Fiscal Year 2020–2021 Site Review Report

for

Denver Health Medical Plan

April 2021

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 (the 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, Title 42 (42 CFR)—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) 2020–2021 was January 1, 2020, through December 31, 2020. This report documents results of the FY 2020–2021 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 FY 2020–2021 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2019–2020 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for both the grievance and appeal 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 (CAP) process the health plan will be required to complete for FY 2020–2021 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) External Quality Review (EQR) *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[1-1]

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: July 15, 2020.

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

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable/ Not Scored	Score* (% of Met Elements)
V. Member Information Requirements	21	20	19	1	0	1	95%
VI. Grievance and Appeal Systems	34	34	32	2	0	0	94%
VII. Provider Participation and Program Integrity	16	15	14	1	0	1	93%
IX. Subcontractual Relationships and Delegation	4	4	3	1	0	0	75%
Totals	**75**	**73**	**68**	**5**	**0**	**2**	**93%**

*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. Some items were marked as "Not Scored" due to regulation changes which came into effect in December 2020.

Table 1-2 presents the scores for **DHMP** for the grievance and appeal 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)
Grievances	36	36	28	8	0	78%
Appeals	60	53	53	0	7	100%
Totals	**96**	**89**	**81**	**8**	**7**	**91%**

*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 V—Member Information Requirements

Summary of Strengths and Findings as Evidence of Compliance

DHMP maintained an efficient system to ensure new CHP+ members receive a CHP+ identification card, a welcome letter, a medical home letter, and other resource materials, including how to obtain translation services. Mailings occurred daily based on new member eligibility files received from the Department. Member handbooks, provider directories, and the formulary were all available electronically with links provided for easy access. The letter informed members that paper copies were available by calling **DHMP**'s health plan services department.

DHMP's website was easy to navigate and included an accessibility option tab that allowed the user to change font size, line spacing, contrast, and enhance inputs such as links, buttons, and menus. A separate webpage for CHP+ members contained information about the requirements and benefits of the plan. Materials included a new member orientation video in English and Spanish and a list of downloadable Portable Document Format (PDF) documents. The CHP+ webpage offered an expandable list of benefits; a link for accessing care, including urgent care and the 24/7 NurseLine; and an option for members to access their health records. In addition to the benefit information summarized above, **DHMP** provided quarterly member newsletters written in English and Spanish.

The member handbook included the necessary information regarding member rights and responsibilities, recognizing and reporting fraud, filing grievances and appeals, cost-sharing, and emergency access. Informational materials used easy-to-understand language in 12-point font and included the required taglines in large print. Documents available to members in a PDF format met accessibility requirements for machine readability.

Summary of Findings Resulting in Opportunities for Improvement

While most definitions were accurate, **DHMP** defined a grievance as "a formal complaint you may submit if you are unhappy with your service, or think you were treated unfairly." This definition is inconsistent with the Department's definition that a grievance is any expression of dissatisfaction about any matter other than a notice of adverse benefit determination. Additionally, the medical necessity definition lacked certain criteria. HSAG recommends that **DHMP** review and compare the managed care terminology definitions listed in the **DHMP** member handbook to the definitions used for those terms by the Department and revise the **DHMP** definitions as needed to ensure consistency and avoid confusion for CHP+ members.

Within **DHMP**'s formulary, there were various formats used for the font, but no clear explanation for each variation (i.e., italics, underlined, bold). HSAG recommends **DHMP** clarify the variations in the text font used for drug names and what the variations signify (i.e., what does an italicized or capitalized drug name indicate?). Clarification could be accomplished by adding a legend or modifying the instructions for use.

Summary of Required Actions

The member handbook section regarding continued benefits during an appeal and State fair hearing (SFH) was combined in a way that the criteria were not entirely accurate or clear. For example, expiration of the original service authorization only applies to requesting continued benefits during the appeal, not how long benefits will continue during the appeal, and does not apply for an SFH. Procedures, timelines, and criteria within the section switched back and forth between appeal and SFH, which could be confusing to the member. **DHMP** must update the *Continuation of Benefits* section of the member handbook to clarify which procedures and timelines apply to appeals and which apply to SFHs.

Standard VI—Grievance and Appeal Systems

Summary of Strengths and Findings as Evidence of Compliance

Policies and procedures used to address both grievances and appeals were complete and comprehensively written, and specified who was able to file a grievance, appeal, and an SFH on behalf of a member. The policies, letters, and handbooks for members and providers included correct time frames for filing grievances, appeals, and SFHs. **DHMP**'s policy to address continuation of benefits included accurate information.

Mechanisms used to inform members how to file grievances and appeals included the member handbook, website, and the health plan services department staff members, who were available to answer questions and provide assistance. Staff members completed grievance and appeal training at time of hire, and more frequently for those having regular contact with members. **DHMP** used a data system to log grievances, and response due dates were tracked to assure timelines were met.

DHMP described how staff members responsible for making appeal decisions considered all comments, documents, and other information submitted by the member or authorized representative without regard to whether the information was considered in the initial adverse benefit determination. **DHMP** resolved all grievance and appeals timely and all appeal resolution letters were easy to understand and included the required content.

Summary of Findings Resulting in Opportunities for Improvement

HSAG has identified no opportunities for improvement for this standard.

Summary of Required Actions

DHMP processed grievances according to the federal requirements only when the grievances met **DHMP**'s definition of a "formal" grievance. Expressions of dissatisfaction that were able to be resolved

at the point of contact were handled through a less formal complaint process that did not fully meet the requirements. These complaints were not included in grievance reporting to HSAG or the Department. Additionally, the grievance record review identified a potential denial of service that was misclassified and processed as a grievance. **DHMP** must develop and implement a mechanism to define, identify, and manage grievances in compliance with all grievance requirements, and ensure this process is used consistently to address *any* expression of dissatisfaction received from a member about any matter other than an adverse benefit determination. **DHMP** must provide training to staff members that clearly defines the difference between a grievance and an appeal to ensure accurate documentation and corresponding procedures.

The grievance resolution letters correctly included information that the member may contact the Department if they are unhappy with the grievance decision; however, the letter also included an attachment stating that the member could file an appeal, a quick appeal, or an SFH. This attachment was misleading to the member as there is no appeal or SFH process available to members for grievances. The appeal and SFH processes are only available to members when an adverse benefit determination is made. **DHMP** must remove the appeal and SFH attachment from grievance resolution letters.

Standard VII—Provider Participation and Program Integrity

Summary of Strengths and Findings as Evidence of Compliance

Policies, procedures, and other submitted evidence demonstrated comprehensive provider participation and compliance programs. The provider relations and contracting department was a small team comprised of various roles such as credentialing specialists, liaison representatives, and a manager. The network management team contracted with Perspecta to ensure a regularly updated provider directory, which was populated with data from the QNXT system. The compliance department delegated its Special Investigation Unit functions to Lexis-Nexis, which performed data mining for claims and pharmacy data to identify any fraud, waste, and abuse. **DHMP** also delegated credentialing functions to the Denver Health and Hospital Authority (DHHA) medical staff office.

The network management team analyzed both qualitative and quantitative data such as network adequacy reports, providers who experienced referral barriers, and grievance and appeal trends to determine if gaps in the network existed. If gaps were identified, recruiting efforts were deployed. Staff members reported the addition of the Metro Community Provider Network (also known as STRIDE) as a major enhancement to the network in calendar year (CY) 2020. Provider education and training were conducted by this team through various means such as newsletters (biweekly), direct interactions, letters, and postings to the centralized provider Web portal. Efforts to retain providers included an annual *Provider and Practitioner Experience Survey*, which assessed satisfaction. CY 2020's provider survey focused on providers' satisfaction regarding interactions with utilization management.

Credentialing and recredentialing policies aligned with the National Committee for Quality Assurance (NCQA) and included procedures to ensure **DHMP** did not discriminate against providers. Staff members reported that no providers were declined during the review period. Verification sources such as

the National Practitioner Database, List of Excluded Individuals/Entities, System for Award Management, and State websites were used to verify work history, education, licensure, and ensure **DHMP** did not employ or contract with providers or other individuals or entities excluded from participation with federal healthcare programs.

The Enterprise Compliance Services (ECS) program presented well-developed arrangements and procedures that articulated **DHMP**'s commitment to comply with federal, State, and contract requirements related to detecting and preventing fraud, waste, and abuse. This included clear responsibilities of the chief executive officer; board of directors; compliance committee; and chief compliance and audit officer. Onboarding and annual trainings were required for general staff members, and in-person, individualized trainings were conducted for board members. ECS staff member training requirements were noted in policy and described by staff members as ranging in expectations from maintenance of medical degrees, certifications in healthcare compliance, research compliance, internal audit, and more.

