CHP+

Child Health Plan *Plus*

Fiscal Year 2022–2023 Compliance Review Report

for

Denver Health Medical Plan

April 2023

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

Public Law 111-3, Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, requires that each state's Children's Health Insurance Program (CHIP) apply several provisions of Section 1932 of the Social Security Act (the Act) in the same manner as the provisions apply under Title XIX of the Act. This requires managed care organizations (MCOs) to comply with provisions of the Code of Federal Regulations, Title 42 (42 CFR)—Medicaid and CHIP managed care regulations published May 6, 2016, which became applicable to CHIP MCOs effective July 1, 2018. Additional revisions were released in November 2020, with an effective date of December 2020. The Department administers and oversees the Child Health Plan *Plus* (CHP+) program (Colorado's implementation of CHIP).

The CFR requires that states conduct a periodic evaluation of their MCOs and PIHPs (collectively referred to as managed care entities [MCEs]) to determine compliance with federal healthcare regulations and managed care contract requirements. The Department of Health Care Policy & Financing (the Department) has elected to complete this requirement for Colorado's CHP+ MCOs by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

In order to evaluate the CHP+ MCOs' compliance with federal managed care regulations and State contract requirements, the Department determined that the review period for fiscal year (FY) 2022–2023 was January 1, 2022, through December 31, 2022. This report documents results of the FY 2022–2023 compliance 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 2022–2023 compliance monitoring review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2021–2022 compliance review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the denials of authorization of services (denials), grievances, and appeals record reviews. Appendix C lists HSAG, CHP + MCO, and Department personnel who participated in some way in the compliance review process. Appendix D describes the corrective action plan (CAP) process the CHP+ MCO will be required to complete for FY 2022–2023 and the required template for doing so. Appendix E contains a detailed description of HSAG's compliance 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: Feb 24, 2023.

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)
I. Coverage and Authorization of Services	34	34	33	1	0	0	97%
II. Adequate Capacity and Availability of Services	14	14	13	1	0	0	93%
VI. Grievance and Appeal Systems	31	31	24	7	0	0	77%
XII. Enrollment and Disenrollment	6	6	6	0	0	0	100%
Totals	85	85	76	9	0	0	**89%**

*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 denials, grievances, and appeals record reviews. Details of the findings for the record reviews are in Appendix B—Record Review Tools.

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Denials	100	61	51	10	39	84%
Grievances	NA	NA	NA	NA	NA	NA
Appeals	36	32	27	5	4	84%
Totals	136	93	78	15	43	**84%**

*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. Since DHMP did not report any grievances during the review period, the scores are not applicable (NA).

Standard I—Coverage and Authorization of Services

Evidence of Compliance and Strengths

Documentation submitted by **DHMP** addressed procedures to ensure sufficient covered services, furnished to members in alignment with requirements for processing requests for authorization of services. Criteria used for service authorization decisions included the Department's definition of "medical necessity" which included Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), and the use of Milliman Care Guidelines, and Hayes, Inc. Knowledge Center Guidelines. In addition to the **DHMP** medical director's review, the subcontractor All-Med Healthcare Management physician specialists performed clinical reviews that were outside the scope of a family physician. The Pharmacy Prior Authorization and Utilization Management Process and Documentation policy described how notification via fax to the provider is to occur immediately upon the decision, within the 24-hour turnaround, and that the pharmacy system authorizations would update in real time.

Interrater reliability (IRR) testing most recently occurred in August 2022, and staff members reported that the passing rate was 97 percent. **DHMP** leadership decided to raise the passing rate from 80 percent to 90 percent to align with Colorado Access (COA). Additionally, **DHMP** intends to reduce passing attempts from three attempts to two. Monthly peer-to-peer reviews of randomly selected charts provide an additional opportunity for utilization management (UM) staff members to receive feedback throughout the year. **DHMP** monitored COA IRR results via a semiannual process; the most recent reported results from December 2022 met the 90 percent passing rate. All-Med's most recent IRR results met the current requirement of 85 percent, with the lowest score reported at 86 percent and an average score of 91 percent.

