Fiscal Year 2021–2022 Site Review Report

for

Denver Health Medical Plan

April 2022

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

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

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. The updated Medicaid and Child Health Plan *Plus* (CHP+) managed care regulations published May 6, 2016, became applicable to CHIP effective July 1, 2018. Additional revisions were released in November 2020, with an effective date of December 2020. 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 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) 2021–2022 was January 1, 2021, through December 31, 2021. This report documents results of the FY 2021–2022 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 2021–2022 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2020–2021 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 credentialing and recredentialing record reviews. Appendix C lists HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan (CAP) process the health plan will be required to complete for FY 2021–2022 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: Sep 27, 2021.

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	Score* (% of Met Elements)
III. Coordination and Continuity of Care	10	10	10	0	0	0	100%
IV. Member Rights, Protections, and Confidentiality	5	5	5	0	0	0	100%
VIII. Credentialing and Recredentialing	32	32	31	1	0	0	97%
X. Quality Assessment and Performance Improvement	18	18	18	0	0	0	100%
Totals	**65**	**65**	**64**	**1**	**0**	**0**	**98%**

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

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

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Credentialing	100	90	90	0	10	100%
Recredentialing	90	82	82	0	8	100%
Totals	**190**	**172**	**172**	**0**	**18**	**100%**

*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 III—Coordination and Continuity of Care

Summary of Strengths and Findings as Evidence of Compliance

DHMP described a team of 26 employees comprised of care managers providing healthcare provider coordination across 17 care management programs, ranging from transition of care, disease management, complex case management, high utilizers, emotional well-being, medication management, and other lower-level supports. Members are informed about how to contact their primary healthcare providers through welcome materials, and members enrolled in a specific care management program receive a welcome letter with additional contact information.

Submitted documentation provided a wide variety of details regarding how **DHMP** makes its best effort to assess member healthcare needs within the first 90 days after enrollment. The contracted vendor, Symphony Performance Health, Inc. (SPH), works to collect initial assessment information in paper format and follows up with a telephone survey if the mailed assessment is unsuccessful. If the initial assessment data indicates a healthcare or support need, **DHMP** care management staff members follow up on any identified needs with additional specialized assessments in a timely manner. Members with special healthcare needs were clearly defined in the policy and procedure and could be identified through data. The case management referral form was also available online for ease of submitting outside referrals.

Members could access the **DHMP** portal which included programs to assist with healthcare self-management skills and goals. **DHMP** documented all other care planning in the Altruista GuidingCare system. **DHMP** stated that its staff members monitored notes, care plans, and documentation through various audits and cross-functional activities.

Care management leadership described frequent, internal coordination and planning meetings that are attended by staff members such as social workers, transition-of-care nurses, and other specialty providers, as needed, in an effort to communicate the member's status to the treatment team and reduce duplication of activities. **DHMP**'s ability to coordinate efficiently and effectively is further supported by the EPIC system's ability to send out a system-wide message to the treatment team, which **DHMP** staff members described as particularly useful if there were to be a roadblock in seeking care/next steps. When communication outside **DHMP**'s EPIC system was required, staff members reported providers and administrative staff utilized encrypted email to ensure compliance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) and privacy standards.

To aid with additional referrals, call center and care management staff members maintained access to a master list of community resources, services, and supports. Additionally, care management staff members described that these entities frequently joined the care management team meetings to provide details about the way to effectively refer members.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Required Actions

HSAG identified no required actions for this standard.

Standard IV—Member Rights, Protections, and Confidentiality

Summary of Strengths and Findings as Evidence of Compliance

DHMP's government products team maintained responsibility for the distribution and consistency of information related to member rights throughout the year. **DHMP** informs members of these rights through the CHP+ member handbook, member newsletter, member website, notice of privacy practices, and member complaint and appeal procedures. The CHP+ member handbook educates members of their rights to willing participate in decisions concerning their healthcare, receive information about treatment options and alternatives, and obtain a second opinion or review regarding the member's case. Staff members described the role of **DHMP**'s call center in supporting members in connecting with healthcare services outside of the **DHMP** network if members are unable to obtain services within the network. Members are also informed of the right to file a grievance if they believe that these rights have been violated.

The *Member Rights and Responsibility* policy discussed **DHMP**'s compliance with applicable federal and State laws. The *2020 Denver Health Code of Conduct* stated that employees and providers should treat members with respect and dignity, and ensure members' privacy. Staff members described how **DHMP** updates providers when there is a change in these laws, and how the legal and compliance committee regularly reviews the code of conduct. **DHMP** also stated that it raises awareness of its policies on nondiscriminatory behaviors towards members through trainings.

DHMP's *Notice of Privacy Practices* outlined member rights regarding protected health information (PHI) and provided information on how to exercise these rights and report any complaints regarding violation of members' privacy. The *HIPAA Hybrid Entity Health Care Components* and *Protected Health Information Uses and Disclosures without Authorization* policies detailed procedures to maintain compliance with HIPAA and privacy standards, including safeguards.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Required Actions

HSAG identified no required actions for this standard.

Standard VIII—Credentialing and Recredentialing

Summary of Strengths and Findings as Evidence of Compliance

DHMP's credentialing and recredentialing processes demonstrated compliance with the National Committee for Quality Assurance (NCQA) standards and the *Credentialing and Recredentialing of Practitioners* policy described the types of practitioners that **DHMP** credentials. The policy stated that the medical director is responsible for providing primary oversight of the credentialing program. **DHMP** described that the credentialing department personnel reviews files for completeness and timeliness of NCQA-required elements. Practitioners are notified within 60 calendar days of the medical director's or the credentialing committee's decision as observed in the sample records submitted for review.

The sample record review demonstrated that current and valid licenses to practice, education and trainings (including board certifications, where applicable), history of professional liability claims, National Provider Identifier (NPI) National Plan and Provider Enumeration System (NPPES), licensure/registration sanctions database, National Practitioner Data Bank (NPDB), Office of Inspector General (OIG), and System for Award Management (SAM) databases were verified within time limits. HSAG observed that all individual practitioner sample records submitted for review were signed and approved by a medical director. **DHMP** ensured the accuracy and completeness of applications by requesting additional clarifying information in writing, as needed.

DHMP directly credentialed and recredentialed all of the individual practitioners within the sample record review. **DHMP** also delegated credentialing and recredentialing responsibilities to four entities. **DHMP**'s policies and procedures described delegate audits and as additional evidence, **DHMP** submitted the *2021 Credentialing Delegate Audit File Worksheet*, *2021 Credentialing Delegate Audit File Tool*, and a sample letter informing these delegates of the results from its audits. **DHMP** staff members reported there were no current corrective action plans for delegates.