DHMP contracted with the vendor ValuesLine, which was described by ECS staff members as having positively impacted the staff's feelings of safety in being able to anonymously report issues to a third party. The compliance officer noted that this approach has worked as intended, with increased reporting year over year, while remaining within range of national reporting trends. The vendor platform included capabilities to categorize the reported concern and automatically filter to the appropriate **DHMP** department and staff member responsible for an investigation.

Procedures outlined how **DHMP** monitored and updated databases based on member date of death, change of address, disenrollment and eligibility updates, and how staff members would research claims and provide notification to the Department in a timely manner. Overpayment notification timelines, auditing timelines, and provider termination timelines were all thoroughly documented. Staff members described both an automated and manual process for researching overpayments.

Summary of Findings Resulting in Opportunities for Improvement

Although **DHMP** did not object to providing services on moral or religious grounds, the member handbook contained information that may be confusing to the member. Page 15 noted that members would be notified if there were significant changes due to moral or religious objections, and page 16 noted that the member could request disenrollment if **DHMP** was not able to provide a service based on such objections. HSAG recommends that these sections be updated to further clarify that, while an individual provider may have such objections, **DHMP** as an organization does not, and that the member has the right to change providers if an individual provider has objections to performing a service.

Summary of Required Actions

Although **DHMP**'s desktop policy included procedural steps to verify that services billed had been received by the member, per staff member report, the verification process had not occurred for the CHP+ line of business in CY 2020 and had not launched by the time of the audit. **DHMP** must ensure

that CHP+ services are verified regularly to ensure services represented by providers were received by members. Furthermore, HSAG encourages **DHMP** to expand sampling methodology to all CHP+ members, not only adults.

Standard IX—Subcontractual Relationships and Delegation

Summary of Strengths and Findings as Evidence of Compliance

DHMP's *Delegation of Credentialing Activities* policy described a list of eight predelegation evaluation and initial delegation activities, along with **DHMP**'s process for managing delegated credentialing activities. The policy included a statement that it is company policy to comply with all federal, State, and local laws and regulations. Audits were annual, and expectations of delegates were listed, including reporting requirements. **DHMP** also provided a contract template for Medicaid and CHP+, which **DHMP** was in the process of transitioning into use for all delegated credentialing activities.

Many of the delegated activities were related to credentialing and recredentialing. Delegated functions also included printing and mailing member materials, pharmacy services, and hospital/clinic services. Subcontracts contained the majority of information necessary to meet the requirements. HSAG requested a sample of four **DHMP** subcontracts for audit.

DHMP presented evidence of monitoring activities for several of the delegated entities. Delegate oversight included regular meetings, a CAP process, and a tracking log. **DHMP** also supplied audit results for review.

Summary of Findings Resulting in Opportunities for Improvement

While **DHMP** submitted a delegation policy, it only addressed delegated credentialing. HSAG recommends that **DHMP** expand the *Delegation of Credentialing Activities* policy or develop a second policy to address delegation expectations for the other types of activities that **DHMP** subcontracts to other organizations.

Summary of Required Actions

The language used in the subcontracts reviewed varied significantly across contracts. While the required language was included in the new contract template for Medicaid/CHP+ submitted for review, three of the four subcontracts reviewed did not contain all required language. The University Physicians Incorporated (UPI) contract contained the correct language, except the right to audit statement listed a six-year rather than a 10-year right to audit time frame from the final date of the contract period. HSAG noted that neither the Clarity agreement nor the DHHA agreement specifically addressed the right of CMS or the Department of Health and Human Services Office of Inspector General (HHS-OIG) to audit, the right to audit for 10 years from the final date of the contract periods, the types of documents or records to be made available, or other specifics outlined in the language of 42 CFR 438.230(c)(3). **DHMP** must revise the subcontracts to include all required language.

2. Overview and Background

Overview of FY 2020–2021 Compliance Monitoring Activities

For the FY 2020–2021 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard V—Member Information Requirements, Standard VI—Grievance and Appeal Systems, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontractual Relationships and Delegation. Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Site Review Methodology

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

HSAG also reviewed a sample of the health plan's administrative records related to CHP+ grievances and CHP+ appeals 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 five records (to the extent that a sufficient number existed) for each of grievances and appeals. Using a random sampling technique, HSAG selected the sample from all CHP+ grievance records that occurred between January 1, 2020, and December 31, 2020, and all CHP+ appeal records that occurred between January 1, 2020, and December 31, 2020. For the record review, the health plan received a score of *Met (M)*, *Not Met (NM)*, or *Not Applicable (NA)* for each required element. Results of record reviews were considered in the review of applicable requirements in Standard VI—Grievance and Appeal Systems. HSAG separately calculated a record review score for each record review requirement and an overall record review score.

The site review processes were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS EQR protocol. The four standards chosen for the FY 2020–2021 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement.

Objective of the Site Review

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

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

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

FY 2019–2020 Corrective Action Methodology

As a follow-up to the FY 2019–2020 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 2019–2020 compliance monitoring site review.

Summary of FY 2019–2020 Required Actions

For FY 2019–2020, HSAG reviewed Standard I—Coverage and Authorization of Services and Standard II—Access and Availability.

DHMP was required to address three required actions. First, to correct medical necessity denial letters regarding dates, time frames, and information for continuation of benefits and SFHs for Standard I—Coverage and Authorization of Services. Regarding Standard II—Access and Availability, **DHMP** was required to develop mechanisms to 1) track timely access for behavioral health, substance use disorder, non-urgent symptomatic care, and follow-up care after inpatient hospitalization; and 2) monitor providers to ensure compliance with timely access standards and use CAPs if the providers fail to comply.

Summary of Corrective Action/Document Review

DHMP submitted a proposed CAP in April 2020. HSAG and the Department reviewed and approved the CAP in May, **DHMP** submitted initial documents as evidence of completion in August, and the CAP was approved in September 2020.

Summary of Continued Required Actions

DHMP successfully completed the FY 2019–2020 CAP, resulting in no continued corrective actions.

