Fiscal Year 2019–2020 Site Review Report

for

Denver Health Medical Plan

March 2020

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

Public Law 111-3, Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, requires that each state's Children's Health Insurance Program (CHIP) apply several provisions of Section 1932 of the Social Security Act 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 federal managed care regulations and State contract requirements, the Department determined that the review period for fiscal year (FY) 2019–2020 was January 1, 2019, through December 31, 2019. This report documents results of the FY 2019–2020 site review activities for **Denver Health Medical Plan** (**DHMP**). For each of the standard areas reviewed this year, this section contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 2 describes the background and methodology used for the 2019–2020 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the 2018–2019 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 denials of authorization of services (denials) 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 2019–2020 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)
I. Coverage and Authorization of Services	36	32	31	1	0	4	97%
II. Access and Availability	16	16	14	2	0	0	88%
Totals	**52**	**48**	**45**	**3**	**0**	**4**	**94%**

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

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

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	* Score (% of Met Elements)
Denials	90	53	44	9	37	83%
Totals	**90**	**53**	**44**	**9**	**37**	**83%**

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

Standard I—Coverage and Authorization of Services

Summary of Strengths and Findings as Evidence of Compliance

DHMP's *Utilization Review Determination Including Approvals and Action* policy (*Utilization Determinations* policy) accurately addressed processes for ensuring sufficient services are furnished to members and requirements for processing requests for authorization of services, including: definition of "medical necessity," authorization criteria used, ensuring that the medical reviewer has appropriate clinical expertise, consulting with the requesting provider, required time frames for making decisions and providing notification to members and providers, and content of information in the notice of adverse benefit determination (NABD). On-site denial record reviews confirmed compliance with all procedural requirements. **DHMP** presented two template NABD letters—CHP+ Medical Necessity Denial Letter (used for utilization management [UM] authorizations) and CHP+ Adverse Benefit Determination Letter (used for claims denials)—both of which included all required content. **DHMP** applied the Department's medical necessity criteria, Milliman Care Guidelines, and Hayes, Inc. Knowledge Center Guidelines in making authorization decisions. **DHMP** submitted evidence of annual and new hire inter-rater reliability testing to ensure consistent application of criteria. Staff members stated that **DHMP**'s medical director or a subcontracted All-Med Healthcare Management physician specialist reviewer makes all denial decisions, ensuring that appropriate clinical expertise is applied. The content in the body of the NABD letter—including the text describing the reason for the decision—and attached information pertaining to appeals and a State fair hearing (SFH) were written in language easy for the member to understand and the NABD was available in alternative formats. The template extension letter to the member included the member's right to file a grievance if he or she disagrees with the extension decision. The *Drug Authorization, Utilization Review and Formulary Management* policy defined procedures for reviewing and authorizing pharmacy requests and notifying the provider and/or requestor of approval or denial of the request no later than 24 hours after receiving the request. Staff members stated that the pharmacy benefit manager provides written notice via fax to the requestor and sends a written letter to the member. **DHMP** provided evidence of pharmacy approval and denial letters to members and providers, which included all required information. All requests for authorization and notices to the member were time and date stamped to ensure that expedited authorizations were processed within the required 72-hour time frame or outpatient drug authorization requests were processed within the required 24-hour time frame. **DHMP**'s UM software automatically flagged reviewers for all required time frames and **DHMP** management regularly monitored compliance with time frames through system-generated reports.

DHMP's *Utilization Determinations* policy and *Adjudication of Urgent, Emergency Care, Emergency Observation, and Emergency Admission and Post Stabilization Claims* policy (*Emergency and Post-Stabilization Claims* policy) accurately defined emergency services, emergency condition, and post-stabilization policies, and addressed requirements for coverage and payment of emergency services. The *Emergency and Post-Stabilization Claims* policy and on-site interviews confirmed that **DHMP** pays all emergency facility claims, regardless of circumstances. The *Utilization Determinations* policy and *Emergency and Post-Stabilization Claims* policy also addressed verbatim the requirements for payment of post-stabilization services. During on-site interviews, staff members stated that all services provided

during the first 24 hours of a post-stabilization inpatient stay are paid in full, regardless of circumstances. If a post-stabilization inpatient stay has not been previously authorized, claims are pended and forwarded to the UM department for application of review criteria and UM authorization determination for the remainder of the inpatient stay. Staff members stated that adjudication of a post-stabilization claim is not completed until the UM department has issued a determination and instructed the claims department accordingly. For post-stabilization services delivered out of network, the UM department also engages the Denver Health transfer team to assist the member with transfer to a **DHMP** network facility. Staff stated that **DHMP** does not balance bill any members for any services delivered in or out of network and communicates to out-of-network providers that they may not balance bill a member.

Summary of Findings Resulting in Opportunities for Improvement

HSAG noted that the information in the CHP+ member handbook and the information in **DHMP**'s UM policies concerning the CHP+ definition of "medically necessary" appeared disconnected. While the definition in UM policies failed to specifically document "not solely for cosmetic purposes" and "failure to provide services would adversely affect the member" as considerations for medically necessary, the member handbook explicitly noted "cosmetic surgery" and "failure to provide care would negatively affect the member" in its description of medically necessary. HSAG recommends that **DHMP** attempt to better align medical necessity definitions between these sources.

HSAG noted that the CHP+ Medical Necessity Denial Letter informed members of availability in alternative formats; however, this information was included in the Notice of Non-Discrimination attachment to the letter rather than the body of the letter. HSAG suggests that **DHMP** inform the member of the availability of the letter in alternative formats in the body of the letter.

HSAG noted that information in the CHP+ Medical Necessity Denial Letter refers to the "Notice of Action." Whereas the 2016 revisions to managed care regulations changed this term to "Notice of Adverse Benefit Determination," HSAG recommends that **DHMP** update "Notice of Action" to current regulatory language.

Information in attachments to the CHP+ Medical Necessity Denial Letter—specifically, the Designation of Personal Representative form and Notice of Non-Discrimination—includes language beyond a sixth-grade reading level. HSAG also noted that this information is not specifically required per managed care regulations to be included in the NABD and considerably extends the length of the letter. HSAG recommends that **DHMP** evaluate the necessity of including these attachments in the NABD and, if retained, correct the attachments to include language that the member can easily understand.

In review of the CHP+ Adverse Benefit Determination Letter and the CHP+ Medical Necessity Denial Letter, HSAG found information in the CHP+ Adverse Benefit Determination Letter easier for the member to understand and accurate in its entirety. HSAG recommends that **DHMP** consider incorporating similar information and language into its template CHP+ Medical Necessity Denial Letter.

The *Utilization Determinations* policy addressed all required content areas of the NABD except "the member's right to appeal under the Child Mental Health Treatment Act (CMHTA), when applicable." In addition, the policy included no procedures for staff members to determine when it is applicable to include the CMHTA appeal information in the denial letter to the member. The CHP+ Medical Necessity Denial Letter template did not include CMHTA information, whereas the CHP+ Adverse Benefit Determination Letter did include such information. During on-site interviews, staff members stated that **DHMP** would further evaluate processes for determining when CMHTA information is appropriately included—or not—in NABDs and that **DHMP** intends in the near future to be able to program the UM system to include CMHTA appeal information in specific letters where the CMHTA applies. HSAG encourages **DHMP** to proceed in this manner to ensure that CMHTA information is communicated in denial letters where it specifically applies.

While staff members stated that it is **DHMP**'s policy to pay all post-stabilization claims for the first 24 hours of hospitalization as well as to pend the payment of a post-stabilization inpatient claim until all UM processes and determinations have been completed, these procedures were not clearly stated in the *Emergency and Post-Stabilization Claims* policy. HSAG recommends that **DHMP** describe these procedures in its *Adjudication of Urgent, Emergency Care, Emergency Observation, and Emergency Admission and Post Stabilization Claims* policy, as these processes supersede and account for application of most of the managed care requirements for determining financial responsibility for post-stabilization services.

