CHP+

Child Health Plan *Plus*

Fiscal Year 2018–2019 Site Review Report

for

Denver Health Medical Plan

February 2019

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

Table of Contents

1. Executive Summary 1-1
Introduction 1-1
Summary of Results 1-1
Standard III—Coordination and Continuity of Care 1-3
Summary of Strengths and Findings as Evidence of Compliance 1-3
Summary of Findings Resulting in Opportunities for Improvement 1-3
Summary of Required Actions 1-4
Standard IV—Member Rights and Protections 1-5
Summary of Strengths and Findings as Evidence of Compliance 1-5
Summary of Findings Resulting in Opportunities for Improvement 1-5
Summary of Required Actions 1-5
Standard VIII—Credentialing and Recredentialing 1-5
Summary of Strengths and Findings as Evidence of Compliance 1-5
Summary of Findings Resulting in Opportunities for Improvement 1-6
Summary of Required Actions 1-6
Standard X—Quality Assessment and Performance Improvement 1-7
Summary of Strengths and Findings as Evidence of Compliance 1-7
Summary of Findings Resulting in Opportunities for Improvement 1-8
Summary of Required Actions 1-9

2. Overview and Background 2-1
Overview of FY 2018–2019 Compliance Monitoring Activities 2-1
Compliance Monitoring Site Review Methodology 2-1
Objective of the Site Review 2-2

3. Follow-Up on Prior Year's Corrective Action Plan 3-1
FY 2017–2018 Corrective Action Methodology 3-1
Summary of FY 2017–2018 Required Actions 3-1
Summary of Corrective Action/Document Review 3-2
Summary of Continued Required Actions 3-2

Appendix A. Compliance Monitoring Tool A-1
Appendix B. Record Review Tools B-1
Appendix C. Site Review Participants C-1
Appendix D. Corrective Action Plan Template for FY 2018–2019 ..... D-1
Appendix E. Compliance Monitoring Review Protocol Activities E-1

1. Executive Summary

Introduction

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

In order to evaluate the CHP+ health plans' compliance with new federal managed care regulations published May 2016, the Department determined that the review period for fiscal year (FY) 2018–2019 was July 1, 2018, through December 31, 2018. This report documents results of the FY 2018–2019 site review activities for **Denver Health Medical Plan** (**DHMP**). 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 2018–2019 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the 2017–2018 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 credentialing and recredentialing record reviews. Appendix C lists HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process the health plan will be required to complete for FY 2018–2019 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 requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable.* HSAG assigned required actions to any requirement receiving a score of *Partially Met* or *Not Met.* HSAG also identified opportunities for improvement with associated recommendations for some elements, regardless of the score.

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

Table 1-1—Summary of Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
III. Coordination and Continuity of Care	10	10	6	3	1	0	60%
IV. Member Rights and Protections	8	8	8	0	0	0	100%
VIII. Credentialing and Recredentialing	32	30	30	0	0	2	100%
X. Quality Assessment and Performance Improvement	18	18	16	2	0	0	89%
Totals	**68**	**66**	**60**	**5**	**1**	**2**	**91%**

*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 **DHMP** for the credentialing and recredentialing record reviews. Details of the findings for the record reviews are in Appendix B—Record Review Tools.

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Credentialing	100	85	85	0	15	100%
Recredentialing	90	84	84	0	6	100%
Totals	**190**	**169**	**169**	**0**	**21**	**100%**

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

Standard III—Coordination and Continuity of Care

Summary of Strengths and Findings as Evidence of Compliance

With the exception of case management processes performed by the **DHMP** utilization management (UM) staff, care coordination for CHP+ members was delivered through a collaborative care coordination approach that integrated the care coordination resources and tools implemented throughout the Denver Health and Hospitals Authority (DHHA) delivery system. Documents submitted and on-site discussions demonstrated that care was coordinated through numerous resources, such as pediatric and family medicine clinic-based navigators, pediatric care coordinators, registered nurse (RN) care coordinators, social workers, hospital discharge planners, Healthy Communities, the Nurse Family Partnership, and other system-wide programs. Documents also demonstrated criteria for making referrals among various programs and providers. **DHMP** and DHHA had mechanisms to coordinate care between different settings of care, with services provided through external entities—e.g., medical providers, managed care plans, and fee-for-service (FFS) providers—and with community and social support organizations. Discharge planning processes were coordinated between DHHA, Children's Hospital (as applicable), and **DHMP** UM staff. Through DHHA's Care Management program and/or its designated pediatric specialty clinics, DHHA staff conducted a comprehensive needs assessment and developed a service plan for members with special health care needs (SHCN). **DHMP** policies described that these members were allowed direct access to specialists through a standing referral or a preauthorized number of visits.

Care coordination assessments, plans, interventions, and referrals were documented and communicated through the Epic electronic health record system, available to all DHHA providers and care coordination staff, as well as approved external provider entities. Member health records were also accessible in Epic to providers throughout the DHHA delivery system and to select external providers with access credentials. Staff members stated that DHHA may also share care coordination information with other entities and providers participating in the member's care through communication mechanisms such as secure faxes or private phone calls. DHHA policies and procedures regarding Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance described mechanisms for maintaining security of personal health information (PHI) among DHHA's healthcare components and addressed prohibited disclosure of PHI.

Summary of Findings Resulting in Opportunities for Improvement

While the overall care coordination activities available to CHP+ members were comprehensive and well-resourced, HSAG noted that only a few of these processes were performed directly through **DHMP**. In addition, sources of documentation demonstrating compliance were from disparate and multiple points of service within the DHHA system. **DHMP** demonstrated little oversight or monitoring of these processes to ensure that care coordination requirements were met for individual CHP+ members. As **DHMP** is the CHP+ contractor and has ultimate accountability for all care coordination provided to CHP+ members, HSAG strongly recommends that **DHMP** develop and adopt a **DHMP** care coordination program document that consolidates the applicable processes and procedures of the DHHA

system into a cohesive care coordination process flow with designated roles and responsibilities for providing care coordination to CHP+ members. HSAG also recommends that **DHMP** implement mechanisms for enhanced oversight of CHP+ member care coordination.

HSAG observed that **DHMP**'s policies and procedures tended to make policy statements compliant (and sometimes verbatim) with regulatory language; however, these documents either lacked a description of procedures for implementation or they lacked a description of procedures that correlated with on-site interview discussions—e.g., UM staff roles in coordinating care with service providers outside the DHHA network. HSAG recommends that **DHMP** review its policies applicable to care coordination and enhance the description of procedures for implementation, giving particular attention to these documents: Coordination and Continuity of Care of Members with Special Health Care Needs, Clinical Criteria for Utilization Management Decisions, and Utilization Review Determinations Including Approvals and Actions.

Summary of Required Actions

DHMP did not have a process in place to ensure that all newly enrolled members needing continuity of care were identified and that services to prevent disruption in care were provided as needed. **DHMP** must define and implement procedures for providing continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services.

DHMP did not have an active mechanism to ensure that each CHP+ member has an ongoing source of care—e.g. primary care provider (PCP). **DHMP** must implement mechanisms to ensure that each CHP+ member has an ongoing source of care, and that it provides information to the member on how to contact his or her provider.

DHMP staff members confirmed that **DHMP** did not have procedures to conduct an initial assessment of each new member's needs that includes the required initial assessment elements. **DHMP** must implement a mechanism within 90 days of enrollment to attempt to conduct an initial screening of each new member's health needs, including assessment of mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health needs.

DHHA's Care Management program included a comprehensive assessment of SHCN when members are referred to the Care Management program; however, mechanisms were unclear regarding how members with SHCN were identified and referred to the Care Management program. **DHMP** must ensure that each member with SHCN receives a comprehensive assessment to identify any ongoing special conditions that require a course of treatment or regular care monitoring.

Standard IV—Member Rights and Protections

Summary of Strengths and Findings as Evidence of Compliance

DHMP's policies and procedures that addressed member rights and protections included a list of all federally mandated CHP+ member rights, as well as articulated a spirit of respect toward members. The intent to respect member rights and ensure that rights are taken into account when furnishing services was also well-articulated in the CHP+ member handbook and provider manual. **DHMP** provided evidence of initial and annual training regarding member rights for **DHMP** staff members and providers.

DHMP had adequate processes for ensuring that written communication is provided in languages and formats that meet the requirements of 42 CFR §438.10. **DHMP** also had robust policies, procedures, and organizational practices to ensure that the member's privacy and confidentiality rights under HIPAA are protected. In addition, policies and procedures adequately addressed federal regulations related to advance directives, and information regarding advance directives was available on **DHMP**'s website.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to this standard.

Summary of Required Actions

HSAG identified no required corrective actions related to this standard.