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor provides all required member information to members in a manner and format that may be easily understood and is readily accessible by enrollees. *Note: Readily accessible means electronic information which complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines.* *42 CFR 438.10(b)(1)* CHP Contract: Section 21.A.	• CHP+ Member Handbook 2020 Eng 508 (whole document is 508) also Pg. 7 • CHP+_Provider Directory_Tips_Eng • How to Submit a Marketing Request (Purpose) • Cultural and Linguistic Appropriate Services- Pg. 1 (Purpose) Pg. 2 (B-D & F-G) (Definitions Alternative Format) Description: The Member Handbook explains to members that written information is available in other forms such as braille, large fonts, audiotapes, sign language, and more.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor has in place a mechanism to help members understand the requirements and benefits of the plan. *42 CFR 438.10(c)(7)* CHP+ Contract: Exhibit B1—6.3.1.15	• CHP+ Member Handbook 2020 Eng 508 - Pg. 9 (member orientation videos link https://www.denverhealthmedicalplan.org/child-health-plan-plus-chp • DHMP Member Newsletter Fall 2020 Eng. Description: As an additional mode of communicating to our membership, DHMP produces a quarterly newsletter with information on benefits and resources available to our members. Attached as evidence the Fall 2020 newsletter	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. For consistency in the information provided to members, the Contractor uses the following as developed by the State: • Definitions for managed care terminology, including appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. • Model member handbooks and member notices. *42 CFR 438.10(c)(4)* CHP+ Contract: Exhibit B1—2.8.4	• CHP+ Member Handbook 2020 Eng 508 - Pg. 5 (Terminology) Description: The DHMC Member Handbooks include a terminology page defining the required terms and definitions set out by the HCPF member handbook (model handbook), the contracts, and the federal government glossary website	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • All written materials for members must: – Use easily understood language and format. – Use a font size no smaller than 12 point. – Be available in alternative formats and through provision of auxiliary aids and service that takes into consideration the special needs of members with disabilities or limited English proficiency.	Written materials that are critical to obtaining services include: provider directories, member handbooks, appeal and grievance notices, and denial and termination notices. • CHP+ Member Handbook 2020 Eng 508 – Pg. 2 & 6 • CHP+ Web Tagline (JPG) • Language Assistance web page (JPG) • Website Footer -Language Assistance (JPG) • Translation- 508 Compliance -Alternative Format	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Include taglines in large print (18 point) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service number, and availability of materials in alternative formats. *42 CFR 438.10(d)(3) and (d)(6)* CHP+ Contract: Exhibit B1—6.3.1.14, 14.1.3.1, 14.1.3.2, 14.1.3.4, 14.1.3.5	– Pg. 2 & 3 • How to Submit a Marketing Request – Pg. 2 (K-M) Description: DHMP displays language assistance within the footer of all our website pages.	
5. If the Contractor makes information available electronically—Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of readily accessible above). • The information is placed in a website location that is prominent and readily accessible. • The information can be electronically retained and printed. • The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge upon request and is provided within five (5) business days. *42 CFR 438.10(c)(6)* CHP+ Contract: Exhibit B1—14.1.3.13.2	• CHP+ Member Handbook 2020 Eng 508 – Pg. 7 • AssesiblityOptionWeb (PNG) • https://www.denverhealthmedicalplan.org/chp-member-handbook Description: The Member handbook _Link Screenshot points out where you can click to access the information, that is readily accessible and link to handbook for prominent for a member to also print copy from PDF	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor makes available to members in electronic or paper form information about its formulary: • Which medications are covered (both generic and name brand). • What tier each medication is on. • Formulary drug list must be available on the Contractor's website in a machine readable file and format. *42 CFR 438.10(i)* CHP+ Contract Amendment 3: Exhibit B1—6.7.1.5	• Formulary web - https://www.denverhealthmedicalplan.org/chp-pharmacy • CHP+ Formulary paper • CHP+ Formulary_Accesiblity (PNG)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The Contractor makes interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and how to access them. • This includes oral interpretation and use of auxiliary aids such as TTY/TDY and American Sign Language. *42 CFR 438.10(d)(4)* CHP+ Contract: Exhibit B1—7.5, 14.1.3.3, 14.1.7.6	• CHP+ Member Handbook 2020 Eng 508 - Pg. 2 & 7 • 2021 CHP Daily QRG_English – Pg. 1 • Language Assistance web page (JPG) • CHP+ web pages taglines	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor notifies members that auxiliary aids and services are available upon request and at no cost for members with disabilities, and how to access them. *42 CFR 438.10(d)(5)* CHP+ Contract: Exhibit B1—14.1.3.5, 14.1.3.10.1.3	• CHP+ Member Handbook 2020 Eng 508 – Pg. 6 • 2021 CHP Daily QRG_English – Pg. 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor provides each member with a member handbook in both electronic and paper format within a reasonable time after receiving notification of the member's enrollment. *42 CFR 438.10(g)(1)* CHP+ Contract Amendment 3: Exhibit B1—6.7.1	• 2021 CHP Daily QRG_English – Pg. 2 • CHP+ Welcome Notice Letter Description: When 834 comes in with an enrollment this prompts a code to issue out the Welcome letter, ID and a Quick Reference Guide (QRG)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor gives members written notice of any significant change (as defined by the State) in the information required at 438.10(g) at least 30 days before the intended effective date of the change. *42 CFR 438.10(g)(4)* CHP+ Contract: Exhibit B1—6.7.2, 14.1.3.13.3	• CHP+ Member Handbook 2020 Eng 508 – Pg. 13	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. *42 CFR 438.10(f)(1)* CHP+ Contract: Exhibit B1—7.12.2, 14.1.8.1	• Provider Termination Policy – Pg. 1 (Purpose) • Kornfield Term Letter	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, pharmacies, and behavioral health providers, and LTSS providers (as applicable): • The provider's name and group affiliation, street address(es), telephone number(s), website URL, specialty (as appropriate), whether the providers will accept new enrollees.	• Web-Based Provider and Hospital Directory Policy – Pg. 2 (B), Pg. 2 (#8) & Pg. 4 (A#5) • Provider Manual 2020 – Pg. 5 • CHP+ Denver Health Provider Directory Tips– Pg. 7-8	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training. • Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment. *Note: Information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after the Contractor receives updated provider information.* *42 CFR 438.10(h)(1-3)* CHP+ Contract: Exhibit B1—14.1.3.6-7		
13. Provider directories are made available on the Contractor's website in a machine readable file and format. *42 CFR 438.10(h)(4)* CHP+ Contract: Exhibit B1—14 1.3.8	Provider Directory UAT URL accessibility verification (Word Document)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The member handbook provided to members following enrollment includes: • The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled. • Procedures for obtaining benefits, including authorization requirements and/or referrals for specialty care and for other benefits not furnished by the member's primary care provider.	• CHP+ Member Handbook 2020 Eng 508 – Pg. 36 – 51 (for bullet 1) Pg. 34 (for bullet 2) Pg. 13 & 30 (for bullet 3) Pg. 12 (for bullet 4 & 5) Pg. 14 (for bullet 6) • P&P Religious Accommodations and Conscience Objections Relative to Provision of Care.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The extent to which and how members may obtain benefits, including family planning services, from out-of-network providers. This includes an explanation that the Contractor cannot require the member to obtain a referral before choosing family planning provider. • The process of selecting and changing the member's primary care provider. • Any restrictions on the member's freedom of choice among network providers. • In the case of a counseling or referral service or CHP+ covered benefit that the Contractor does not cover due to moral or religious objections, the Contractor informs the member that the service is not covered because of moral or religious objections and how and where the member can obtain the services. *42 CFR 438.10(g)(2)(iii, iv, vi, vii, x) and (g)(ii)(A-B)* CHP+ Contract: Exhibit B1—14.1.3.10 14.1.3.13.3.7 Exhibit K—1.1.4.1–3, 1.1.14, 1.1.30 Amendment 3: Exhibit K—1.1.7		
15. The member handbook provided to members following enrollment includes the following member rights and protections as specified in 42 CFR 438.100. Members have the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for his or her dignity and privacy.	• CHP+ Member Handbook 2020 Eng 508 – Pg. 21 • 2021 CHP Daily QRG_English – Pg. 7	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding his or her health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. • Request and receive a copy of his or her medical records, and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for access, coverage, and coordination of medically necessary services. • Freely exercise his or her rights, and the exercising of those rights will not adversely affect the way the Contractor, its network providers, or the State Medicaid agency treats the member. *42 CFR 438.10(g)(2)(ix)* CHP+ Contract: Exhibit B1—14.1.3.10, 14.1.1.2.1-6, 14.1.1.3 Exhibit K—1.1.2		
16. The member handbook provided to members following enrollment includes the following information regarding the grievance, appeal, and fair hearing procedures and time frames: • The right to file grievances and appeals. • The requirements and time frames for filing a grievance or appeal. • The right to a request a State fair hearing after the Contractor has made a determination on a member's appeal which is adverse to the member.	• CHP+ Member Handbook 2020 Eng 508 – Bullet 1 Pg. 53 (grievance) & Pg. 55 (appeal) Bullet 2, Pg. 56 -57 (appeal) & Pg. 53 Bullet 3, Pg. 57 Bullet 4, Pg. 54 (Grievance) & Pg. 57 (appeals) Bullet 5, Pg. 58 -59	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The availability of assistance in the filing process. • The fact that, when requested by the member: – Benefits that the Contractor seeks to reduce or terminate will continue if the member files an appeal or a request for State fair hearing is filed within the time frames specified for filing. – If benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal or State fair hearing is pending if the final decision is adverse to the member. *42 CFR 438.10(g)(2)(xi)* CHP+ Contract: Exhibit B1—14.1.3.10 Exhibit K—1.1.18, 1.1.18.1, 1.1.18.1.1, 1.1.18.1.3, 1.1.18.2.1	• 2021 CHP Daily QRG_English Bullet 1, Pg. 10 (grievance) & Pg. 11 (appeal) Bullet 2, Pg. 11 (grievance) & Pg. 12 Bullet 3, Pg. 12 Bullet 4, Pg. 10 (grievance) & Pg. 13 (appeal)	
Findings: The member handbook section regarding continued benefits during an appeal and SFH was combined in a way that the criteria was not entirely accurate or clear. For example, the expiration of the original service authorization only applies to requesting continuation of benefits during the appeal, not how long benefits will continue during the appeal, and does not apply for an SFH. Procedures, timelines, and criteria within the section switched back and forth between appeal and SFH, which could be confusing to the member.		
Required Actions: DHMP must update the continuation of benefits section of the member handbook to clarify what procedures and timelines apply to appeals and which apply to SFHs.		
17. The member handbook provided to members following enrollment includes the extent to which and how after-hours and emergency coverage are provided, including: • What constitutes an emergency medical condition and emergency services. • The fact that prior authorization is not required for emergency services.	• CHP+ Member Handbook 2020 Eng 508 – Pg. 13, 21, 23 • 2021 CHP Daily QRG_English – Pg. 3 & 4	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The fact that the member has the right to use any hospital or other setting for emergency care. *42 CFR 438.10(g)(2)(v)* CHP+ Contract: Exhibit B1—14.1.3.10 Exhibit K—1.1.10.1, 1.1.10.1.1, 1.1.10.2, 1.1.10.5		
18. The member handbook provided to members following enrollment includes: • Cost-sharing, if any is imposed under the State plan. • How and where to access any benefits that are available under the State plan but not covered under the CHP+ managed care contract. • How transportation is provided. • The toll-free telephone number for member services, medical management, and any other unit providing services directly to members. • Information on how to report suspected fraud or abuse. • How to access auxiliary aids and services, including information in alternative formats or languages. *42 CFR 438.10(g)(2)(ii, viii, xiii, xiv, xv)* CHP+ Contract: Exhibit B1—14.1.3.10 Exhibit K—1.1.3, 1.1.19	• CHP+ Member Handbook 2020 Eng 508 – Bullet 1- Pg. 36 Bullet 2 – Pg. 37 Bullet 4 – Pg. 6 Important phone numbers Bullet 5 – Pg. 16 Bullet 6 – Pg. 6, Pg. 63-64 Description: CHP+ does not have many wrap services as part of the plan; however Dental services is an example of a benefit provided by the State. Transportation is not an included benefit of CHP+ and is not mentioned in the book.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
19. The member handbook provided to members following enrollment includes how to exercise an advance directive as required in 438.3 (j): • The member's right under the State law to make decisions regarding medical care and to formulate advance directives, including the right to accept or refuse medical or surgical treatment. • The Contractor's policies and procedures respecting implementation of advance directives, with a clear statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience. • Informing members that grievances concerning noncompliance with the advance directive requirements may be filed with the State Department of Public Health and Environment. *42 CFR 438.10(g)(2)(xii)* CHP+ Contract: Exhibit B1—14.1.1.2.7, 14.1.1.2.7.1, 14.1.9 Exhibit K—1.1.24	• CHP+ Member Handbook 2020 Eng 508 – Pg. 18 -19 • Advance Medical Directives P&P	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Scored