Summary of Required Actions

While the *Utilization Determinations* policy, as well as the two template NABD letters—one for claims and one for denials of medical necessity—addressed all required content areas, the CHP+ Medical Necessity Denial Letter included several inaccuracies in the detailed content of the appeal, SFH, and continuation of benefits information (specific inaccuracies are listed in the findings of element #17 in the compliance monitoring tool). Due to these inaccuracies, HSAG found 8 of 10 denial record reviews were *Not Met* for required content of the NABD. **DHMP** must correct inaccuracies in the required content of the CHP+ Medical Necessity Denial Letter.

Standard II—Access and Availability

Summary of Strengths and Findings as Evidence of Compliance

The Denver Health and Hospital Authority (DHHA)-employed provider network was **DHMP**'s primary source of practitioners to serve its CHP+ members. **DHMP** provided its network adequacy narrative, GeoAccess reports submitted to the Department, and Network Management Committee minutes as evidence that it monitors its network of clinics to determine adequacy of geographical access and timeliness of appointments for primary and non-urgent physical healthcare. The *Network Adequacy Plan* described use of practitioner-to-member ratios, primary care provider (PCP)-to-member ratios, available specialists, open panels, the DHHA provider database, member satisfaction surveys, geographic accessibility based on GeoAccess maps, and analysis of grievance and appeals data to determine adequacy of the network. Given that **DHMP**'s geographical service area is only urban, the geographic analysis focused on a distance of 30 miles rather than analyzing travel times. **DHMP**'s *Network Adequacy Plan* and *Network Adequacy Report* included a table depicting types of accessibility and adaptive equipment available at specific DHHA clinics. The *Network Adequacy Report* also included a table listing all DHHA clinics within a quarter mile of a bus stop. **DHMP** had adequate policies, procedures, and processes for providing direct access to family planning services and services via out-of-network providers for second opinions or due to inability to provide timely services within network. The CHP+ member handbook informed members of all timely access standards and the *Access to Care and Services Standards* policy accurately depicted the timely access standards.

For pharmacy services, **DHMP** members are permitted to use community pharmacies contracted with MedImpact (**DHMP**'s pharmacy benefit manager) in addition to using pharmacies available at most DHHA clinic sites. During the on-site interview, **DHMP** staff members reported recently contracting with a large primary care clinic network, STRIDE Community Health Center, which will provide improved access for **DHMP**'s CHP+ members.

DHMP provided its training program script as evidence of robust training on cultural competency. **DHMP** provided evidence that it used data collected on members' and providers' primary and secondary languages spoken, member language preference, and member and provider ethnicity to determine the cultural competency sufficiency of the network. Although its study had some limitations, HSAG applauds **DHMP** for engaging in this type of analysis.

DHMP's provider directory's "tips for use," member handbook, and provider directory listing had accurate information regarding language, translation, and adaptive services available; timely access standards; and when services are available from out-of-network providers.

Summary of Findings Resulting in Opportunities for Improvement

DHMP's GeoAccess analysis evaluates distance to clinics using a 30-mile diameter, rather than distance traveled via road access. HSAG recommends that **DHMP** consider assessing distance traveled to determine the percentage of members within 30 miles of **DHMP** providers.

DHMP's *Network Adequacy Plan* included a description of processes that were outdated and not currently employed by **DHMP**'s provider support staff members. HSAG recommends that **DHMP** revise the *Network Adequacy Plan* and reports as needed to ensure that these documents reflect current **DHMP** network monitoring processes.

As evidence of monitoring that members receive a follow-up appointment following discharge from an inpatient hospitalization, **DHMP** provided DHHA's *Patient Discharge* policy, which indicated that discharging physicians determine the time frames for follow-up services. The inpatient workflow document indicated that patients are instructed to contact primary care within seven days. **DHMP**'s *Access to Care and Service Standards* policy depicted the required time standard for providing follow-up services; however, it did not adequately provide procedural information **DHMP** uses to ensure compliance with the standard. HSAG recommends that **DHMP** either add procedural information to its existing policies or develop a policy that provides information about how the health plan works with DHHA providers to ensure compliance with the CHP+-specific access standard for follow-up after hospitalization.

DHMP's CHP+ member handbook informed members of all timely appointment standards except the behavioral health standards. **DHMP** should consider informing CHP+ members of the behavioral health appointment standards via the CHP+ member handbook.

Summary of Required Actions

The **DHMP** fourth quarter *Network Adequacy Report* had analysis for the percentage of primary and specialty appointments within 30 days. While the report depicted the number of members that received a mental health visit, a visit related to a substance use disorder, and inpatient hospitalizations related to either mental health or substance use, **DHMP** was unable to provide evidence of tracking to ensure compliance with the timeliness standards for behavioral healthcare, non-urgent symptomatic care within seven days, or an outpatient follow-up appointment within seven days. Staff members reported during the on-site interview that no appointments are needed to receive physical health urgent care services; therefore, tracking timeliness of physical health urgent care appointments is not applicable. **DHMP** must develop a mechanism to track compliance with timely access to appointments for behavioral health and substance use services, non-urgent symptomatic care, and follow-up care following an inpatient hospitalization.

The *Network Adequacy Report* accurately depicted the timely appointment standards. **DHMP** provided evidence of reviewing timeliness of primary and specialty care appointments made through the Denver Health Call Center; however, **DHMP** did not have a mechanism to monitor compliance with timely access standards for its contracted organizational providers (University Physicians, Inc. and The Children's Hospital of Colorado). **DHMP** must develop a mechanism to monitor contracted providers regularly to ensure compliance with timely access standards and implement corrective action plans (CAPs) if the providers fail to comply.

2. Overview and Background

Overview of FY 2019–2020 Compliance Monitoring Activities

For the FY 2019–2020 site review process, the Department requested a review of two areas of performance. HSAG developed a review strategy and monitoring tools consisting of two standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of the two standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the two 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+ denial of authorization.

HSAG also reviewed a sample of the health plan's administrative records related to CHP+ denials to evaluate implementation of federal healthcare regulations. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of six records (to the extent that a sufficient number existed). Using a random sampling technique, HSAG selected the sample from all CHP+ denial records that occurred between January 1, 2019, and December 31, 2019. 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 I—Coverage and Authorization of Services. HSAG separately calculated a record review score for each record 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.[2-1] Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The two standards chosen for the FY 2019–2020 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VI—Grievances and Appeals, Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, and Standard X—Quality Assessment and Performance Improvement.

Objective of the Site Review

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

- The health plan's compliance with federal healthcare regulations and managed care contract requirements in the two 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.

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Aug 5, 2019.

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

FY 2018–2019 Corrective Action Methodology

As a follow-up to the FY 2018–2019 site review, each health plan that received one or more *Partially Met* or *Not Met* scores was required to submit a CAP to the Department addressing those requirements found not to be fully compliant. If applicable, the health plan was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the health plan and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **DHMP** until it completed each of the required actions from the FY 2018–2019 compliance monitoring site review.

Summary of FY 2018–2019 Required Actions

For FY 2018–2019, HSAG reviewed 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.

Related to coordination and continuity of care, **DHMP** was required to complete four corrective actions, including:

- Providing continuity of care for newly enrolled members.
- Ensuring each CHP+ member has an ongoing source of care and is informed of how to contact his or her provider.
- Conducting an initial screening of each new member's health needs.
- Ensuring each member with special health care needs (SHCN) receives a comprehensive assessment.

Related to quality assessment and performance improvement, **DHMP** was required to complete two corrective actions, including:

- Detecting both under- and overutilization of services within its QAPI program.
- Assessing quality of care rendered to members with SHCN.