DHMP's notice of adverse benefit determination (NABD) letters reviewed demonstrated the following strengths:

- All denial record reviews were processed within timeliness standards.
- The letters contained most of the required information.
- The letters were easy for the member to understand, scoring at or around the sixth-grade reading level.
- The letters included the member's right to request additional review under the Child Mental health Treatment Act (CMHTA) and Mental Health Parity Act.
- Requests that were due to out-of-network providers included member-specific information and confirmation that timely appointments were available within the **DHMP** network. HSAG recognizes this communication and follow-up as a best practice.

Finally, **DHMP**'s submitted documents, including the Adjudication of Urgent Care, Emergency Care, Emergency Observation, and Emergency Admission and Post Stabilization Claims policies, accurately defined "emergency services," "emergency conditions," and "poststabilization" and outlined procedures in accordance with federal and State requirements. Staff members described how the claims processing

system ensured that emergency claims with specific place of service codes were set up to pay without the need for UM review. UM department staff members described additional monitoring if a pended claim resulted from a provider coding issue, and staff members confirmed that the review still followed the prudent layperson's definition of "emergency" and that they only reviewed to ensure the accuracy of the service and location.

Opportunities for Improvement and Recommendations

HSAG recommends the following policy updates:

- Further describe the provider outreach process in the Access to Staff policy to include details regarding how staff members conduct one or two phone calls and/or faxes when additional information is needed.
- Regarding service authorization extensions, clarify that **DHMP** will justify *to the Department, upon request*, a need for additional information.
- Clarify that the NABD is mailed for denial of payment, *at the time of any denial affecting the claim* and for service authorization decisions not reached within the required time frames, *on the date the time frames expire*.
- The Utilization Review policy stated that **DHMP** does not reduce, suspend, or terminate previously authorized services. However, HSAG recommends clarifying the exceptions to the 10-day prior notification in the Job Aid: Duplicates and Authorization Change Requests. **DHMP** included many but not all exceptions.
  - The Contractor receives a clear written statement signed by the member that the member no longer wishes services or gives information that requires termination or reduction of services and indicates that the member understands that this must be the result of supplying that information.
  - The member's whereabouts are unknown.
  - A change in the level of medical care is prescribed by the member's physician.
  - And for cases of fraud, notice is given *five days before* the intended effective date.

HSAG recommends updating NABD template language to:

- Remove language that may be confusing to the member such as "not a covered benefit" when the denial is solely regarding out-of-network requests.
- Clarify the denial decision date in headings rather than using the terminology "Effective Date of Denial." The preamble of the original Balanced Budget Act included references to the effective date of the action, but that reference applied to notices which were terminating or reducing services (which is not allowed under the Department of Insurance). Regarding the Department's intended use of the NABD template, HSAG received the following instruction:
  - New requests should include the date the determination was made.

- Concurrent reviews should include the date the current authorization expires or the first nonauthorized day.
- In the rare instance of a termination, suspension, etc. (pursuant to §438.420—prior to the end of an authorization period), it would be a date 10 days in the future as a 10-day advance notice is required (again, **DHMP** would want to change the word "on" to "effective" for ease of reading). For example, "We made the decision to deny services on 1/1/23, for all service dates requested." Using "effective" would apply when there may be a future date involved, such as the concurrent review and subsequent denial of a request for additional services.

Required Actions

DHMP must update its NABD templates to ensure accurate information and must develop a process to ensure that the updated NABD is used consistently. The updated NABD template must:

- Remove references to continuation of benefits which no longer applies to the CHP+ line of business.
- Include the date the appeal is due.
- Remove references indicating that members must submit a signed copy of an appeal.
- Inform members that they may receive a complete copy of their file, *at no cost*, upon request.
- Include that a State fair hearing may be requested within 120 days from the *adverse appeal resolution.*
- Clarify that peer-to-peer reviews after issuance of the NABD will occur as part of the appeal process.