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
20. The Contractor provides member information by either: • Mailing a printed copy of the information to the member's mailing address. • Providing the information by email after obtaining the member's agreement to receive the information by email. • Posting the information on the Contractor's website and advising the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost. • Providing the information by any other method that can reasonably be expected to result in the member receiving that information. *42 CFR 438.10(g)(3)* CHP+ Contract: Exhibit B1—14.1.3.10.1	• CHP Welcome Notice Letter • Home Base Clinic • CHP+ Member Handbook 2020 Eng 508 – Pg. 7 • 2021 CHP Daily QRG_English – Pg. 1 – 4 comments show requirement • CHP+web page tagline (JPG)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
21. The Contractor must make available to members, upon request, any physician incentive plans in place. *42 CFR 438.10(f)(3)* CHP+ Contract: None	• CHP+ Member Handbook 2020 Eng 508 – Pg. 17 Website link - https://www.denverhealthmedicalplan.org/affirmative-statement-about-incentives	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard V—Member Information Requirements							
Total	Met	=	19	X	1.00	=	19
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Scored	=	1	X	NS	=	NS
Total Applicable		=	20	**Total Score**		=	19
				Total Score ÷ Total Applicable		=	95%

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an internal grievance and appeal system in place for members. A grievance and appeal system means the processes the Contractor implements to handle grievances and appeals of an adverse benefit determination, as well as processes to collect and track information about grievances and appeals. *42 CFR 438.400(b)* *42 CFR 438.402(a)* CHP+ Contract: Exhibit B1—7.9.1 10 CCR 2505-10—8.209.1	• Appeals Process Policy and Procedure Grievance Process Policy and Procedure	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor defines adverse benefit determination as: • The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. • The reduction, suspension, or termination of a previously authorized service. • The denial, in whole, or in part, of payment for a service. • The failure to provide services in a timely manner, as defined by the State. • The failure to act within the time frames defined by the State for standard resolution of grievances and appeals. • The denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other).	• Appeals Process Policy and Procedure – Pg. 1 (see definitions)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• For a resident of a rural area with only one managed care plan, the denial of a CHP+ member's request to exercise his or her rights to obtain services outside of the network under the following circumstances: – The service or type of provider (in terms of training, expertise, and specialization) is not available within the network. – The provider is not part of the network, but is the main source of a service to the member—provided that: – The provider is given the opportunity to become a participating provider. – If the provider does not choose to join the network or does not meet the Contractor's qualification requirements, the member will be given the opportunity to choose a participating provider and then will be transitioned to a participating provider within 60 days. *42 CFR 438.400(b)* *42 CFR 438.52(b)(2)(ii)* CHP+ Contract: Exhibit B1—1.1.3 10 CCR 2505-10—8.209.2.A	With regards to rural area; DHMP service area are defined as Urban. There are 3 HMOs that members can chose from.	
3. The Contractor defines "appeal" as a review by the Contractor of an adverse benefit determination. *42 CFR 438.400(b)* CHP+ Contract: Exhibit B1—1.1.4 10 CCR 2505-10—8.209.2.A.7	• Appeals Process Policy and Procedure -Pg. 1 (see definitions)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor defines "grievance" as an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. A grievance includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision. *42 CFR 438.400(b)* CHP+ Contract: Exhibit B1—1.1.44 10 CCR 2505-10—8.209.2.D, 8.209.4.A.3.c.i	• Grievance Process Policy and Procedure – Pg. 1 (A) & Pg. 2 (see definitions)	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DHMP processed grievances according to the federal requirements only when the grievances met DHMP's definition of a "formal" grievance. Expressions of dissatisfaction that were able to be resolved at the point of contact were handled through a less formal complaint process that did not fully meet the requirements. These complaints were not included in grievance reporting to HSAG or the Department. Additionally, the grievance record review identified a potential denial of service that was misclassified and processed as a grievance.		
Required Actions: DHMP must develop and implement a mechanism to define, identify, and manage grievances in compliance with all grievance requirements, and ensure this process is used consistently to address *any* expression of dissatisfaction received from a member about any matter other than an adverse benefit determination. DHMP must provide training to staff members that clearly defines the difference between a grievance and an appeal to ensure accurate documentation and corresponding procedures.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor has provisions for who may file: • A member may file a grievance, a Contractor-level appeal, and may request a State fair hearing. • With the member's written consent, a provider or authorized representative may file a grievance, a Contractor-level appeal, and may request a State fair hearing on behalf of a member. *Note: Throughout this standard, when the term "member" is used it includes providers and authorized representatives (with the exception that providers cannot exercise the member's right to request continuation of benefits under 42 CFR 438.420).* *42 CFR 438.402(c)* CHP+ Contract: Exhibit B1—14.1.4.1.1, 14.1.5.1	• Appeals Process Policy and Procedure – Pg. 3 (B) & Pg. 7 (M) • Grievance Process Policy and Procedure – Pg. 3 (C)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. *42 CFR 438.406(a)(1)* CHP+ Contract: Exhibit B1—None 10 CCR 2505-10—8.209.4.C	• Appeals Process Policy and Procedure – Pg. 3 (C, 3) • Grievance Process Policy and Procedure – Pg. 1 (B)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who: • Were not involved in any previous level of review or decision-making nor a subordinate of any such individual. • Have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding any of the following: – An appeal of a denial that is based on lack of medical necessity. – A grievance regarding the denial of expedited resolution of an appeal. – A grievance or appeal that involves clinical issues. *42 CFR 438.406(b)(2)* CHP+ Contract: Exhibit B1—14.1.4.1.6, 14.1.5.8 10 CCR 2505-10 8.209.5.C, 8.209.4.E	• Appeals Process Policy and Procedure – Pg. 6 (J) • Grievance Process Policy and Procedure – Pg. 2 (E)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor ensures that the individuals who make decisions on grievances and appeals: • Take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. *42 CFR 438.406(b)(2)* CHP+ Contract: None 10 CCR 2505-10—8.209.5.C, 8.209.4.E	• Appeals Process Policy and Procedure – Pg. 6 (J) • Grievance Process Policy and Procedure – Pg. 4 (H,1)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor accepts grievances orally or in writing. *42 CFR 438.402(c)(3)(i)* CHP+ Contract: Exhibit B1—14.1.5.6 10 CCR 2505-10—8.209.5.D	• Grievance Process Policy and Procedure – Pg. 3 (D)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. Members may file a grievance at any time. *42 CFR 438.402(c)(2)(i)* CHP+ Contract: Exhibit B1—14.1.5.4 10 CCR 2505-10—8.209.5.A	• Grievance Process Policy and Procedure – Pg. 3 (D)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor sends the member a written acknowledgement of each grievance within two (2) working days of receipt. *42 CFR 438.406(b)(1)* CHP+ Contract: Exhibit B1—14.1.5.5 10 CCR 2505-10 8.209.5.B	• Grievance Process Policy and Procedure – Pg. 4 (G)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor must resolve each grievance and provide notice as expeditiously as the enrollee's health condition requires, and within 15 working days of when the member files the grievance. • Notice to the member must be in a format and language that may be easily understood by the member. *42 CFR 438.408(a) and (b)(1)and (d)(1)* Contract: Exhibit B1—14.1.5.7, 14.1.5.9, 14.1.3.1 10 CCR 2505-10 8.209.5.D	• Grievance Process Policy and Procedure – Pg. 3 (E) and Pg. 1 (C)	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The grievance resolution letters correctly included information that the member may contact the State if they were unhappy with the grievance decision; however, the letter also included an attachment stating that the member could file an appeal, a quick appeal, or an SFH. This		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
attachment was misleading to the member as there is no appeal or SFH process available to members for grievances. The appeal and SFH processes are only available to members when an adverse benefit determination is made. **Required Actions:** DHMP must remove the appeal and SFH attachment from grievance resolution letters.		
13. The written notice of grievance resolution includes: • Results of the disposition/resolution process and the date it was completed. CHP+ Contract: Exhibit B1—14.1.5.11 10 CCR 2505-10 8.209.5.G	• Grievance Process Policy and Procedure – Pg. 4 (H,1) • Attachment F (Grievance Resolution Letter)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor may have only one level of appeal for members. *42 CFR 438.402(b)* CHP+ Contract: None	• Appeals Process Policy and Procedure -Pg. 2 under Policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. A member may file an appeal with the Contractor within 60 calendar days from the date on the adverse benefit determination notice. *42 CFR 438.402(c)(2)(ii)* CHP+ Contract: Exhibit B1—14.1.4.1.1 10 CCR 2505 10 8.209.4.B	• Appeals Process Policy and Procedure – Pg. 3 (D)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. The member may file an appeal either orally or in writing, and must follow the oral request with a written, signed appeal (unless the request is for expedited resolution). *42 CFR 438.402(c)(3)(ii)* *42 CFR 438.406 (b)(3)* CHP+ Contract: Exhibit B1—14.1.4.1.2, 14.1.4.1.8.2 10 CCR 2505 10 8.209.4.B	• Appeals Process Policy and Procedure – Pg. 3 (C)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The Contractor sends written acknowledgement of each appeal within two (2) working days of receipt, unless the member or designated representative requests an expedited resolution. *42 CFR 438.406(b)(1)* CHP+ Contract: Exhibit B1—14.1.4.1.3 10 CCR 2505-10 8.209. 4.D	• Appeals Process Policy and Procedure – Pg. 5 (I, 8)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