Summary of Corrective Action/Document Review

DHMP submitted a proposed CAP in March 2019. HSAG and the Department reviewed and approved the proposed plan and responded to **DHMP**. **DHMP** submitted initial documents as evidence of completion in August 2019, which included the revision of some planned interventions and a request for extension for completion of the CAP. **DHMP** subsequently provided resubmission of specific documents in September 2019 and November 2019. Following review by HSAG and the Department, **DHMP** was required to resubmit additional documentation as evidence of completion for one outstanding proposed intervention. **DHMP** resubmitted documentation in January 2020, and all required actions were found to be successfully completed.

Summary of Continued Required Actions

DHMP successfully completed the FY 2018–2019 CAP, resulting in no continued corrective actions.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor ensures that the services are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished. *42 CFR 438.210(a)(3)(i)* Contract: Exhibit B-1—8.3	• Utilization Review Determination Including Approvals and Action - Pg. 4, C.1.c	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42 CFR 438.210(a)(3)(ii)* Contract: Exhibit B-1—8.11	• Utilization Review Determination Including Approvals and Action - Page 5 (D)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
3. The Contractor may place appropriate limits on services— • On the basis of criteria applied under the State plan (such as medical necessity). • For the purpose of utilization control, provided that: – The services furnished can reasonably achieve their purpose. – Family planning services are provided in a manner that enables the member to be free from coercion and choose the method of family planning to be used. – Long-term services and supports (LTSS) supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the member's ongoing need for such services. *42 CFR 438.210(a)(4)* Contract: Exhibit B-1—8.15.8.1	• Utilization Review Determination Including Approvals and Action - Pg.5 (E) (B.2) • CHP+ Member Handbook – Pg. 28	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor may place appropriate limits on services for utilization control, provided that any financial requirement or treatment limitation applied to mental health or SUD benefits in any classification is no more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to members (whether or not the benefits are furnished by the same Contractor). *HB19-1269: Section 3—10-16-104(3)(B)* Contract: Exhibit B-1—8.15.4.1		*For Information Only*
5. The Contractor must ensure that the diagnosis of an intellectual or developmental disability, a neurological or neurocognitive disorder, or a traumatic brain injury does not preclude an individual from receiving a covered behavioral health (BH) service. *HB19-1269: Section 12—25.5-5-402(3)(h)*		*For Information Only*
6. The Contractor covers all medically necessary covered treatments for covered BH diagnoses, regardless of any co-occurring conditions. *HB19-1269: Section 12—25.5-5-402(3)(i)*		*For Information Only*
7. The Contractor specifies what constitutes "medically necessary" in a manner that is: • Consistent with the symptom, diagnosis, and treatment of a member's medical condition. • Widely accepted by the practitioner's peer group as effective and reasonably safe based on scientific evidence.	• Utilization Review Determination Including Approvals and Action - Pg.3 – (A-G) • CHP+ Member Handbook – Pg. 33	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Not experimental, investigational, unproven, unusual, or not customary. • Not solely for cosmetic purposes. • Not solely for the convenience of the member, subscriber, physician, or other provider. • The most appropriate level of care that can be safely provided to the member, and failure to provide the service would adversely affect the member's health. • When applied to inpatient care—medically necessary services cannot be safely provided in an ambulatory setting. Contract: Exhibit B-1—1.1.62.1–8		
8. The Contractor and its subcontractors have in place and follow written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42 CFR 438.210(b)(1)* Contract: Exhibit B-1—11.1.5	• Utilization Review Determination Including Approvals and Action- Pg. 1 (A)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor and its subcontractors have in place mechanisms to ensure consistent application of review criteria for authorization decisions. *42 CFR 438.210(b)(2)(i)* Contract: Exhibit B-1—11.1.6	• Inter-Rater Reliability of Utilization Management – Pg. 1- (II)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. The Contractor and its subcontractors have in place mechanisms to consult with the requesting provider for medical services when appropriate. *42 CFR 438.210(b)(2)(ii)* Contract: Exhibit B-1—11.1.6	• Utilization Review Determinations Including Approvals and Action- Pg. 8 (B.1.c)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by an individual who has appropriate expertise in treating the member's medical or BH needs. *42 CFR 438.210(b)(3)* Contract: Exhibit B-1—11.1.3	• Utilization Review Determinations Including Approvals and Action- Pg. 5 (C)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor notifies the requesting provider and gives the member written notice of any decision by the Contractor to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. *Note: Notice to the provider may be oral or in writing.* *42 CFR 438.210(c)* Contract: Exhibit B-1—11.1.8	• Utilization Review Determinations Including Approvals and Action- Pg. 11 (C.2.a)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. The Contractor adheres to the following time frames for making standard and expedited authorization decisions: • For standard authorization decisions—as expeditiously as the member's condition requires and not to exceed 10 calendar days following the receipt of the request for service. • If the provider indicates, or the Contractor determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service. *42 CFR 438.210(d)(1–2)* Contract: Exhibit B-1—11.1.10–11.1.12	• Utilization Review Determinations Including Approvals and Action- Pg. 6 (A.1.b.i & ii), Pg. 7 (A.2.a.i & ii), Pg. 7 (A.4.a) • UM Prior Authorization Request Form 2019 - fillable	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor may extend the time frame for making standard or expedited authorization decisions by up to 14 additional calendar days if: • The member or the provider requests an extension, or • The Contractor justifies a need for additional information and how the extension is in the member's interest. *42 CFR 438.210(d)(1)(i–ii) and (d)(2)(ii)* Contract: Exhibit B-1—11.1.10.1–2; 11.1.12.1–2	• Utilization Review Determinations Including Approvals and Action- Pg. 7 (A.1.iii) (A.4.b.i)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
15. The Contractor provides telephonic or telecommunications notice within twenty-four (24) hours of a request for prior authorization of covered outpatient drugs. *42 CFR 438.210(c)(3)* *42 US Code 1396r-8(d)(5)(a)* Contract: Exhibit B-1—8.18.3.1	• Drug Authorization, Utilization Review and Formulary Management P&P. Page 9- #4	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
16. The notice of adverse benefit determination must be written in language easy to understand, available in prevalent non-English languages in the region, and available in alternative formats for persons with special needs. *42 CFR 438.404(a)* *42 CFR 438.10(c)* Contract: Exhibit B-1—14.1.3.15.1.1–4	Inform the health plan on-site that proposed federal rule changes include eliminating the 18-point requirement for taglines on denial notices. (Reviewed in Member Information standard.) • Utilization Review Determinations Including Approvals and Action- Pg. 11 (C.2.b) • Attachment H – CHP+ Medicaid Medical Necessity Denial Letter • Creation- Review and Readability of Member Materials- Pg. 2	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to and copies of all documents and records relevant to the adverse benefit determination (includes medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits). • The member's (or member's designated representative's) right to request one level of appeal with the Contractor and the procedures for doing so. • The member's right to request a State review after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State review. • The circumstances under which an appeal process can be expedited and how to make this request. • The member's rights to have benefits/services continue (if applicable) pending the resolution of the appeal, how to request that benefits continue, and the circumstances under which the member may be required to pay the cost of these services. • The member's right to appeal under the Child Mental Health Treatment Act (CMHTA), when applicable. *42 CFR 438.404(b)* Contract: Exhibit B-1—14.1.3.15.1.5–12	Inform health plan on-site that federal rule changes for CHIP exclude the requirement that member information include "benefits will continue when the member files an appeal." (However, State contract currently overrides.) • Utilization Review Determinations Including Approvals and Action- Pg. 12 (3.a) • Attachment H – CHP+ Medicaid Medical Necessity Denial Letter • CHP+ Adverse Benefit Determination Letter	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The Utilization Determinations policy, as well as the two template NABD letters—one for claims and one for denials of medical necessity—addressed all required content areas. However, the CHP+ Medical Necessity Denial Letter included several inaccuracies in the content of the appeal, SFH, and continuation of benefits information, specifically: • Must file the appeal by **the date listed on the NABD letter** (the only date listed on the letter is the date the NABD was sent; the date for filing an appeal is 60 calendar days after the NABD). • **Will continue services** during your appeal if: you **file your appeal** by the **date listed on your NABD** letter (member must request *continued benefits* within 10 days of the NABD or intended effective date of the proposed adverse benefit determination; member still has 60 days from date on NABD to file the appeal). • Will keep giving you these services until: **the time period of a previously authorized service has been met** (this criterion has been removed from federal regulations and is no longer applicable). • May request an **SFH** within **120 days of the NABD letter** (may request an SFH within 120 days of the *appeal resolution* letter). Due to the inaccuracies in content of the CHP+ Medical Necessity Denial Letter, HSAG scored 8 of 10 denial record reviews *Not Met* for required content of the NABD. The information in the content of the CHP+ Adverse Benefit Determination Letter (used for claims denials) was accurate in its entirety.		
Required Actions: DHMP must correct the inaccuracies in the required content of the CHP+ Medical Necessity Denial Letter.		
18. Notice of adverse benefit determination for denial of behavioral, mental health, or SUD benefits includes, in plain language: • A statement explaining that members are protected under the federal Mental Health Parity and Addiction Equity Act (MHPAEA), which provides that limitations placed on access to mental health and SUD benefits may be no greater than any limitations placed on access to medical and surgical benefits. • A statement providing information about contacting the office of the ombudsman for BH care if the member believes his or her rights under the MHPAEA have been violated.		*For Information Only*