Standard VIII—Credentialing and Recredentialing

Summary of Strengths and Findings as Evidence of Compliance

DHMP demonstrated that it had a well-defined credentialing and recredentialing program that met all National Committee for Quality Assurance (NCQA) standards and guidelines for credentialing practitioners and assessing organizational providers with which the health plan contracts for furnishing services to CHP+ members. **DHMP**'s credentialing and recredentialing policies and procedures addressed all NCQA requirements for the selection and retention of practitioners providing care to Colorado's CHP+ members. Through on-site record reviews, HSAG confirmed that primary source verification occurred within the required time limits and that recredentialing occurred within 36 months following the initial credentialing or previous recredentialing date. On-site record review of a sample of contracted organizational providers demonstrated that **DHMP** implemented procedures for ensuring that organizational providers remained in good standing with federal and State regulatory agencies, had not been excluded from federal healthcare participation, and employed processes for credentialing and recredentialing their own practitioners. **DHMP** provided evidence of ongoing monitoring to ensure

practitioners and providers had unrestricted licenses and had not been excluded from federal healthcare participation.

DHMP directly credentialed and recredentialed all independently contracted practitioners and contracted organizational providers that served **DHMP**'s CHP+ members. The DHHA's employed provider network was **DHMP**'s primary source of practitioners to serve its CHP+ members. **DHMP** had a delegation agreement with DHHA for credentialing and recredentialing practitioners that served CHP+ members through DHHA clinics and facilities. **DHMP** provided evidence of adequate oversight to ensure the quality and completeness of DHHA's credentialing and recredentialing activities.

Summary of Findings Resulting in Opportunities for Improvement

While **DHMP**'s credentialing and recredentialing policies and procedures described processes for ensuring nondiscriminatory credentialing and recredentialing practices, the procedures actually employed by **DHMP** to ensure nondiscriminatory credentialing and recredentialing were not those described in the policy/procedure; however, they did meet the NCQA requirement. HSAG recommended that **DHMP** review its policy/procedure and practices and make revisions where appropriate to ensure that procedures implemented are adequately described in policies and procedures.

While **DHMP** described adequate processes for ensuring provider retention, **DHMP**'s policies and procedures for the selection and retention of providers did not adequately address its organizational process to ensure provider retention. HSAG recommended that **DHMP** revise or develop policies and procedures that describe its organizational practices to ensure provider retention.

DHMP's Credentialing and Recredentialing of Practitioners policy and procedure included reference to updating **DHMP**'s online provider directory; however, when reviewing the website to determine implementation of this process, HSAG noted that in one place on the **DHMP** website, the link to the "Find a Provider" feature led to the **DHMP** provider network, while another link led to the DHHA provider network. Furthermore, HSAG found that typical navigation of the website would most likely lead a member to the DHHA directory, rather than the **DHMP** directory. The DHHA network does not represent the complete list of **DHMP** credentialed providers. **DHMP** staff members reported that at the time of the site visit, the **DHMP** website was being upgraded and revised. HSAG recommended that **DHMP** improve the navigability of its website to ensure that members are readily directed to the **DHMP** provider directory, consistent with credentialing and recredentialing processes.

Summary of Required Actions

HSAG identified no required corrective actions related to this standard.

Standard X—Quality Assessment and Performance Improvement

Summary of Strengths and Findings as Evidence of Compliance

DHMP's Quality Improvement (QI) Program Description and 2017–2018 QI Impact Analysis demonstrated that a comprehensive quality assessment and performance improvement (QAPI) program is in place at **DHMP**. The program is conducted in partnership with Denver Health, and the **DHMP** Board has ultimate accountability for the program. The program description defined a multidisciplinary, multidepartmental active engagement structure and process with organization-wide reporting, analysis of results, and planned interventions for improvement. The scope of the program was defined to include the following:

- Cultural and linguistic member needs
- Preventive health promotion
- Patient safety
- Health management
- Adequacy and availability of services
- Clinical and practice guidelines
- Continuity and coordination of care
- Quality of care complaints
- Member satisfaction
- Practitioner satisfaction
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

The annual impact analysis report was thorough and comprehensive, reflecting statistical and narrative reporting of measures and activities, analysis of outcomes, opportunities for improvement, and proposed interventions related to each scope area. Components of the QAPI program included performance improvement projects (PIPs) and Healthcare Effectiveness Data and Information Set (HEDIS®)[2-1] and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[2-2] measures, with required reporting of each to the Department. The PIP met the required design parameters (previously evaluated by HSAG). Grievance and appeal data were trended quarterly, and analyses and interventions were reflected in the annual impact analysis report, as were quality of care concerns.

DHMP adopted clinical practice guidelines in compliance with requirements and had practice guidelines in place for all specific health conditions required by the Department. **DHMP** distributed practice guidelines to providers through the DHHA intranet, via targeted mailings, and on the **DHMP** website. **DHMP** member communications (e.g., newsletters) informed members of practice guidelines and how

[2-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[2-2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

to access them. **DHMP**'s Clinical Practice and Preventive Care Guidelines policy stated that medical management staff ensure that member information and other clinical materials and guidelines are consistent with practice guidelines.

DHMP described and submitted health information system (HIS) documents which demonstrated that **DHMP** had access to a robust, enterprise-wide DHHA information system with well-integrated components, allowing **DHMP** to access all necessary data for management of the plan and for producing a variety of routine or custom reports. The four major transactional HIS integrated system components applicable to **DHMP** operations include:

- QNXT—claims, provider and member demographics, and member eligibility data.
- Altruista Health GuidingCare—utilization management, care management, customer relations, and appeals and grievances.
- MedImpact—provider and pharmacy claims adjudication.
- Encounter Data Manager—extraction and submission of encounter data to the Department.

The Denver Health enterprise data warehouse was also accessible to **DHMP** users for reporting. Data were collected from providers in standardized formats; encrypted files were transferred through secure file transfer protocol (FTP) sites. Claims data received from providers were verified for completeness on initial submission to QNXT. Clean claims were further screened for coding accuracy and appropriateness by QNXT electronic edits, and the adjudication system performed additional screening of authorizations, dates, and codes. If necessary, the system sent claims to a queue for manual review prior to final adjudication. **DHMP** described the data flow to the encounter data manager for electronic monthly batch submission of paid, denied, and adjusted claims to the Department via ASC X12N 837 and National Council for Prescription Drug Programs (NCPDP) file formats.

Summary of Findings Resulting in Opportunities for Improvement

During on-site interviews regarding over- or underutilization of services, staff members stated that some of the HEDIS measures may be used as indicators of over- or underutilization, and that **DHMP** was in the process of designing new reporting of utilization measures that would become an ongoing component of the QAPI program. HSAG encourages **DHMP** to use the extensive claims database of services and member and provider demographics to track selected service utilization trends as an additional mechanism to detect over- or underutilization.

During on-site interviews, staff members provided examples of how practice guidelines were cross-checked with other guidelines being used in the organization to ensure consistency. However, the Clinical Practice and Preventive Care Guidelines policy did not outline procedures or accountabilities for doing so. HSAG recommends that **DHMP** enhance its policy to more specifically define expectations for ensuring that member information and other clinical materials and guidelines are consistent with practice guidelines.

Summary of Required Actions

DHMP did not provide any documents that demonstrated detection or analysis of under- or overutilization of services as a component of the QAPI program. **DHMP** must incorporate mechanisms to detect both under- and overutilization of services into its QAPI program.

While **DHMP** had operational care processes targeted toward enhancing the quality of care delivered to individual members with SHCN, **DHMP** did not provide evidence that demonstrated it periodically assesses the overall quality of care being delivered to SHCN members. **DHMP** must develop and implement mechanisms within its QAPI program to demonstrate assessment of the quality and appropriateness of care rendered to members with SHCN.

2. Overview and Background

Overview of FY 2018–2019 Compliance Monitoring Activities

For the FY 2018–2019 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement. Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of 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+ credentialing and recredentialing.

HSAG also reviewed a sample of the health plan's administrative records related to CHP+ credentialing and recredentialing to evaluate implementation of federal healthcare regulations and compliance with NCQA requirements effective July 2018. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records (to the extent that a sufficient number existed). Using a random sampling technique, HSAG selected the samples from all CHP+ credentialing and recredentialing records that occurred between July 1, 2018, and December 31, 2018. 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 VIII—Credentialing and Recredentialing. HSAG also separately calculated a credentialing record review score, a recredentialing record review score, and an overall record review score.

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.[2-3] 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 2018–2019 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

Objective of the Site Review

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

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

[2-3] 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, 2018.

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

FY 2017–2018 Corrective Action Methodology

As a follow-up to the FY 2017–2018 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 **DHMP** until it completed each of the required actions from the FY 2017–2018 compliance monitoring site review.

