involved in any previous level of review or decision-making nor a subordinate of any such individual. • Have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding any of the following: – An appeal of a denial that is based on lack of medical necessity. – A grievance regarding the denial of expedited resolution of an appeal. – A grievance or appeal that involves clinical issues. *42 CFR 438.406(b)(2)* CHP+ Contract: Exhibit B—14.1.5.8 Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.2.4, 3.1.2.4.5 10 CCR 2505-10—8.209.4.E, 8.209.5.C	• MCD_CHP_CGA22 v.16 Grievance Process, Section I. Policy Statement, Item E describes individual who makes a grievance decision cannot be involved in any previous level of review. • MCD_CHP_CGA09 v.3 Appeal Process, Section VI. Procedures Item I "Receipt and Processing of an Appeal" No. 12, and Item J "Appeal Decisions".	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. Contractor ensures that the individuals who make decisions on grievances and appeals: • **Take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.** *42 CFR 438.406(b)(2)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—3.1.2.2.5	MCD_CHP_CGA09 v.3 Appeal Process, Section VI. Procedures Item I" Receipt and Processing of an Appeal" No. 13.	**CHP+:** ☒ Met ☐ Not Scored **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
15. A member may file an appeal with the Contractor **within 60 calendar days** from the date on the adverse benefit determination notice. *42 CFR 438.402(c)(2)(ii)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.4.4.1 10 CCR 2505-10—8.209.4.B	MCD_CHP_CGA09 v.3 Appeal Process, Section VI. Procedures Item D describes the member timely filing timeframe.	**CHP+:** ☐ Met ☒ Not Scored **Medicaid:** ☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: The Appeal Process policy language under the "Procedures" section was compliant with this requirement; however, the Untimely Filing Letter (Attachment 2 to the policy) included inaccurate information. The attachment specifically indicated that the member has "30 calendar days from the date of an incident to file a grievance. DHMC cannot resolve a grievance that is filed thirty (30) calendar days after the incident." Additionally, this Untimely Filing Letter attachment referenced grievance information which does not apply and would be confusing to a member. The policy and all attachments must be updated to apply to the Appeals Process; and the timeline for filing an appeal must be updated to 60 calendar days from the date of the adverse benefit determination. During the on-site review, HSAG confirmed that the current Untimely Filing Letter included appropriate timelines and information.		
CHP+ Recommendations: DHMP's policies related to the appeals process should be updated to include compliant language, including time frames within which a member may file an appeal with DHMP.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Medicaid Required Actions: DHMC's policies related to the appeals process must be updated to include compliant language, including time frames, within which a member may file an appeal with DHMC.		
16. The member may file an appeal either orally or in writing, and must follow the oral request with a written, signed appeal (unless the request is for expedited resolution). *42 CFR 438.402(c)(3)(ii)* *42 CFR 438.406(b)(3)* CHP+ Contract: Exhibit B—14.1.4.6, 14.1.4.16.1 Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.4.1.2 10 CCR 2505-10—8.209.4.F	MCD_CHP_CGA09 v.3 Appeal Process, Section VI. Procedures Item C "How an Appeal is Filed" describes that a member can file an appeal orally or in writing.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
17. The Contractor sends written acknowledgement of each appeal within two (2) working days of receipt, unless the member or designated client representative requests an expedited resolution. *42 CFR 438.406(b)(1)* CHP+ Contract: Exhibit B—14.1.4.7 Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.4.2 10 CCR 2505-10—8.209.4.D	MCD_CHP_CGA09 v.3 Appeal Process, Section VI. Procedures Item I "Receipt and Processing of an Appeal" No. 8.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. The Contractor's appeal process must provide: • That oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date), and must be confirmed in writing unless the member or provider requests expedited resolution. • That if the member orally requests an expedited appeal, the Contractor shall not require a written, signed appeal following the oral request. • That included, as parties to the appeal, are: – The member and his or her representative, or – The legal representative of a deceased member's estate. *42 CFR 438.406(b)(3) and (6)* CHP+ Contract: Exhibit B—14.1.4.9.3 Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.4.4.1, 3.1.2.4.4.4, 3.1.2.5.2 10 CCR 2505-10—8.209.4.F, 8.209.4.I	MCD_CHP_CGA09 v.3 Appeal Process, Section VI. Procedures Item C "How an Appeal is Filed" describes oral inquiries seeking to appeal an adverse benefit determination are treated as appeals.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
19. The Contractor's appeal process must provide: • The member a reasonable opportunity, in person and in writing, to present evidence **and testimony** and make legal and factual arguments. (The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution timeframe in the case of expedited resolution.) • The member and his or her representative the member's case file, including medical records, other documents and	• MCD_CHP_CGA09 v.3 Appeal Process, Section VI. Procedures Item J "Appeal Decisions" Item ii. Describes the opportunity to present evidence and testimony • MCD_CHP_CGA09 v.3 Appeal Process, Section VI. Procedures Item J "Appeal Decisions" Item iii. Describes the opportunity for member to obtain case file free of charge.	**CHP+:** ☒ Met ☐ Not Scored **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
records, and **any new or additional documents considered, relied upon, or generated by the Contractor in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution timeframe.** *42 CFR 438.406(b)(4-5)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.4.4.2–3, 3.1.2.5.3 10 CCR 2505-10—8.209.4.G, 8.209.4.H		
20. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. *Note: If the written appeal is not signed by the member or designated client representative (DCR), the appeal resolution will remain pending until the appeal is signed. All attempts to gain a signature shall be included in the record of the appeal.* • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)* *42 CFR 438.408(d)(2)* *42 CFR 438.10*	• MCD_CHP_CGA09 v.3 Appeal Process, Section VI. Procedures, Item F "Timeframes" Item 1. • MCD_CHP_CGA09 v.3 Appeal Process, Section I. Policy Statement, second paragraph.	**CHP+:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
CHP+ Contract: Exhibit B—14.1.4.8, 14.1.3.1 Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.4.3, 2.5.6.3.5 10 CCR 2505-10—8.209.4.J(1), 8.209.4.L		
Findings: The Appeals Process policy was compliant with the timeliness requirement for providing written notice of the appeal disposition. Appeal resolution letters reviewed during the on-site file reviews, however, indicated that content language was not consistently written for ease of comprehension. Specifically, one of the four Medicaid appeals and the single CHP+ appeal reviewed were not written in manners that would be easily understood by members.		
Required Actions: DHMC/P must ensure that written notices of appeal resolutions are in formats and language that may be easily understood by members.		
21. For expedited appeal, the Contractor must resolve the appeal and provide written notice of disposition to affected parties **within 72 hours** after the Contractor receives the appeal. • For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. *42 CFR 438.408(b)(3) and (d)(2)(ii)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.5.4.2, 3.1.2.5.4.5 10 CCR 2505-10—8.209.4.J.(2), 8.209.4.L	• MCD_CHP_CGA09 v.3 Appeal Process, Section VI. Procedures, Item F "Timeframes" Item 2.	**CHP+:** ☒ Met ☐ Not Scored **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
22. The Contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: • The member requests the extension; or • The Contractor shows (to the satisfaction of the Department, upon request) that there is need for additional information and how the delay is in the member's interest. *42 CFR 438.408(c)(1)* CHP+ Contract: Exhibit B—14.1.5.10 Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.4.3.1, 3.1.2.5.4.3 10 CCR 2505-10—8.209.4.K	• MCD_CHP_CGA09 v.3 Appeal Process, Section VI. Procedures, Item G "Extension of Timeframes" Item 1.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
23. If the Contractor extends the timeframes, it must—for any extension not requested by the member: • Make reasonable efforts to give the member prompt oral noice of the delay. • **Within 2 calendar days**, give the member written notice of the reason for the delay **and inform the member of the right to file a grievance if he or she disagrees with that decision.** • Resolve the appeal as expeditiously as the enollees health condition requires and no later than the date the extension expires. *42 CFR 438.408(c)(2)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.4.3.2, 3.1.2.5.4.4 10 CCR 2505-10—8.209.4.K (2)	• MCD_CHP_CGA09 v.3 Appeal Process, Section VI. Procedures, Item G "Extension of Timeframes" Item 1.	**CHP+:** ☒ Met ☐ Not Scored **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