18. The Contractor's appeal process must provide: • That oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date). • That if the member orally requests an expedited appeal, the Contractor shall not require a written, signed appeal following the oral request. • That included, as parties to the appeal, are: – The member and his or her representative, or – The legal representative of a deceased member's estate. *42 CFR 438.406(b)(3-5)* CHP+ Contract: Exhibit B1—14.1.4.1.5.1, 14.1.4.1.8.2, 14.1.4.1.5.4 10 CCR 2505-10 8.209. 4.F, 8.209.4.I	• Appeals Process Policy and Procedure – Pg. 6 (J,1) Pg. 3 (C) Pg. 7 (J, 4)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
19. The Contractor's appeal process must provide: • The member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. (The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution time frame in the case of expedited resolution.) • The member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional documents considered, relied upon, or generated by the Contractor in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame. *42 CFR 438.406(b)(3-5)* CHP+ Contract: Exhibit B1—14.1.4.1.5.2-3 10 CCR 2505-10 8.209. 4.G, 8.209.4.H	• Appeals Process Policy and Procedure – Pg. 6 (J, 2-3)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
20. The Contractor maintains an expedited review process for appeals when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life; physical or mental health; or ability to attain, maintain, or regain maximum function. The Contractor's expedited review process includes that: • The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.	• Appeals Process Policy and Procedure – Pg. 4 (H, 1)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.410(a–b) CHP+ Contract: Exhibit B1—14.1.4.1.8.1, 14.1.4.1.8.5 10 CR 2505-10 8.209.4.Q-R		
21. If the Contractor denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the time frame for standard resolution. • Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and within two (2) calendar days provide the member written notice of the reason for the decision and inform the member of the right to file a grievance if he or she disagrees with that decision. *42 CFR 438.410(c)* CHP+ Contract: Exhibit B1—14.1.4.1.8.4.1 10 CCR 2505-10 8.209.4.S	• Appeals Process Policy and Procedure – Pg. 4 (H, 2 a- c)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
22. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)* *42 CFR 438.408(d)(2)* *42 CFR 438.10*	• Appeals Process Policy and Procedure -Page 4, (F, 1) Pg. 2, Policy section	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
CHP+ Contract: Exhibit B1—14.1.4.1.4, 14.1.3.1 10 CCR 2505-10 8.209.4.J.1		
23. For expedited appeal, the Contractor must resolve the appeal and provide written notice of disposition to affected parties within 72 hours after the Contractor receives the appeal. • For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. *42 CFR 438.408(b)(3) and (d)(2)(ii)* CHP+ Contract: Exhibit B1—14.1.4.1.8.4.2, 14.1.4.1.8.4.5 10 CCR 2505-10 8.209.4.J.2, 8.209.4.L	• Appeals Process Policy and Procedure- Pg. 4 (F,2)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
24. The Contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: • The member requests the extension; or • The Contractor shows (to the satisfaction of the Department, upon request) that there is need for additional information and how the delay is in the member's interest. *42 CFR 438.408(c)(1)* CHP+ Contract: Exhibit B1—14.1.4.1.4.1, 14.1.4.1.8.4.3 10 CCR 2505-10 8.209.4.K, 8.209.5.E	• Grievance Process Policy and Procedure – Pg. 3 (F) • Appeals Process Policy and Procedure – Pg. 4 (G)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
25. If the Contractor extends the time frames, it must—for any extension not requested by the member: • Make reasonable efforts to give the member prompt oral notice of the delay. • Within two (2) calendar days, give the member written notice of the reason for the delay and inform the member of the right to file a grievance if he or she disagrees with that decision. • Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. *42 CFR 438.408(c)(2)* CHP+ Contract: Exhibit B1—14.1.4.1.4.2, 14.1.4.1.8.4.4–5	• Grievance Process Policy and Procedure – Pg. 3 (F, a-c) • Appeals Process Policy and Procedure – Pg. 4 (G)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
26. The written notice of appeal resolution must include: • The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. – The right to request that benefits/services continue* while the hearing is pending, and how to make the request. – That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's adverse benefit determination.	• Appeals Process Policy and Procedure – Pg. 8-9 (N, 1-2) and Pg. 7 (K) • Attachment J (CHP Appeal Resolution Adverse to Member	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
**Continuation of benefits applies only to previously authorized services for which the Contractor provided 10-day advance notice to terminate, suspend, or reduce. In addition, to be eligible for continued benefits during a State fair hearing, the member must have received continued benefits during the Contractor appeal process.* *42 CFR 438.408(e)* CHP+ Contract: Exhibit B1—14.1.4.1.7 10 CCR 2505-10 8.209.4.M		
27. The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of resolution. • If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. *42 CFR 438.408(f)(1–2)* CHP+ Contract: Exhibit B1—14.1.4.1.10.1-2 10 CCR 2505-10 8.209.4.N and O	• Appeals Process Policy and Procedure – Pg. 7-8 (M, & 1)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
28. The parties to the State fair hearing include the Contractor as well as the member and his or her representative or the representative of a deceased member's estate. *42 CFR 438.408(f)(3)* CHP+ Contract: Exhibit B1—14.1.4.1.10.3	• Appeals Process Policy and Procedure – Pg. 8 (M, 5)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
29. The Contractor provides for continuation of benefits/services (when requested by the member) while the Contractor-level appeal is pending if: • The member files in a timely manner* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the Contractor mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal within 60 days of the notice of adverse benefit determination. **This definition of timely filing only applies for this scenario—i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced. (Note: The provider may not request continuation of benefits on behalf of the member.)* The Contractor provides for continuation of benefits/services (when requested by the member) while the State fair hearing is pending if: • The member requests a State fair hearing with a request for continuation of benefits in a timely manner—defined as on or before the following:	• Appeals Process Policy and Procedure – Pg. 8-9 (N, 1-2) Pg. 3 (D)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Within 10 days of the Contractor mailing the notice of appeal resolution not in favor of the member. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment (and the member requested and received continued benefits during the Contractor appeal). • The services were ordered by an authorized provider. *42 CFR 438.420(a) and (b)* CHP+ Contract: Exhibit B1—14.1.4.1.9.1 10 CCR 2505-10 8.209.4.T		
30. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal is pending, the benefits must be continued until one of the following occurs: • The member withdraws the appeal. • The member does not request continued benefits during a State fair hearing within 10 calendar days after the Contractor sends the notice of an appeal resolution not in the member's favor. If, at the member's request, the Contractor continues or reinstates the benefits while the State fair hearing is pending, the benefits must be continued until one of the following occurs: • The member withdraws the request for a State fair hearing. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR 438.420(c)* CHP+ Contract: Exhibit B1—14.1.4.1.9.2 10 CCR 2505-10 8.209.4.U	• Appeals Process Policy and Procedure – Pg. 9 (N, 2-3a -c)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
31. Member responsibility for continued services: • If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's adverse benefit determination, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. *42 CFR 438.420(d)* CHP+ Contract: Exhibit B1—14.1.4.1.9.3 10 CCR 2505-10 8.209.4.V	• Appeals Process Policy and Procedure – Pg. 9 (N, 4a)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
32. Effectuation of reversed appeal resolutions: • If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than seventy-two (72) hours from the date it receives notice reversing the determination. • If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the Contractor must pay for those services. *42 CFR 438.424* CHP+ Contract: Exhibit B1—14.1.4.1.9.4–5 10 CCR 2505-10 8.209.4.W-X	• Appeals Process Policy and Procedure – Pg. 9 (N, 5a-b)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
33. The Contractor maintains records of all grievances and appeals. The records must be accurately maintained in a manner accessible to the State and available on request to CMS. • The record of each grievance and appeal must contain, at a minimum, all of the following information: – A general description of the reason for the grievance or appeal. – The date received. – The date of each review or, if applicable, review meeting. – Resolution at each level of the appeal or grievance. – Date of resolution at each level, if applicable. – Name of the person for whom the appeal or grievance was filed. • The Contractor quarterly submits to the Department a Grievance and Appeals report including this information. *42 CFR 438.416* CHP+ Contract: Exhibit B1—14.1.4.1.12, 15.5.1 10 CCR 2505-10 8.209.3.C	• Appeals Process Policy and Procedure – Pg. 10 (O,1-6) • DHMP CHP+ Compliance Q1 SFY21 - Pg. 4-5	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
34. The Contractor provides the information about the grievance, appeal, and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals.	• Provider Manual 2020 Pg. 35 -41	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing.* – The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member. * *Time frames specified for filing:* *During an appeal: Request continued benefits within 10 days of the notice of adverse benefit determination.* *During a State fair hearing: Request continued benefits within 10 days of the notice of adverse appeal resolution.* *42 CFR 438.414* *42 CFR 438.10(g)(xi)* CHP+ Contract Amendment 3: Exhibit B1—14.1.4.1.1.1, 14.1.5.1.1 10 CCR 2505-10 8.209.3.B		