Summary of FY 2017–2018 Required Actions

For FY 2017–2018, HSAG reviewed Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

Related to member information, **DHMP** was required to:

- Revise its CHP+ member handbook to include accurate time frames for filing grievances, appeals, and State fair hearings.
- Revise its member handbook to inform members how to access benefits available under the State plan but not covered by the managed care contract.

Related to provider participation and program integrity, **DHMP** was required to:

- 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 eligibility to participate in the Medicaid program.
- Have documented procedures for notifying the Department of written disclosure of any prohibited affiliation, written disclosure of ownership and control, and identification of any excess payments made to the contractor.
- Have mechanisms for ensuring that network providers report to **DHMP** when they have received an overpayment, return the overpayment to **DHMP**, and notify **DHMP** of the reason for the overpayment; and that **DHMP** reports annually to the Department on recoveries of overpayments.

Related to the grievance system, **DHMP** was required to:

- Ensure that written notices of appeal resolutions are in formats and language that may be easily understood by members.
- Ensure that all providers and subcontractors are provided with information about the grievance, appeal, and State fair hearing system upon entering into contracts with **DHMP**.

HSAG scored all requirements for subcontracts and delegation as not applicable for CHP+ health plans due to an effective date, for new federal regulations, of July 1, 2018. As such, HSAG identified no required actions for this standard.

Summary of Corrective Action/Document Review

DHMP submitted a proposed CAP in February 2018. HSAG and the Department reviewed and approved the proposed plan and responded to **DHMP**. **DHMP** submitted documents as evidence of completion of its proposed interventions in October 2018. As of the date of this compliance report, HSAG and the Department had not completed review and approval of documents submitted by **DHMP**.

Summary of Continued Required Actions

As of the date of this 2018–2019 compliance report, all required 2017–2018 required actions were continued pending review of CAP documents submitted by **DHMP**. HSAG will review **DHMP**'s CAP submission with the Department and work with the health plan to ensure full implementation of all corrective actions.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements procedures to deliver care to and coordinate services for all members. These procedures meet State requirements, including: • Ensuring timely coordination with any of a member's providers, including mental health providers, for the provision of covered services. • Addressing those members who may require services from multiple providers, facilities, and agencies; and who require complex coordination of benefits and services. • Ensuring that all members and authorized family members or guardians are involved in treatment planning and consent to any medical treatment. • Criteria for making referrals and coordinating care with specialists, subspecialists, and community-based organizations. • Providing continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services. *42 CFR 438.208(b)* Contract: Exhibit B—10.5.1, 10.5.2, 10.5.3.3, 10.5.3.5, 10.5.3.6	**Tip Sheet_Close-the-Loop Management_12.6.17** **Standard Work Referral Process** **Screenshots GAD 7 and MHCD** **Referral_Redacted** **RN Care Coordinator ACS 16 - DBBH2653** **Referrals** **Primary Care Standard Work_Referral Tracking_5.1.18** **PHQ-9_English** **PHQ-4 Tip Sheet v5** **Peds - Non-DH Medical- e-g- Childrens Hospital Clinical Referral Guideline** **Peds - Healthy Lifestyle Clinical Referral Guideline** **Pediatrics Early Intervention- Child Find or Developmental Delay Clinical Referral Guideline** **Pediatric Referral Coordinator Job Description**	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Pediatric Development Screening –ACS **Pediatric and Adolescent Preventive Healthcare Guidelines** **Nurse Family Partnership Referral Form 2016** **Nurse Family Partnership Program** **Initial Interview - CHP+_Pregnant** **Healthy Communities Standard Work** **General Consent for Treatment** **GAD-7_English** **Future Appointments and Recent Visits** **Future Appointments and Recent Visits 2** **Episodes of Care** **End to End Referral Process** **CsCAT RNCC - Working Document March 2018 (2)** **Closing the Loop in Primary Care**	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	CHP+ Dental Letter (2) **CHP Well-Child Script** **Chp Newborn** **Care Teams** **Care Gaps** **Protocols for Authorization of Out-of-Network Referrals P&P** *This evidence shows clinical care guidelines that pertain to the CHP+ population which shows what care coordination policies are, how DHMP communicates with other providers, how DHMP addresses services and how referrals are made. Some examples included are of existing programs to demonstrate that services are coordinated for all. Standard work for external and internal referrals, screenshots and survey tools for coordination for mental health are also included. Job descriptions for roles that do care coordination for evaluations and support are included.*	

Findings:

DHMP submitted numerous documents and provided on-site discussion to demonstrate that the Denver Health system has numerous resources and tools to coordinate care for CHP+ members between different providers and programs. The collection of these processes and tools demonstrated mechanisms for coordination with a member's providers, addressing members who require complex coordination of benefits and services, ensuring that members and family members are involved in and consent to treatment planning, and providing criteria for making

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
referrals to various providers and organizations. However, DHMP did not have a process in place to ensure that all newly enrolled members needing continuity of care were identified and, as needed, services to prevent disruption in care were provided. In addition, HSAG noted that most resources and responsibilities for coordination of care were provided through DHHA, with little or no DHMP oversight or monitoring of care coordination provided to CHP+ members. HSAG recommends that DHMP define a consolidated, comprehensive DHMP program description of the many disparate care coordination processes available to members and consider implementing monitoring mechanisms such that DHMP may ensure that CHP+ members are receiving care coordination as required by federal regulations and DHMP's contract with the State.		
Required Actions: DHMP must define and implement procedures for providing continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services.		
2. The Contractor ensures that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member. • The member must be provided information on how to contact the designated person or entity. *42 CFR 438.208(b)(1)* Contract: Exhibit B—1.1.79, 7.11.1.2	**Nurse Care Coordinator as Primary Responsible for Coordinating Health_Redacted Initial Interview - CHP+_Pregnant** **Healthy Communities Standard Work** **CHP+ Dental Letter (2)** **CHP Well-Child Script** **Chp Newborn** **Care Team Activity - Care Coordinator Primary** *Evidence included is the purpose to outline how DHMP reaches out to each member and informs them how they can access the program. Included are some of the scripts used when members are called as well as the standard of work.*	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: DHMP demonstrated that Health Communities' family health coordinators outreach specific groups of CHP+ members to explain benefits and offer to help connect the member to providers. In addition, DHHA had mechanisms to provide contact information to a member regarding any care coordinator that might be involved with his or her care. However, DHMP did not have an active mechanism to ensure that each CHP+ member has an ongoing source of care—e.g., a PCP.		
Required Actions: DHMP must implement mechanisms to ensure that each CHP+ member has an ongoing source of care, and that it provides information to members on how to contact his or her provider.		
3. The Contractor implements procedures to coordinate services the Contractor furnishes the member: • Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. • With the services the member receives from any other managed care plan. • With the services the member receives in fee-for-service (FFS) Medicaid. • With the services the member receives from community and social support providers. *42 CFR 438.208(b)(2)* Contract—Exhibit B—10.5.3.3.1	**20170509_TOC Standard Work_Final** **Inpatient Assessment and Documentation Standard Work 4.7.17** **Inpatient Discharge Flowsheet** **Member Handbook** **NICU Discharge Flowsheet p2** **NICU Discharge Flowsheet** **Patient Discharge** **Pediatric Community Resources on Social Work Intranet Page** **Pediatric Transitions of Care in Epic for ACS** *Evidence includes the standard of work for the inpatient side to demonstrate the connection when patients are discharged from the pediatric unit or NICU. Information about the transition of care standard of work and how outreach to patients is*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	done that have been discharged. Also included are screenshot of community resources that are used for kids after discharge	
4. The Contractor provides best efforts to conduct an initial screening of each new member's needs within 90 days of enrollment, including subsequent attempts if the initial attempt to contact the member is unsuccessful. • Assessment includes screening for special health care needs including mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems. *42 CFR 438.208(b)(3)* Contract: Exhibit B—10.5.3.1.1	**Annual QRG** **Member Handbook Requirements QRG** *The Annual QRG is one attempt to conduct the initial screening.*	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: DHMP staff members confirmed that DHMP did not have procedures to conduct an initial assessment of each new member's needs that includes the required assessment elements. Staff members stated that an assessment is performed on initial visit to a DHHA clinic; however, HSAG observed that members may not make an initial clinic appointment soon after enrollment. Similarly, the Health Communities Standard Work document described contacting all newly enrolled CHP+ members, but it specifically excluded conducting screening of the required assessment elements. DHMP staff members acknowledged that an initial assessment process "is a work in progress."		
Required Actions: DHMP must implement a mechanism within 90 days of enrollment to attempt to conduct an initial screening of each new member's health needs, including assessment of mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health needs.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor shares with other entities serving the member the results of identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR 438.208(b)(4)* Contract: Exhibit B—10.6.1	**Care Everywhere in Epic_Redacted** **Pediatric Nurse Care Coordination InBasket Message_Redacted** **Pediatric Progress Note** **Pediatric RNCC use of CareEverywhere_Redacted** *Evidence includes screenshots of how nurses document and how they use Care Everywhere to communicate with outside providers and Inbasket messaging for internal providers.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The Contractor ensures that each provider furnishing services to members maintains and shares, as appropriate, a member health record, in accordance with professional standards. *42 CFR 438.208(b)(5)* Contract: Exhibit B—14.1.6.6–7	**Provider Manual** **Legal Medical Record**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The Contractor ensures that, in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent applicable. *42 CFR 438.208(b)(6)* Contract: Exhibit B—10.5.1.1	**HIPAA Hybrid Entity Health Care Components**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor implements mechanisms to comprehensively assess each CHP+ member identified by the State as having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. *42 CFR 438.208(c)(2)* Contract: Exhibit B—10.6.2	**Care Management Intake Summary and Plan of Care_Redacted** **HCP for Children with Special Healthcare Needs Pediatric Care Coordination Clinical Referral Guideline** **Webb Pediatrics Complex Care Clinical Referral Guideline** *Evidence includes children with special health care referral guidelines and screenshots of what is done for their plan of care*	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DHHA's Care Management program included a comprehensive assessment of SHCN when members are referred to the Care Management program; however, mechanisms were unclear regarding how members with SHCN needs were identified and referred to the Care Management program.		
Required Actions: DHMP must ensure that each member with SHCN receives a comprehensive assessment to identify any ongoing special conditions that require a course of treatment or regular care monitoring.		
9. The Contractor produces a treatment or service plan for members with special health care needs who are determined, through assessment, to need a course of treatment or regular care monitoring. The treatment plan must be: • Developed by the member's primary care provider with member participation, and in consultation with any specialists caring for the enrollee. • Approved by the Contractor in a timely manner (if such approval is required by the Contractor). • In accordance with any applicable State quality assurance and utilization review standards.	**Allergies and Problems** **Care Coordination Note** **Care Management Intake Standard Work April2018** **Care Team Activity - External Team members** **CSW Goals and Interventions**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Reviewed and revised upon reassessment of functional need, at least every 12 months, when the member's circumstances or needs change significantly, or at the request of the member. *42 CFR 438.208(c)(3)* Contract: Exhibit B—10.5.3.2.1–4	**Goal and care team from another hospital** **Goals Activity – Non DH Goals (external) Goals** **Longitudinal Plan of Care Epic** **Plan of Care #1** **Treatment Plan with Outside Specialist Consultation** **Clinical Criteria for Utilization Management Decisions P&P** **Utilization Review Determinations Including Approvals and Actions P&P** **Protocols for Authorization of Out-of-Network Referrals P&P** *Evidence listed includes information about what the social workers do, how intake assessments are completed and how social workers work with patients to set goals. Screenshots include how that is documented and reflected in the care plan in EPIC internally and externally from other hospitals.*	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. For members with special health care needs determined to need a course of treatment or regular care monitoring, the Contractor must have a mechanism in place to allow members direct access to a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. *42 CFR 438.208(c)(4)* Contract: Exhibit B—10.5.3.5; 10.6.3	**Coordination and Continuity of Care for Members with Special Needs P&P-** The specific section is highlighted in this policy which shows that members may see a Specialist as a PCP or have a standing referral to see Specialists for needed care.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	3	X	.00	=	0
	Not Met	=	1	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	10	**Total Score**		=	6
				Total Score ÷ Total Applicable		=	60%