24. The written notice of appeal resolution must include: • The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. – The right to request that benefits/services continue* while the hearing is pending, and how to make the request. o That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's adverse benefit determination. **Continuation of benefits applies only to previously authorized services for which the Contractor provides 10-day advance notice to terminate, suspend or reduce.* *42 CFR 438.408(e)* CHP+ Contract: Exhibit B—14.1.4.10 Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.4.6.1–2 10 CCR 2505-10—8.209.4.M	MCD_CHP_CGA09 v.3 Appeal Process, Section VI. Procedures, Item K entitled "Appeal Resolution Letter Content Requirements"	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
25. **The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of resolution.** • If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. *42 CFR 438.408(f)(1–2)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.7.1–2 10 CCR 2505-10—8.209.4.N, 8.209.4.O	MCD_CHP_CGA09 v.3 Appeal Process, Section VI. Procedures, Item M entitled "State Fair Hearings"	**CHP+:** ☐ Met ☒ Not Scored **Medicaid:** ☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: The Appeals Process policy under "State Fair Hearings" was compliant with State fair hearing requirements. However, Attachment 11, DHMC_CHP: "What is a State Fair Hearing" contained inaccurate information. Specifically, the attached letter stated that the member does not have to go through the appeals process prior to asking for a State fair hearing. Additionally, the letter stated that the member or designated representative could ask for a State fair hearing within thirty (30) calendar days from the date of the notice of action letter. Additionally, the Standard Appeal Acknowledgment Letter, attached to the Appeals Process policy, included a statement that the member or the member's representative could ask for a State fair hearing without going through the appeals process. During the on-site record review, instances (three of four cases) were noted in which inaccurate information was provided to members in the Appeal Resolution Letter and accompanying attachments; errors involved State fair hearing timelines and when a hearing could be requested. During the on-site review, HSAG confirmed that DHMC/P's current State fair hearing letters included appropriate timelines and information.		
CHP+ Recommendations: The written notice of appeal resolution letter and policies and procedures related to appeal resolution should be updated to contain accurate information about when a member or a designated representative may request a State fair hearing.		
Medicaid Required Actions: The written notice of appeal resolution letter and policies and procedures related to appeal resolution must contain accurate information about when a member or a designated representative may request a State fair hearing.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
26. The parties to the State fair hearing include the Contractor, as well as the member and his or her representative or the representative of a deceased member's estate. *42 CFR 438.408(f)(3)* CHP+ Contract: Exhibit B—14.1.4.17.5 Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.7.3 10 CCR 2505-10—8.209.4.H	MCD_CHP_CGA09 v.3 Appeal Process, Section VI. Procedures, Item B entitled "Who May File and Appeal"	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
27. The Contractor maintains an expedited review process for appeals when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health; or ability to attain, maintain, or regain maximum function. The Contractor's expedited review process includes that: • The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. *42 CFR 438.410(a-b)* CHP+ Contract: Exhibit B—14.1.4.16, 14.1.4.16.4 Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.5.1, 3.1.2.5.5 10 CCR 2505-10—8.209.4.Q, 8.209.4.R	MCD_CHP_CGA09 v.3 Appeal Process, Section VI. Procedures, Item H entitled "When to Expedite an Appeal Versus the standard Resolution Timeframe" extending into No. 1	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
28. If the Contractor denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the time frame for standard resolution. • **Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and within two (2) calendar days provide the member written notice of the reason for the decision and inform the member of the right to file a grievance if he or she disagrees with that decision.** *Note: Changed in federal rules only. Same as existing Colorado requirement.* *42 CFR 438.410(c)* CHP+ Contract: Exhibit B—15.1.4.16.5 Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.5.4.1 10 CCR 2505-10—8.209.4.S	MCD_CHP_CGA09 v.3 Appeal Process, Section VI. Procedures, Item H entitled "When to Expedite an Appeal Versus the standard Resolution Timeframe"	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
29. The Contractor provides for continuation of benefits/services while the Contractor-level appeal and the State fair hearing are pending if: • The member files timely* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the Contractor mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.	MCD_CHP_CGA09 v.03 Appeals Process – Page 14, Item N entitled "Continuation of Benefits Pending Appeal or State Fair Hearing Decision" item a	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal in accordance with required timeframes. ** This definition of timely filing only applies for this scenario–i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced. (Note: The provider may not request continuation of benefits on behalf of the member.)* *42 CFR 438.420(a) and (b)* CHP+ Contract: Exhibit B—14.1.4.11 Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.6.1 10 CCR 2505-10—8.209.4.T		
30. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of the following occurs: • The member withdraws the appeal or request for a State fair hearing. • The member fails to request a State fair hearing and continuation of benefits within 10 calendar days after the Contractor sends the notice of an adverse resolution to the member's appeal.	MCD_CHP_CGA09 v.03 Appeals Process – Page 15, Item N entitled "Continuation of Benefits Pending Appeal or State Fair Hearing Decisions, Section b	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR 438.420(c)* CHP+ Contract: Exhibit B—14.1.4.12 Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.6.2 10 CCR 2505-10—8.209.4.U		
31. Member responsibility for continued services: • If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's adverse benefit determination, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. *42 CFR 438.420(d)* CHP+ Contract: Exhibit B—14.1.4.13 Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.6.3 10 CCR 2505-10—8.209.4.V	MCD_CHP_CGA09 v.03 Appeals Process – Page 15, Item N entitled "Continuation of Benefits Pending Appeal or State Fair Hearing Decisions, Section c	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
32. If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than **72 hours** from the date it receives notice reversing the determination. *42 CFR 438.424(a)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.6.4 10 CCR 2505-10—8.209.W	MCD_CHP_CGA09 v.03 Appeals Process – Page 15-16, Item N entitled "Continuation of Benefits Pending Appeal or State Fair Hearing Decisions, Section d "Effectuation of Reversed Appeal Resolutions, items i.1	**CHP+:** ☒ Met ☐ Not Scored **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
33. If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCO or the State must pay for those services, in accordance with State policy and regulations. *42 CFR 438.424(b)* CHP+ Contract: Exhibit B—14.1.4.15 Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.6.5 10 CCR 2505-10—8.209.4.X	MCD_CHP_CGA09 v.03 Appeals Process – Page 15-16, Item N entitled "Continuation of Benefits Pending Appeal or State Fair Hearing Decisions, Section d "Effectuation of Reversed Appeal Resolutions, items ii.1	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
34. The Contractor maintains records of all grievances and appeals. **The records must be accurately maintained in a manner accessible to the State and available on request to CMS. The record of each grievance and appeal must contain, at a minimum, all of the following information:** • **A general description of the reason for the grievance or appeal.** • **The date received.** • **The date of each review or, if applicable, review meeting.** • **Resolution at each level of the appeal or grievance.** • **Date of resolution at each level, if applicable.** • **Name of the person for whom the appeal or grievance was filed.** *42 CFR 438.416* CHP+ Contract: N/A Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.9.1–2 10 CCR 2505-10—8.209.3.C	MCD_CHP_CGA09 v.03 Appeals Process – Page 16, Item O entitled "Record Retention"	**CHP+:** ☒ Met ☐ Not Scored **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
35. The Contractor provides the information about the grievance appeal, and fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member.	The Provider Manual describes the internal grievance and appeal process and state fair hearing process.	**CHP+:** ☐ Met ☐ Partially Met ☒ Not Met ☐ N/A **Medicaid:** ☐ Met ☐ Partially Met ☒ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The availability of assistance in the filing processes. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. – The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member. *42 CFR 438.414* *42 CFR 438.10(g)(xi)* CHP+ Contract: Exhibit B—11.1.12 Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.1.8.1–6 10 CCR 2505-10—8.209.3.B		
Findings: The Appeals Process policy stated that a HCPF-approved description of the appeal and State fair hearing procedures and time frames were provided to all providers and subcontractors at the time that the providers/subcontractors entered into contracts with the company. DHMC/P did not provide documentation to support that this process was being implemented.		
Required Actions: DHMC/P must have mechanisms in place to ensure that all providers and subcontractors are provided with information about the grievance, appeal, and fair hearing system upon entering into contracts with DHMC/P.		