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• A statement specifying that members are entitled, upon request to the Contractor and free of charge, to a copy of the medical necessity criteria for any behavioral, mental, and SUD benefit. *HB19-1269: Section 6—10-16-113 (I), and (II), and (III)* Contract: None		
19. The Contractor mails the notice of adverse benefit determination within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, as defined in 42 CFR 431.211, 431.213 and 431.214 (see below). • For denial of payment, at the time of any denial affecting the claim. • For standard service authorization decisions that deny or limit services, no later than 10 calendar days after receipt of request for service. • For expedited service authorization decisions, no later than 72 hours after receipt of request for service. • For extended service authorization decisions, no later than the date the extension expires. • For service authorization decisions not reached within the required time frames, on the date the time frames expire. *42 CFR 438.404(c)* Contract: Exhibit B-1—14.1.3.15.2.1–7	• Utilization Review Determinations Including Approvals and Action- Pg. 12 a. & Pg. 13 c.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
20. For reduction, suspension, or termination of a previously authorized Medicaid-covered service, the Contractor gives notice at least ten (10) days before the intended effective date of the proposed adverse benefit determination except: • The Contractor gives notice on or before the intended effective date of the proposed adverse benefit determination if: – The Agency has factual information confirming the death of a member. – The Agency receives a clear written statement signed by the member that he/she no longer wishes services, or gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information. – The member has been admitted to an institution where he/she is ineligible under the plan for further services. – The member's whereabouts are unknown, and the post office returns Agency mail directed to him/her indicating no forwarding address. – The Agency establishes that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth. – A change in the level of medical care is prescribed by the member's physician. – The notice involves an adverse benefit determination made with regard to the preadmission screening requirements. • If probable member fraud has been verified, the Contractor gives notice five (5) calendar days before the intended effective date of the proposed adverse benefit determination.	• Utilization Review Determinations Including Approvals and Action- Pg. 12 (I,a.-ii-a,b.i and iii) • CHP+ Member Handbook Pg. 53	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.404(c) *42 CFR 431.211* *42 CFR 431.213* *42 CFR 431.214* Contract: Exhibit B-1—14.1.3.15.2.1–3		
21. If the Contractor extends the time frame for standard authorization decisions, it must give the member written notice of the reason for the extension and inform the member of the right to file a grievance if he or she disagrees with that decision. *42 CFR 438.404(c)(4)* Contract: Exhibit B-1—14.1.3.15.2.5.2	Utilization Review Determinations Including Approvals and Action- Pg. 9 (b.)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
22. The Contractor provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42 CFR 438.210(e)* Contract: Exhibit B-1—11.1.1	• Utilization Review Determinations Including Approvals and Action- Pg. 5 (H)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
23. The Contractor defines emergency medical condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;	• Utilization Review Determinations Including Approvals and Action- Pg. 2 (A-C) • CHP+ Member Handbook- Pg. 22	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part. *42 CFR 438.114(a)* Contract: Exhibit B-1—1.1.31		
24. The Contractor defines emergency services as covered inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title and are needed to evaluate or stabilize an emergency medical condition. *42 CFR 438.114(a)* Contract: Exhibit B-1—1.1.32	• Utilization Review Determinations Including Approvals and Action- Pg. 2	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
25. The Contractor defines poststabilization care services as covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or provided to improve or resolve the member's condition. *42 CFR 438.114(a)* Contract: Exhibit B-1—1.1.75	• Utilization Review Determinations Including Approvals and Action- Pg. 4	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
26. The Contractor does not require prior authorization for emergency services or urgently needed services. Contract: Exhibit B-1—8.17.1.3	• Utilization Review Determination Including Approvals and Action. Page 2 (B.) • CHP+ Member Handbook. Pg. 22	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
27. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. *42 CFR 438.114(c)(1)(i)* Contract: Exhibit B-1—8.17.1.4	• Utilization Review Determinations Including Approvals and Action- Pg. 6 (M) • CHP+ Member Handbook 20 • Provider Directory- Pg. 7	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
28. The Contractor may not deny payment for treatment obtained under either of the following circumstances: • A member had an emergency medical condition, including cases in which the absence of immediate medical attention would *not* have had the following outcomes: – Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; – Serious impairment to bodily functions; or – Serious dysfunction of any bodily organ or part. *(Note: The Contractor bases its coverage decisions for emergency services on the severity of the symptoms at the time of presentation and covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. 42 CFR 438.114—Preamble)* • A representative of the Contractor's organization instructed the member to seek emergency services. *42 CFR 438.114(c)(1)(ii)* Contract: Exhibit B-1—8.17.1.4, 8.17.1.6	• Utilization Review Determinations Including Approvals and Action- Pg. 6 (K and L)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
29. The Contractor does not: • Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms. • Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent failing to notify the member's primary care provider or the Contractor of the member's screening and treatment within 10 calendar days of presentation for emergency services. *42 CFR 438.114(d)(1)* Contract: Exhibit B-1—8.17.3.3, 8.20.1, 8.17.1.7	• Utilization Review Determinations Including Approvals and Action- Pg. 6 (N and O)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
30. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42 CFR 438.114(d)(2)* Contract: Exhibit B-1—8.17.1.8	• Utilization Review Determinations Including Approvals and Action- Pg. 10 (4.c)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
31. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment. *42 CFR 438.114(d)(3)* Contract: Exhibit B-1—8.17.1.5	• Utilization Review Determinations Including Approvals and Action- Pg. 10 (4.d.i.) • Concurrent Utilization Management of Inpatient and Observation Stays- Pg. 4 (2.h)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
32. The Contractor is financially responsible for poststabilization services that are prior authorized by an in-network provider or Contractor representative, regardless of whether they are provided within or outside the Contractor's network of providers. *42 CFR 438.114(e)* *42 CFR 422.113(c)(i)* Contract: Exhibit B-1—8.17.4.1, 8.17.4.3, 8.17.4.5	• Utilization Review Determinations Including Approvals and Action- Pg. 10 (B.4.e) • Concurrent Utilization Management of Inpatient and Observation Stays- Pg. 5 (c.)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
33. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative but are administered to maintain the member's stabilized condition within one (1) hour of a request to the organization for pre-approval of further poststabilization care services. *42 CFR 438.114(e)* *42 CFR 422.113(c)(ii)* Contract: Exhibit B-1—8.17.4.6	• Utilization Review Determinations Including Approvals and Action- Pg. 10 (B.4.e&f) • Concurrent Utilization Management of Inpatient and Observation Stays- Pg. 4 (d.)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
34. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the member's stabilized condition if: • The organization does not respond to a request for pre-approval within 1 hour. • The organization cannot be contacted. • The organization's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation,	• Utilization Review Determinations Including Approvals and Action- Pg. 10 (B.4.f and g) • CHP+ Member Handbook- Pg. 23 under "Post Stabilization Care • Concurrent Utilization Management of Inpatient and Observation Stays- Pg. 4 (d)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
the organization must give the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with care of the patient until a plan provider is reached or one of the criteria in 422.113(c)(3) is met. *42 CFR 438.114(e)* *42 CFR 422.113(c)(iii)* Contract: Exhibit B-1—8.17.4.7		
35. The Contractor's financial responsibility for poststabilization care services it has not pre-approved ends when: • A plan physician with privileges at the treating hospital assumes responsibility for the member's care, • A plan physician assumes responsibility for the member's care through transfer, • A plan representative and the treating physician reach an agreement concerning the member's care, or • The member is discharged. *42 CFR 438.114(e)* *42 CFR 422.113(c)(3)* Contract: Exhibit B-1—8.17.4.9	• Utilization Review Determinations Including Approvals and Action- Pg. 10 (B.4.g. i,ii,iii) • CHP+ Member Handbook- Pg.23 • Concurrent Utilization Management of Inpatient and Observation Stays- 4 (2.e)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
36. If the member receives poststabilization services from a provider outside the Contractor's network, the Contractor does not charge the member more than he or she would be charged if he or she had obtained the services through an in-network provider. *42 CFR 438.114(e)* *42 CFR 422.113(c)(iv)* Contract: Exhibit B-1—8.17.4.8	• Concurrent Utilization Management of Inpatient and Observation Stays- Pg. 5 (2.j) • CHP+ Member Handbook- Pg. 23	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	31	X	1.00	=	31
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	4	X	NA	=	NA
Total Applicable		=	32	**Total Score**		=	31
				Total Score ÷ Total Applicable		=	97%