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has written policies regarding the member rights specified in this standard. *42 CFR 438.100(a)(1)* Contract: Exhibit B—14.1.1.2	**Member Rights and Responsibilities P&P**- This policy is highlighted with the specific rights listed in this standard with comments for each specific one.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor complies with any applicable federal and State laws that pertain to member rights and ensures that its employees and contracted providers observe and protect those rights. *42 CFR 438.100(a)(2)* Contract: Exhibit B—14.1.1.1	**Member Rights and Responsibilities P&P**- Page 2 highlights that this policy complies with applicable federal and State laws **Provider Manual 2018_Final-** Pg. 68 -74 show advanced directives and Pg. 80-81 show member rights listed out so providers are aware and can protect member rights	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor's policies and procedures ensure that each member is guaranteed the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for 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.	**Member Rights and Responsibilities P&P**- Each member right is highlighted with a comment attached to the highlight to show this right is included in the policy. Please see Pg. 2-3 under Procedures A.1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210). *42 CFR 438.100(b)(2) and (3)* Contract: Exhibit B—14.1.1.2.1–5; 14.1.1.3		
4. The Contractor ensures that each member is free to exercise his or her rights and that the exercise of those rights does not adversely affect how the Contractor, its network providers, or the State Medicaid agency treat(s) the member. *42 CFR 438.100(c)* Contract: Exhibit B—14.1.1.2.6	**Member Rights and Responsibilities P&P-** Please see Pg. 3 under Procedures, 1. A. xx	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. Member's rights and responsibilities are included in the member handbook and provided to all enrolled members. *42 CFR 438.10(2)(ix)* Contract: Exhibit B—14.1.3.10	**Member Handbook-** Rights and Responsibilities are both listed out on PDF Pg. 16, Handbook page 13 and are highlighted **CHP Quick Ref Guide 2018-** Upon enrollment and yearly thereafter, members are mailed the QRG/annual mailing to direct them where they can find the Member Handbook on the website **CHP Quick Ref Guide Annual Mailing 2018-** Yearly members are mailed the annual Quick Reference Guide that shows their rights and where to find the Member Handbook	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Member Handbook Content Requirements P&P- Demonstrates that the QRG is part of the process for members to receive their rights	
6. The Contractor complies with any other federal and State laws that pertain to member rights, including Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975, as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and Section 1557 of the Patient Protection and Affordable Care Act. *42 CFR 438.100(d)* Contract: 21.A	**Member Rights and Responsibilities P&P-** These specific laws are included and highlighted on Pg. 2 under Procedures, A	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. For medical records and any other health and enrollment information which identify a particular member, the Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42 CFR 438.224* Contract: Exhibit B—14.1.6.7	**HIPAA website-** Screenshot and link to the Notice of Privacy Practices on the CHP+ website **2017 Managed Care HIPAA Privacy Program Manual – FINAL-** This manual describes the specific practices used for HIPAA including 45 CFR parts 160 and 164, subparts A and E (HIPAA)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor maintains written policies and procedures and provides written information to individuals concerning advance directives with respect to adult members receiving care by or through the Contractor. Advance directives policies and procedures include: • A clear statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience. • The difference between institution-wide conscientious objections and those raised by individual physicians. • Identification of the State legal authority permitting such objection. • Description of the range of medical conditions or procedures affected by the conscientious objection. • Provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and unable to receive information. • Provisions for providing advance directive information to the incapacitated member once he or she is no longer incapacitated. • Provisions for documenting in a prominent part of the member's medical record whether the member has executed an advance directive. • Provisions that the decision to provide care to a member is not conditioned on whether the member has executed an advance directive and that members are not discriminated against based on whether they have executed an advance directive.	**Advanced Directives P&P-** This policy documents all of the bullet points listed. Each one is highlighted and marked so they are easy to locate under the Comment section.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Provisions for ensuring compliance with State laws regarding advance directives. • Provisions for informing members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. • Provisions for educating staff concerning policies and procedures about advance directives. • Provisions for community education regarding advance directives, to include: – What constitutes an advance directive. – Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. – Description of applicable State law concerning advance directives. *42 CFR 438.3(j)* *42 CFR 422.128* Contract: Exhibit B—14.1.9.1		