Note: While the scoring of evidence related to individual, new federal requirements in the tool may indicate *Met* or *Not Scored*, all new requirements were scored *Not Applicable* in the total results; new federal requirements do not apply to CHP+ until July1, 2018.

CHP+ Results for Standard VI—Grievance System							
Total	Met	=	20	X	1.00	=	20
	Partially Met	=	1	X	.00	=	0
	Not Met	=	1	X	.00	=	0
	Not Applicable	=	13	X	NA	=	NA
Total Applicable		=	22	**Total Score**		=	20
				Total Score ÷ Total Applicable		=	91%

Medicaid Results for Standard VI—Grievance System							
Total	Met	=	30	X	1.00	=	30
	Partially Met	=	2	X	.00	=	0
	Not Met	=	3	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	35	**Total Score**		=	30
				Total Score ÷ Total Applicable		=	86%

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements written policies and procedures for selection and retention of providers. *42 CFR 438.214(a)* CHP+ Contract: Exhibit B—14.2.1.1 Medicaid Contract: Exhibit A—3.2.1.1	• Q1 _ MCD_CHP CNT06V08 (PURPOSE) Description: To ensure the proper retention and selection of medical providers.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor follows a documented process for credentialing and recredentialing that complies with the State's policies for credentialing. • The Contractor's credentialing program shall comply with the standards of the National Committee on Quality Assurance (NCQA). • The Contractor ensures that all laboratory-testing sites providing services under the Contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration along with a CLIA registration number. *42 CFR 438.214(b)* CHP+ Contract: Exhibit B—14.2.1.3 Medicaid Contract: Exhibit A—3.2.1.3, 3.2.1.5	• Q2_ CRE01 V06 Credentialing and Recredentialing of Practitioners (see PURPOSE statement page 1) • Q2_ Medical Staff By Laws (see page 9 Article III and page 34 Article XVII Section 1 #2) • Q2 _ see copies of example of CLIA certificates Description: Independent Direct Practitioners are chosen through DHMC Contracts Dept and Credentialed according to NCQA standards by the DHMC Credentialing Coordinator. DHHA practitioners are chosen by Department needs and credentialed according to JC & NCQA standards by DHHA Medical Staff Office.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's provider selection policies and procedures include provisions that the Contractor does not: • Discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. • Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42 CFR 438.12(a)(1) and (2)* *42 CFR 438.214(c)* CHP+ Contract: Exhibit B—14.4.1, 14.2.1.6 Medicaid Contract: Exhibit A—3.2.1.6, 3.2.11.1	• Q3_ MCD_CHP_CNT06 V08 Provider Selection and Retention (Page 3 E) • Q3_ CRE01 v. 06 Credentialing and Recredentialing of Practitioners (page 5 and 6 see PROCEDURES letter B) • Q3_ DHHA Medical Staff Bylaws (See pages 45-49 Article XVIII Section 4C-IC) Description: The Company does not make credentialing decisions based on an applicant's race ethnic/national identity gender age or sexual orientation. Provider Relations does not discriminate for reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This is not construed to: • Require the Contractor to contract with providers beyond the number necessary to meet the needs of its members. • Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. • Preclude the Contractor from establishing measures that are designed to maintain quality of services and control	• Q4_MCD_CHP_CNT06 V 08 Provider Selection and Retention (page 3 Letter I) • See copy of letter Description: The Contractor will send the Provider a letter informing the provider of the contractor's decision not to add them to the network.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
costs and are consistent with its responsibilities to members. *42 CFR 438.12(a–b)* CHP+ Contract: Exhibit B—14.4.1, 14.4.1.1–3 Medicaid Contract: Exhibit A—3.2.11.1		
5. The Contractor has a signed contract or participation agreement with each provider. *42 CFR 438.206(b)(1)* CHP+ Contract: Exhibit B—10.1 Medicaid Contract: Exhibit A—2.5.1.1.4	• Q5_ See attached Examples of contrasts	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
6. The Contractor does not employ or contract with providers or other individuals or entities excluded for participation in federal healthcare programs under either Section 1128 or 1128 A of the Social Security Act. *42 CFR 438.214(d)* CHP+ Contract: Exhibit B—19.1.1.1 Medicaid Contract: Exhibit A—3.2.1.7, 3.2.5.14.1	• Q6_ CE04.25 Assessment of Organizational Providers (Page 1 see SCOPE, Page 3and 4 see PROCEDURES and Page 4 see Initial Assessment and Reassessment Application Process) • Q6_ CRE01 V.06 Credentialing and Recredentialing of Practitioners (Page 1 see PURPOSE) Description: Practitioner and Organizational Providers are queried against the OIG & EPLS prior to	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	credentialing, at the time of recredentialing, and on an ongoing basis between credentialing cycles. Please also see Compliance Department Policy and Procedure entitled "CMP04 v.03 Sanction Screening of Individuals, Providers, and Entities," page 5, Item No. 5 entitled "Contracted Entities/Vendors," sub-paragraph iii.	
7. The Contractor may not knowingly have a director, officer, partner, employee, consultant, provider, subcontractor, or owner (owning 5 percent or more of the Contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549. *42 CFR 438.610* CHP+ Contract: Exhibit B—19.1.1, 19.1.2 Medicaid Contract: Exhibit A—3.2.5.14.1, 3.2.5.14.2	• Please see Compliance Department Policy and Procedure entitled "CMP04 v.03 Sanction Screening of Individuals, Providers, and Entities," page 1, Policy Statement, 2nd paragraph	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: • The member's health status, medical care, or treatment options—including any alternative treatments that may be self-administered. • Any information the member needs in order to decide among all relevant treatment options.	• Q8_ CHP Handbook_ Your Rights (Page 14) • Q8_ GVT02v.07 Member Rights and Responsibilities • Q8_ Medicaid Member Handbook_ Your Rights (Page 14)	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The risks, benefits, and consequences of treatment or non-treatment. • The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. *42 CFR 438.102(a)(1)* CHP+ Contract: Exhibit B—10.4.3 Medicaid Contract: Exhibit A—2.5.3.3		
9. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: • To the State upon contracting or when adopting the policy during the term of the contract. • To members before and during enrollment. • To members within 90 days after adopting the policy with respect to any particular service. *42 CFR 438.102(b)* CHP+ Contract: Exhibit B—14.1.3.14, Exhibit K—1.1.7 Medicaid Contract: Exhibit A—2.4.1.5	• N/A. Denver Health Medicaid Choice does not object to providing a service on moral or religious grounds. • Medicaid Choice Contract: Moral and Religious Grounds	**CHP+:** ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A **Medicaid:** ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor has administrative and management arrangements or procedures, including a compliance program to detect and prevent fraud, waste, and abuse, and which includes: • Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal, State, and contract requirements. • The designation of a compliance officer who is responsible for developing and implementing policies, procedures and practices to ensure compliance with requirements of the contract and who reports directly to the CEO and Board of Directors. • The establishment of a compliance committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program. • Training and education of the compliance officer, management, and organization's staff members for the federal and State standards and requirements under the contract. • Effective lines of communication between the compliance officer and the Contractor's employees. • Enforcement of standards through well-publicized disciplinary guidelines. • Implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks.	The following documents address the administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse: • Corporate Compliance Plan • Code of Conduct • Fraud and Abuse Prevention Plan • Fraud, Waste, and Abuse Policy; • Memorandum of Understanding between Denver Health and Hospital Authority and Denver Health Managed Care Division • Corporate Compliance Committee Charter • Compliance_FWA Investigation and Root Cause Analysis Form	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Procedures for prompt response to compliance issues as they are raised, investigation of of potential compliance problems identified in the course of self-evaluation and audits, corection of such problems quickly and thoroughly to reduce the potential for reoccurence, and ongoing compliance with the requirements under the contract. *42 CFR 438.608(a)(1)* CHP+ Contract: Exhibit B—14.2.5.2–4, 14.2.7.3–9 Medicaid Contract: Exhibit A—3.2.5.3, 3.2.5.5.1–2, 3.2.5.6, 3.2.5.9, 3.2.5.10, 3.2.5.11		
11. The Contractor's administrative and management procedures to detect and prevent fraud, waste, and abuse include: • Written policies for all employees, contractors or agents that provide detailed information about the False Claims Act, including the right of employees to be protected as whistleblowers. • Provisions for prompt referral of any potential fraud, waste, or abuse to the State Medicaid program integrity unit and any potential fraud to the State Medicaid Fraud Control Unit. • Provisions for suspension of payments to a network provider for which the State determines there is credible allegation of fraud (in accordance with 455.12.) *42 CFR 438.608(a)(6–8)* CHP+ Contract: Exhibit B—14.2.6.1, 14.2.7.1, 14.2.7.7 Medicaid Contract: Exhibit A—3.2.5.8, 3.2.5.12, 3.2.5.15	• Fraud and Abuse Prevention Plan • Fraud, Waste, and Abuse Policy (FWA01 v.14) • DHMP Subcontractor Compliance Guide	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor's compliance program includes: • Provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potential fraud. • Screening all provider claims, collectively and individually, for potential fraud, waste, or abuse—including mechanisms to identify and report suspected instances of up-coding, unbundling of services, services that were billed for but never rendered, and inflated bills for services and goods provided. • Provision for prompt notification to the State about member circumstances that may affect the member's eligibility, including change in residence and member death. • Provision for notification to the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including termination of the provider agreement with the Contractor. • Provision for a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. *42 CFR 438.608(a)(2–5)* CHP+ Contract: Exhibit B—14.2.5.4.3–8 Medicaid Contract: Exhibit A—3.2.5.4, 3.2.5.5.3, 3.2.5.5.4–6, 2.3.5.9.1, 2.3.5.6.1, 3.2.5.5.7, 3.2.5.5.5, 3.2.5.5.12, 3.2.5.14.4, 3.2.9.1	• Q_12 MCD_CHP_CNT06 v 08 Provider Selection and Retention (page 3 Letter K) • Fraud, Waste, and Abuse Policy (FWA01 v.14) • Recipient Verification of Services Policy	**CHP+:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: DHMC/P did not demonstrate a documented process for promptly reporting to the Department all overpayments identified or recovered, specifying which overpayments are due to potential fraud. Additionally, during the interview session, staff members indicated that they were only aware of overpayments occurring when a provider submitted an overpayment check. While DHMC/P has contracted with a vendor (LexisNexis) to conduct future screenings of all provider claims for potential fraud, waste, or abuse, including suspected instances of up-coding, unbundling of services, services billed for but never rendered, and inflated bills for services and goods, DHMC/P could not demonstrate a current process for identifying, investigating, and reporting these types of issues during the time period under review. Additionally, DHMC/P was unable to demonstrate documented processes for notifying the Department about changes in a network provider's circumstances that could affect that provider's eligibility to participate in the managed care program, including termination of the provider agreement. DHMC/P did provide evidence to support a mechanism for verifying whether or not services were delivered by network providers to members and explained the process for notifying the Department about changes in member circumstances that could affect that member's eligibility.		
Required Actions: DHMC/P must have mechanisms in place for promptly reporting all overpayments identified or recovered due to potential fraud; screening all provider claims for potential fraud, waste, or abuse; and notifying the Department about changes in a network provider's circumstances that could affect that provider's eligibility to participate in the Medicaid managed care program.		
13. **The Contractor ensures that all network providers are enrolled with the State as providers consistent with the provider disclosure, screening, and enrollment requirements of the State.** *42 CFR 438.608(b)* CHP+ Contract: N/A Medicaid Contract: (Not found)	• Q13_ DOP	**CHP+:** ☒ Met ☐ Not Scored **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor has procedures to provide to the State: • Written discosure of any prohibited affiliation (as defined in 438.610). • Written disclosure of ownership and control (as defined in 455.104). • Identification within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract. *42 CFR 438.608(a–c)* CHP+ Contract: 21.B, Exhibit B—19.4.1, 19.1.1.1 Medicaid Contract: Exhibit A—5.2.2, 5.2.6.1	CMP15 v.06 Conflicts of Interest Policy	**CHP+:** ☐ Met ☐ Partially Met ☒ Not Met ☐ N/A **Medicaid:** ☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: DHMC/P submitted its Conflict of Interest policy, which did not provide evidence of compliance with providing the Department with written disclosures of any prohibited affiliations as defined in 438.610, written disclosure of ownership and control, as defined in 455.104, or mechanisms for identifying within 60 calendar days any capitation payments or other payments in excess of the amounts specified in the contract. Additionally, DHMC/P could not demonstrate mechanisms for ensuring that providers were aware of their obligations to report prohibited affiliations, disclose ownership and control, and report payments made for more than the amounts specified in the contract.		
Required Actions: DHMC/P must have documented procedures for notifying the Department of the following: • Written discosure of any prohibited affiliation (as defined in 438.610) • Written disclosure of ownership and control (as defined in 455.104) • Identification within 60 calendar days of any capitation payments or other payments made for more than the amounts specified in the contract		