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor maintains and monitors a network of providers sufficient to provide access to all covered services to all members, including those with limited English proficiency or physical or mental disabilities. The provider network includes the following provider types: • Physicians • Specialists • Hospitals • Pharmacies • BH providers • LTSS providers, as appropriate *42 CFR 438.206(b)(1)* Contract: Exhibit B-1—7.13.1, 14.1.3.6	• Provider Relations Contract – Page 8, Section 3.14 • DHMP CHP+ Compliance Q4 SFY19v2 - Pg. 1 • CHP_NetworkStrategicPlan DHMP SFY19– Pg. 4 • Provider Manual 2019– Pg. 9	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. In establishing and maintaining the network adequacy standards, the Contractor considers: • The anticipated CHP+ enrollment. • The expected utilization of services, taking into consideration the characteristics and health care needs of specific CHP+ populations represented in the Contractor's service area. • The numbers, types, and specialties of network providers required to furnish the contracted CHP+ services. • The number of network providers accepting/not accepting new CHP+ members.	• DHMP CHP+ Compliance Q4 SFY19v2 • Provider Manual 2019 - Pg. 54 (non- English speaking) • Access to Care and Service Standards – Pg. 2 (A, 1-5) • CHP_NetworkStrategicPlan DHMP SFY19- Pg. 3 • CHP+ Member Handbook- Pg. 24- highlights the use of MyChart • Provider Directory- Pg. 7 • Provider Directory Screenshot- the searchable Provider Directory displays provider	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The geographic location of providers in relationship to where CHP+ members live, considering distance, travel time, and means of transportation used by members. • The ability of providers to communicate with limited-English-proficient members in their preferred language. • The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for members with physical or mental disabilities. • The availability of triage lines or screening systems, as well as use of telemedicine, e-visits, and/or other technology solutions. *42 CFR 438.206(a); 438.68(c)(i)–(ix)* Contract: Exhibit B-1—7.13.2.2.1	information like location and specialty as well as languages they speak. Member can also search by language specifically to find a provider that they can communicate with. All DHMC clinics have access to the Language Line which connects interpreters with providers and members *DHMP contracts with a number of providers to increase access. Contracts are available upon request.	
3. The Contractor ensures that its primary care and specialty care provider network complies with time and distance standards as follows: • Pediatric primary care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Pediatric specialty care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—100 miles or 100 minutes	• CHP Pharmacy Geo Access Report • Access to Care and Service Standards- Pg. 4 Obstetrics and gynecology are considered specialists in this policy • DHMP CHP+ Compliance Q4 SFY19v2 – DHMC; counties are all considered Urban counties. • CHP_NetworkStrategicPlan DHMP SFY19 • CHP+ Member Handbook shows all emergency or urgent care is covered in or out of network, Pg. 24 describes emergency care	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Obstetrics or gynecology: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Physical therapy/occupational therapy/speech therapy: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—100 miles or 100 minutes • Pharmacy: – Urban counties—10 miles or 10 minutes – Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes • Acute care hospitals: – Urban counties—20 miles or 20 minutes – Rural counties—30 miles or 30 minutes – frontier counties—60 miles or 60 minutes *42 CFR 438.206(a); 438.68(b)* Contract: Exhibit B-1—10.2.1.10		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor ensures that its BH provider network complies with time and distance standards as follows: • Acute care hospitals: – Urban counties—20 miles or 20 minutes – Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes • Psychiatrists and psychiatric prescribers for children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes • Mental health providers for children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes • SUD providers for children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes *Note: If there are no BH providers that meet the BH provider standards within the defined area for a specific member, then the Contractor shall not be bound by the time and distance requirements. (Exhibit B1—10.2.1.11.1)* *42 CFR 438.206(a); 438.68(b)* Contract: Exhibit B-1—10.2.1.12, 10.2.1.13.1	• DHMP CHP+ Compliance Q4 SFY19v2- Pg. 1-2 (comments section), 14	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor provides female members with direct access to a women's health care specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health care specialist. *42 CFR 438.206(b)(2)* Contract: Exhibit B-1—10.2.1.15	• Provider Relations Contract –Pg. 4, Section 1.27 • CHP+ Member Handbook – Pg. 30 • Access to Care and Service Standards- Pg. 4 (C.7) & 6 (6)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
6. The Contractor provides for a second opinion from a network provider or arranges for the member to obtain one outside the network (if there is no qualified provider within the network), at no cost to the member. *42 CFR 438.206(b)(3)* Contract: Exhibit B-1—10.2.1.16	• CHP+ Member Handbook – Pg. 25 • Access to Care and Service Standards- Pg. 4 (C.8 • Provider Manual 2019 - Pg. 96 • Utilization Review Determinations Including Approvals and Action- Pg. 6 (A.1.a)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
7. If the provider network is unable to provide necessary covered services to a particular member in network, the Contractor must adequately and in a timely manner cover the services out of network for as long as the Contractor is unable to provide them. *42 CFR 438.206(b)(4)* Contract: Exhibit B-1—10.2.2.1	• Access to Care and Service Standards – Pg. 4 (C.1) • Utilization Review Determinations Including Approvals and Action- Pg. 6 (I)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor requires out-of-network providers to coordinate with the Contractor for payment and ensures that the cost to the member is no greater that it would be if the services were furnished within the network. *42 CFR 438.206(b)(5)* Contract: Exhibit B-1—10.2.2.2	• OTA Notice- One Time Agreement • Access to Care and Service Standards– Page 4 (C.2) • CHP+ Member Handbook- Pg. 25	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services. *42 CFR 438.206(b)(7)* Contract: None	• Access to Care and Service Standards Pg. 4 (C.7.d)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. The Contractor must meet, and require its providers to meet, the State standards for timely access to care and services, taking into account the urgency of the need for services. The Contractor ensures that services are available as follows: • Emergency BH care: – By phone within 15 minutes of the initial contact. – In-person within 1 hour of contact in urban and suburban areas. – In-person within 2 hours of contact in rural and frontier areas. • Urgent care within 24 hours from the initial identification of need. • Non-urgent symptomatic care visit within 7 calendar days after member request.	• CHP+ Member Handbook – Pg. 24 • Access to Care and Service Standards – Pg. 5 • Patient Discharge P&P-Pg. 2 shows that providers set a discharge plan with follow up that is appropriate to members condition for hospitalization follow up	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Non-urgent medical or non-symptomatic well care within 30 calendar days after member request. • Outpatient follow-up appointments within 7 days after discharge from hospitalization. • Members may not be placed on waiting lists for initial routine BH services. *42 CFR 438.206(c)(1)(i)* Contract: Exhibit B-1—10.2.1.23.1–7, 10.2.1.23.7.2		
Findings: The DHMP fourth quarter *Network Adequacy Report* had analysis for the percentage of primary and specialty appointments within 30 days. The member handbook informed members of all timely access standards and the *Access to Care and Services* policy accurately depicted the timely access standards. While the report depicted the number of members that received a mental health visit, a visit related to a substance use disorder, and inpatient hospitalizations related to either mental health or substance use, DHMP was unable to provide evidence of tracking to ensure compliance with the timeliness standards for behavioral healthcare, non-urgent symptomatic care within seven days, or an outpatient follow-up appointment within seven days. Staff members reported during the on-site interview that no appointments are needed to receive physical health urgent care services. Members may go to any urgent care center without an appointment or approval; therefore, tracking timeliness of physical health urgent care appointments is not applicable. In addition, DHMP's CHP+ member handbook informed members of all timely appointment standards except the behavioral health standards.		
Required Actions: DHMP must develop a mechanism to track compliance with timely access to appointments for behavioral health and substance use services, non-urgent symptomatic care, and follow-up care following an inpatient hospitalization. DHMP should also consider informing CHP+ members of the behavioral health appointment standards via the CHP+ member handbook.		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor and its providers offer hours of operation that are no less than the hours of operation offered to commercial members or Medicaid members. The Contractors network provides: • Minimum hours of provider operation from 8 a.m. to 5 p.m. Monday through Friday. • Extended hours on evenings and weekends. • Alternatives for emergency department visits for after-hours urgent care. *42 CFR 438.206(c)(1)(ii)* Contract: Exhibit B-1—10.2.1.5–7	• Provider Relations Contract – Pg. 11, section 3.24 • CHP+ Member Handbook –Pg.51 – shows the Nurseline • Access to Care and Service Standards – Pg. 6 (E.7)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor makes services included in the contract available 24 hours a day, 7 days a week, when medically necessary. *42 CFR 438.206(c)(1)(iii)* Contract: Exhibit B-1—10.2.4.1	• Provider Relations Contract – Page 11, section 3.24 • CHP+ Member Handbook – Page 26 • Access to Care and Service Standards- Pg. 4 (3.f, 3.h, 3.i), 5 (D)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. The Contractor ensures timely access by: • Establishing mechanisms to ensure compliance with access (e.g., appointment) standards by network providers. • Monitoring network providers regularly to determine compliance. • Taking corrective action if there is failure to comply. *42 CFR 438.206(c)(1)(iv)–(vi)* Contract: Exhibit B-1—10.2.1.25.2	• CHP_NetworkStrategicPlan SFY19-Pg 6 • Adult and Pediatric Referral Guidelines	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The *Network Adequacy Report* accurately depicted the timely appointment standards. DHMP provided evidence of reviewing timeliness of primary and specialty care appointments made through the Denver Health Call Center; however, DHMP did not have a mechanism to monitor compliance with timely access standards for its contracted organizational providers (University Physicians, Inc. and The Children's Hospital of Colorado).		
Required Actions: DHMP must develop a mechanism to monitor contracted providers regularly to ensure compliance with timely access standards and use CAPs if the providers fail to comply.		
14. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. This includes: • Maintaining policies to provide prevention, health education, and treatment for diseases prevalent in specific cultural or ethnic groups. • Maintaining policies to provide health care services to members that respect individual health care attitudes, beliefs, customs, and practices related to cultural affiliation. • Maintaining written policies and procedures to ensure compliance with requirements of the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973. • Making written materials that are critical to obtaining services available in prevalent non-English languages and alternative formats for the visually and reading-impaired. • Providing cultural competency training programs, as needed, to network providers and health plan staff regarding: – Health care attitudes, values, customs, and beliefs that affect access to and benefit from health care services.	• Cultural and Linguistic Appropriate Services- Pg. 4 (B) • Evaluating Members Non-English Language Needs for Language Translation Services – Pg. 2 • Access to Care and Service Standards- Pg. 4 (3.j), 6 (F) • 2019 Annual - The Denver Health Experience; annual training modules that all DHMP providers have to complete	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Medical risks associated with the member population's racial, ethnic, and socioeconomic conditions. • Identifying members whose cultural norms and practices may affect their access to health care. These efforts shall include, but are not limited to, inquiries conducted by the Contractor of the language proficiency of individual members. • Providing language assistance services for all Contractor interactions with members, including interpreter services and TDD. *42 CFR 438.206(c)(2)* Contract: Exhibit B-1—10.8.2.1-4, 10.8.2.9-10, 10.8.2.12-13		
15. The Contractor must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities. *42 CFR 438.206(c)(3)* Contract: Exhibit B-1—10.8.2.10	• Provider Relations Contract – Page 9, section 3.14 • Provider Directory – Page 8 highlights accessibility at each DHMC clinic	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
16. The Contractor submits to the State (in a format specified by the State) documentation to demonstrate that the Contractor offers an appropriate range of preventive, primary care, and specialty services that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. • A Provider Network Strategic Plan is submitted to the State annually. • A Provider Network Capacity and Services Report is submitted to the State quarterly. *42 CFR 438.207(b)* Contract: Exhibit B-1—15.3.1, 15.3.2	• DHMP CHP+ Compliance Q4 SFY19v2- Pg. 1 • CHP+ Network Strategic Plan DHMP SFY19	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard II—Access and Availability							
Total	Met	=	14	X	1.00	=	14
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	16	**Total Score**		=	14
			Total Score ÷ Total Applicable			=	88%