Results for Standard IV—Member Rights and Protections							
Total	Met	=	8	X	1.00	=	8.00
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	8	**Total Score**		=	8
				Total Score ÷ Total Applicable		=	100%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. • The Contractor's credentialing program complies with the standards of the National Committee on Quality Assurance (NCQA) for initial credentialing and re-credentialing of participating providers. *42 CFR 438.214(a)* Contract: Exhibit B—14.2.1.3	**Credentialing and Recredentialing of Practitioners P&P -** Policy purpose is highlighted and marked on Page 1. NCQA Regulatory References are listed on Pg. 21 for Credentialing guidelines	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: • The types of practitioners it credentials and recredentials. This includes all physicians and non-physician practitioners who have an independent relationship with the Contractor. (Examples include MDs, DOs, podiatrists, nurse practitioners, and each type of behavioral health provider.) NCQA CR1—Element A1	**Credentialing and Recredentialing of Practitioners P&P -** Types of practitioners are listed and highlighted on Pg. 1-2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor's written policies and procedures for the selection and retention of providers specify: • The verification sources it uses. NCQA CR1—Element A2	**Credentialing and Recredentialing of Practitioners P&P -** Pg. 12-19 lists out verifications needed. Attachment 2 lists out the websites that are acceptable to use for credentialing.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor's written policies and procedures for the selection and retention of providers specify: • The criteria for credentialing and recredentialing. NCQA CR1—Element A3	**Credentialing and Recredentialing of Practitioners P&P -** Pg. 8-11 shows all verifications and criteria for credentialing and recredentialing that is needed	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	**Credentialing and Recredentialing of Practitioners P&P -** The final determination is made by the Medical Director at the bottom of Pg. 3. File review is on Pg. 9-11	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for managing credentialing and recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	**Credentialing and Recredentialing of Practitioners P&P -** File Maintenance and Confidentiality is listed on Pg. 5, III.A	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for delegating credentialing or recredentialing (if applicable). NCQA CR1—Element A6	**Delegation of Credentialing Activities P&P -** Process for delegation Pg.2-5, Procedures A and B	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for ensuring that credentialing and recredentialing are conducted in a non-discriminatory	**Credentialing and Recredentialing of Practitioners P&P -** Pg. 6, III.B on Non Discrimination	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
manner, (i.e., must describe the steps the Contractor takes to ensure that it does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnic or national identity, gender, age, sexual orientation, or patient type in which the practitioner specializes). NCQA CR1—Element A7		
9. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for notifying practitioners if information obtained during the Contractor's credentialing/recredentialing process varies substantially from the information provided to the Contractor. NCQA CR1—Element A8	**Credentialing and Recredentialing of Practitioners P&P -** Pg. 6, III.C	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for ensuring that practitioners are notified of credentialing and recredentialing decisions within 60 calendar days of the committee's decision. NCQA CR1—Element A9	**Credentialing and Recredentialing of Practitioners P&P -** Pg. 19, K. Notification of Credentialing and Recredentialing Decision	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor's written policies and procedures for the selection and retention of providers specify: • The medical director's or other designated physician's direct responsibility and participation in the credentialing/recredentialing program. NCQA CR1—Element A10	**Credentialing and Recredentialing of Practitioners P&P -** Pg. 3details the Medical Director's participation	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for ensuring the confidentiality of all information obtained in the credentialing/recredentialing process. NCQA CR1—Element A11	**Credentialing and Recredentialing of Practitioners P&P -** Pg. 5, III.A describes the process for handling information collected during the credentialing and recredentialing process	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
13. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for ensuring that listings in provider directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty. NCQA CR1—Element A12	**Credentialing and Recredentialing of Practitioners P&P -** Pg. 19, M Listings in Provider Directory and Member Materials	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contactor notifies practitioners about their rights: • To review information submitted to support their credentialing or recredentialing application. • To correct erroneous information. • To receive the status of their credentialing or recredentialing application, upon request. NCQA CR1—Element B	**Credentialing and Recredentialing of Practitioners P&P -** Pg. 6-7. Each bullet is highlighted and marked with a comment	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing and recredentialing decisions. The committee uses participating practitioners to provide advice and expertise for credentialing decisions. NCQA CR2—Element A1		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. The Credentialing Committee: • Reviews credentials for practitioners who do not meet established thresholds. • Ensures that files which meet established criteria are reviewed and approved by a medical director or designated physician. NCQA CR2—Element A2 and A3	**Credentialing and Recredentialing of Practitioners P&P** - Pg. 7, E. Credentialing Committee, 3. iv and v	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
17. The Contractor verifies credentialing and recredentialing information through primary sources to ensure that practitioners have the legal authority and relevant training and experience to provide quality care. Verification is within the prescribed time limits and includes: • A current, valid license to practice (verification time limit=180 calendar days). • A current, valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (verification time limit=prior to the credentialing decision). • Education and training—highest level obtained—e.g., medical/ professional school graduate; residency	**Credentialing and Recredentialing of Practitioners P&P** - Pg. 8-9. Each bullet is highlighted and labeled under the table for Credentialing and Recredentialing Criteria and Verification Time Limits	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
(verification time limit=prior to the credentialing decision). Required at initial credentialing only. • Board certification—if the practitioner states on the application that he or she is board certified (board certification time limit=180 calendar days). • Work history—most recent five years—if less, from time of initial licensure—from practitioner's application or curriculum vitae (CV) (verification time limit=365 calendar days). Required at initial credentialing only. • History of malpractice settlements—most recent five years (verification time limit=180 calendar days). NCQA CR3—Element A		
18. The Contractor verifies the following sanction information for credentialing and recredentialing (verification time limit=180 days): • State sanctions, restrictions on licensure, or limitations on scope of practice. • Medicare and Medicaid sanctions. NCQA CR3—Element B	**Credentialing and Recredentialing of Practitioners P&P** - Pg. 9 & Pg. 15-16 with each bullet highlighted with the evidence	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
19. Practitioners complete an application for network participation (at initial credentialing and recredentialing) that includes a signed attestation (attestation verification time limit=365 days). The application addresses the following: • Reasons for inability to perform the essential functions of the position. • Lack of present illegal drug use.	**Credentialing and Recredentialing of Practitioners P&P** - Each bullet is highlighted on Pg. 12 covering these as well as Pg. 15 for malpractice insurance	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• History of loss of license and felony convictions. • History of loss or limitation of privileges or disciplinary actions. • Current malpractice or professional liability insurance coverage (minimums=physician—0.5mil/1.5mil; facility—0.5mil/3mil). • Attestation confirming the correctness and completeness of the application. NCQA CR3—Element C		
20. The Contractor formally recredentials practitioners at least every 36 months. NCQA CR4	**Credentialing and Recredentialing of Practitioners P&P -** This is highlighted at the top of Pg. 12	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
21. The Contractor has and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints, and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identifies issues related to poor quality. Monitoring includes: • Collecting and reviewing Medicare and Medicaid sanctions. • Collecting and reviewing sanctions or limitations on licensure. • Collecting and reviewing complaints. • Collecting and reviewing information from identified adverse events. • Implementing appropriate interventions when it identifies instances of poor quality related to the above. NCQA CR5—Element A	**Credentialing and Recredentialing of Practitioners P&P -** Each bullet is highlighted and marked so they are easy to find on Pg. 20-21	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
22. The Contractor has policies and procedures for taking action against a practitioner for quality reasons, reporting the action to the appropriate authorities, and offering the practitioner a formal appeal process. Policies and procedures address: • The range of actions available to the Contractor to improve practitioner performance before termination. • Procedures for reporting to National Practitioner Data Bank (NPDB), State agency, or other regulatory body, as appropriate. NCQA CR6—Element A1 and A2	**Practitioner Appeal Rights and Notification to Authorities Based on Issues of QOC P&P -** Highlights for each bullet can be found on Pg. 3 and Pg. 4	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
23. When taking action against a practitioner for quality reasons, the Contractor offers the practitioner a formal appeal process. Policies and procedures address: • A well-defined practitioner appeal process, including: – Written notification when a professional review action has been brought against a practitioner, reasons for the action, and a summary of the appeal rights and process. – Allowing practitioners to request a hearing and the specific time period for submitting the request. – Allowing at least 30 calendar days, after notification for practitioners, to request a hearing. – Allowing practitioners to be represented by an attorney or another person of their choice. – Appointing a hearing officer or a panel of individuals to review the appeal.	**Practitioner Appeal Rights and Notification to Authorities Based on Issues of QOC P&P -** Highlights for each requirement can be found on Pg. 2-6	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Notifying practitioners of the appeal decision in writing, including specific reasons for the decision. • Making the appeal process known to practitioners. NCQA CR6—Element A3 and A4		
24. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of *organizational* providers with which it contracts, which include: • The Contractor confirms—initially and at least every three years—that the provider is in good standing with State and federal regulatory bodies. – Policies specify the sources used to confirm—which may only include applicable State or federal agency, agent of the applicable State or federal agency, or copies of credentials (e.g., state licensure) from the provider. NCQA CR7—Element A1	**Assessment of Organizational Providers P&P -** This requirement is shown and highlighted on Pg. 3-4	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
25. The Contractor confirms, initially and at least every three years, provider review and approval by an accrediting body. • Policies specify the sources used to confirm—which may only include applicable State or federal agency or applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, or copies of credentials—e.g., licensure, accreditation report or letter—from the provider. NCQA CR7—Element A2	**Assessment of Organizational Providers P&P -** This requirement is shown and highlighted on Pg. 3-4 and Pg. 5.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
26. The Contractor conducts, initially and at least every three years, an on-site quality assessment if the provider is not accredited. • Polices include: on-site quality assessment criteria for each type of unaccredited organizational provider; a process for ensuring that that the provider credentials its practitioners. • The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: – The CMS or state review is no more than three years old. – The organization obtains a survey report or letter from CMS or the State, from either the provider or from the agency, stating that the facility was reviewed and passed inspection. – The report meets the organization's quality assessment criteria or standards. NCQA CR7—Element A3	**Assessment of Organizational Providers P&P -** Documentation and Criteria for Approval, A.6 demonstrates procedures for non-accredited providers	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
27. The Contractor's organizational provider assessment policies and processes include assessment of at least the following medical providers: • Hospitals • Home health agencies • Skilled nursing facilities • Freestanding surgical centers NCQA CR7—Element B	**Assessment of Organizational Providers P&P -** Pg. 1 has these providers highlighted	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
28. The Contractor has documentation that it has assessed contracted medical health care (organizational) providers. NCQA CR7—Element D		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
29. If the Contractor delegates any NCQA-required credentialing or recredentialing activities, the Contractor has a written delegation document with the delegate that: • Is mutually agreed upon. • Describes the delegated activities and responsibilities of the Contractor and the delegated entity. • Requires at least semiannual reporting by the delegated entity to the Contractor. • Describes the process by which the Contractor evaluates the delegated entity's performance. • Specifies that the organization retains the right to approve, suspend, or terminate individual practitioners, providers, and sites—even if the organization delegates decision making. • Describes the remedies available to the Contractor (including revocation of the contract) if the delegate does not fulfill obligations. NCQA CR8—Element A	**Delegation Agreement Template-** Each bullet is highlighted and marked out in this document. **Delegation of Credentialing Activities P&P -** Bullets from this standard are highlighted and marked	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
30. If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes the following provisions: • The allowed uses of PHI. • A description of delegate safeguards to protect the information from inappropriate use or further disclosure. • A stipulation that the delegate will ensure that subdelegates have similar safeguards. • A stipulation that the delegate will provide members with access to their PHI. • A stipulation that the delegate will inform the Contractor if inappropriate use of information occurs. • A stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends. NCQA CR8—Element B	**Delegation of Credentialing Activities P&P -** DHMP requires delegates to follow the rules and standards of the Health Insurance Portability and Department Accountability Act (HIPAA)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Findings: DHMP reported that PHI is not used during credentialing or recredentialing activities. Quality information considered during recredentialing is either aggregated or deidentified.		
31. For new delegation agreements in effect fewer than 12 months, the Contractor evaluated delegate capacity to meet NCQA requirements before delegation began. NCQA CR8—Element C	**Delegation of Credentialing Activities P&P -** This policy states that DHMP uses NCQA standards regarding credentialing and when considering a delegate, compares the delegate's program against Company standards to ensure they meet the minimum standards.	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Findings: DHMP entered into no new credentialing delegation agreement during the 12 months preceding the site review.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
32. For delegation agreements in effect 12 months or longer, the Contractor: • Annually reviews its delegates' credentialing policies and procedures. • Annually audits credentialing and recredentialing files against NCQA standards for each year that delegation has been in effect. • Annually evaluates delegate performance against NCQA standards for delegated activities. • Semiannually evaluates delegate reports specified in the written delegation agreement. • At least once in each of the past two years, identified and followed up on opportunities for improvement, if applicable. NCQA CR8—Elements D and E	**Delegation of Credentialing Activities P&P-** This policy states that DHMP uses NCQA standards regarding credentialing and during annual evaluation of a delegate, compares the delegate's program against Company standards to ensure they meet the minimum standards. **Delegation Agreement Template**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	30	X	1.00	=	30
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	2	X	NA	=	NA
Total Applicable		=	30	**Total Score**		=	30
				Total Score ÷ Total Applicable		=	100%