Standard II—Adequate Capacity and Availability of Services

Evidence of Compliance and Strengths

The Network Adequacy Plan, quarterly network reports, GeoAccess reports, and other submitted documents described a provider network through the Denver Health and Hospital Authority (DHHA) employed providers, contracted network (ADD LIST), pharmacies, and specialists. **DHMP** reported in the FY 2022–2023 *CHP+ Network Plan* that it expanded its primary care footprint by contracting with STRIDE Community Health Center, in addition to previously contracted organizations such as Children's Hospital of Colorado, University Hospital. As other Colorado CHP+ plans experienced in previous years, membership for **DHMP**'s CHP+ line of business decreased by nearly half in the last two years due to the coronavirus disease 2019 (COVID-19) public health emergency (PHE).

Staff members described oversight and monitoring of access to care through the Provider Relations Committee, the higher-level Quality Management Committee, and the Problem Solvers workgroup that takes a hands-on approach to reviewing access trends and opportunities.

The *DHHA Annual Training* included topics related to cultural competency such as embracing diversity, ensuring inclusion, maximizing positive interactions with members and their caregivers/family, and other methods to ensure members feel "comfortable, cared for, and valued." Staff members described ongoing targeted efforts for lesbian, gay, bisexual, transgender, and queer (LGBTQ), criminal justice, foster care, and refuge members, and the training addressed ways to support members with body type diversity to ensure correctly sized medical equipment. Submitted documents such as *Cultural and Linguistic Appropriate Services* and *Evaluating Members Non-English Language Needs* policies further detailed **DHMP**'s methods to ensure care for members needing physical and medical accommodations and linguistic supports. During the review period, **DHMP** also hired a health equity director position to ensure that health equity components are woven throughout the **DHMP** system. The provider contract outlined detailed expectations related to accessibility and cultural competence and the Provider Directory tips document as well as the online provider directory website included the ability to query and filter for providers with different types of accessibility.

Opportunities for Improvement and Recommendations

The Provider Access Survey presentation from quarter 3 2022 indicated that contracted providers had low compliance with timely appointments. HSAG recommends reintroducing CAPs when the focus of larger efforts begins to move away from the COVID-19 PHE.

Required Actions

The **DHMP** CHP+ handbook included both physical and behavioral health appointment timeliness content but did not clarify that well-visits may be shorter than one month if indicated by the Bright Futures Periodicity schedule. Additionally, the Network Plan stated that urgently needed services are available within 48 hours of request by the member or the member's provider(s). **DHMP** must update its CHP+ member handbook to include the Bright Futures Periodicity schedule in regard to well-care appointment timeliness standards and the Network Plan to include the 24-hour urgent care timeliness requirement.

Standard VI—Grievance and Appeal Systems

Evidence of Compliance and Strengths

DHMP submitted a thorough policy and procedure that indicated a sufficient process to accept, document, and respond to grievances and appeals. Evidence of these policies and procedures included an Appeal Process, Grievance Process, CHP+ Member Handbook, Provider Manual, Grievance and Appeals quarterly reports, grievance acknowledgment letter templates, appeal acknowledgement letter templates, and expedited appeal request downgrade letter template. In all policies and other submitted documents, **DHMP** identified who can file and how to file a grievance, an appeal, and State fair hearing.

DHMP has a standardized system, Altruista Health's Guiding Care, that accurately tracks all information and data related to grievances and appeals.

Staff reported that they very rarely miss a deadline when sending grievance and appeal acknowledgment letters and resolution letters to members. Specifically, the grievance and appeal manager stated that if a coordinator ever missed a deadline, an intervention and prevention task would be implemented during staff biweekly one-on-one meetings to avoid any future delays in sending these letters.

When a provider files an appeal on behalf of a member, in addition to sending a written acknowledgement letter to the member, **DHMP** will verbally contact the provider to request additional documents and inform the provider that documents can be submitted via Epic Systems Corporation's online system. Additionally, when an appeal was denied due to the provider or a facility incorrectly billing the wrong code, staff reported that they would outreach that provider or facility to ensure the member was not responsible due to an error on behalf of the provider or facility.