Summary of Findings Resulting in Opportunities for Improvement

The *Credentialing and Recredentialing of Practitioners* policy described a process to redact demographic and identifiable information from applications when presenting credentialing or recredentialing files to the Credentialing Committee for review and approval. Staff members reported that the Credentialing Committee did not decline any providers in calendar year (CY) 2021. Although there are no declined providers to review currently, HSAG recommends that **DHMP** includes in its policy or procedure a process to retrospectively review declined provider data and validate that the process of redacting demographic identifiers proved sufficient to ensure that declined providers were not declined based on discrimination. NCQA recommends this review is completed on an annual basis.

One organizational provider sample record demonstrated a four-month gap between the date of credentialing staff validation and medical director approval. While all verification time frames were still met, the date captured in the submission file as the "current approval date" stated May 2021; however, documentation provided showed staff member's review occurred in February and April 2021, and the medical director's final approval date was not until September 2021. HSAG recommends that **DHMP** review internal procedures for handling credentialing data to ensure accuracy when reporting internally and to external entities. Additionally, **DHMP** checked for any reported quality of care concerns (QOCCs) in January 2021 for this file; however, the file did not receive final approval until September 2021. HSAG recommends that **DHMP** consider more timely monitoring of quality issues and complaints.

Summary of Required Actions

DHMP described a quarterly audit process to ensure that credentialing data and provider directory data are accurate, and **DHMP** provided screenshots for three CHP+ providers to demonstrate that listings in practitioner directories are consistent with credentialing data, including education, training, and certification (including board certification, if applicable). However, when accessing the **DHMP** CHP+ provider directory online, searching as a CHP+ member, and using the location "Colorado," HSAG was unable to find 16 of the 20 practitioners from the record review sample. **DHMP** must expand its audit process or develop a mechanism to ensure that listings in practitioner directories are consistent with credentialing data.

Standard X—Quality Assessment and Performance Improvement

Summary of Strengths and Findings as Evidence of Compliance

The **DHMP** Quality Assessment and Performance Improvement (QAPI) program included a comprehensive approach to reviewing member care and outcomes at various levels of the organization. Staff members highlighted the quality workgroups as a strength of **DHMP** and described that the strength of the Quality Management Committee (QMC) and workgroup structure is the ability to discuss data with a diverse subset of providers who are engaged in improvement initiatives and are able to build understanding of key performance metrics. Submitted documentation and the virtual interview outlined a clear report-out structure from the workgroups, up to QMC, and eventually to the Board of Directors, which approved the annual work plan and analysis.

During the virtual interviews, clinical leadership reported that during the review period, **DHMP** redistributed the QMC voting membership to ensure that the voting structure reflected equal input from key departments across **DHMP**. HSAG recognized this approach as a best practice.

Submitted documentation reflected regular monitoring of member services and oversight of quality activities, such as performance improvement projects, performance measures, over- and under-utilization, development and dissemination of clinical practice guidelines, and mechanisms to monitor members'

perceptions of accessibility and adequacy of services provided. Notably, staff members described the new mechanism **DHMP** had implemented to track and report disenrollment for reasons other than loss of Medicaid eligibility.

DHMP operated health information systems that staff reported effectively managed data inputs, outputs, and some platform connectivity. Staff members described various automated and manual checks for claims data integrity and quality assurance. **DHMP** noted a strength from CY 2021 was an increased sense of partnership with the Department.

Summary of Findings Resulting in Opportunities for Improvement

Although **DHMP** submitted detailed procedural steps to identify, track, and trend QOCCs, there were no reported QOCCs for the CHP+ line of business during the review period. HSAG recommends that **DHMP** further investigate possible gaps in member, staff, and provider training regarding QOCCs and work to strengthen awareness to ensure members, staff, and providers are comfortable and aware of their requirement to report quality issues. Furthermore, **DHMP**'s customer service, case management, and utilization management staff (and other staff members, as applicable) should be aware of their requirement to document such issues.

Summary of Required Actions

HSAG identified no required actions for this standard.

2. Overview and Background

Overview of FY 2021–2022 Compliance Monitoring Activities

For the FY 2021–2022 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard III—Coordination and Continuity of Care, Standard IV—Member Rights, Protections, and Confidentiality, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement. Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of 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+ credentialing and recredentialing to evaluate implementation of federal healthcare regulations. Reviewers used standardized monitoring tools based on NCQA credentialing standards and guidelines 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 credentialing and recredentialing, and three records with an oversample of an additional three records for organizational providers. Using a random sampling technique, HSAG selected the sample from all CHP+ credentialing and recredentialing records that occurred between January 1, 2021, and December 31, 2021. 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 VIII—Credentialing and Recredentialing. 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 2021–2022 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard V—Member Information Requirements, Standard VI—Grievance and Appeal Systems, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontractual Relationships and Delegation.

Objective of the Site Review

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

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

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

FY 2020–2021 Corrective Action Methodology

As a follow-up to the FY 2020–2021 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 2020–2021 compliance monitoring site review.

Summary of FY 2020–2021 Required Actions

For FY 2020–2021, HSAG reviewed 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.

Related to Standard V—Member Information Requirements, **DHMP** was required to update the member handbook to clarify procedures and timelines that apply to appeals and State Fair Hearings (SFHs).

Related to Standard VI—Grievance and Appeal Systems, **DHMP** was required to complete the following required actions:

- Develop mechanisms to address all expressions of dissatisfaction received by members about any matter other than an adverse benefit determination.
- Ensure staff members are trained to identify and process grievances and appeals.
- Update information in the grievance resolution letter to exclude the appeal and SFH attachments.

Related to Standard IX—Subcontractual Relationships and Delegation, **DHMP** was required to revise subcontracts to include all required language as outlined in 42 CFR 438.230(c)(3).

Related to Standard VII—Provider Participation and Program Integrity, **DHMP** was required to develop mechanisms to ensure that CHP+ services are verified regularly and expand sampling methodology to all CHP+ members.

Summary of Corrective Action/Document Review

DHMP submitted a proposed CAP in May 2021. HSAG and the Department reviewed and approved the proposed plan. Initial documents as evidence of completion were submitted in September 2021 and additional documents in October 2021. **DHMP** resubmitted final CAP documents in November 2021.