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The Contractor has a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days of identifying the overpayment, and to notify the Contractor in writing of the reason for the overpayment. • The Contractor reports annually to the State on recoveries of overpayments. *42 CFR 438.608 (d)(2) and (3)* CHP+ Contract: (Not found) Medicaid Contract: Exhibit A—2.6.2.5.6, 3.2.5.4	MCD_CHP_CLM10 v. 01 describes the overpayment process	**CHP+:** ☐ Met ☐ Partially Met ☒ Not Met ☐ N/A **Medicaid:** ☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: The Provider Refund policy described the process for handling provider refund checks and associated claims but did not describe how network providers were made aware of the requirement to report overpayments and the process for reporting overpayments. Additionally, no evidence was presented to support that the Department was notified annually of any recoveries of overpayments.		
Required Actions: DHMC/P must have mechanisms in place for ensuring that network providers report to DHMC/P when they have received an overpayment, return the overpayment to DHMC/P within 60 calendar days of its identification as such, and notify DHMC/P in writing of the reason for the overpayment. DHMC/P must also report annually to the Department on recoveries of overpayments.		
16. The Contractor provides that members are not held liable for: • The Contractor's debts in the event of the Contractor's insolvency. • Covered services provided to the member for which the State does not pay the Contractor. • Covered services provided to the member for which the State or the Contractor does not pay the health care provider that furnishes the services under a contractual, referral, or other arrangement. • Payments for covered services furnished under a contract, referral, or other arrangement to the extent that	Standard provider agreement contains provision	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. *42 CFR 438.106* CHP+ Contract: Exhibit B—16.4.1–4 Medicaid Contract: Exhibit A—2.2.9		

Note: While the scoring of evidence related to individual, new federal requirements in the tool may indicate *Met* or *Not Scored*, all new requirements were scored *Not Applicable* in the total results; new federal requirements do not apply to CHP+ until July 1, 2018.

CHP+ Results for Standard VII—Provider Participation and Program Integrity							
Total	Met	=	11	X	1.00	=	11
	Partially Met	=	1	X	.00	=	0
	Not Met	=	2	X	.00	=	0
	Not Applicable	=	2	X	NA	=	NA
Total Applicable		=	14	**Total Score**		=	11
				Total Score ÷ Total Applicable		=	79%

Medicaid Results for Standard VII—Provider Participation and Program Integrity							
Total	Met	=	12	X	1.00	=	12
	Partially Met	=	1	X	.00	=	0
	Not Met	=	2	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	15	**Total Score**		=	12
				Total Score ÷ Total Applicable		=	80%

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. **Notwithstanding any relationship(s) with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State.** The Contractor must: • Evaluate the prospective subcontractor's ability to perform the activities to be delegated. • Implement written procedures to monitor the subcontractor's performance on an ongoing basis. • Identify deficiencies or areas for improvement, and ensure that the subcontractor takes corrective action. *42 CFR 438.230(b)(1)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—2.2.1, 2.2.2, 2.2.4, 2.2.5	• Subcontractor Oversight Evaluation Form • DHMP_DHMC Subcontractor Management and Oversight Program	**CHP+:** ☐ Met ☒ Not Scored **Medicaid:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: DHMC/P's Subcontractor/Delegated Entity First Tier, Downstream & Related Entity (FDR) Compliance Guide (dated 2016) and its Subcontractor Management and Oversight Program (no date) documents stated that DHMC/P maintained ultimate responsibility for all delegated activities. The documents described the process for pre-delegation review of all potential subcontractors to ensure the subcontractor's ability to perform the activities to be delegated. The documents also required that DHMC/P management staff members perform, at least annually, a reassessment to ensure that the subcontractor maintains its ability to fulfill contractual obligations and to meet all applicable federal and State laws and regulations. DHMC/P required ongoing review of compliance with contractual requirements, prompt response to identified deficiencies, and "periodic" reporting of each subcontractor's performance to the Compliance Committee. DHMC/P provided a subcontractor oversight evaluation form that may be used by DHMC/P management to evaluate the performance of subcontractors. While DHMC/P provided evidence of having written procedures for pre-delegation review, ongoing monitoring, and implementing corrective actions to address identified deficiencies, staff members were unable to demonstrate that these processes are implemented for all subcontractors. At the time of the site review, DHMC/P staff described a recent initiative to: reconcile its list of subcontractors, identify staff members responsible for oversight, and track ongoing and formal monitoring of each delegate.		

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
CHP+ Recommendations: DHMP is encouraged to complete its process of identifying all subcontractors, tracking ongoing monitoring of delegated activities, and requiring that subcontractors take corrective action to mitigate identified deficiencies or areas of improvement. HSAG suggests that DHMP carefully review its Subcontractor/Delegated Entity FDR Compliance Guide and its Subcontractor Management and Oversight Program and implement the program described, or revise these documents to describe the new process for ensuring compliance with federal and State requirements.		
Medicaid Required Actions: DHMC must subject all potential subcontractors to a pre-delegation assessment to ensure that the organization is qualified and capable of performing the tasks to be delegated. DHMC must also ensure ongoing and formal monitoring of every subcontractor and require corrective actions to mitigate any identified deficiencies or areas of improvement.		
2. All contracts or written arrangements between the Contractor and any subcontractor specify: • The delegated activities **or obligations** and related reporting responsibilities. • **That the subcontractor agrees to perform the delegated activities and reporting responsibilities.** • Provision for revocation of the delegation of activities or obligation, or **specify other remedies in instances where the State or Contractor determines** that the subcontractor has not performed satisfactorily. *42 CFR 438.230(b)(2) and (c)(1)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—2.2.2, 2.2.3	Note: Subcontractor requirements do not apply to network provider agreements.	**CHP+:** ☐ Met ☒ Not Scored **Medicaid:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: DHMC/P's contract with MedImpact detailed the delegated activities and required that MedImpact submit numerous reports, with frequencies ranging from weekly to annually. The contract is signed and dated to demonstrate that MedImpact agreed to perform the delegated activities and comply with the reporting requirements. The contract required that MedImpact design and implement corrective action plans to address any		

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
identified deficiencies. If MedImpact fails to develop and/or implement a required corrective action plan, DHMC/P may revoke delegation of the activity that is subject to the corrective action plan. While the MedImpact contract included the required provisions, DHMC/P was unable to demonstrate that it held written agreements with all subcontracted providers.		
CHP+ Recommendations: DHMP should ensure having, with every subcontractor, a written agreement that includes the delegated activities and related reporting responsibilities and that specifies remedies for instances wherein the State or DHMP determines that the subcontractor fails to meet performance standards. These agreements must be signed to indicate that the subcontractor agrees to perform the delegated activities and agrees to comply with the reporting requirements.		
Medicaid Required Actions: DHMC must have a written agreement with every subcontractor that includes the delegated activities and related reporting responsibilities and that specifies remedies for instances wherein the State or DHMC determines that the subcontractor fails to meet performance standards. These agreements must be signed to indicate that the subcontractor agrees to perform the delegated activities and agrees to comply with the reporting requirements.		
3. The Contractor's written agreement with any subcontractor includes: • **The subcontractor's agreement to comply with all applicable Medicaid laws and regulations, including applicable sub-regulatory guidance and contract provisions.** *42 CFR 438.230(c)(2)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—2.2.2	A copy of a subcontractor written agreement will be produced onsite for review.	**CHP+:** ☐ Met ☒ Not Scored **Medicaid:** ☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: The contract between DHMC/P and MedImpact failed to require compliance with all applicable Medicaid laws and regulations. Additionally, DHMC/P was unable to demonstrate that it held written agreements with all subcontracted providers.		
CHP+ Recommendations: DHMP should ensure having, with every subcontractor, a written agreement that requires the subcontractor to comply with all applicable Medicaid laws and regulations, including applicable sub-regulatory guidance and contract provisions.		

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Medicaid Required Actions: DHMC must have a written agreement with every subcontractor that requires the subcontractor to comply with all applicable Medicaid laws and regulations, including applicable sub-regulatory guidance and contract provisions.		
4. The written agreement with the subcontractor includes: • **The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State.** – **The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, and computer or other electronic systems related to CHP+ members.** – **The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.** – **If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.** *42 CFR 438.230(c)(3)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—2.2.8, 2.6.6.2	Denver Health and Hospital Authority Provider Services Agreement – standard template, Article 9 "General Provisions, Item No. 9.23	**CHP+:** ☐ Met ☒ Not Scored **Medicaid:** ☐ Met ☐ Partially Met ☒ Not Met ☐ N/A

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The contract between DHMC/P and MedImpact failed to include the provisions related to 42 CFR 438.230(c)(3). Additionally, DHMC/P was unable to demonstrate that it held written agreements with all subcontracted providers.		
CHP+ Recommendations: DHMP should ensure having, with every subcontractor, a written agreement that includes the provisions related to 42 CFR 438.230(c)(3).		
Medicaid Required Actions: DHMC must have a written agreement with every subcontractor that includes the provisions related to 42 CFR 438.230(c)(3).		