Results for Standard VI—Grievance and Appeal Systems							
Total	Met	=	32	X	1.00	=	32
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	34	**Total Score**		=	32
				Total Score ÷ Total Applicable		=	94%

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements written policies and procedures for selection and retention of providers. *42 CFR 438.214(a)* CHP+ Contract: Exhibit B1—14.2.1.1	• P&P- Provider Selection and Retention	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor follows a documented process for credentialing and recredentialing of providers that complies with the standards of the National Committee for Quality Assurance (NCQA). The Contractor shall assure that all laboratory-testing sites providing services under this contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration. *42 CFR 438.214(b) and (e)* CHP+ Contract: Exhibit B1—14.2.1.3, 14.2.1.5	• P&P- Credentialing and Recredentialing of Practitioners • P&P- Assessment of Organizational Providers • DHMP CLIA	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor's provider selection policies and procedures include provisions that the Contractor does not: • Discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. • Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42 CFR 438.12(a)(1) and (2)* *42 CFR 438.214(c)* CHP+ Contract: Exhibit B1—14.2.1.1.2.1—2	• P&P- Credentialing and Recredentialing of Practitioners- Pg. 5, Section A: Non-Discrimination • P&P- Provider Selection and Retention- Pg. 2, E	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This is not construed to: • Require the Contractor to contract with providers beyond the number necessary to meet the needs of its members. • Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. • Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members. *42 CFR 438.12(a-b)* CHP+ Contract: Exhibit B1—14.2.1.1.2.4, 14.2.1.1.5	• P&P- Credentialing and Recredentialing of Practitioners- Pg. 14, J Notification of Credentialing and Recredentialing Decision • Attachment C - Sample Notification of CredentialingRecredentialing Decision	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Contractor has a signed contract or participation agreement with each provider. *42 CFR 438.206(b)(1)* CHP+ Contract: Exhibit B1—10.1	• Contract Template	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor does not employ or contract with providers or other individuals or entities excluded for participation in federal health care programs under either Section 1128 or 1128 A of the Social Security Act. *(This requirement also requires a policy.)* *42 CFR 438.214(d)* *42 CFR 438.610* CHP+ Contract: Exhibit B1—14.2.1.6, 19.1.1	• Contract template- Section 3.2 • P&P- Credentialing and Recredentialing of Practitioners- Pg. 15, Ongoing Monitoring • P&P- Sanction Screening of Individuals-Providers and Entities- Pg. 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549. *42 CFR 438.610* CHP+ Contract: Exhibit B1—19.1.1 and 19.1.2	• P&P- Provider Selection and Retention- Pg.2, H • P&P- Credentialing and Recredentialing- Pg. 7 • P&P- Sanction Screening of Individuals-Providers and Entities- Pg. 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: • The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered. • Any information the member needs in order to decide among all relevant treatment options.	• P&P- Provider Selection and Retention- Pg.2, F	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The risks, benefits, and consequences of treatment or non-treatment. • The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. *42 CFR 438.102(a)(1)* CHP+ Contract: Exhibit B1—10.4.3		
9. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: • To the State upon contracting or when adopting the policy during the term of the contract. • To members before and during enrollment. • To members within 90 days after adopting the policy with respect to any particular service. *42 CFR 438.102(b)* CHP+ Contract: Exhibit B1—14.1.3.13.3.7 Amendment 3: Exhibit K—1.1.7	• Provider Manual 2020_Final- Pg. 7 • 2020 CHP+ Member Handbook- Pg. 14 • P&P- Religious Accommodations and Conscience Objections Relative to Provision of Care	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
10. The Contractor has administrative and management arrangements or procedures, including a compliance program to detect and prevent fraud, waste, and abuse and includes: • Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal, State, and contract requirements. • The designation of a compliance officer who is responsible for developing and implementing policies, procedures and	• 2020 DHMP Compliance Program - pp 5, 7, 8, 9, 10, 11, 12, 14 • 2020 CodeofConduct	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
practices to ensure compliance with requirements of the contract and reports directly to the CEO and Board of Directors. • The establishment of a Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program. • Training and education of the compliance officer, management, and organization's staff members for the federal and State standards and requirements under the contract. • Effective lines of communication between the compliance officer and the Contractor's employees. • Enforcement of standards through well-publicized disciplinary guidelines. • Implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks. • Procedures for prompt response to compliance issues as they are raised, investigation of potential compliance problems identified in the course of self-evaluation and audits, corection of such problems quickly and thoroughly to reduce the potential for reoccurence, and ongoing compliance with the requirements under the contract. *42 CFR 438.608(a)(1)* CHP+ Contract: Exhibit B1—14.2.5.2–3, 14.2.5.4.1–2, 14.2.5.4.9, 14.2.7.2–5		

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor's administrative and management procedures to detect and prevent fraud, waste, and abuse include: • Written policies for all employees, contractors or agents that provide detailed information about the False Claims Act, including the right of employees to be protected as whistleblowers. • Provisions for prompt referral of any potential fraud, waste, or abuse to the Department and any potential fraud to the State Medicaid Fraud Control Unit. • Provisions for suspension of payments to a network provider for which the State determines there is credible allegation of fraud (in accordance with 455.12.) *42 CFR 438.608 (a)(6-8)* CHP+ Contract: Exhibit B1—14.2.6.1, 14.2.7.1, 14.2.7.6	• 2020 DHMP Compliance Program – Pg. 13 • DHMP FWA Policy -Pg. 5 • P&P- False Claims-Fraud-Waste and Abuse-Pg.1, Pg. 5	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor's Compliance Program includes: • Provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potenial fraud. • Provision for prompt notification to the State about member circumstances that may affect the member's eligibility, including change in residence and member death. • Provision for notification to the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including termination of the provider agreement with the Contractor.	• P&P- Provider-Vendor-Subcontractor Overpayments- Pgs. 4-5 • DOD Workflow • Change of Address Workflow • CHP Verification of Services_Combined • DOP-Verification of Services • P&P- Provider Terminations	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Provision for a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. *42 CFR 438.608 (a)(2-5)* CHP+ Contract: Exhibit B1—14.2.5.4.3–7		
Findings: Although DHMP's desktop policy included procedural steps to verify that services billed had been received by the member, per staff member report, the verification process had not occurred for the CHP+ line of business in CY 2020 and had not launched by the time of the audit.		
Required Actions: DHMP must ensure that CHP+ services are verified regularly to ensure services represented by providers were received by members. Furthermore, HSAG encourages DHMP to expand sampling methodology to all CHP+ members, not only adults.		
13. The Contractor ensures that all network providers are enrolled with the State as CHP+ providers consistent with the provider disclosure screening, and enrollment requirements of the State. • The Contractor may execute network provider agreements pending the outcome of the State's screening and enrollment process of up to one-hundred and twenty (120) days, but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one one-hundred and twenty (120)-day period without enrollment of the provider, and notify affected enrollees. *42 CFR 438.608 (b)* CHP+ Contract: None	• Medicaid and Child Health Plan Plus Provider Revalidation Process	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor has procedures to provide to the State: • Written disclosure of any prohibited affiliation (as defined in 438.610). • Written disclosure of ownership and control (as defined in 455.104) • Identification within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract. *42 CFR 438.608(c)* CHP+ Contract: Exhibit B1—19.4.1, 19.4.4	• Policy: Credentialing and Recredentialing of Practitioners – Pg. 7 • DOP- Recon Process	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. The Contractor has a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days of identifying the overpayment, and to notify the Contractor in writing of the reason for the overpayment. • The Contractor reports annually to the State on recoveries of overpayments. *42 CFR 438.608(d)(2) and (3)* CHP+ Contract: Exhibit B1—16.3.4.1.6	• Claims Guide 2020- Pg. 34-36 • P&P- Provider-Vendor-Subcontractor Overpayments- Pgs. 2-5	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. The Contractor provides that members are not held liable for: • The Contractor's debts in the event of the Contractor's insolvency. • Covered services provided to the member for which the State does not pay the Contractor.	• Provider Manual- Pg. 65 in Overview	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Covered services provided to the member for which the State or the Contractor does not pay the health care provider that furnishes the services under a contractual, referral, or other arrangement. • Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. *42 CFR 438.106* CHP+ Contract Amendment 3: Exhibit B1—16.4.1		