Summary of Continued Required Actions

DHMP successfully completed the FY 2020–2021 CAP, resulting in no continued corrective actions.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements procedures to deliver care to and coordinate services for all members. These procedures meet State requirements, including: • Ensuring timely coordination with any of a member's providers, including mental health providers, for the provision of covered services. • Addressing those members who may require services from multiple providers, facilities, and agencies; and who require complex coordination of benefits and services. • Ensuring that all members and authorized family members or guardians are involved in treatment planning and consent to any medical treatment. • Criteria for making referrals and coordinating care with specialists, subspecialists, and community-based organizations. • Providing continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services. *42 CFR 438.208(b)* Contract: Exhibit B-2—10.5.1, 10.5.2, 10.5.3.3	• Case Management for Medicaid Choice and Child Health Plans Plus Members • CM Activity Health Care Coordination (bullet 1 &2) • CM Activity BH Coordination (bullet 1) • CM Activity Community Resources (bullet 4) • CM Activity Practitioner Communication (bullet 4) • OTA Job Aid (bullet 4&5) • Medicaid and CHP+ Health Needs Survey- (bullet 4) • Coordination and Continuity of Care for Members with Special Health Care Needs (bullets 1,2,3,4) • Access to Care and Services- Pg. 6 (bullet 1&5) • Protocols for Authorization of Out-of-Network Referrals (bullets 1,2,5) • Provider Tips for Authorization (bullet 1,2,5) • Services Requiring Prior Auth (bullets 1,2,5)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor ensures that each member has an ongoing source of care appropriate to the member's needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member. • The member must be provided information on how to contact the designated person or entity. *42 CFR 438.208(b)(1)* Contract: Exhibit B-2—10.5.3.1	• Care Management Self-Referral Form • DHMP Member Newsletter Fall 2021-508_Eng • Case Management for Medicaid Choice and Child Health Plan Plus Members • Standard III_Screenshots_CHP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor implements procedures to coordinate services the Contractor furnishes the member: • Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. • With the services the member receives from any other managed care plan. • With the services the member receives from community and social support providers. *42 CFR 438.208(b)(2)* Contract: Exhibit B-2—10.5.3.2.1, 10.5.3.2.1.1-2, 10.5.3.2.1.4	• CM Activity Transitions of Care CHP 2021 (bullet 1) • DHMP Care Management and Care Coordination Transitions Procedures All Lines of Business (bullet 1) • Sample CM Transition of Care Assessment (Bullet 1) • CM Activity Community Resources CHP 2021 (bullet 3) • One Time Agreement TOC-COC Network Adequacy OON Referrals (bullet 1&2) • Case Management for Medicaid Choice and Child Health Plan Plus Members	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor provides best efforts to conduct an initial screening of each new member's needs within 90 days of enrollment, including: • Subsequent attempts if the initial attempt to contact the member is unsuccessful. • An assessment for special health care needs including mental health, high-risk health problems, functional	• Scope of Work SPH HNS (Bullet 1) • Sample CM CHP Health Needs Survey (Bullet 2) • Sample CM Complex Health Assessment (bullet 2) • Sample CM Functional Assessment • Sample CM SDOH Assessment (Bullet 2)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
problems, language or comprehension barriers, and other complex health problems. • Using the results of the assessment to inform member outreach and care coordination activities. *42 CFR 438.208(b)(3)* Contract: Exhibit B-2—10.4.1, 10.4.1.1, 10.4.1.2, 10.4.1.4	• CHP HNS Metrics 2021 (bullet 3) • CM Activity Care Coordination CHP 2021 (bullet 3) • Case Management for Medicaid Choice and Child Health Plan Plus Members (bullet 2&3) • Special Health Care Needs and or Disabilities (All) • Coordination and Continuity of Care for Members with Special Health Care Needs (All) • Medicaid and CHP -Health Needs Survey (All) • Screening CHP SPH Phone Script • Denver Health HNA CHP Q1-Q2 Letter Q133439	
5. The Contractor shares with other entities serving the member the results of identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR 438.208(b)(4)* Contract: Exhibit B-2—10.4.1.3	• Care Coordination via Epic Healthy Planet Link • CM Activity BH Coordination CHP 2021 • CM Activity Epic Health Planet Link CHP 2021 • CM Activity Practitioner Communication CHP 2021 • Epic Health Planet Link (HPL) Screenshots • Case Management for Medicaid Choice and Child Health Plan Plus Members • Coordination and Continuity of Care for Members with Special Health Care Needs	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor ensures that each provider furnishing services to members maintains and shares, as appropriate, a member health record, in accordance with professional standards. *42 CFR 438.208(b)(5)* Contract: Exhibit B-2—10.5.6	Legal Medical Record New Contract Template 2021- Pg. 11	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The Contractor ensures that, in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent applicable. *42 CFR 438.208(b)(6)* Contract: Exhibit B-2—10.5.5.9, 13.1.2	• HIPAA Hybrid Entity Health Care Components • Case Management for Medicaid Choice and Child Health Plan Plus Members	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor implements mechanisms to comprehensively assess each CHP+ member identified by the State as having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. • The assessment must be completed within 30 calendar days from the completion of the initial screening, if the initial screening identified special health care needs. *42 CFR 438.208(c)(2)* Contract: Exhibit B-2—10.5.9.1.1	• Complex Case Management Process • High Risk Pregnancy v20 Assessment • Maternity First Trimester v20 Assessment • Maternity Second Trimester v20 Assessment • Maternity Third Trimester v20 Assessment • Post-Partum Follow Up v20_Assessment & Treatment • Post-Partum Follow Up v20_Rehab & Lifestyle Modification • Coordination and Continuity of Care for Members with Special Health Care Needs • Medicaid and CHP- Health Needs Survey	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Special Health Care Needs and-or Disabilities • Sample CM CHP_Health Needs Survey • Sample CM Complex Health Assessment • Sample CM Edinburgh Postnatal Depression Scale (EPDS) • CM Functional Assessment • Sample CM SDOH Assessment • Sample CM Transition of Care Assessment • Screenshots_Member Handbook_Special Health Care Needs	
9. The Contractor produces a treatment or service plan for members with special health care needs who are determined, through assessment, to need a course of treatment or regular care monitoring. The treatment plan must be: • Approved by the Contractor in a timely manner (if such approval is required by the Contractor). • In accordance with any applicable State quality assurance and utilization review standards. • Reviewed and revised upon reassessment of functional need, at least every 12 months, when the member's circumstances or needs change significantly, or at the request of the member. *42 CFR 438.208(c)(3)* Contract: Exhibit B-2—10.5.9.1.2-3	• Job Aid - Time Frame Special Needs (bullet 1) • Coordination and Continuity of Care for Members with Special Health Care Needs (All) • CM Activity Care Plan Update-Review CHP 2021 • CM Screenshots Plan of Care following Assessment • Essential Care Management Elements of the Plan of Care • Case Management for Medicaid Choice and Child Health Plan Plus Members • Complex Case Management Process • Special Health Care Needs and-or Disabilities • Screenshots Member Handbook Special Health Care Needs	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. For members with special health care needs determined to need a course of treatment or regular care monitoring, the Contractor must have a mechanism in place to allow members direct access to a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. *42 CFR 438.208(c)(4)* Contract: Exhibit B-2—10.5.9.1.4	• Complex Case Management Process • Job Aid - Time Frame Special Needs • Coordination and Continuity of Care for Members with Special Health Care Needs • Special Health Care Needs and-or Disabilities • PROVIDER TIPS FOR AUTHORIZATION SUBMISSIONS • Screenshots_Member Handbook_Special Health Care Needs • Access to Care and Service Standards	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	10	X	1.00	=	10
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	10	**Total Score**		=	10
				Total Score ÷ Total Applicable		=	100%