Note: While the scoring of evidence related to individual, new federal requirements in the tool may indicate *Met* or *Not Scored*, all new requirements were scored *Not Applicable* in the total results; new federal requirements do not apply to CHP+ until July 1, 2018.

CHP+ Results for Standard IX—Subcontracts and Delegation							
Total	Met	=	0	X	1.00	=	0
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	4	X	NA	=	NA
Total Applicable		=	0	**Total Score**		=	NA
				Total Score ÷ Total Applicable		=	NA

Medicaid Results for Standard IX—Subcontracts and Delegation							
Total	Met	=	0	X	1.00	=	0
	Partially Met	=	2	X	.00	=	0
	Not Met	=	2	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	4	**Total Score**		=	0
				Total Score ÷ Total Applicable		=	0%

Appendix B. Record Review Tools

The completed record review tools follow this cover page.

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Appeals Record Review Tool
for Denver Health Medical Plans

Review Period:	July 1, 2017–October 15, 2017
Date of Review:	November 7, 2017
Reviewer:	Lee Ann Dougherty and Rachel Henrichs
Participating Health Plan Staff Member:	Marques Haley and Ramona Lopez

1	2	3	4	5	6	7	8	9	10	11	12
File #	**Member ID #**	**Date Appeal Received**	**Acknowledgment Sent Within 2 Working Days**	**Decision Maker Not Previous Level**	**Decision Maker Has Clinical Expertise**	**Expedited**	**Time Frame Extended**	**Date Resolution Letter Sent**	**Notice Sent Within Time Frame**	**Resolution Letter Includes Required Content**	**Resolution Letter Easy to Understand**
1	****	9/25/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	10/2/17	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: DHMP's resolution letter included narrative from the third-party reviewer, including the member's entire medical history documentation. The contents of the letters must be summarized to be clear and written at the appropriate level for members to understand.											
2			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
3			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
4			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
5			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
6			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
7			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
8			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
9			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
10			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Appeals Record Review Tool
for Denver Health Medical Plans

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
OS1			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS2			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS3			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS4			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS5			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
Do not score shaded columns below.											
Column Subtotal of Applicable Elements			**1**	**1**	**1**				**1**	**1**	**1**
Column Subtotal of Compliant (M) Elements			**1**	**1**	**1**				**1**	**1**	**0**
Percent Compliant (Divide Compliant by Applicable)			**100%**	**100%**	**100%**				**100%**	**100%**	**0%**

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

Total Applicable Elements	**6**
Total Compliant (M) Elements	**5**
Total Percent Compliant	**83%**

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Grievance Record Review Tool
for Denver Health Medical Plans

Review Period:	July 1, 2017–December 31, 2017
Date of Review:	November 7, 2017
Reviewer:	Lee Ann Dougherty and Rachel Henrichs
Participating Health Plan Staff Member:	NA—DHMP reported no grievances during the review period.

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame	Decision Maker Not Previous Level (If Clinical)	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
1			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
2			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
3			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
4			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
5			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
6			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
7			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
8			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
9			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
10			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Grievance Record Review Tool
for Denver Health Medical Plans

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame	Decision Maker Not Previous Level (If Clinical)	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
OS 1			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 2			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 3			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 4			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 5			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
Do not score shaded columns below.										
Column Subtotal of Applicable Elements										
Column Subtotal of Compliant (Yes) Elements										
Percent Compliant (Divide Compliant by Applicable)										

Key: Y = Yes; N = No
N/A = Not Applicable

Total Applicable Elements	**N/A**
Total Compliant (Yes) Elements	**N/A**
Total Percent Compliant	**N/A**

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Appeals Record Review Tool
for Denver Health Medicaid Choice

Review Period:	July 1, 2017–December 31, 2017
Date of Review:	November 7, 2017
Reviewer:	Lee Ann Dougherty and Rachel Henrichs
Participating Health Plan Staff Member:	Marques Haley and Ramona Lopez

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
1	****	7/17/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☐	7/26/17	M ☒ N ☐	M ☐ N ☒	M ☒ N ☐
Comments: The acknowledgment letter incorrectly informed members that they could file State fair hearings (members must wait for an appeal resolution before requesting a State fair hearing). Additionally, the resolution letter stated that members had 60 days to file a State fair hearing (members have 120 days to file a State fair hearing).											
2	****		M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: This record was included with the appeals record review; however, since this issue is related to a member being balance-billed by a provider, it should have been processed by DHMC as a grievance.											
3	****		M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: This record was included with the appeals record review; however, since this issue is related to a claims issue (due to a member record erroneously logging the member as ineligible) it should have been processed by DHMC as a grievance.											
4	****	8/22/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒		M ☒ N ☐	M ☐ N ☒	M ☒ N ☐
Comments: The resolution letter sent to the member contained outdated language. The "When Am I Able to Ask for a State Fair Hearing?" section must be updated with current requirements.											
5	****		M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: This record was included with the appeals record review; however, it should have been processed by DHMC as a grievance. The provider did not submit the claim within the timely filing period, and the member should not have been held responsible for payment of a claim.											
6	****		M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: This record was included with the appeals record review; however, it should have been processed by DHMC as a grievance. Member complained that she was billed for an out-of-network claim.											
7	****		M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: This record was included with the appeals record review; however, it should have been processed by DHMC as a grievance. Member complained that she was billed for a mammogram.											

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
8	****		M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: This record was included with the appeals record review; however, it should have been processed by DHMC as a Medicare appeal and not included on the Medicaid appeal file.											
9	****	9/29/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒		M ☒ N ☐	M ☐ N ☒	M ☒ N ☐
Comments: The resolution letter sent to the member contained outdated language. The letter must be updated with current requirements, including time frames specific to the State fair hearing process.											
10	****	10/11/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	10/19/17	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: DHMC's resolution letter contained updated time frames and current language based on the updated Managed Care Final Rule requirements. For this case, DHMC sent the appeal to a third-party reviewer for clinical decision making. The resolution letter contained narrative from the consultant, including the member's medical history, which could be confusing to the member. DHMC must ensure that the resolution letter contains information which may be easily understood by the member.											

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Appeals Record Review Tool
for Denver Health Medicaid Choice

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
OS1	****		M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: This record was included with the appeals record review; however, this appeal was outside the time frame for the review.											
OS2	****		M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: This record was included with the appeals record review; however, this appeal was outside the time frame for the review.											
OS3			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS4			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS5			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
Do not score shaded columns below.											
Column Subtotal of Applicable Elements			**4**	**4**	**4**				**4**	**4**	**4**
Column Subtotal of Compliant (M) Elements			**4**	**4**	**4**				**4**	**1**	**3**
Percent Compliant (Divide Compliant by Applicable)			**100%**	**100%**	**100%**				**100%**	**25%**	**75%**

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

Total Applicable Elements	**24**
Total Compliant (M) Elements	**20**
Total Percent Compliant	**83%**

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Grievance Record Review Tool
for Denver Health Medicaid Choice

Review Period:	July 1, 2017–December 31, 2017
Date of Review:	November 7, 2017
Reviewer:	Lee Ann Dougherty and Rachel Henrichs
Participating Health Plan Staff Member:	Marques Haley and Ramona Lopez

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame	Decision Maker Not Previous Level (If Clinical)	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
1	****	7/17/17	Y ☒ N ☐ N/A ☐	7/17/17	0	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments: DHMC sent a combined acknowledgement and resolution letter within required time frames.										
2	****	7/19/17	Y ☒ N ☐ N/A ☐	7/28/17	7	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments: The sent date on the resolution letter was documented incorrectly; however, DHMC provided evidence that the resolution letter was sent timely.										
3	****	8/16/17	Y ☒ N ☐ N/A ☐	8/23/17	5	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments: DHMC should review resolution letters prior to sending to members to ensure that no typographical errors exist.										
4	****	8/22/17	Y ☒ N ☐ N/A ☐	8/31/17	7	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments: None.										
5	****	9/29/17	Y ☒ N ☐ N/A ☐	10/13/17	11	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments: DHMC should review resolution letters prior to sending to members to ensure that no typographical errors exist.										
6	****	10/9/17	Y ☒ N ☐ N/A ☐	10/10/17	1	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments: DHMC sent a combined acknowledgement and resolution letter within required time frames.										
7	****	8/9/17	Y ☒ N ☐ N/A ☐	8/16/17	5	Y ☒ N ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☐ N/A ☒
Comments: DHMC should review its Quality of Care Complaints (QOCC) process to ensure that quality of care-related grievances are closed within required grievance timelines. The grievance resolution letter should notify the member that the quality of care issue is being reviewed and investigated, as appropriate. While DHMC indicated that the QOCC was not closed at the time of this review, DHMC had notified the member that the issue was being reviewed with appropriately qualified medical staff.										
8			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
9			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
10			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Grievance Record Review Tool
for Denver Health Medicaid Choice

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame	Decision Maker Not Previous Level (If Clinical)	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
OS 1			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 2			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 3			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 4			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 5			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
Do not score shaded columns below.										
Column Subtotal of Applicable Elements			**7**			**7**	**1**	**1**	**7**	**6**
Column Subtotal of Compliant (Yes) Elements			**7**			**7**	**1**	**1**	**7**	**6**
Percent Compliant (Divide Compliant by Applicable)			**100%**			**100%**	**100%**	**100%**	**100%**	**100%**

Key: Y = Yes; N = No
N/A = Not Applicable

Total Applicable Elements	**29**
Total Compliant (Yes) Elements	**29**
Total Percent Compliant	**100%**

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2017–2018 site review of **DHMC** and **DHMP**.