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. *42 CFR 438.330(a)* Contract: Exhibit B—12.1	**MCD_CHP+_2018-2019_QI_Program_Description_FINAL**– demonstrates that we have a QI program in place. There is documentation of the program scope, goals, objectives and structure. **2018-2019 MCD_CHP+ Work Plan_FINAL –** demonstrates our yearly planned activities for our QI program. **2017-2018 MCD_CHP_Evaluation_FINAL -** demonstrates the analysis of the QI program's past year activities including barrier analysis and action plans for the upcoming year. **QMC minutes_09_11_18_Signed_Redacted-** approval of the QI program. See bookmarks	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor's QAPI Program includes conducting and submitting (to the State) annually and when requested by the Department performance improvement projects (PIPs) that focus on both clinical and nonclinical areas. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. Each PIP includes the following: • Measurement of performance using objective quality indicators. • Implementation of interventions to achieve improvement in the access to and quality of care.	**2016-2018 CHP+ DHMP PIPs-** includes validation report for 2017-2018 and Modules 1 & 2 for the new PIP cycle.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Evaluation of the effectiveness of the interventions based on the objective quality indicators. • Planning and initiation of activities for increasing or sustaining improvement. *42 CFR 438.330(b)(1) and (d)(2) and (3)* Contract: Exhibit B—12.3.1, 12 3.2, 12.3.4		
3. The Contractor's QAPI Program includes collecting and submitting (to the State) annually: • Performance measure data using standard measures identified by the State. • Data, specified by the State, which enable the State to calculate the Contractor's performance using the standard measures identified by the State. • A combination of the above activities. *42 CFR 438.330(b)(2) and (c)* Contract: Exhibit B—12.4.1, 12.4.2	**2017-2018 MCD_CHP_Evaluation_FINAL-** demonstrates the analysis of the QI program's past year activities using performance measure data. **FW_ Final MCD & CHP IDSS File Upload-** email confirmation of HEDIS data upload to State **RE_ CAHPS database submission-** email confirmation of CAHPS data upload to State	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42 CFR 438.330(b)(3)* Contract: Exhibit B—12.4.4	**2017-2018 MCD_CHP_Evaluation_FINAL-** demonstrates the analysis of the QI program's past year activities including barrier analysis and action plans for the upcoming year. **2018 OCT 3 HEDIS 2018 Rates Compared to H2017 2016 2015 2014 2013 2012 & 2011 Rates**– This workbook trends CHP+ HEDIS data. This	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	master book is used for interventions and analysis for both the QI team and leadership (including providers involved). **MCD_CHP+_CareCoordination_18-19_Program_Description_FINAL-** Describes the ACS Care Coordination program for the current year. Including risk stratification and predictive modeling to identify care gaps. **QMC minutes_09_11_18_Signed_Redacted-** approval of the ACS Care Coordination program. See bookmarks	
Findings: DHMP did not provide any documents that demonstrated detection or analysis of under- or overutilization of services. During on-site interviews, staff members stated that some of the HEDIS measures may be used as indicators of over- or underutilization, and that DHMP was in the process of designing new reporting of utilization measures that would become an ongoing component of the QAPI program. HSAG encouraged DHMP to use the extensive claims database of services and member and provider demographics to trend utilization patterns as another mechanism to detect over- or underutilization.		
Required Actions: DHMP must incorporate mechanisms to detect both under- and overutilization of services into its QAPI program.		
5. The Contractor's QAPI program includes investigation of any alleged quality of care concerns. Contract: Exhibit B—12.4.5.1	**2017-2018 MCD_CHP_Evaluation_FINAL**– demonstrates the investigation of QOCCs. See bookmarks. **Notification and Investigation of Quality of Care Complaints_FINAL P&P-** Notification and Investigation of Quality of Care Complaints-	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Outlines the development and implementation process for investigating quality of care complaints.	
6. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. *Note: Persons with special health care needs means persons with ongoing heath conditions that: have lasted or are expected to last for at least one year; produce significant limitations in physical, cognitive, emotions, or—in the case of children—social growth or developmental function; or produce dependency on medical or assistive devices; or—in the case of children—unusual need for psychological, educational, or medical services or ongoing special treatments (e.g. medications, special diets, accommodations at home or at school).* *42 CFR 438.330(b)(4)* Contract: Exhibit B—None	**2017-2018 MCD_CHP_Evaluation_FINAL –** demonstrates the analysis of the care furnished to members with special health care needs. **Coordination and Continuity of Care for Members with Special Needs P&P-** This policy describes the coordination of services for members with special health needs as well as procedures to assess that the member is able to get quality care that meets their needs.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DHMP did not provide any documents that demonstrated specific assessment of the quality and appropriateness of care delivered to members with SHCN. While DHMP had operational care processes targeted toward enhancing the quality of care delivered to individual members with SHCN, such as comprehensive care coordination activities or a designated clinic for providing care to children with SHCN, HSAG did not find any evidence that DHMP periodically assessed the overall quality of care being delivered to SHCN members or a designated subset of these members.		
Required Actions: DHMP must develop and implement mechanisms within its QAPI program to demonstrate assessment of the quality and appropriateness of care rendered to members with SHCN.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program at least annually. *42 CFR 438.330(e)(2)* Contract: Exhibit B—12.4.7.1	**2017-2018 MCD_CHP_Evaluation_FINAL-** demonstrates the analysis of the QI program's past year activities including barrier analysis and action plans for the upcoming year. **QMC minutes_09_11_18_Signed_Redacted-** approval of the QI program. See bookmarks.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor adopts practice guidelines that meet the following requirements: • Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. • Consider the needs of the Contractor's members. • Are adopted in consultation with participating providers. • Are reviewed and updated at least every two years. *42 CFR 438.236(b)* Contract: Exhibit B—12.2.1.2	**Clinical Practice and Preventive Care Guidelines P&P**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor develops practice guidelines for the following: • Perinatal, prenatal, and postpartum care. • Conditions related to persons with a disability or special health care needs. • Well-child care. Contract: Exhibit B—12.2.1.1	**DHMP__Perinatal Guideline_2017_FINAL_w_Attachments** **ADHD Guideline_01_2018_FINALwAttachments** **Asthma Guideline_2018_FINAL**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Treatment of Depression in Adults in Primary Care Guideline _2018_FINAL **DHMP_Diabetes_Guideline_2017revisionFINAL** **Well Newborn_2018_FINAL_Signed** **Well child and adolescent health guideline 2018_FINAL_Signed**	
10. The Contractor disseminates the guidelines to all affected providers and, upon request, members, non-members, and the public—at no cost. *42 CFR 438.236(c)* Contract: Exhibit B—12.2.1.3	**Clinical Practice and Preventive Care Guidelines P&P** **DHMP Website_QI Guidelines Screenshot-** Where providers and members can access all guidelines. **Member Newsletter - Summer 2018** **ManagedCareMinute_Quality Improvement_7-13-18**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42 CFR 438.236(d)* Contract: Exhibit B—12.2.1.4	**Clinical Practice and Preventive Care Guidelines P&P** **Clinical Criteria for UM Decisions P&P** **Inter-Rater Reliability of Utilization Management P&P** **MCD_CHP+_CareCoordination_18-19_Program_Description_FINAL**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42 CFR 438.242(a)* Contract: Exhibit B—12.4.10.1	**AltruistaHealth-DHHA-ETL-Process-1510** **Information System-2018** **MedImpact File Specs**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
13. The Contractor's health information system provides information about areas including but not limited to utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility. *42 CFR 438.242(a)* Contract: Exhibit B—12.4.10.1	**AltruistaHealth-DHHA-ETL-Process-1510** **Information System-2018** **MedImpact File Specs**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor's claims processing and retrieval systems collect data elements necessary to enable the mechanized claims processing and information retrieval systems operated by the State. • Contractor electronically submits encounter claims data in the interChange ANSI X12N 837 format directly to the Department's fiscal agent using the Department's data transfer protocol. The 837-format encounter claims (reflecting claims paid, adjusted, and/or denied by the Contractor) shall be submitted via a regular batch process. *42 CFR 438.242(b)(1)* Contract: Exhibit B—18.2.1	**Encounter Workflow** **Encounter 837 Examples-** Zipped file **Denver Health Medicaid Medical Submission Process Overview with Screen Shots** **Denver Health Medicaid NCPDP Submission Process Overview with Screen Shots**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The Contractor collects data on member and provider characteristics and on services furnished to members through an encounter data system (or other methods specified by the State). *42 CFR 438.242(b)(2)* Contract: Exhibit B—12.4.10.2	**AltruistaHealth-DHHA-ETL-Process-1510** **Information System-2018** **MedImpact File Specs**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. The Contractor ensures that data received from providers are accurate and complete by: • Verifying the accuracy and timeliness of reported data, including data from network providers compensated through capitation payments. • Screening the data for completeness, logic, and consistency. • Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies used for Medicaid quality improvement and care coordination efforts. *42 CFR 438.242(b)(3) and (4)* Contract: Exhibit B—12.4.10.3.1	**Provider Data Workflow**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
17. The Contractor: • Collects and maintains sufficient member encounter data to identify the provider who delivers any items or services to members.	**Encounter Workflow** **Encounter 837 Examples-** Zipped file **Denver Health Medicaid Medical Submission Process Overview with Screen Shots**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Submits member encounter data to the State in standardized ASC X12N 837, NCPDP, and ASC X12N 835 formats as appropriate. • Submits member encounter data to the State at the level of detail and frequency specified by the State. *42 CFR 438.242(c)* Contract: Exhibit B—18.2.6; 18.2.7, 18.2.8	**Denver Health Medicaid NCPDP Submission Process Overview with Screen Shots**	
18. The Contractor monitors members' perceptions of accessibility and adequacy of services provided, including: • Member surveys. • Anecdotal information. • Grievance and appeals data. • Enrollment and disenrollment information. Contract: Exhibit B—12.4.3.2	**2017-2018 MCD_CHP_Evaluation_FINAL-** demonstrates monitoring of members' perceptions including member surveys, anecdotal information and grievance and appeals data. **CHP+ Disenrollment 7.1.18 - 10.31.18-** disenrollment is monitored monthly via DHMP's business intelligence portal to understand reasons for member disenrollment. Appropriate action is determined based on disenrollment reasons. In the attached report the only two reasons for disenrollment are loss of eligibility and termination for other health coverage **CHP_Enrollment Tracking_SharePoint-** screen shot of DHMP SharePoint site where CHP enrollment is tracked/monitored.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard X—Quality Assessment and Performance Improvement							
Total	Met	=	16	X	1.00	=	16
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	18	**Total Score**		=	16
				Total Score ÷ Total Applicable		=	89%