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has written policies regarding the member rights specified in this standard. *42 CFR 438.100(a)(1)* Contract: Exhibit B-2—7.3.6.1	• Member Rights and Responsibilities Policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor complies with any applicable federal and State laws that pertain to member rights (e.g., non-discrimination, Americans with Disabilities Act) and ensures that its employees and contracted providers observe and protect those rights. *42 CFR 438.100(a)(2) and (d)* Contract: Exhibit B-2—15.10.9.2	• Member Rights and Responsibilities Policy- Pg. 1 (Purpose) and Pg.2 • 2022 Code of Conduct- Pg. 11 • Provider Manual – Pg. 6 section xx, Pg. 51 and 53	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor's policies and procedures ensure that each member is guaranteed the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for the member's dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding their 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 their medical records and request that they be amended or corrected.	• Member Rights and Responsibilities - Pg. 2 & 3 (a. -e., j. and p.)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210). *42 CFR 438.100(b)(2) and (3)* Contract: Exhibit B-2—7.3.6.2-6		
4. The Contractor ensures that each member is free to exercise their rights and that the exercise of those rights does not adversely affect how the Contractor, its network providers, or the Department treat(s) the member. *42 CFR 438.100(c)* Contract: Exhibit B-2—7.3.6.3.7	• Member Rights and Responsibilities Policy Pg.- 3 (t.) • CHP+ Member Handbook 2021 Eng	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. For medical records and any other health and enrollment information which identify a particular member, the Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42 CFR 438.224* Contract: Exhibit B-2—10.5.5.9, 13.1.2	• CHP+ HIPPA Privacy Web with link in word document • Protected Health Information Uses and Disclosures without Authorization	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard IV—Member Rights, Protections, and Confidentiality							
Total	Met	=	5	X	1.00	=	5
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	5	**Total Score**		=	5
				Total Score ÷ Total Applicable		=	100%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. • The Contractor shall use National Committee on Quality Assurance (NCQA) credentialing and recredentialing standards and guidelines as the uniform and required standards for all applicable providers. *42 CFR 438.214(b)* NCQA CR1 Contract: Exhibit B-2—9.2.3.1	Note: These are NCQA health plan (HP) requirements available at the time of drafting this tool (07/2021). • Credentialing and Re-credentialing of Practitioners- Page 1 Under Purpose	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners it credentials and recredentials. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. *Examples of BH practitioners include psychiatrists, physicians, addiction medicine specialists, doctoral or master's-level psychologists, master's-level clinical social workers, master's-level clinical nurse specialists or psychiatric nurse practitioners, and other behavioral health care specialists.* *Examples of HP practitioners include medical doctors, chiropractors, osteopaths, podiatrists, NPs, etc.* *42 CFR 438.214(a)* NCQA CR1—Element A1	• Credentialing and Re-credentialing of Practitioners- Pg. 1 & 2 Under Scope • Provider Selection and Retention Policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.B. The verification sources it uses. NCQA CR1—Element A2	• Credentialing and Re-credentialing of Practitioners- Pg. 11 (H) • Attachment B-Acceptable Verification Sources for Practitioner Credentialing	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	• Credentialing and Re-credentialing of Practitioners- Pg. 7 table E	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	• Credentialing and Re-credentialing of Practitioners – Pg. 15 (I & J)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.E. The process for managing credentialing/recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	• Credentialing and Re-credentialing of Practitioners- Pgs. 4 & 5 (A. full section), Pg. 8 (F)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.F. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. *Examples include: non-discrimination of applicant, process for preventing and monitoring discriminatory practices, and monitoring the credentialing/recredentialing process for discriminatory practices at least annually.* NCQA CR1—Element A6	• Credentialing and Re-credentialing of Practitioners- Pg. 5 (A) Non-Discrimination	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.G. The process for notifying practitioners if information obtained during the Contractor's credentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A7	• Credentialing and Re-credentialing of Practitioners- Pg. 6 (B,1)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.H. The process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the Credentialing Committee's decision. NCQA CR1—Element A8	• Credentialing and Re-credentialing of Practitioners- Pg. 15 (J)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.I. The medical director or other designated physician's direct responsibility and participation in the credentialing program. NCQA CR1—Element A9	• Credentialing and Re-credentialing of Practitioners- Pg. 2-3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.J. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law. NCQA CR1—Element A10	• Credentialing and Re-credentialing of Practitioners- Pg. 5 (#4)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.K. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification (including board certification, if applicable) and specialty. NCQA CR1—Element A11	• Credentialing and Re-credentialing of Practitioners Pg. 15 (L) • Web Based Provider Directory page 4-6	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: DHMP described a quarterly audit process to ensure that credentialing data and provider directory data are accurate, and DHMP provided screenshots for three CHP+ providers to demonstrate that listings in practitioner directories are consistent with credentialing data, including education, training, and certification (including board certification, if applicable). However, when accessing the DHMP CHP+ provider directory online, searching as a CHP+ member, and using the location "Colorado," HSAG was unable to find 16 of the 20 practitioners from the record review sample.		
Required Actions: DHMP must expand its audit process or develop a mechanism to ensure that listings in practitioner directories are consistent with credentialing data.		
3. The Contractor notifies practitioners about their rights: 3.A. To review information submitted to support their credentialing or recredentialing application. *The contractor is not required to make references, recommendations, and peer-review protected information available.* NCQA CR1—Element B1	• Credentialing and Re-credentialing of Practitioners- Pg. 6 (B)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3.B. To correct erroneous information. NCQA CR1—Element B2	• Credentialing and Re-credentialing of Practitioners- Pg. 5 (B,2)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3.C. To receive the status of their credentialing or recredentialing application, upon request. NCQA CR1—Element B3	• Credentialing and Re-credentialing of Practitioners – Pg. 6 (B,3)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing and recredentialing decisions. NCQA CR2—Element A1	• Credentialing and Re-credentialing of Practitioners- Pg. 3 (D) and Pg. 6 (D)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Credentialing Committee: • Uses participating practitioners to provide advice and expertise for credentialing decisions. • Reviews credentials for practitioners who do not meet established thresholds. • Ensures that clean files are reviewed and approved by a medical director or designated physician. NCQA CR2—Element A	• Credentialing Committee Charter	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. For credentialing and recredentialing, the Contractor verifies the following within the prescribed time limits: • A current, valid license to practice (verification time limit = 180 calendar days). • A valid, current Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (verification time limit = prior to the credentialing decision). • Education and training—the highest of the following: graduation from medical/professional school graduate; completion of residency; or board certification (verification time limit = prior to the credentialing decision; if board certification, time limit = 180 calendar days).	• Credentialing and Re-credentialing of Practitioners- Pg. 7 & 8 (E)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Work history—most recent five years—if less, from time of initial licensure—from practitioner's application or CV (verification time limit = 365 calendar days). – If a gap in employment exceeds six months, the practitioner clarifies the gap verbally or in writing and notes clarification in the credentialing file. If the gap in employment exceeds one year, the practitioner clarifies the gap in writing. • History of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner—most recent five years (verification time limit = 180 calendar days). – The organization is not required to obtain this information for practitioners who had a hospital insurance policy during a residency or fellowship. *Note: Education/training and work history are NA for recredentialing. Verification of board certification does not apply to nurse practitioners or other health care professionals unless the organization communicates board certification of those types of providers to member.* NCQA CR3—Element A		