Appeal notices were written at approximately a sixth-grade reading level. **DHMP** consistently met the timeliness requirements for appeals acknowledgement and resolution notices. **DHMP** demonstrated strong monitoring over grievances and appeals and conducted regular committee meetings to discuss issues.

Opportunities for Improvement and Recommendations

DHMP staff reported no grievances this review period, and in FY 2020–2021, **DHMP** reported only six CHP+ grievances. **DHMP**'s recently hired grievance and appeals manager stated that she will be investigating and monitoring further. HSAG recommends that **DHMP** review member informational materials and training documents for possible root causes of low numbers of recorded grievances. Additionally, HSAG recommends that the grievance and appeal manager or other appropriate appointed staff members outreach to DHHA patient representatives to identify any complaints that may not have been communicated to the CHP+ grievance and appeal department.

Required Actions

On page 3, **DHMP**'s Appeal Process stated the accurate time frame for a member to file an appeal, set by the State. However, on page 5 the Appeal Process stated that a **DHMP** specialist would write the member's appeal and send it with the acknowledgement letter, and that the member is required to sign and return the written appeal within 10 working days. Additionally, page 60 of the CHP+ Member Handbook also stated that the member must sign and return a written appeal. **DHMP** must remove any language from both the Appeal Process and CHP+ Member Handbook that requires the member to sign and return a written appeal to **DHMP**.

DHMP included accurate information in the Appeal Process and member appeal acknowledgement letters which informed members that they have reasonable opportunity to present evidence, testimony, and make legal and factual arguments and that they have limited time available for this sufficiently in

advance of the resolution time frame in the case of an expedited resolution. While page 60 of **DHMP**'s CHP+ Member Handbook, the "After you file an appeal" section of the CHP+ website, and **DHMP**'s NABDs stated that the member or member's representative "may look" at the case file before and during the appeal process, **DHMP** did not inform the members that the request is free of charge. **DHMP** must update the CHP+ Member Handbook and CHP+ website to inform the member and member's representative that **DHMP** will provide the case file to the member or the member's representative, including medical records, other documents, and records, and any new or additional documents considered, relied on, or generated by **DHMP** in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame, upon request.

HSAG found one CHP+ appeal resolution letter that would not have been easy for the member to understand. The resolution letter stated that the member was not responsible although **DHMP** was still denying the service due to a billing code error. Staff reported that the paragraph stating the service was still denied was mistakenly included. **DHMP** must remove any language that is deemed confusing and that could potentially confuse the member.

The **DHMP** CHP+ website stated that expedited appeal decisions are to be made within three working days after receiving the appeal. However, federal regulation set forth the time frame for expedited resolution to not exceed 72 hours. **DHMP** must update the CHP+ website sections "Filing an expedited (quick) appeal" and "After you file an appeal" to reflect the accurate time frame of 72 hours set forth by federal and State regulations.

DHMP's appeal record reviews demonstrated compliance with 84 percent of elements reviewed. Inaccuracy in the **DHMP** CHP+ appeal resolution letters, CHP+ Member Handbook, and on the CHP+ website stated that the member can request continuation of benefits while the State fair hearing is pending and how to make that request. DHMP must remove all language that references continuation of benefits in its CHP+ appeal resolution letters, CHP+ Member Handbook, and on its CHP+ website as this does not apply to the CHP+ line of business. If documents are used across multiple lines of business, they must clarify that continuation of benefits during appeals and State fair hearings does not apply to CHP+.

The "State Fair Hearing" section of **DHMP**'s CHP+ website and its Provider Manual did not clarify that if an appeal was resolved in the member's favor, services will be provided no later than 72 hours from the date **DHMP** receives notice reversing the determination. **DHMP** must update the "State Fair Hearing" section of its CHP+ website and the "Effectuation of Appeal Resolutions" section of its Provider Manual to clarify that **DHMP** will provide the disputed services as promptly and as expeditiously as the member's health condition requires *but no later than 72 hours* from the date it receives notice reversing the determination.