Table C-1—HSAG Reviewers and DHMC/DHMP and Department Participants

HSAG Review Team	Title
LeeAnn Dougherty	Director, State and Corporate Services
Rachel Henrichs	EQR Compliance Auditor
DHMC/DHMP Participants	**Title**
Cailey Chrissinger	Government Products Analyst
Elizabeth England	Director, Utilization Management
Jeffery Cole	Supervisor, Member Services
Keri Gottlieb	Provider Relations/Contracting Manager
Lorna Pate	Compliance and Privacy Officer
Marina Mourzina	Managed Care Compliance Auditor
Marques Haley	Grievance and Appeals Manager
Mary Fischer	Director, Claims
Michael Robinson	Director, Government Products
Michael Wagner	Chief Administrative Officer
Michelle Anderson	Director, Pharmacy
Natalie Score	Manager, Government Products
Norma Stiglich	Medical Director
Patricia Williams	Claims Manager
Ramona Lopez	Lead Grievance and Appeals Specialist
Reina Gordon	Manager, Provider Credentialing
Rhonda Muschim	Finance Manager
Theresa Foster	Operations Manager, Member Services
Department Observers	**Title**
Chris Tzortzis	Contract Manager
Patricia Connally	Quality Improvement
Teresa Craig	Program and Contract Manager, CHP+

Appendix D. Corrective Action Plan Template for FY 2017–2018

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

Table D-1—Corrective Action Plan Process

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

Step	Action
Step 5	**Technical Assistance**
	HSAG will schedule with the health plan a one-time, interactive, verbal consultation and technical assistance session during the six-month time frame. The session may be scheduled at the health plan's discretion at any time the health plan determines would be most beneficial. HSAG will not document results of the verbal consultation in the CAP document.
Step 6	**Review and completion**
	Following a review of the CAP and all supporting documentation, the Department or HSAG will inform the health plan as to whether or not the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements. Any documentation that is considered unsatisfactory to complete the CAP requirements at the six-month deadline will result in assignment as a delinquent corrective action that will be continued into the following compliance review year. (HSAG will list delinquent actions in the annual technical report and the health plan's subsequent year's compliance site review report.)

The CAP template follows.

HSAG and the Department remind Denver Health that its CHP+ line of business must also be compliant with requirements marked as "Medicaid Only" no later than July 1, 2018.

Table D-2—FY 2017–2018 Corrective Action Plan for DHMC and DMHP

Standard V—Member Information—Medicaid Only		
Requirement	**Findings**	**Required Action**
5. Written materials that are critical to obtaining services include: provider directories, member handbooks, appeal and grievance notices, and denial and termination notices. All written materials for members must: • Use a font size no smaller than 12 point. • Be available in alternative formats and through provision of auxiliary aids and service that takes into consideration the special needs of members with disabilities or limited English proficiency. • Include taglines in large print (18 point) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service number, and availability of materials in alternative formats.	DHMC's Creation, Review, and Readability of Member Materials policy required that member materials be written in a font size no smaller than 12 points, be available in alternative formats and through provision of auxiliary aids and services, and include taglines in large print (18 point) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service number. While most member materials reviewed complied with these requirements, some documents (e.g., member complaint and appeal form, template letter to notify members about terminated providers) were missing the large-print tag line.	DHMC must ensure that all critical member communications include the large-print tag line informing members how to request auxiliary aids and services.

Standard V—Member Information—Medicaid Only		
Requirement	**Findings**	**Required Action**
42 CFR 438.10(d)(3) and (d)(6)(ii–iv) CHP+ Contract: N/A Medicaid Contract: Exhibit A—2.5.6.3.5, 2.5.6.3.7, 2.5.6.3.12-13, 3.1.1.4.4, 3.1.2.1.7		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard V—Member Information—Medicaid Only		
Requirement	**Findings**	**Required Action**
6. If the Contractor makes information available electronically—Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of readily accessible above). • The information is placed in a Web site location that is prominent and readily accessible. • The information can be electronically retained and printed. • The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge upon request, and is provided within 5 business days. *42 CFR 438.10(c)(6)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—3.1.1.4.2	The forms and documents on the DHMC website were placed in prominent locations, could be electronically retained and printed, and complied with content and language requirements. The member handbook and provider directory inform members that the documents are available in hard copy, free of charge, and within 5 days—including a telephone number members may call to get a copy. HSAG used the Adobe Acrobat Pro accessibility checker to test the CHP+ and Medicaid member handbooks, provider directories, winter 2017 newsletter, and Medicaid Member Complaint and Appeal form. The Adobe checker noted several accessibility errors related to each document. Additionally, WAVE Web Accessibility Evaluation Tool identified several issues with the Denver Health Medicaid Choice and Denver Health Medical Plan websites.	DHMC must develop a process to ensure that all information available on its websites is readily accessible (i.e., complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines). HSAG also suggested that DHMC state on its website that information is available in paper form without charge upon request.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard V—Member Information—Medicaid Only		
Requirement	**Findings**	**Required Action**
13. The Contractor makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, pharmacies, and behavioral health providers, and long-term services and supports (LTSS) providers: • The provider's name and group affiliation, street address(es), telephone number(s), Web site URL, specialty (as appropriate), and whether the providers will accept new members. • The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training. • Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment. *(Note: Information included in a paper provider directory must be updated at least monthly, and electronic provider*	DHMC's Required Provider Directory Information policy stated that provider directories must be updated at least monthly and available in paper copy, and delineated the information that must be included. The CHP+ and Medicaid provider directories listed the names, location, telephone number, and linguistic capabilities of contracted providers. The directories described accommodations available for persons with physical disabilities (including deaf, hard of hearing, and blind) and how to request these services. The provider directories failed to designate which providers had completed cultural competency training. Additionally, while DHMC/P described numerous resources available to accommodate person with physical disabilities, it failed to designate locations with accessible medical diagnostic equipment (e.g., height-adjustable examination tables, weight scales, mammography equipment, x-ray machines).	DHMC must revise its provider directory to designate which providers have completed cultural competency training and identify office locations that have accessible medical diagnostic equipment. DHMC should also update applicable policies and procedures that list required content of the provider directories to include these items.

Standard V—Member Information—Medicaid Only		
Requirement	**Findings**	**Required Action**
directories must be updated no later than 30 calendar days after the Contractor receives updated provider information.) *42 CFR 438.10(h)(1–3)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—3.1.1.3.2–3		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard V—Member Information—Medicaid Only		
Requirement	**Findings**	**Required Action**
15. For any information provided to members by the Contractor, the Contractor ensures that information is consistent with federal requirements in 42 CFR 438.10. *42 CFR 438.10 (b)*	The Department assumed responsibility for the development and distribution of the Health First Colorado Member Handbook, thereby waiving the member handbook requirements for contracted Medicaid managed care plans. However, DHMC opted to continue producing and distributing a Medicaid member handbook to ensure communication of information specific to DHMC members. The Denver Health Medicaid member handbook included inaccurate time frames for filing grievances and appeals and incorrectly stated that members may request State fair hearings before completing the health plan appeals process.	DHMC must revise its Medicaid member handbook to include accurate time frames for filing grievances (any time) and appeals (60 days after the notice of adverse benefit determination). The handbook must also clarify that members must exhaust the DHMC appeals process before requesting a State fair hearing. HSAG also suggested that DHMC clarify that continuation of benefits applies only to services that DHMC terminates, suspends, or reduces.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard V—Member Information—CHP+ Only		
Requirement	**Findings**	**Required Action**
19. The member handbook provided to members following enrollment includes the following information regarding the grievance, appeal, and fair hearing procedures and timeframes: • The right to file grievances and appeals. • The requirements and timeframes for filing a grievance or appeal. • The right to a request a State fair hearing after the Contractor has made a determination on a member's appeal which is adverse to the member. • The availability of assistance in the filing process. • The fact that, when requested by the member: – Benefits that the Contractor seeks to reduce or terminate will continue if the member file an appeal or a request for State fair hearing is filed within the time frames specified for filing. – If benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal or State fair hearing is pending if the final	The CHP+ handbook included members' rights and processes to file a grievance, appeal, or State fair hearing; informed members that its Member Services staff is available to assist with the filing process; included the circumstances under which a member may request continuation of benefits; and expressed circumstances under which the member would have to pay for services continued during an appeal and/or State fair hearing. The CHP+ handbook included inaccurate time frames for filing grievances and appeals and incorrectly stated that members may request State fair hearings before completing the health plan appeals process.	DHMP must revise its CHP+ member handbook to include accurate time frames for filing grievances (any time) and appeals (60 days after the notice of adverse benefit determination). The handbook must also clarify that members must exhaust the DHMP appeals process before requesting a State fair hearing. HSAG also suggested that Denver Health clarify that continuation of benefits applies only to services that DHMP terminates, suspends, or reduces.