7. The Contractor verifies the following sanction information for credentialing and recredentialing (verification time limit = 180 days): • State sanctions, restrictions on licensure or limitations on scope of practice. • Medicare and Medicaid sanctions. NCQA CR3—Element B	• Credentialing and Re-credentialing of Practitioners- Pg. 8 (E)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. Applications for credentialing include the following (attestation verification time limit = 365 days): • Reasons for inability to perform the essential functions of the position, with or without accommodation. • Lack of present illegal drug use. • History of loss of license and felony convictions. • History of loss or limitation of privileges or disciplinary actions. • Current malpractice insurance coverage (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate). • Current and signed attestation confirming the correctness and completeness of the application. NCQA CR3—Element C	• Credentialing and Re-credentialing of Practitioners- Pg. 10-11 (G) and Pg. 14 (e.) 5th bullet	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor formally recredentials its practitioners within the 36-month time frame. NCQA CR4	• Credentialing and Re-credentialing of Practitioners- Pg. 10 (G)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor implements policies and procedures for ongoing monitoring and takes appropriate action, including: • Collecting and reviewing Medicare and Medicaid sanctions. • Collecting and reviewing sanctions or limitations on licensure. • Collecting and reviewing complaints. • Collecting and reviewing information from identified adverse events.	• Credentialing and Re-credentialing of Practitioners- Pg. 16 (A-G)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Implementing appropriate interventions when it identifies instances of poor quality related to the above. NCQA CR5—Element A		
11. The Contractor has policies and procedures for taking action against a practitioner who does not meet quality standards: • The range of actions available to the Contractor. • Making the appeal process known to practitioners. *Examples of range of actions: how the organization reviews practitioners whose conduct could adversely affect members' health or welfare; the range of actions that may be taken to improve practitioner performance before termination; reporting actions taken to the appropriate authorities.* NCQA CR6—Element A	• Credentialing and Re-credentialing of Practitioners- Pg. 15 (K) Practitioner Appeal Rights and Notification to Authorities based on Issues of Quality of Care and Pg. 16 (E) • Practitioner Appeal Rights & Notification to Authorities Based on Issues of Quality of Care	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of *organizational* health care delivery providers and specifies that before it contracts with a provider, and for at least every 36 months thereafter: 12.A. The Contractor confirms that the organizational provider is in good standing with State and federal regulatory bodies. *Policies specify the sources used to confirm--which may only include applicable state or federal agency, agent of the applicable state or federal agency, or copies of credentials (e.g., state licensure) from the provider. Attestations are not acceptable.* NCQA CR7—Element A1	• Assessment of Organizational Providers- Pg. 4-5 (6) A-C	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12.B. The Contractor confirms that the organizational provider has been reviewed and approved by an accrediting body. *Policies specify the sources used to confirm—which may only include applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, copies of credentials—e.g., licensure, accreditation report or letter—from the provider. Attestations are not acceptable.* NCQA CR7—Element A2	• Assessment of Organizational Providers- Pg. 4 (5) A-H	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12.C. The Contractor conducts an on-site quality assessment if the organizational provider is not accredited. *Policies include: on-site quality assessment criteria for each type of unaccredited organizational provider; a process for ensuring that the provider credentials its practitioners.* *The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: The CMS or State review is no more than three years old; the organization obtains a survey report or letter from CMS or the State, from either the provider or from the agency, stating that the facility was reviewed and passed inspection; the report meets the organization's quality assessment criteria or standards. (Exception: Rural areas.)* NCQA CR7—Element A3	• Assessment of Organizational Providers- Pg. 5 First full paragraph	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
13. The Contractor's organizational provider assessment policies and process includes: • For behavioral health, facilities providing mental health or substance abuse services in the following settings: – Inpatient	• Assessment of Organizational Providers- Pg. 1-2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Residential – Ambulatory • For physical health, at least the following providers: – Hospitals – Home health agencies – Skilled nursing facilities – Free-standing surgical centers NCQA HP CR7-Elements B&C		
14. The Contractor has documentation that it assesses behavioral health and/or physical health providers every 36 months. NCQA HP CR7-Elements D&E	• Assessment of Organizational Providers – Pg. 1 (Scope section)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. If the Contractor delegates credentialing/recredentialing activities, the Contractor has a written delegation document with the delegate that: • Is mutually agreed upon. • Describes the delegated activities and responsibilities of the Contractor and the delegated entity. • Requires at least semiannual reporting by the delegated entity to the Contractor (includes details of what is reported, how, and to whom). • Describes the process by which the Contractor evaluates the delegated entity's performance. • Specifies that the organization retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making.	• Delegation Template o Bullet one: Pg. 1 paragraphs 1 & 3 o Bullet two: Pg. 3 (B) o Bullet three: Pg. 5 (F) o Bullet Four: Pg. 3 #6 o Bullet Five: Pg. 2 #3 o Bullet Six: Pg. 3 #6 & 8	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Describes the remedies available to the Contractor (including circumstances that result in revocation of the contract) if the delegate does not fulfill its obligations, including revocation of the delegation agreement. NCQA CR8—Element A		
16. For new delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity to meet NCQA requirements before delegation began. *NA if the contractor does not delegate or if delegation arrangements have been in effect for longer than the look-back period.* NCQA CR8—Element B	• Delegation of Credentialing Activities – Pg. 2 A 1-10	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
17. For delegation agreements in effect 12 months or longer, the Contractor: • Annually reviews its delegate's credentialing policies and procedures. • Annually audits credentialing and recredentialing files against its standards for each year that delegation has been in effect. • Annually evaluates delegate performance against its standards for delegated activities. • Semiannually evaluates regular reports specified in the written delegation agreement. NCQA CR8—Element C	• Delegation of Credentialing Activities – Pg. 2-3 B 1-11	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. For delegation agreements that have been in effect for more than 12 months, at least once in each of the past two years, the Contractor identified and followed up on opportunities for improvement, if applicable. NCQA CR8—Element D	• Delegation of Credentialing Activities- Pg. 3 #8	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	31	X	1.00	=	31
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	32	**Total Score**		=	31
				Total Score ÷ Total Applicable		=	97%