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Denials Record Review Tool
for Denver Health Medical Plan CHP+

Review Period:	January 1, 2019–December 31, 2019
Date of Review:	January 8, 2020
Reviewer:	Kathy Bartilotta
Participating Plan Staff Member(s):	Christina Porter, Corie Culter, Lisa Artale Bross, Josh Holte

Requirements	File 1	File 2	File 3	File 4	File 5
Member ID	****	****	****	****	****
Date of initial request	Omit	Omit	Omit	Omit	4/8/19
What type of denial? (Termination [T], New Request [NR], or Claim [CL])					NR
(Standard [S], Expedited [E], or Retrospective [R])					R
Date notice of adverse benefit determination (NABD) sent					6/6/19
Notice sent to provider and member? (M or NM)*					M
Number of days for decision/notice					59
Notice sent within required time frame? (M or NM) (S = 10 Cal days after; E = 72 hours after; T = 10 Cal days before)*					NM
Was authorization decision timeline extended? (Y or N)					N
If extended, extension notification sent to member? (M, NM, or NA)*					NA
If extended, extension notification includes required content? (M, NM, or NA)*					NA
NABD includes required content? (M or NM)*					NM
Authorization decision made by qualified clinician? (M, NM, or NA)*					NA
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (M, NM, or NA)*					NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (M or NM)*					M
Was correspondence with the member easy to understand? (M or NM)*					M
Total Applicable Elements					**5**
Total Met Elements					**3**
Score (Number Met / Number Applicable) = %					**60%**

***** = Reference Denial Record Review Instructions for Corresponding Requirement in Compliance Monitoring Tool

M = Met, **NM** = Not Met, **NA** = Not Applicable, **Cal** = Calendar, **Y** = Yes, **N** = No (Yes and No = not scored—informational only)

**** = Redacted Member ID

Comments:

File 1: CHP+ was the secondary payor; primary payor paid services in full. No services were required to be paid or reviewed by CHP+. This record was erroneously included in the sample universe.