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2018–2019 Credentialing Record Review Tool
for Denver Health Medical Plan

Review Period:	July 1–December 31, 2018
Date of Review:	December 4, 2018
Reviewer:	Barbara McConnell and Katherine Bartilotta
Health Plan Participant:	Reina Gordon

Sample #	1	2	3	4	5
Provider ID	***	***	***	***	***
Credentialing Date	07/26/18	07/26/18	07/26/18	07/26/18	07/26/18
The Contractor, using primary sources, verifies that the following are present:					
1. A current, valid license to practice with verification that no State sanctions exist	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
2. A valid DEA or CDS certificate (if applicable)	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐
3. Education and training	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
4. Board certification (if the practitioner states on the application that he or she is board certified)	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒
5. Work history (most recent 5 years or from time of initial licensure)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
6. History of malpractice settlements (most recent 5 years)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
7. Current malpractice insurance in required amount (physicians: 0.5mil/1.5mil)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
8. Verification that the provider has not been excluded from participation in federal programs	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
9. Signed application and attestation	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
10. Verification was within the allowed time limits (verification time limits are included below).	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Number of applicable elements	**10**	**8**	**9**	**9**	**9**
Number of compliant elements	**10**	**8**	**9**	**9**	**9**
Percentage compliant	**100%**	**100%**	**100%**	**100%**	**100%**

Verification time limits:

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

Comments:

Sample #	6	7	8	9	10
Provider ID	***	***	***	***	***
Credentialing Date	06/14/18	08/23/18	09/21/18	10/25/18	10/25/18
The Contractor, using primary sources, verifies that the following are present:					
1. A current, valid license to practice with verification that no State sanctions exist	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
2. A valid DEA or CDS certificate (if applicable)	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐
3. Education and training	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
4. Board certification (if the practitioner states on the application that he or she is board certified)	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒
5. Work history (most recent 5 years or from time of initial licensure)	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐
6. History of malpractice settlements (most recent 5 years)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
7. Current malpractice insurance in required amount (physicians: 0.5mil/1.5mil)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
8. Verification that the provider has not been excluded from participation in federal programs	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
9. Signed application and attestation	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
10. Verification was within the allowed time limits (verification time limits are included below).	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Number of applicable elements	**8**	**8**	**8**	**7**	**9**
Number of compliant elements	**8**	**8**	**8**	**7**	**9**
Percentage compliant	**100%**	**100%**	**100%**	**100%**	**100%**

Total number of applicable elements	**85**
Total number of compliant elements	**85**
Overall percentage compliant	**100%**

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2018–2019 Recredentialing Record Review Tool
for Denver Health Medical Plan

Review Period:	July 1–December 31, 2018
Date of Review:	December 4, 2018
Reviewer:	Barbara McConnell and Katherine Bartilotta
Health Plan Participant:	Reina Gordon