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. *42 CFR 438.330(a)(1)* Contract: Exhibit B-2—14.1.1	• MCD_CHP+_QI_Program_Description_2020-2021 P. 15-17 • 2020-2021 MCD_CHP+ QI Impact Analysis. Pg. 1 • 2020-2021 MCD_CHP+ Work Plan Pg. 1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor's QAPI Program includes conducting and submitting (to the State) annually and when requested by the Department performance improvement projects (PIPs) that focus on both clinical and nonclinical areas. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. Each PIP includes the following: • Measurement of performance using objective quality indicators. • Implementation of interventions to achieve improvement in the access to and quality of care. • Evaluation of the effectiveness of the interventions based on the objective quality indicators. • Planning and initiation of activities for increasing or sustaining improvement. *42 CFR 438.330(b)(1) and (d)(2) and (3)* Contract: Exhibit B-2—14.2.1.1, 14.3	• CHP+ CO2020-21_MCO_PIP-Val_Module 1_Submission Form - Resubmission FINAL • CO2020-21_DHMP CHP+_PIP-Val_Module 2_Submission Form_F1_V6-2_DepressionScreening-Follow-up D1 • CO2020-21_DHMP CHP+PIP-Val_Module 3_Submission Form_F1_V6-2_Depression Follow-up • 2020-2021 MCD_CHP+ QI Impact Analysis. P. 9-10 • MCD_CHP+_QI_Program_Description_2020-2021- Pg. 15	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's QAPI Program includes collecting and submitting (to the State) annually: • Performance measure data using standard measures identified by the State. • Data, specified by the State, which enable the State to calculate the Contractor's performance using the standard measures identified by the State. • A combination of the above activities. *42 CFR 438.330(b)(2) and (c)* Contract: Exhibit B-2—14.4	• 2020-2021 MCD_CHP+ QI Impact Analysis. P. 3,4,10, 31, 33 • IDSS File Upload HEDIS CAHPS 2021	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42 CFR 438.330(b)(3)* Contract: Exhibit B-2—14.6	• 2020-2021 MCD_CHP+ QI Impact Analysis. P. 4 & 5 • HEDIS Over-Under Utilization Measures • Over-Under Utilization August 2021 slides 8 & 9	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Contractor's QAPI Program includes mechanisms for identifying, investigating, analyzing, tracking, trending, and resolving any alleged quality of care concerns. Contract: Exhibit B-2—14.7.1-2	• Notification and Investigation of Quality of Care Complaints • Quality of Care Complaints Process • QOCC Q1 Report • QOCC Q2 Report • 2020-2021 MCD_CHP+ QI Impact Analysis. P. 38, 43, 44, 46 & 59	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• MCD_CHP+QI Program Description 2020-2021-Pg. 27	
6. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. *Note: Persons with special health care needs shall mean persons having ongoing health conditions that have a biological, psychological, or cognitive basis; have lasted or are estimated to last for at least one year; and produce one or more of the following: (1) a significant limitation in areas of physical, cognitive, or emotional function; (2) dependency on medical or assistive devices to minimize limitation of function or activities; (3) for children: significant limitation in social growth or developmental function; need for psychological, educational, medical, or related services over and above the usual for the child's age; or special ongoing treatments such as medications, special diets, interventions or accommodations at home or at school.* *42 CFR 438.330(b)(4)* Contract: Exhibit B-2—14.6.1	• 2020-2021 MCD_CHP+ QI Impact Analysis. P. 3, 28, 56 • Quality Performance for Members with Special Health Care Needs report January 2021 – December 2021	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program at least annually. *42 CFR 438.330(e)(2)* Contract: Exhibit B-2—14.2.5	• 2020-2021 MCD_CHP+ QI Impact Analysis. P. 1 & 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor adopts or develops practice guidelines that meet the following requirements: • Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. • Consider the needs of the Contractor's members. • Are adopted in consultation with participating providers. • Are reviewed and updated periodically, as appropriate. *42 CFR 438.236(b)* Contract: Exhibit B-2—10.5.8.2-4	• 2020-2021 MCD_CHP+ QI Impact Analysis. P. 3, 4 & 26 • FINAL 2021 Pediatric Adol and Adult Immunizations • FINAL ADHD Guidelines 2021 • FINAL Asthma 2021 Guideline • FINAL Diabetes 2021 Guideline • FINAL Smoking Cessation Guideline 2021 • FINAL Well Newborn Care Guideline 2021 with attachments • FINAL Well Child and Adolescent Health Guideline • FINAL Cervical Cancer Screening Guideline 2021 • Quality Improvement Program _ Denver Health Medical Plan- P. 2 & 3 • Clinical Practice and Preventive Care Guidelines	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor adopts or develops practice guidelines for the following: • Perinatal, prenatal, and postpartum care. • Conditions related to persons with a disability or special health care needs. • Well-child care. Contract: Exhibit B-2—10.5.8.1	• FINAL Perinatal Care Guideline 2021 • FINAL 2021 Pediatric Adol and Adult Immunizations • FINAL ADHD Guidelines 2021 • FINAL Well Newborn Care Guideline 2021 with attachments • FINAL Asthma 2021 Guideline • FINAL Well Child and Adolescent Health Guideline	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Clinical Practice and Preventive Care Guidelines Pg. 1 (C,4)	
10. The Contractor disseminates the guidelines to all affected providers and, upon request, members and potential members. *42 CFR 438.236(c)* Contract: Exhibit B-2—10.5.8	• DHMP Member Newsletter Winter 2021 Eng 508 • Clinical Practice Guidelines 7-7-21 • CHP+ Member Handbook 2021 Eng- Pg. 37 • Provider Newsletter Clinical Practice Guidelines	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42 CFR 438.236(d)* Contract: Exhibit B-2—10.5.8.5	• Clinical Criteria for Utilization Management Decisions • Consistency in Applying UM Criteria - Inter-Rater Reliability	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42 CFR 438.242(a)* Contract: Exhibit B-2—13.1.1	• DHMP DW Technical Architecture - V4 • StandardX_Req12,13,15 - Information System-Summary • Highlevel DHMP Foot Print • DHH QNXT 5.8 - TMS - EDM - HOC 3 - Logical Diagrams_V3.2 (1) • IntegrationDiagram-DHMP-20180626 • QNXT580-ProductOverview-141220-1622-4253 • AltruistaHealth-DHHA-ETL-Process-1510	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor's health information system provides information about areas including but not limited to utilization, claims, grievances and appeals, and disenrollment for other than loss of CHP+ eligibility. *42 CFR 438.242(a)* Contract: Exhibit B-2—13.1.1, 8.1	• StandardX_Req12,13,15 - Information System-Summary • Highlevel DHMP Foot Print • DHH QNXT 5.8 - TMS - EDM - HOC 3 - Logical Diagrams_V3.2 (1) • IntegrationDiagram-DHMP-20180626 • AltruistaHealth-Executive-Summary-DHMP • QNXT580-ProductOverview-141220-1622-4253 • qnxt-core-admin-eboo • AltruistaHealth-DHHA-ETL-Process-1510 • HPS Disenrollment Tracker Job Aid	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor's claims processing and retrieval systems collect data elements necessary to enable the mechanized claims processing and information retrieval systems operated by the State. • Contractor electronically submits encounter claims data in the interChange ANSI X12N 837 format directly to the Department's fiscal agent using the Department's data transfer protocol. The 837-format encounter claims (reflecting claims paid, adjusted, and/or denied by the Contractor) shall be submitted via a regular batch process. *42 CFR 438.242(b)(1)* Contract: Exhibit B-2—13.1.6.2	• Encounter Submission Example with Member Provider Data-CHP • Edifecs EncounterManagement for MCO Overview	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The Contractor collects data on member and provider characteristics and on services furnished to members through an encounter data system (or other methods specified by the State). *42 CFR 438.242(b)(2)* Contract: Exhibit B-2—13.1.5.1, 13.1.6.2	• StandardX_Req12,13,15 - Information System-Summary • Highlevel DHMP Foot Print • DHH QNXT 5.8 - TMS - EDM - HOC 3 - Logical Diagrams_V3.2 (1) • IntegrationDiagram-DHMP-20180626 • QNXT580-ProductOverview-141220-1622-4253 • Encounter Submission Example with Member Provider Data-CHP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. The Contractor ensures that data received from providers are accurate and complete by: • Verifying the accuracy and timeliness of reported data, including data from network providers compensated through capitation payments. • Screening the data for completeness, logic, and consistency. • Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies used for CHP+ quality improvement and care coordination efforts. *42 CFR 438.242(b)(3) and (4)* Contract: Exhibit B-2—13.6.1, 13.1.6.5.1	• Required Provider Directory Information • Web-Based Provider and Hospital Directory • Usability Testing for Web-Based Physician and Hospital Directories	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The Contractor: • Collects and maintains sufficient member encounter data to identify the provider who delivers any items or services to members. • Submits member encounter data to the State in Accredited Standards Committee (ASC) X12N 837, National Council for Prescription Drug Programs (NCPDP), and ASC X12N 835 formats as appropriate. • Submits member encounter data to the State at the level of detail and frequency specified by the State. *42 CFR 438.242(c)* Contract: Exhibit B-2—13.1.6.2, 13.1.6.3.1, 13.1.6.4-5	• Edifects EncounterManagment for MCO Overview • Pharmacy Encounters Job Aid	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
18. The Contractor monitors members' perceptions of accessibility and adequacy of services provided, including: • Member surveys. • Anecdotal information. • Grievance and appeals data. • Call center data. • Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[A-1] surveys. Contract: Exhibit B-2—14.5.1-2	• DHMP Member Newsletter Winter 2021_Eng 508 P. 9 • DHMP HEDIS CAHPS intervention SFY20-21 • Network Management Committee Report G&A (bullet 3) • NMC_HPS Report Oct-Nov 2021 • Access to Care and Services Standards- Pg. 4 (performance Tools) 1 &2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