Standard V—Member Information—CHP+ Only		
Requirement	**Findings**	**Required Action**
decision is adverse to the member. *42 CFR 438.10(g)(2)(xi)* CHP+ Contract: Exhibit B—1.1.16.6, 1.1.16.6.1, 1.1.16.6.3 Medicaid Contract: Exhibit A—3.1.1.3.6 and Exhibit F—13		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard V—Member Information—CHP+ Only		
Requirement	**Findings**	**Required Action**
21. The member handbook provided to members following enrollment includes: • That cost-sharing, if any, is imposed under the State plan. • How and where to access any benefits that are available under the State plan but not covered under the CHP+ managed care contract. • How transportation is provided. *42 CFR 438.10(g)(2)(ii, viii)* CHP+ Contract: Exhibit K—1.1.3 Medicaid Contract: Exhibit A—3.1.1.3.6, 3.1.1.4.3.7, 2.4.4.9.1 and Exhibit F—18, 19, and 32	The CHP+ handbook described instances in which a member may be required to pay for services. The handbook also described wraparound benefits; however, it included no information about how to access these services or where to learn more about them.	DHMP must revise its member handbook to inform members how to access benefits available under the State plan but not covered by the DHMP CHP+ managed care contract.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance System—Medicaid Only		
Requirement	**Findings**	**Required Action**
1. The Contractor has established internal grievance procedures under which members, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance. The Contractor must have a grievance and appeal system in place to handle appeals of an adverse benefit determination and grievances, as well as processes to collect and track information about them. • The Contractor may have only one level of appeal for members (or providers acting on their behalf). • A member may request a State fair hearing after receiving an appeal resolution notice from the Contractor that the adverse benefit determination has been upheld. • If the Contractor fails to adhere to required timeframes for processing appeals, the member is deemed to have exhausted the Contractor's appeal process and the member may initiate a State fair hearing. *42 CFR 438.400(a)(3)* *42 CFR 438.402(a-c)* *42 CFR 438.400(b)* CHP+ Contract: N/A	While DHMC submitted processes and procedures related to the grievance system, HSAG noted concerns with both the Grievance Process policy and the Appeals Process policy. First, while both had effective dates of July 1, 2017, these policies were not signed by staff with approval authority until November 10, 2017. The Grievance Process policy emphasized that the purpose of the policy was for the Grievance and Appeal Department to follow established Company grievance processes but did not include other Company staff members' accountability for handling grievances. The Grievance Process policy, Section VI(A), also indicated that the company had a data tracking system to log, process, track, and trend all member appeals. DHMC demonstrated the system used to maintain all written documentation, including the nature and substance of each grievance, receipt date, actions taken, any results, and resolution date. This language demonstrated inconsistencies in the policy; this policy was applicable only to the Grievance process. Additionally, while the Appeals Process policy indicated, "the Company maintains a standard and an expedited appeals process, which consists of only one level of appeal," the Appeals Process policy under Attachment 6—Appeal Investigation Worksheet included information regarding the 2nd-level appeals process. For Medicaid programs, managed care plans are prohibited from having more than one level of appeal for members. This policy is applicable to	DHMC must update policies and procedures, including all appendices and attachments, with language in compliance with the Medicaid managed care rule and all associated State and program contract requirements. Additionally, DHMC must ensure that all staff members are aware of and have mechanisms in place for appropriately managing appeals and grievances. DHMC must also ensure that policies and procedures are updated timely in accordance with all federal, State, and program rule changes.

Standard VI—Grievance System—Medicaid Only		
Requirement	**Findings**	**Required Action**
Medicaid Contract: Exhibit A—3.1.2.1.1-2, 3.1.2.7.1-2 10 CCR 2505-10—8.209.3.A, 8.209.4.A.2.c, 8.208.4.N, 8.209.4.O	Medicaid programs; therefore, the attachments must clearly demonstrate the requirements for Medicaid appeals. Additionally, both the Grievance Process and Appeals Process policies included outdated attachments. DHMC must ensure that policies and procedures, including all attachments and appendices, include current requirements. Finally, through the file reviews, DHMC demonstrated inaccuracies in the processing of appeals. Five of 10 appeal cases reviewed were deemed grievances and should have followed grievance timelines and requirements for resolution. Additionally, few grievances were tracked by DHMC, which indicated potential issues with reporting and subsequent tracking of member-reported complaints.	
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance System—Medicaid Only		
Requirement	**Findings**	**Required Action**
15. A member may file an appeal with the Contractor **within 60 calendar days** from the date on the adverse benefit determination notice. *42 CFR 438.402(c)(2)(ii)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.4.4.1 10 CCR 2505-10—8.209.4.B	The Appeal Process policy language under the "Procedures" section was compliant with this requirement; however, the Untimely Filing Letter (Attachment 2 to the policy) included inaccurate information. The attachment specifically indicated that the member has "30 calendar days from the date of an incident to file a grievance. DHMC cannot resolve a grievance that is filed thirty (30) calendar days after the incident." Additionally, this Untimely Filing Letter attachment referenced grievance information which does not apply and would be confusing to a member. The policy and all attachments must be updated to apply to the Appeals Process; and the timeline for filing an appeal must be updated to 60 calendar days from the date of the adverse benefit determination. During the on-site review, HSAG confirmed that the current Untimely Filing Letter included appropriate timelines and information.	DHMC's policies related to the appeals process must be updated to include compliant language, including time frames, within which a member may file an appeal with DHMC.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance System—CHP+ and Medicaid		
Requirement	**Findings**	**Required Action**
20. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. *Note: If the written appeal is not signed by the member or designated client representative (DCR), the appeal resolution will remain pending until the appeal is signed. All attempts to gain a signature shall be included in the record of the appeal.* • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)* *42 CFR 438.408(d)(2)* *42 CFR 438.10* CHP+ Contract: Exhibit B—14.1.4.8, 14.1.3.1 Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.4.3, 2.5.6.3.5 10 CCR 2505-10—8.209.4.J(1), 8.209.4.L	The Appeals Process policy was compliant with the timeliness requirement for providing written notice of the appeal disposition. Appeal resolution letters reviewed during the on-site file reviews, however, indicated that content language was not consistently written for ease of comprehension. Specifically, one of the four Medicaid appeals and the single CHP+ appeal reviewed were not written in manners that would be easily understood by members.	DHMC/P must ensure that written notices of appeal resolutions are in formats and language that may be easily understood by members.

Standard VI—Grievance System—CHP+ and Medicaid		
Requirement	**Findings**	**Required Action**
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance System—Medicaid Only		
Requirement	**Findings**	**Required Action**
25. The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of resolution. • If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. *42 CFR 438.408(f)(1–2)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.7.1–2 10 CCR 2505-10—8.209.4.N, 8.209.4.O	The Appeals Process policy under "State Fair Hearings" was compliant with State fair hearing requirements. However, Attachment 11, DHMC_CHP: "What is a State Fair Hearing" contained inaccurate information. Specifically, the attached letter stated that the member does not have to go through the appeals process prior to asking for a State fair hearing. Additionally, the letter stated that the member or designated representative could ask for a State fair hearing within thirty (30) calendar days from the date of the notice of action letter. Additionally, the Standard Appeal Acknowledgment Letter, attached to the Appeals Process policy, included a statement that the member or the member's representative could ask for a State fair hearing without going through the appeals process. During the on-site record review, instances (three of four cases) were noted in which inaccurate information was provided to members in the Appeal Resolution Letter and accompanying attachments; errors involved State fair hearing timelines and when a hearing could be requested. During the on-site review, HSAG confirmed that DHMC/P's current State fair hearing letters included appropriate timelines and information.	The written notice of appeal resolution letter and policies and procedures related to appeal resolution must contain accurate information about when a member or a designated representative may request a State fair hearing.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

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

Standard VI—Grievance System—CHP+ and Medicaid		
Requirement	**Findings**	**Required Action**
35. The Contractor provides the information about the grievance appeal, and fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. – The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member.	The Appeals Process policy stated that a HCPF-approved description of the appeal and State fair hearing procedures and time frames were provided to all providers and subcontractors at the time that the providers/subcontractors entered into contracts with the company. DHMC/P did not provide documentation to support that this process was being implemented.	DHMC/P must have mechanisms in place to ensure that all providers and subcontractors are provided with information about the grievance, appeal, and fair hearing system upon entering into contracts with DHMC/P.

Standard VI—Grievance System—CHP+ and Medicaid		
Requirement	**Findings**	**Required Action**
42 CFR 438.414 *42 CFR 438.10(g)(xi)* CHP+ Contract: Exhibit B—11.1.12 Medicaid Contract: Exhibit A—3.1.2.1.2, 3.1.2.1.8.1–6 10 CCR 2505-10—8.209.3.B		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VII—Provider Participation and Program Integrity—CHP+ and Medicaid		
Requirement	**Findings**	**Required Action**
12. The Contractor's compliance program includes: • Provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potential fraud. • Screening all provider claims, collectively and individually, for potential fraud, waste, or abuse—including mechanisms to identify and report suspected instances of up-coding, unbundling of services, services that were billed for but never rendered, and inflated bills for services and goods provided. • Provision for prompt notification to the State about member circumstances that may affect the member's eligibility, including change in residence and member death. • Provision for notification to the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including termination of the provider agreement with the Contractor. • Provision for a method to verify on a regular basis, by sampling or other methods, whether services represented	DHMC/P did not demonstrate a documented process for promptly reporting to the Department all overpayments identified or recovered, specifying which overpayments are due to potential fraud. Additionally, during the interview session, staff members indicated that they were only aware of overpayments occurring when a provider submitted an overpayment check. While DHMC/P has contracted with a vendor (LexisNexis) to conduct future screenings of all provider claims for potential fraud, waste, or abuse, including suspected instances of up-coding, unbundling of services, services billed for but never rendered, and inflated bills for services and goods, DHMC/P could not demonstrate a current process for identifying, investigating, and reporting these types of issues during the time period under review. Additionally, DHMC/P was unable to demonstrate documented processes for notifying the Department about changes in a network provider's circumstances that could affect that provider's eligibility to participate in the managed care program, including termination of the provider agreement. DHMC/P did provide evidence to support a mechanism for verifying whether or not services were delivered by network providers to members and explained the process for notifying the Department about changes in member circumstances that could affect that member's eligibility.	DHMC/P must have mechanisms in place for promptly reporting all overpayments identified or recovered due to potential fraud; screening all provider claims for potential fraud, waste, or abuse; and notifying the Department about changes in a network provider's circumstances that could affect that provider's eligibility to participate in the Medicaid managed care program.