The Provider Manual included inaccurate information regarding the time frame for expedited appeals. **DHMP** must update its Provider Manual to:

- Remove references to continuation of benefits related to CHP+ or clarify that this only applies to Medicaid

- Update the time frame of a decision for an expedited appeal, which is 72 hours from the request.
- Clarify that the time frame to file a State fair hearing is 120 days from the adverse *appeal* resolution

Standard XII—Enrollment and Disenrollment

Evidence of Compliance and Strengths

DHMP submitted its Enrollment and Disenrollment Practice policies, which described a process and procedure to electronically receive daily 834 files from the Department, and to add members into the system in the order in which they are received. Staff members described that on receipt of the 834 files from the Department, validation checks for errors were performed daily.

DHMP described a process to ensure that it does not discriminate against members. **DHMP** staff members reported that if a member had a complaint related to discrimination, **DHMP** would assist the member to file a grievance with the grievance team and work with the member to resolve the situation to the member's satisfaction. Staff members also reported that when they "ingest" members from the Department files, they immediately begin supporting and providing healthcare services to those members.

Additionally, staff members reported that they only disenroll a member strictly by contractual requirements if the member was behaving in an aggressive or violent manner that becomes a threat to the staff, other patients, or provider. For instances involving a disruptive member, **DHMP** would work with the member and with the Department extensively during biweekly operational meetings to discuss unique cases.

Opportunities for Improvement and Recommendations

HSAG identified no opportunities for improvement or recommendations for this standard.

Required Actions

HSAG identified no required actions for this standard.

2. Overview and Background

Overview of FY 2022–2023 Compliance Monitoring Activities

For the FY 2022–2023 compliance 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 I—Coverage and Authorization of Services, Standard II—Adequate Capacity and Availability of Services, Standard VI—Grievance and Appeal Systems, and Standard XII—Enrollment and Disenrollment. Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the CHP+ MCO's contract requirements and regulations specified by the federal Medicaid and CHIP managed care regulations published May 6, 2016. Additional revisions were released in November 2020, with an effective date of December 2020. HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable.* The Department determined that the review period was January 1, 2022, through December 31, 2022. HSAG conducted a desk review of materials submitted prior to the compliance review activities; a review of records, documents, and materials requested during the compliance review; and interviews of key CHP+ MCO personnel to determine compliance with federal managed care regulations and contract requirements. Documents submitted for the desk review and compliance review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to denials of authorization, grievances, and appeals.

HSAG reviewed a sample of the CHP+ MCO's administrative records related to denials, grievances, and appeals to evaluate implementation of federal and State healthcare regulations. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records (to the extent that a sufficient number existed) for each of the denials, grievances, and appeals. Using a random sampling technique, HSAG selected the samples from all CHP+ MCO denial, grievance, and appeal records that occurred between January 1, 2022, and December 31, 2022. For the record review, the CHP+ MCO 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 I—Coverage and Authorization of Services and Standard VI—Grievance and Appeal Systems. HSAG separately calculated a record review score for each record review requirement and an overall record review score.

The compliance 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 compliance review activities consistent with those outlined in the CMS EQR protocol. The four standards chosen for the FY 2022–2023 compliance reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights, Protections, and Confidentiality, Standard V—Member Information Requirements, Standard VII—Provider Selection and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontractual Relationships and Delegation, and Standard X—Quality Assessment and Performance Improvement (QAPI).

Objective of the Compliance Review

The objective of the compliance review was to provide meaningful information to the Department and the CHP + MCO regarding:

- The CHP + MCO'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 CHP + MCO 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 CHP + MCO, as assessed by the specific areas reviewed.
- Possible interventions recommended to improve the quality of the CHP + MCO's services related to the standard areas reviewed.

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

FY 2021–2022 Corrective Action Methodology

As a follow-up to the FY 2021–2022 compliance review, each CHP+ MCO 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 CHP+ MCO 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 CHP+ MCO 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 2021–2022 compliance monitoring review.

Summary of FY 2021–2022 Required Actions

For FY 2021–2022, HSAG reviewed Standard III—Coordination and Continuity of Care; Standard IV—Member Rights, Protections, and Confidentiality; Standard VIII—Credentialing and Recredentialing; and Standard X—QAPI.