[A-1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Results for Standard X—Quality Assessment and Performance Improvement							
Total	Met	=	18	X	1.00	=	18
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	18	**Total Score**		=	18
				Total Score ÷ Total Applicable		=	100%

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2021–2022 Credentialing Record Review Tool
for Denver Health Medical Plan

Review Period:	January 2021–December 2021
Date of Review:	January 21, 2022
Reviewer:	Evarista Ogbon
Health Plan Participant:	Shanique Horne

Sample #	1	2	3	4	5	6	7	8	9	10
	Valid License/No Sanctions	DEA/CDS Certificate	Education/ Training	Board Certified	Work History	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits
File #1 Provider ID: **** Credentialing Date: 01/31/21	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #2 Provider ID: **** Credentialing Date: 04/26/21	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #3 Provider ID: **** Credentialing Date: 05/30/21	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #4 Provider ID: **** Credentialing Date: 06/30/21	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #5 Provider ID: **** Credentialing Date: 06/30/21	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments: Although the practitioner is licensed to practice in Oklahoma, the practitioner's license was present in the Department of Regulatory Agencies (DORA) Colorado license database, implying reciprocity of Colorado recognizing this license.										

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2021–2022 Credentialing Record Review Tool
for Denver Health Medical Plan

Sample #	1	2	3	4	5	6	7	8	9	10
	Valid License/No Sanctions	DEA/CDS Certificate	Education/ Training	Board Certified	Work History	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits
File #6 Provider ID: **** Credentialing Date: 10/31/21	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #7 Provider ID: **** Credentialing Date: 11/30/21	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #8 Provider ID: **** Credentialing Date: 11/30/21	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #9 Provider ID: **** Credentialing Date: 11/30/21	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #10 Provider ID: **** Credentialing Date: 12/07/21	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
Number of Applicable Elements	**10**	**3**	**10**	**7**	**10**	**10**	**10**	**10**	**10**	**10**
Number of Compliant Elements	**10**	**3**	**10**	**7**	**10**	**10**	**10**	**10**	**10**	**10**
Percentage Compliant	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Total Number of Applicable Elements	**90**
Total Number of Compliant Elements	**90**
Overall Percentage Compliant	**100%**

Key: Y = Yes; N = No; NA = Not Applicable

Instructions:

1. Current, valid license with verification that no State sanctions exist
2. Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate (applicable to practitioners qualified to write prescriptions—e.g., psychiatrists, MD, DO)
3. Education/training—the highest of board certification, residency, graduation from medical/professional school
4. Applicable if the practitioner states on the application that he or she is board certified
5. Most recent five years or from time of initial licensure (if less than five years)
6. Malpractice settlements in most recent five years
7. Current malpractice insurance (physicians: $500,000/$1.5 million) verified through certificate of insurance
8. Verified that provider is not excluded from participation in federal programs
9. Application must be complete (see compliance tool for elements of complete application)
10. Verification time limits:

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

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2021–2022 Recredentialing Record Review Tool
for Denver Health Medical Plan