File 2: CHP+ was the secondary payor; primary payor paid services in full. No services were required to be paid or reviewed by CHP+. This record was erroneously included in the sample universe.

File 3: CHP+ was the secondary payor; primary payor paid services in full. No services were required to be paid or reviewed by CHP+. This record was erroneously included in the sample universe.

File 4: The services rendered were eligible for payment through another State program and were referred to the Department for approval and payment. Member was not eligible for UM review determination by DHMP.

File 5: This was a partially retrospective request. Request for authorization was April 8, 2019, for services provided March 1, 2019, through May 30. 2019. Services rendered prior to receipt of request were administratively denied due to "no prior authorization for out-of-network (OON) services"; services from April 8 through May 30 were approved. Per DHMP policy, retrospective (post-service) review determinations require notice sent 30 days from request but the notice was sent 59 days after request. The appeal information in the NABD included inaccurate information in required content.

Appendix B. Colorado Department of Health Care Policy and Financing FY 2019–2020 Denials Record Review Tool for Denver Health Medical Plan

Requirements	File 6	File 7	File 8	File 9	File 10
Member ID	****	****	****	****	****
Date of initial request	7/27/19	9/3/19	9/25/19	10/17/19	Omit
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	CL	NR	NR	
(Standard [S], Expedited [E], or Retrospective [R])	R	R	R	S	
Date notice of adverse benefit determination (NABD) sent	8/21/19	9/11/19	10/4/19	10/22/19	
Notice sent to provider and member? (M or NM)*	M	M	M	M	
Number of days for decision/notice	25	8	9	5	
Notice sent within required time frame? (M or NM) (S = 10 Cal days after; E = 72 hours after; T = 10 Cal days before)*	M	M	M	M	
Was authorization decision timeline extended? (Y or N)	N	N	N	N	
If extended, extension notification sent to member? (M, NM, or NA)*	NA	NA	NA	NA	
If extended, extension notification includes required content? (M, NM, or NA)*	NA	NA	NA	NA	
NABD includes required content? (M or NM)*	NM	M	NM	NM	
Authorization decision made by qualified clinician? (M, NM, or NA)*	M	NA	NA	NA	
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (M, NM, or NA)*	NA	NA	NA	NA	
Was the decision based on established authorization criteria (i.e., not arbitrary)? (M or NM)*	M	M	M	M	
Was correspondence with the member easy to understand? (M or NM)*	M	M	M	M	
Total Applicable Elements	**6**	**5**	**5**	**5**	
Total Met Elements	**5**	**5**	**4**	**4**	
Score (Number Met / Number Applicable) = %	**83%**	**100%**	**80%**	**80%**	

***** = Reference Denial Record Review Instructions for Corresponding Requirement in Compliance Monitoring Tool

M = Met, **NM** = Not Met, **NA** = Not Applicable, **Cal** = Calendar, **Y** = Yes, **N** = No (Yes and No = not scored—informational only)

**** = Redacted Member ID

Comments:

File 6: This was a retrospective request. Request for authorization was July 27, 2019, for services provided March 21, 2019. Services were administratively denied due to "no prior authorization for OON services." Per DHMP policy, retrospective (post-service) review determinations require notice sent 30 days from request. The appeal information in the NABD included inaccurate information in required content.

File 7: Claim processed on September 10 was denied due to "no authorization for OON provider." Notice sent on September 11.

File 8: This was a retrospective request. Request for authorization was September 25, 2019, for services provided September 12, 2019. Services were administratively denied due to "no prior authorization for OON services." Per DHMP policy, retrospective (post-service) review determinations require notice sent 30 days from request. The appeal information in the NABD included inaccurate information in required content.

File 9: This service was administratively denied; did not require a decision to be made by a qualified clinician. The appeal information in the NABD included inaccurate information in required content.

File 10: This was a duplicate claim rejected by the system for services already processed and paid in a previous claim. This record was erroneously included in the sample universe.

Appendix B. Colorado Department of Health Care Policy and Financing FY 2019–2020 Denials Record Review Tool for Denver Health Medical Plan

Requirements	OS 1	OS 2	OS 3	OS 4	OS 5
Member ID	****	****	****	****	****
Date of initial request	Omit	7/12/19	8/26/19	10/3/19	10/24/19
What type of denial? (Termination [T], New Request [NR], or Claim [CL])		CL	NR	NR	NR
(Standard [S], Expedited [E], or Retrospective [R])		R	R	R	R
Date notice of adverse benefit determination (NABD) sent		7/24	8/27	10/8	10/31
Notice sent to provider and member? (M or NM)*		M	M	M	M
Number of days for decision/notice		12	0	5	7
Notice sent within required time frame? (M or NM) (S = 10 Cal days after; E = 72 hours after; T = 10 Cal days before)*		M	M	M	M
Was authorization decision timeline extended? (Y or N)		N	N	N	N
If extended, extension notification sent to member? (M, NM, or NA)*		NA	NA	NA	NA
If extended, extension notification includes required content? (M, NM, or NA)*		NA	NA	NA	NA
NABD includes required content? (M or NM)*		M	NM	NM	NM
Authorization decision made by qualified clinician? (M, NM, or NA)*		NA	NA	NA	NA
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (M, NM, or NA)*		NA	M	NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (M or NM)*		M	M	M	M
Was correspondence with the member easy to understand? (M or NM)*		M	M	M	M
Total Applicable Elements		**5**	**6**	**5**	**5**
Total Met Elements		**5**	**5**	**4**	**4**
Score (Number Met / Number Applicable) = %		**100%**	**83%**	**80%**	**80%**

***** = Reference Denial Record Review Instructions for Corresponding Requirement in Compliance Monitoring Tool

M = Met, **NM** = Not Met, **NA** = Not Applicable, **Cal** = Calendar, **Y** = Yes, **N** = No (Yes and No = not scored—informational only)

**** = Redacted Member ID

Comments:

File OS1: This was a duplicate claim rejected by the system for services already processed and paid in a previous claim. This record was erroneously included in the sample universe.

File OS2: Claim processed on July 23 was denied due to "no authorization for OON services." Notice sent on July 24.

File OS3: This was a retrospective request for authorization received on August 26 for inpatient services rendered August 23 through August 25. DHMP made multiple requests to provider for more information but provider did not respond. DHMP required time frame for inpatient authorizations is 24 hours. DHMP does not extend retrospective determinations. Administratively denied and notice sent on August 27 for no "prior authorization for inpatient services and no additional information received from provider." The appeal information in the NABD included inaccurate information in required content.

File OS4: This was a partially retrospective request. Request for authorization was October 3, 2019, for services provided September 1, 2019, through December 31, 2019. Services rendered prior to receipt of request were administratively denied due to "no prior authorization for OON services"; services from October 4 through December 31 were approved. The appeal information in the NABD included inaccurate information in required content.

File OS5: This was a partially retrospective request. Request for authorization was October 24, 2019, for services already in progress. Services rendered prior to receipt of request were administratively denied due to "no prior authorization for OON services"; services from date of request (October 23) forward were approved. The appeal information in the NABD included inaccurate information in required content.