Results for Standard VII—Provider Participation and Program Integrity							
Total	Met	=	14	X	1.00	=	14
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	15	**Total Score**		=	14
Total Score ÷ Total Applicable						=	93%

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. Notwithstanding any relationship(s) with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. *42 CFR 438.230(b)(1)* CHP+ Contract: Exhibit B1—5.5.3.3	• Contract for Medicaid and CHP Template- Pg. 6 (3.2) • Delegated Credentialing Agreement, Section A,1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. All contracts or written arrangements between the Contractor and any subcontractor specify— • The delegated activities or obligations and related reporting responsibilities. • That the subcontractor agrees to perform the delegated activities and reporting responsibilities. Provision for revocation of the delegation of activities or obligations or specify other remedies in instances where the Contractor determines that the subcontractor has not performed satisfactorily. *Note: Subcontractor requirements do not apply to network provider agreements. In addition, wholly-owned subsidiaries of the health plan are not considered subcontractors.* *42 CFR 438.230(b)(2) and (c)(1)* CHP+ Contract: Exhibit B1—2.3	• Contract for Medicaid and CHP Template- Pg. 9 (3.17) • Delegated Credentialing Agreement, Bullet 1- Section B • Bullet 2- cover and final page • Bullet 3- section A, 6	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's written agreement with any subcontractor includes: • The subcontractor's agreement to comply with all applicable Medicaid/CHP+ laws, regulations, including applicable subregulatory guidance and contract provisions. *42 CFR 438.230(c)(2)* CHP+ Contract: Exhibit B1—20.B	• Contract for Medicaid and CHP Template- Pg. 6 (3.2) • Delegated Credentialing Agreement – Section B, 2 • Delegation of Credentialing Activities Policy Pg 1. Policy Section	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The written agreement with the subcontractor includes: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State. – The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems related to CHP+ enrollees. – The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. – If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. *42 CFR 438.230(c)(3)* CHP+ Contract: Exhibit B1—2.3	• Contract for Medicaid and CHP Template- Pg. 8 (3.12) • Delegated Credentialing Agreement- Section B, 5-8 • Delegation of credentialing Activities Policy- Pg. Section B,1	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The language used in the subcontracts reviewed varied significantly across contracts. While the required language was included in the new contract template for Medicaid/CHP+ submitted for review, three of the four subcontracts reviewed did not contain all required language. The UPI contract contained the correct language, except the right to audit statement listed a six-year rather than a 10-year right to audit time frame from the final date of the contract period. HSAG noted that neither the Clarity agreement nor the DHHA agreement specifically addressed the right of CMS or the HHS-OIG to audit, the right to audit for 10 years from the final date of the contract periods, the types of documents or records to be made available, or other specifics outlined in the language of 42 CFR 438.230(c)(3).		
Required Actions: DHMP must revise the subcontracts to include all required language.		

Results for Standard IX—Subcontractual Relationships and Delegation							
Total	Met	=	3	X	1.00	=	3
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	4	**Total Score**		=	3
				Total Score ÷ Total Applicable		=	75%

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Appeals Record Review Tool
for Denver Health Medical Plan

Review Period:	January 1, 2020–December 31, 2020
Date of Review:	February 9, 2021–February 11, 2021
Reviewer:	Erica Arnold-Miller
Participating Health Plan Staff Member(s):	Stacy Grein

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame*	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
1	****	02/18/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☐ N ☐ N/A ☒	Yes ☐ No ☒	Yes ☐ No ☒	03/02/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
2	****	11/03/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☐ N ☐ N/A ☒	Yes ☐ No ☒	Yes ☐ No ☒	11/16/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
3	****	09/21/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☐ N ☐ N/A ☒	Yes ☐ No ☒	Yes ☐ No ☒	09/30/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
4	****	09/21/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☐ N ☐ N/A ☒	Yes ☐ No ☒	Yes ☐ No ☒	09/30/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
5	****	11/13/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☐ N ☐ N/A ☒	Yes ☐ No ☒	Yes ☐ No ☒	11/23/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
6	****	04/20/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	04/29/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
7	****	02/04/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	02/14/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
8	****	08/10/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☐ N ☐ N/A ☒	Yes ☐ No ☒	Yes ☐ No ☒	08/20/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
9	****	07/15/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	07/22/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
10	****	09/02/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☐ N ☐ N/A ☒	Yes ☐ No ☒	Yes ☐ No ☒	09/15/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Appeals Record Review Tool
for Denver Health Medical Plan

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame*	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
Do not score shaded columns below.											
		Column Subtotal of Applicable Elements	**10**	**10**	**3**				**10**	**10**	**10**
		Column Subtotal of Compliant (Met) Elements	**10**	**10**	**3**				**10**	**10**	**10**
		Percent Compliant (Divide Met by Applicable)	**100%**	**100%**	**100%**				**100%**	**100%**	**100%**

Key: M = Met; N = Not Met
N/A = Not Applicable
Yes; No = Not scored—information only

Total Applicable Elements	**53**
Total Compliant (Met) Elements	**53**
Total Percent Compliant	**100%**

***Appeal resolution letter time frame** does not exceed 10 working days from the day the health plan receives the appeal (unless expedited—three calendar days; or unless extended—+14 calendar days).

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

**** = Redacted Member ID

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Grievance Record Review Tool
for Denver Health Medical Plan

Review Period:	January 1, 2020–December 31, 2020
Date of Review:	February 9, 2021–February 11, 2021
Reviewer:	Erica Arnold-Miller
Participating Health Plan Staff Member(s):	Stacy Grein

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame*	Decision Maker Not Previous Level	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
1	****	09/02/20	M ☒ N ☐ N/A ☐	09/21/20	12	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☐ N ☒ N/A ☐	M ☒ N ☐ N/A ☐
Comments: Billing issue. Resolution response attachment includes an option to file an appeal; a grievance cannot be appealed. Letter content is incorrect.										
2	****	09/02/20	M ☒ N ☐ N/A ☐	09/21/20	12	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☐ N ☒ N/A ☐	M ☒ N ☐ N/A ☐
Comments: Billing issue. Resolution response attachment includes an option to file an appeal; a grievance cannot be appealed. Letter content is incorrect.										
3	****	06/02/20	M ☒ N ☐ N/A ☐	06/08/20	4	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☐ N ☒ N/A ☐	M ☐ N ☒ N/A ☐
Comments: This issue was processed as a grievance; however, it should have been classified as an adverse benefit determination and documented as an appeal. Resolution letter content is incorrect. Resolution letter tests at grade level 14.										
4	****	02/13/20	M ☒ N ☐ N/A ☐	03/04/20	13	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☐ N ☒ N/A ☐	M ☒ N ☐ N/A ☐
Comments: Billing issue. Resolution response attachment includes an option to file an appeal; a grievance cannot be appealed. Letter content is incorrect.										
5	****	01/22/20	M ☒ N ☐ N/A ☐	02/10/20	13	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☐ N ☒ N/A ☐	M ☒ N ☐ N/A ☐
Comments: Client billed in error. Resolution response attachment includes an option to file an appeal; a grievance cannot be appealed. Letter content is incorrect.										
6	****	08/05/20	M ☐ N ☒ N/A ☐	08/24/20	15	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☐ N ☒ N/A ☐	M ☒ N ☐ N/A ☐
Comments: Cancellation of authorizations and denied referral. Acknowledgement letter sent on fifth working day. This issue was processed as a grievance; however, it should have been classified as an adverse benefit determination and appealed. Resolution letter content is incorrect.										
Do not score shaded columns below.										
Column Subtotal of Applicable Elements			**6**			**6**	**6**	**6**	**6**	**6**
Column Subtotal of Compliant (Met) Elements			**5**			**6**	**6**	**6**	**0**	**5**
Percent Compliant (Divide Met by Applicable)			**83%**			**100%**	**100%**	**100%**	**0%**	**83%**

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

Total Applicable Elements	**36**
Total Compliant (Met) Elements	**28**
Total Percent Compliant	**78%**

* Grievance timeline for resolution and notice sent is 15 working days (unless extended).
**Grievance resolution letter required content includes (1) results of the disposition/resolution process and (2) the date the disposition/resolution process was completed.
**** = Redacted Member ID

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2020–2021 site review of **DHMP**.