Sample #	1	2	3	4	5
Provider ID	***	***	***	***	***
Prior Credentialing or Recredentialing Date	08/18/16	08/25/16	09/15/16	08/18/16	09/22/16
Current Recredentialing Date	07/19/18	07/26/18	08/16/18	07/26/18	08/23/18
The Contractor, using primary sources, verifies that the following are present:					
1. A current, valid license to practice with verification that no State sanctions exist	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
2. A valid DEA or CDS certificate (if applicable)	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐
3. Board certification (if the practitioner states on the application that he or she is board certified)	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐
4. History of malpractice settlements (most recent 5 years)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
5. Current malpractice insurance in required amount (physicians: 0.5mil/1.5mil)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
6. Verification that the provider has not been excluded from participation in federal programs	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
7. Signed application and attestation	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
8. Verification was within the allowed time limits (verification time limits are included below).	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
9. Provider was recredentialed within 36 months of previous approval date.	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Number of applicable elements	**7**	**9**	**7**	**9**	**9**
Number of compliant elements	**7**	**9**	**7**	**9**	**9**
Percentage compliant	**100%**	**100%**	**100%**	**100%**	**100%**

Verification time limits:

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

Comments:

Sample #	6	7	8	9	10
Provider ID	***	***	***	***	***
Prior Credentialing or Recredentialing Date	10/20/16	08/25/16	10/27/16	11/17/18	12/15/16
Current Recredentialing Date	09/20/18	07/26/18	09/27/18	10/25/18	11/15/18
The Contractor, using primary sources, verifies that the following are present:					
1. A current, valid license to practice with verification that no State sanctions exist	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
2. A valid DEA or CDS certificate (if applicable)	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐
3. Board certification (if the practitioner states on the application that he or she is board certified)	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐
4. History of malpractice settlements (most recent 5 years)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
5. Current malpractice insurance in required amount (physicians: 0.5mil/1.5mil)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
6. Verification that the provider has not been excluded from participation in federal programs	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
7. Signed application and attestation	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
8. Verification was within the allowed time limits (verification time limits are included below).	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
9. Provider was recredentialed within 36 months of previous approval date.	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Number of applicable elements	**7**	**9**	**9**	**9**	**9**
Number of compliant elements	**7**	**9**	**9**	**9**	**9**
Percentage compliant	**100%**	**100%**	**100%**	**100%**	**100%**

Total number of applicable elements	**84**
Total number of compliant elements	**84**
Overall percentage compliant	**100%**

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2018–2019 site review of **DHMP**.

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

HSAG Review Team	Title
Barbara McConnell	Executive Director
Katherine Bartilotta	Associate Director
DHMP Participants	**Title**
Catharine Fortney	Chief Compliance and Audit Officer
Debra Gardner	Associate Chief Nurse, Ambulatory Services
Greg McCarthy	Chief Executive Officer
Gregg Kamas	Director, Quality Improvement
Jeremy Sax	Manager, Government Products
Jessica Johnson-Simmons	Managed Care Coordinator
Kaitlin Gaffney	Managed Care Analyst/DHMP
Kathryn Burch	Project Manager, Quality Improvement
Keri Gottlieb	Contracting Manager, Provider Relations
Lucas Wilson	Director, Information Systems/DHMP
Mike Wagner	Chief Administrative Officer
Natalie Score	Manager, Government Products
N. Stiglich	Medical Director, DHMP
Rachel Baker	Interim Compliance Officer
Reina Gordon	Manager, Provider Credentialing
Department Observers	**Title**
Russell Kennedy	Quality Improvement
Teresa Craig (telephonic)	Program and Contract Manager, CHP+

Appendix D. Corrective Action Plan Template for FY 2018–2019

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

Table D-1—Corrective Action Plan Process

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

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

The CAP template follows.

Table D-2—FY 2018–2019 Corrective Action Plan for DHMP

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
1. The Contractor implements procedures to deliver care to and coordinate services for all members. These procedures meet State requirements, including: • Ensuring timely coordination with any of a member's providers, including mental health providers, for the provision of covered services. • Addressing those members who may require services from multiple providers, facilities, and agencies; and who require complex coordination of benefits and services. • Ensuring that all members and authorized family members or guardians are involved in treatment planning and consent to any medical treatment. • Criteria for making referrals and coordinating care with specialists, subspecialists, and community-based organizations. • Providing continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services. *42 CFR 438.208(b)* Contract: Exhibit B—10.5.1, 10.5.2, 10.5.3.3, 10.5.3.5, 10.5.3.6	DHMP submitted numerous documents and provided on-site discussion to demonstrate that the Denver Health system has numerous resources and tools to coordinate care for CHP+ members between different providers and programs. The collection of these processes and tools demonstrated mechanisms for coordination with a member's providers, addressing members who require complex coordination of benefits and services, ensuring that members and family members are involved in and consent to treatment planning, and providing criteria for making referrals to various providers and organizations. However, DHMP did not have a process in place to ensure that all newly enrolled members needing continuity of care were identified and, as needed, services to prevent disruption in care were provided.	DHMP must define and implement procedures for providing continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services.

Standard III—Coordination and Continuity of Care		
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 III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
2. The Contractor ensures that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member. • The member must be provided information on how to contact the designated person or entity. *42 CFR 438.208(b)(1)* Contract: Exhibit B—1.1.79, 7.11.1.2	DHMP demonstrated that Healthy Communities' family health coordinators outreach specific groups of CHP+ members to explain benefits and offer to help connect the member to providers. In addition, DHHA had mechanisms to provide contact information to a member regarding any care coordinator that might be involved with his or her care. However, DHMP did not have an active mechanism to ensure that each CHP+ member has an ongoing source of care—e.g., a PCP.	DHMP must implement mechanisms to ensure that each CHP+ member has an ongoing source of care, and that it provides information to members on how to contact his or her provider.
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 III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
4. The Contractor provides best efforts to conduct an initial screening of each new member's needs within 90 days of enrollment, including subsequent attempts if the initial attempt to contact the member is unsuccessful. • Assessment includes screening for special health care needs including mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems. *42 CFR 438.208(b)(3)* Contract: Exhibit B—10.5.3.1.1	DHMP staff members confirmed that DHMP did not have procedures to conduct an initial assessment of each new member's needs that includes the required assessment elements. Staff members stated that an assessment is performed on initial visit to a DHHA clinic; however, HSAG observed that members may not make an initial clinic appointment soon after enrollment. Similarly, the Healthy Communities Standard Work document described contacting all newly enrolled CHP+ members, but it specifically excluded conducting screening of the required assessment elements. DHMP staff members acknowledged that an initial assessment process "is a work in progress."	DHMP must implement a mechanism within 90 days of enrollment to attempt to conduct an initial screening of each new member's health needs, including assessment of mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health needs.
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 III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
8. The Contractor implements mechanisms to comprehensively assess each CHP+ member identified by the State as having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. *42 CFR 438.208(c)(2)* Contract: Exhibit B—10.6.2	DHHA's Care Management program included a comprehensive assessment of SHCN when members are referred to the Care Management program; however, mechanisms were unclear regarding how members with SHCN needs were identified and referred to the Care Management program.	DHMP must ensure that each member with SHCN receives a comprehensive assessment to identify any ongoing special conditions that require a course of treatment or regular care monitoring.
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 X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
4. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42 CFR 438.330(b)(3)* Contract: Exhibit B—12.4.4	DHMP did not provide any documents that demonstrated detection or analysis of under- or overutilization of services. During on-site interviews, staff members stated that some of the HEDIS measures may be used as indicators of over- or underutilization, and that DHMP was in the process of designing new reporting of utilization measures that would become an ongoing component of the QAPI program. HSAG encouraged DHMP to use the extensive claims database of services and member and provider demographics to trend utilization patterns as another mechanism to detect over- or underutilization.	DHMP must incorporate mechanisms to detect both under- and overutilization of services into its QAPI program.
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 X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
6. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. *Note: Persons with special health care needs means persons with ongoing heath conditions that: have lasted or are expected to last for at least one year; produce significant limitations in physical, cognitive, emotions, or—in the case of children—social growth or developmental function; or produce dependency on medical or assistive devices; or—in the case of children—unusual need for psychological, educational, or medical services or ongoing special treatments (e.g. medications, special diets, accommodations at home or at school).* *42 CFR 438.330(b)(4)* Contract: Exhibit B—None	DHMP did not provide any documents that demonstrated specific assessment of the quality and appropriateness of care delivered to members with SHCN. While DHMP had operational care processes targeted toward enhancing the quality of care delivered to individual members with SHCN, such as comprehensive care coordination activities or a designated clinic for providing care to children with SHCN, HSAG did not find any evidence that DHMP periodically assessed the overall quality of care being delivered to SHCN members or a designated subset of these members.	DHMP must develop and implement mechanisms within its QAPI program to demonstrate assessment of the quality and appropriateness of care rendered to members with SHCN.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
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 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 Integrated Quality Improvement Committee (IQuIC) 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 four 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 credentialing and recredentialing records that occurred between July 1, 2018, and December 31, 2018 (to the extent available at the time of the site visit). 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 credentialing and recredentialing of providers. • While on-site, HSAG collected and reviewed additional documents as needed. • 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 2018–2019 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.