Review Period:	January 2021–December 2021
Date of Review:	January 21, 2022
Reviewer:	Evarista Ogbon
Health Plan Participant:	Shanique Horne

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
File #1 Provider ID: **** Current Recredentialing Date: 01/31/21 Prior Credentialing or Recredentialing Date: 01/22/18	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #2 Provider ID: **** Current Recredentialing Date: 02/26/21 Prior Credentialing or Recredentialing Date: 02/02/18	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #3 Provider ID: **** Current Recredentialing Date: 03/31/21 Prior Credentialing or Recredentialing Date: 03/28/18	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #4 Provider ID: **** Current Recredentialing Date: 05/30/21 Prior Credentialing or Recredentialing Date: 05/22/18	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
Comments:									
File #5 Provider ID: **** Current Recredentialing Date: 05/30/21 Prior Credentialing or Recredentialing Date: 05/09/18	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #6 Provider ID: **** Current Recredentialing Date: 07/31/21 Prior Credentialing or Recredentialing Date: 08/06/18	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #7 Provider ID: **** Current Recredentialing Date: 08/31/21 Prior Credentialing or Recredentialing Date: 08/08/18	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #8 Provider ID: **** Current Recredentialing Date: 08/31/21 Prior Credentialing or Recredentialing Date: 08/07/18	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
File #9 Provider ID: **** Current Recredentialing Date: 10/31/21 Prior Credentialing or Recredentialing Date: 11/14/18	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #10 Provider ID: **** Current Recredentialing Date: 11/30/21 Prior Credentialing or Recredentialing Date: 11/14/18	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
Number of Applicable Elements	**10**	**6**	**6**	**10**	**10**	**10**	**10**	**10**	**10**
Number of Compliant Elements	**10**	**6**	**6**	**10**	**10**	**10**	**10**	**10**	**10**
Percentage Compliant	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Total Number of Applicable Elements	**82**
Total Number of Compliant Elements	**82**
Overall Percentage Compliant	**100%**

Key: Y = Yes; N = No; NA = Not Applicable

Instructions:

1. Current, valid license with verification that no State sanctions exist
2. Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate (applicable to practitioners qualified to write prescriptions—e.g., psychiatrists, MD, DO)

3. Applicable if the practitioner states on the application that he or she is board certified

4. Malpractice settlements in most recent five years

5. Current malpractice insurance (physicians: $500,000/$1.5 million) verified through certificate of insurance

6. Verified that provider is not excluded from participation in federal programs

7. Application must be complete (see compliance tool for elements of complete application)

8. Verification time limits:

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

9. Within 36 months of previous credentialing or recredentialing approval date

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2021–2022 site review of **DHMP**.

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

HSAG Review Team	Title
Sarah Lambie	Project Manager III
Evarista Ogbon	Project Manager I
Crystal Brown	Project Coordinator III

DHMP Participants	Title
Alicia Persich	Marketing and Engagement Manager
Barbara Toney	Contractor for Denver Health Medical Plan
Catharine Fortney	Chief Compliance and Audit Officer
Christina Porter	HPMM Q&A Training Manager
Clesson Connelly	Pharmacy Compliance Analyst
Dallen Waldenrath Gomez	Health Plan Compliance Analyst
Darla Schmidt	Contractor for Denver Health Medical Plan
Dawn Robinson	Care Coordination Operations Manager
Dr. Christine Seals	Medical Director
Elaina Holland	Director, Health Plan Services
Elizabeth Flood	Intervention Manager
Greg McCarthy	Executive Director, Managed Care
Jacqueline De La Torre	Project Manager
Jason Casey	Health Plan Compliance Analyst
Jeremy Sax	Government Products Manager
Kaitlin Gaffney	Lead Health Plan Compliance Analyst
Lisa Artale Bross	Compliance Manager
Lucas Wilson	Associate Chief Operating Officer
Marissa Schillaci-Kayton	Population Health and Quality Improvement Project Manager
Melanie Haste	Grievance and Appeals Manager
Michael Grimpo	Privacy Officer
Mike Wagner	Chief Operating Officer
Murielle Romine	Provider Relations and Contracts Analyst
Natalie Score	Director of Insurance Products

DHMP Participants	Title
Paula Diaz	Marketing Public Relations Strategist III
Robert Lodge	Pharmacy Manager
Ruie Winters	Director of Pharmacy
Shanique Horne	Director of Provider Relations and Contracts
Shannon Godbout	Project Manager I
Department Observers	**Title**
Curt Curnow	Quality Improvement Section Manager
Gina Robinson	Program Administrator
Jeff Helm	Program Design and Policy
Russell Kennedy	Quality and Compliance Specialist

Appendix D. Corrective Action Plan Template for FY 2021–2022

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

Table D-1—Corrective Action Plan Process

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

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

The CAP template follows.

Table D-2—FY 2021–2022 Corrective Action Plan for DHMP CHP+

Standard VIII—Credentialing and Recredentialing		
Requirement	**Findings**	**Required Action**
2.K. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification (including board certification, if applicable) and specialty. NCQA CR1—Element A11	DHMP described a quarterly audit process to ensure that credentialing data and provider directory data are accurate, and DHMP provided screenshots for three CHP+ providers to demonstrate that listings in practitioner directories are consistent with credentialing data, including education, training, and certification (including board certification, if applicable). However, when accessing the DHMP CHP+ provider directory online, searching as a CHP+ member, and using the location "Colorado," HSAG was unable to find 16 of the 20 practitioners from the record review sample.	DHMP must expand its audit process or develop a mechanism to ensure that listings in practitioner directories are consistent with credentialing data.
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 VIII—Credentialing and Recredentialing		
Requirement	**Findings**	**Required Action**
HSAG Initial Review:		
Documents for Final Submission:		
Date of Final Evidence:		

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 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 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 review dates, group technical assistance, and training, as needed. • HSAG confirmed a primary health plan contact person for the review and assigned HSAG reviewers to participate in the review. • Sixty days prior to the scheduled date of the review, HSAG notified the health plan in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and review agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and the review activities. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. • Documents submitted for the review consisted of the completed desk review form, the compliance monitoring tool with the health plan's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. • The health plans also submitted a list of all credentialing, recredentialing, and organizational provider records that occurred between January 1, 2021, and December 31, 2021 (to the extent available at the time of the 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 the review. HSAG notified the health plan five days following receipt of the lists of records regarding the sample records selected.

For this step,	HSAG completed the following activities:
	• The HSAG review team reviewed all documentation submitted prior to the review and prepared a request for further documentation and an interview guide to use during the review.
Activity 3:	**Conduct the Review**
	• During the 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 review, HSAG provided health plan staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2021–2022 Department-approved Site Review Report template to compile the findings and incorporate information from the pre-review and 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.