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

HSAG Review Team	Title
Barbara McConnell	Executive Director
Sarah Lambie	Project Manager III
Erica Arnold-Miller	Project Manager II
DHMP Participants	**Title**
Bridget Johnson	Director of Compliance and Internal Audit
Bridget Kalell	DHMP Marketing and Sales Manager
Catherine Fortney	Chief Compliance and Audit Officer
Christopher Garcia	MC Government Products Analyst
Cynthia Chachas	Director of Pharmacy
Dallen Waldenrath Gomez	Health Plan Compliance Analyst
Greg McCarthy	Executive Director, Managed Care
Jeremy Sax	Government Products Manager
Kaitlin Gaffney	MC Government Products Analyst
Kerilyn Matsunaga Gottlieb	Contract Manager, Provider Relations
Lisa Artale Bross	Compliance Manager
Marques Haley	Monitoring, Auditing and Training Manager
Michael Wagner	Chief Administrative Officer Managed Care DHMP
Natalie Score	Director of Insurance Products
Shanique Horne	Director of Provider Relations and Contracts
Stacy Grein	Grievance and Appeals Manager
Department Observers	**Title**
Amy Ryan	CHP+ Contract and Program
Curt Curnow	Quality Improvement Section Manager
Elizabeth Mattes	Project Coordinator
Russ Kennedy	Quality Program Manager

Appendix D. Corrective Action Plan Template for FY 2020–2021

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 SAFE 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 2020–2021 Corrective Action Plan for DHMP CHP+

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
16. The member handbook provided to members following enrollment includes the following information regarding the grievance, appeal, and fair hearing procedures and time frames: • The right to file grievances and appeals. • The requirements and time frames for filing a grievance or appeal. • The right to a request a State fair hearing after the Contractor has made a determination on a member's appeal which is adverse to the member. • The availability of assistance in the filing process. • The fact that, when requested by the member: – Benefits that the Contractor seeks to reduce or terminate will continue if the member files an appeal or a request for State fair hearing is filed within the time frames specified for filing. – If benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal or State fair hearing is pending if the final	The member handbook section regarding continued benefits during an appeal and SFH was combined in a way that the criteria was not entirely accurate or clear. For example, the expiration of the original service authorization only applies to requesting continuation of benefits during the appeal, not how long benefits will continue during the appeal, and does not apply for an SFH. Procedures, timelines, and criteria within the section switched back and forth between appeal and SFH, which could be confusing to the member.	DHMP must update the continuation of benefits section of the member handbook to clarify what procedures and timelines apply to appeals and which apply to SFHs.

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
decision is adverse to the member. *42 CFR 438.10(g)(2)(xi)* CHP+ Contract: Exhibit B1—14.1.3.10 Exhibit K—1.1.18, 1.1.18.1, 1.1.18.1.1, 1.1.18.1.3, 1.1.18.2.1		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
4. The Contractor defines "grievance" as an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. A grievance includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision. *42 CFR 438.400(b)* CHP+ Contract: Exhibit B1—1.1.44 10 CCR 2505-10—8.209.2.D, 8.209.4.A.3.c.i	DHMP processed grievances according to the federal requirements only when the grievances met DHMP's definition of a "formal" grievance. Expressions of dissatisfaction that were able to be resolved at the point of contact were handled through a less formal complaint process that did not fully meet the requirements. These complaints were not included in grievance reporting to HSAG or the Department. Additionally, the grievance record review identified a potential denial of service that was misclassified and processed as a grievance.	DHMP must develop and implement a mechanism to define, identify, and manage grievances in compliance with all grievance requirements, and ensure this process is used consistently to address *any* expression of dissatisfaction received from a member about any matter other than an adverse benefit determination. DHMP must provide training to staff members that clearly defines the difference between a grievance and an appeal to ensure accurate documentation and corresponding procedures.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
12. The Contractor must resolve each grievance and provide notice as expeditiously as the enrollee's health condition requires, and within 15 working days of when the member files the grievance. • Notice to the member must be in a format and language that may be easily understood by the member. *42 CFR 438.408(a) and (b)(1)and (d)(1)* Contract: Exhibit B1—14.1.5.7, 14.1.5.9, 14.1.3.1 10 CCR 2505-10 8.209.5.D	The grievance resolution letters correctly included information that the member may contact the State if they were unhappy with the grievance decision; however, the letter also included an attachment stating that the member could file an appeal, a quick appeal, or an SFH. This attachment was misleading to the member as there is no appeal or SFH process available to members for grievances. The appeal and SFH processes are only available to members when an adverse benefit determination is made.	DHMP must remove the appeal and SFH attachment from grievance resolution letters.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VII—Provider Participation and Program Integrity		
Requirement	**Findings**	**Required Action**
12. The Contractor's Compliance Program includes: • Provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potenial fraud. • Provision for prompt notification to the State about member circumstances that may affect the member's eligibility, including change in residence and member death. • Provision for notification to the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including termination of the provider agreement with the Contractor. • Provision for a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. *42 CFR 438.608 (a)(2-5)* CHP+ Contract: Exhibit B1—14.2.5.4.3–7	Although DHMP's desktop policy included procedural steps to verify that services billed had been received by the member, per staff member report, the verification process had not occurred for the CHP+ line of business in CY 2020 and had not launched by the time of the audit.	DHMP must ensure that CHP+ services are verified regularly to ensure services represented by providers were received by members. Furthermore, HSAG encourages DHMP to expand sampling methodology to all CHP+ members, not only adults.

Standard VII—Provider Participation and Program Integrity		
Requirement	**Findings**	**Required Action**
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Findings**	**Required Action**
4. The written agreement with the subcontractor includes: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State. – The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems related to CHP+ enrollees. – The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. – If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State,	The language used in the subcontracts reviewed varied significantly across contracts. While the required language was included in the new contract template for Medicaid/CHP+ submitted for review, three of the four subcontracts reviewed did not contain all required language. The UPI contract contained the correct language, except the right to audit statement listed a six-year rather than a 10-year right to audit time frame from the final date of the contract period. HSAG noted that neither the Clarity agreement nor the DHHA agreement specifically addressed the right of CMS or the HHS-OIG to audit, the right to audit for 10 years from the final date of the contract periods, the types of documents or records to be made available, or other specifics outlined in the language of 42 CFR 438.230(c)(3).	DHMP must revise the subcontracts to include all required language.

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Findings**	**Required Action**
CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. *42 CFR 438.230(c)(3)* CHP+ Contract: Exhibit B1—2.3		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review Protocol Activities

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

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal managed care regulations and Department contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all site reviewers to ensure consistency in scoring across health plans.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided health plans with proposed site review dates, group technical assistance, and training, as needed. • HSAG confirmed a primary health plan contact person for the site review and assigned HSAG reviewers to participate in the site review. • Sixty days prior to the scheduled date of the site 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 site review agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and the site review 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 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 member grievance and all member appeal records that occurred between January 1, 2020, and December 31, 2020 (to the extent available at the time of the site review). Health plans submitted the lists to HSAG 10 days following receipt of the desk review request. HSAG used a random sampling technique to select records for desk review and the site review. HSAG notified the

For this step,	HSAG completed the following activities:
	health plan five days following receipt of the lists of records regarding the sample records selected. • The HSAG review team reviewed all documentation submitted prior to the site review and prepared a request for further documentation and an interview guide to use during the site review.
Activity 3:	**Conduct Health Plan Site Review**
	• During the site review, HSAG met with groups of the health plan's key staff members to obtain a complete picture of the health plan's compliance with federal healthcare regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan's performance. • HSAG requested, collected, and reviewed additional documents as needed. • At the close of the site review, HSAG provided health plan staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2020–2021 Department-approved Site Review Report Template to compile the findings and incorporate information from the pre-site review and site review activities. • HSAG analyzed the findings and calculated final scores based on Department-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the Department**
	• HSAG populated the Department-approved report template. • HSAG submitted the draft Site Review Report to the health plan and the Department for review and comment. • HSAG incorporated the health plan and Department comments, as applicable, and finalized the report. • HSAG included a pre-populated CAP template in the final report for all elements determined to be out of compliance with managed care regulations. • HSAG distributed the final report to the health plan and the Department.