Standard VII—Provider Participation and Program Integrity—CHP+ and Medicaid		
Requirement	**Findings**	**Required Action**
to have been delivered by network providers were received by members. *42 CFR 438.608(a)(2–5)* CHP+ Contract: Exhibit B—14.2.5.4.3–8 Medicaid Contract: Exhibit A—3.2.5.4, 3.2.5.5.3, 3.2.5.5.4–6, 2.3.5.9.1, 2.3.5.6.1, 3.2.5.5.7, 3.2.5.5.5, 3.2.5.5.12, 3.2.5.14.4, 3.2.9.1		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VII—Provider Participation and Program Integrity—CHP+ and Medicaid		
Requirement	**Findings**	**Required Action**
14. The Contractor has procedures to provide to the State: • Written discosure of any prohibited affiliation (as defined in 438.610). • Written disclosure of ownership and control (as defined in 455.104). • Identification within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract. *42 CFR 438.608(a–c)* CHP+ Contract: 21.B, Exhibit B—19.4.1, 19.1.1.1 Medicaid Contract: Exhibit A—5.2.2, 5.2.6.1	DHMC/P submitted its Conflict of Interest policy, which did not provide evidence of compliance with providing the Department with written disclosures of any prohibited affiliations as defined in 438.610, written disclosure of ownership and control, as defined in 455.104, or mechanisms for identifying within 60 calendar days any capitation payments or other payments in excess of the amounts specified in the contract. Additionally, DHMC/P could not demonstrate mechanisms for ensuring that providers were aware of their obligations to report prohibited affiliations, disclose ownership and control, and report payments made for more than the amounts specified in the contract.	DHMC/P must have documented procedures for notifying the Department of the following: • Written discosure of any prohibited affiliation (as defined in 438.610) • Written disclosure of ownership and control (as defined in 455.104) • Identification within 60 calendar days of any capitation payments or other payments made for more than the amounts specified in the contract
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VII—Provider Participation and Program Integrity—CHP+ and Medicaid		
Requirement	**Findings**	**Required Action**
15. The Contractor has a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days of identifying the overpayment, and to notify the Contractor in writing of the reason for the overpayment. • The Contractor reports annually to the State on recoveries of overpayments. *42 CFR 438.608 (d)(2) and (3)* CHP+ Contract: (Not found) Medicaid Contract: Exhibit A—2.6.2.5.6, 3.2.5.4	The Provider Refund policy described the process for handling provider refund checks and associated claims but did not describe how network providers were made aware of the requirement to report overpayments and the process for reporting overpayments. Additionally, no evidence was presented to support that the Department was notified annually of any recoveries of overpayments.	DHMC/P must have mechanisms in place for ensuring that network providers report to DHMC/P when they have received an overpayment, return the overpayment to DHMC/P within 60 calendar days of its identification as such, and notify DHMC/P in writing of the reason for the overpayment. DHMC/P must also report annually to the Department on recoveries of overpayments.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard IX—Subcontracts and Delegation—Medicaid Only		
Requirement	**Findings**	**Required Action**
1. Notwithstanding any relationship(s) with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. The Contractor must: • Evaluate the prospective subcontractor's ability to perform the activities to be delegated. • Implement written procedures to monitor the subcontractor's performance on an ongoing basis. • Identify deficiencies or areas for improvement, and ensure that the subcontractor takes corrective action. *42 CFR 438.230(b)(1)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—2.2.1, 2.2.2, 2.2.4, 2.2.5	DHMC's Subcontractor/Delegated Entity First Tier, Downstream & Related Entity (FDR) Compliance Guide (dated 2016) and its Subcontractor Management and Oversight Program (no date) documents stated that DHMC maintained ultimate responsibility for all delegated activities. The documents described the process for pre-delegation review of all potential subcontractors to ensure the subcontractor's ability to perform the activities to be delegated. The documents also required that DHMC management staff members perform, at least annually, a reassessment to ensure that the subcontractor maintains its ability to fulfill contractual obligations and to meet all applicable federal and State laws and regulations. DHMC required ongoing review of compliance with contractual requirements, prompt response to identified deficiencies, and "periodic" reporting of each subcontractor's performance to the Compliance Committee. DHMC provided a subcontractor oversight evaluation form that may be used by DHMC management to evaluate the performance of subcontractors. While DHMC provided evidence of having written procedures for pre-delegation review, ongoing monitoring, and implementing corrective actions to address identified deficiencies, staff members were unable to demonstrate that these processes are implemented for all subcontractors. At the time of the site review, DHMC staff described a recent	DHMC must subject all potential subcontractors to a pre-delegation assessment to ensure that the organization is qualified and capable of performing the tasks to be delegated. DHMC must also ensure ongoing and formal monitoring of every subcontractor and require corrective actions to mitigate any identified deficiencies or areas of improvement.

Standard IX—Subcontracts and Delegation—Medicaid Only		
Requirement	**Findings**	**Required Action**
	initiative to: reconcile its list of subcontractors, identify staff members responsible for oversight, and track ongoing and formal monitoring of each delegate.	
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard IX—Subcontracts and Delegation—Medicaid Only		
Requirement	**Findings**	**Required Action**
2. All contracts or written arrangements between the Contractor and any subcontractor specify: • The delegated activities or obligations and related reporting responsibilities. • That the subcontractor agrees to perform the delegated activities and reporting responsibilities. • Provision for revocation of the delegation of activities or obligation, or specify other remedies in instances where the State or Contractor determines that the subcontractor has not performed satisfactorily. *42 CFR 438.230(b)(2) and (c)(1)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—2.2.2, 2.2.3	DHMC's contract with MedImpact detailed the delegated activities and required that MedImpact submit numerous reports, with frequencies ranging from weekly to annually. The contract is signed and dated to demonstrate that MedImpact agreed to perform the delegated activities and comply with the reporting requirements. The contract required that MedImpact design and implement corrective action plans to address any identified deficiencies. If MedImpact fails to develop and/or implement a required corrective action plan, DHMC may revoke delegation of the activity that is subject to the corrective action plan. While the MedImpact contract included the required provisions, DHMC was unable to demonstrate that it held written agreements with all subcontracted providers.	DHMC must have a written agreement with every subcontractor that includes the delegated activities and related reporting responsibilities and that specifies remedies for instances wherein the State or DHMC determines that the subcontractor fails to meet performance standards. These agreements must be signed to indicate that the subcontractor agrees to perform the delegated activities and agrees to comply with the reporting requirements.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard IX—Subcontracts and Delegation—Medicaid Only		
Requirement	**Findings**	**Required Action**
3. The Contractor's written agreement with any subcontractor includes: • The subcontractor's agreement to comply with all applicable Medicaid laws and regulations, including applicable sub-regulatory guidance and contract provisions. *42 CFR 438.230(c)(2)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—2.2.2	The contract between DHMC and MedImpact failed to require compliance with all applicable Medicaid laws and regulations. Additionally, DHMC was unable to demonstrate that it held written agreements with all subcontracted providers.	DHMC must have a written agreement with every subcontractor that requires the subcontractor to comply with all applicable Medicaid laws and regulations, including applicable sub-regulatory guidance and contract provisions.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard IX—Subcontracts and Delegation—Medicaid Only		
Requirement	**Findings**	**Required Action**
4. The written agreement with the subcontractor includes: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State. – The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, and computer or other electronic systems related to CHP+ members. – The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. – If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State,	The contract between DHMC and MedImpact failed to include the provisions related to 42 CFR 438.230(c)(3). Additionally, DHMC was unable to demonstrate that it held written agreements with all subcontracted providers.	DHMC must have a written agreement with every subcontractor that includes the provisions related to 42 CFR 438.230(c)(3).

Standard IX—Subcontracts and Delegation—Medicaid Only		
Requirement	**Findings**	**Required Action**
CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. *42 CFR 438.230(c)(3)* CHP+ Contract: N/A Medicaid Contract: Exhibit A—2.2.8, 2.6.6.2		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review Protocol Activities

The following table describes the activities performed throughout the compliance monitoring process. The activities listed below are consistent with CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal Medicaid and CHP+ managed care regulations and contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, on-site agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all site reviewers to ensure consistency in scoring across plans.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Medical Quality Improvement Committee (MQuIC) meetings and provided group technical assistance and training, as needed. • Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the health plan in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the two standards and on-site activities. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. • Documents submitted for the desk review and on-site review consisted of the completed desk review form, the compliance monitoring tool with the health plan's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The health plans also submitted a list of all Medicaid and CHP+ appeals and grievances that occurred between July 1, 2017, and December 31, 2017 (to the extent possible). HSAG used a random sampling technique to select records for review during the site visit. • The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct Site Visit**
	• During the on-site portion of the review, HSAG met with the 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. • HSAG reviewed a sample of administrative records to evaluate implementation of managed care regulations related to Medicaid and CHP+ appeals and grievances. • Also while on-site, 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 confidential or proprietary, or were requested as a result of the pre-on-site document review.) • At the close of the on-site portion of the site review, HSAG met with health plan staff and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2017–2018 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. • HSAG analyzed the findings. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the State**
	• HSAG populated the report template. • HSAG submitted the draft site review report to the health plan and the Department for review and comment. • HSAG incorporated the health plan's and Department's comments, as applicable, and finalized the report. • HSAG distributed the final report to the health plan and the Department.