Requirements	OS 6
Member ID	****
Date of initial request	9/16/19
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR
(Standard [S], Expedited [E], or Retrospective [R])	S
Date notice of adverse benefit determination (NABD) sent	9/26/19
Notice sent to provider and member? (M or NM)*	M
Number of days for decision/notice	10
Notice sent within required time frame? (M or NM) (S = 10 Cal days after; E = 72 hours after; T = 10 Cal days before)*	M
Was authorization decision timeline extended? (Y or N)	N
If extended, extension notification sent to member? (M, NM, or NA)*	NA
If extended, extension notification includes required content? (M, NM, or NA)*	NA
NABD includes required content? (M or NM)*	NM
Authorization decision made by qualified clinician? (M, NM, or NA)*	M
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (M, NM, or NA)*	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (M or NM)*	M
Was correspondence with the member easy to understand? (M or NM)*	M
Total Applicable Elements	**6**
Total Met Elements	**5**
Score (Number Met / Number Applicable) = %	**83%**

***** = Reference Denial Record Review Instructions for Corresponding Requirement in Compliance Monitoring Tool
M = Met, **NM** = Not Met, **NA** = Not Applicable, **Cal** = Calendar, **Y** = Yes, **N** = No (Yes and No = not scored—informational only)
**** = Redacted Member ID

Comments:

File OS6: The medical reviewer determined services could be provided in network. The case was denied for "OON services." The appeal information in the NABD included inaccurate information in required content.

Total Record Review Score*	Total Applicable Elements:	Total Met Elements:	Total Record Review Score:
	53	44	83%

* Only requirements with an "*" in the tool were used to calculate the score. The total record review score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements.

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2019–2020 site review of **DHMP**.

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

HSAG Review Team	Title
Barbara McConnell	Executive Director
Kathy Bartilotta	Associate Director
DHMP Participants	**Title**
Catharine Fortney	Chief Compliance and Audit Officer
Christina Porter	Utilization Management Quality Assurances and Training
Christine Seals	Medical Director
Corie Culter	Manager of Utilization Management
Dallen Waldenroth Gomez	Analyst for CHP+ and Medicaid Denver Health
Elizabeth Strammiello	Colorado Access Chief Compliance Officer
Gina Eisenach	Director, Compliance and Internal Auditor
Jeremy Sax	Government Manager
Josh Holte	Interim Director of Claims
Kaitlin Gaffney	Analyst, CHP+ and Medicaid
Keri Gottlieb	Provider Relations and Contracting Manager
Lisa Artale Bross	Compliance Manager
Marques Haley	Monitoring, Auditing, Training Manager
Mike Wagner	Chief Administrative Officer
Robert Lodge	Pharmacist
Shanique Horne	Director of Provider Relations and Contracting
Stacy Grein	Compliance Analyst
Shayna Garcia	Pharmacy Compliance Analyst
Department Observers	**Title**
Russell Kennedy	Quality Program Manager—HCPF
Teresa Craig	Contract Manager—HCPF

Appendix D. Corrective Action Plan Template for FY 2019–2020

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 2019–2020 Corrective Action Plan for DHMP

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
17. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to and copies of all documents and records relevant to the adverse benefit determination (includes medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits). • The member's (or member's designated representative's) right to request one level of appeal with the Contractor and the procedures for doing so. • The member's right to request a State review after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State review.	The Utilization Determinations policy, as well as the two template NABD letters—one for claims and one for denials of medical necessity—addressed all required content areas. However, the CHP+ Medical Necessity Denial Letter included several inaccuracies in the content of the appeal, SFH, and continuation of benefits information, specifically: • Must file the appeal by **the date listed on the NABD letter** (the only date listed on the letter is the date the NABD was sent; the date for filing an appeal is 60 calendar days after the NABD). • **Will continue services** during your appeal if: you **file your appeal** by the **date listed on your NABD** letter (member must request *continued benefits* within 10 days of the NABD or intended effective date of the proposed adverse benefit determination; member still has 60 days from date on NABD to file the appeal). • Will keep giving you these services until: **the time period of a previously authorized service has been met** (this criterion has been removed from federal regulations and is no longer applicable). • May request an **SFH** within **120 days of the NABD letter** (may request an SFH	DHMP must correct the inaccuracies in the required content of the CHP+ Medical Necessity Denial Letter.

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
• The circumstances under which an appeal process can be expedited and how to make this request. • The member's rights to have benefits/services continue (if applicable) pending the resolution of the appeal, how to request that benefits continue, and the circumstances under which the member may be required to pay the cost of these services. • The member's right to appeal under the Child Mental Health Treatment Act (CMHTA), when applicable. *42 CFR 438.404(b)* Contract: Exhibit B-1—14.1.3.15.1.5–12	within 120 days of the *appeal resolution* letter). Due to the inaccuracies in content of the CHP+ Medical Necessity Denial Letter, HSAG scored 8 of 10 denial record reviews *Not Met* for required content of the NABD. The information in the content of the CHP+ Adverse Benefit Determination Letter (used for claims denials) was accurate in its entirety.	
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 II—Access and Availability		
Requirement	**Findings**	**Required Action**
10. The Contractor must meet, and require its providers to meet, the State standards for timely access to care and services, taking into account the urgency of the need for services. The Contractor ensures that services are available as follows: • Emergency BH care: – By phone within 15 minutes of the initial contact. – In-person within 1 hour of contact in urban and suburban areas. – In-person within 2 hours of contact in rural and frontier areas. • Urgent care within 24 hours from the initial identification of need. • Non-urgent symptomatic care visit within 7 calendar days after member request. • Non-urgent medical or non-symptomatic well care within 30 calendar days after member request. • Outpatient follow-up appointments within 7 days after discharge from hospitalization. • Members may not be placed on waiting lists for initial routine BH services.	The DHMP fourth quarter *Network Adequacy Report* had analysis for the percentage of primary and specialty appointments within 30 days. The member handbook informed members of all timely access standards and the *Access to Care and Services* policy accurately depicted the timely access standards. While the report depicted the number of members that received a mental health visit, a visit related to a substance use disorder, and inpatient hospitalizations related to either mental health or substance use, DHMP was unable to provide evidence of tracking to ensure compliance with the timeliness standards for behavioral healthcare, non-urgent symptomatic care within seven days, or an outpatient follow-up appointment within seven days. Staff members reported during the on-site interview that no appointments are needed to receive physical health urgent care services. Members may go to any urgent care center without an appointment or approval; therefore, tracking timeliness of physical health urgent care appointments is not applicable. In addition, DHMP's CHP+ member handbook informed members of all timely appointment standards except the behavioral health standards.	DHMP must develop a mechanism to track compliance with timely access to appointments for behavioral health and substance use services, non-urgent symptomatic care, and follow-up care following an inpatient hospitalization. DHMP should also consider informing CHP+ members of the behavioral health appointment standards via the CHP+ member handbook.

Standard II—Access and Availability		
Requirement	**Findings**	**Required Action**
42 CFR 438.206(c)(1)(i) Contract: Exhibit B-1—10.2.1.23.1–7, 10.2.1.23.7.2		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard II—Access and Availability		
Requirement	**Findings**	**Required Action**
13. The Contractor ensures timely access by: • Establishing mechanisms to ensure compliance with access (e.g., appointment) standards by network providers. • Monitoring network providers regularly to determine compliance. • Taking corrective action if there is failure to comply. *42 CFR 438.206(c)(1)(iv)–(vi)* Contract: Exhibit B-1—10.2.1.25.2	The *Network Adequacy Report* accurately depicted the timely appointment standards. DHMP provided evidence of reviewing timeliness of primary and specialty care appointments made through the Denver Health Call Center; however, DHMP did not have a mechanism to monitor compliance with timely access standards for its contracted organizational providers (University Physicians, Inc. and The Children's Hospital of Colorado).	DHMP must develop a mechanism to monitor contracted providers regularly to ensure compliance with timely access standards and use CAPs if the providers fail to comply.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review Protocol Activities

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

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal 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 two standards and on-site activities. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. • Documents submitted for the desk review and on-site review consisted of the completed desk review form, the compliance monitoring tool with the health plan's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The health plans also submitted a list of all denials of authorization of services (denials) records that occurred between January 1, 2019, and December 31, 2019 (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 denials. • 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 2019–2020 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 Department**
	• 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.