Related to Standard VIII—Credentialing and Recredentialing, **DHMP** was required to complete one corrective action, which was to expand its audit process or develop a mechanism to ensure that listings in practitioner directories are consistent with credentialing data.

Summary of Corrective Action/Document Review

DHMP submitted a proposed CAP in May 2022. HSAG and the Department reviewed and approved the proposed plan and responded to **DHMP**. **DHMP** submitted final evidence that included the Delegation of Credentialing Activities Policy, Web-Based Provider and Hospital Directory Policy, and Credentialing and Recredentialing Audit Report to HSAG as evidence and completed the CAP in October 2022.

Summary of Continued Required Actions

DHMP successfully completed the FY 2021–2022 CAP, resulting in no continued corrective actions.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor ensures that the services are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished. *42 CFR 438.210(a)(3)(i)* Contract: Exhibit B—11.11.1	• Policy: Utilization Review Determinations, pg. 5 • Services Requiring Prior Authorization	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42 CFR 438.210(a)(3)(ii)* Contract: Exhibit B—11.11.3	• Policy: Utilization Review Determinations pg. 5 • Services Requiring Prior Authorization	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor may place appropriate limits on services— • On the basis of criteria applied under the State plan (such as medical necessity). • For the purpose of utilization control, provided that: – The services furnished can reasonably achieve their purpose. – Family planning services are provided in a manner that enables the member to be free from coercion and choose the method of family planning to be used. *42 CFR 438.210(a)(4)* Contract: Exhibit B—11.11.2, 11.11.4.1, 11.11.4.2, and 11.11.4.2.2	• Policy: Utilization Review Determinations, pg. 5 • Member handbook pg. 30, 38 Family Planning	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor covers all medically necessary covered treatments for covered behavioral health (BH) diagnoses, regardless of any co-occurring conditions. The Contractor must ensure that the diagnosis of an intellectual or developmental disability, a neurological or neurocognitive disorder, or a traumatic brain injury does not preclude an individual from receiving a covered BH service. *HB19-1269: Section 12—25.5-5-402(3)(h-i)* Contract: Exhibit B—11.9.1.3	• Services Requiring Prior Authorization • Member Handbook pg. 46	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Contractor definition of "medically necessary": • Is no more restrictive than that used in Colorado's Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in Colorado statutes and regulations, the Health First Colorado plan, and other Colorado policies and procedures; and • Addresses the extent to which the CHP+ is responsible for covering services that address: – The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability. – The ability for a member to achieve age-appropriate growth and development. – The ability for a member to attain, maintain, or regain function capacity. *42 CFR 438.210(a)(5)*	• Member handbook page 4 • Policy Utilization Review Determinations, pg. 3 & 4	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract: Exhibit B—2.1.71 and 11.1.2 10 CCR 2505-10 8.076.1.8		
6. The Contractor and its subcontractors have in place and follow written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42 CFR 438.210(b)(1)* Contract: Exhibit B—11.12.2	• Policy: Utilization Review Determinations, Page 6	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The Contractor and its subcontractors have mechanisms in place to ensure consistent application of review criteria for authorization decisions. *42 CFR 438.210(b)(2)(i)* Contract: Exhibit B—11.12.2	• Policy: Consistency in Appling UM Criteria Inter Rater Reliability pg. 1 & 2 • Policy, Utilization Review Determinations, pg. 5	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor and its subcontractors have in place mechanisms to consult with the requesting provider for medical services when appropriate. *42 CFR 438.210(b)(2)(ii)* Contract: Exhibit B—11.12.2.4	• Policy: Access to Staff, page 1 & 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by an individual who has appropriate expertise in treating the member's medical or BH needs.	• Policy: Utilization Review Determinations, pg. 7 & 8 • Policy: Appropriate Professionals - Use of Qualified Licensed Professionals for UM Decisions, pg. 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.210(b)(3) Contract: Exhibit B—11.11.5		
10. The Contractor notifies the requesting provider and gives the member written notice of any decision by the Contractor to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. *Note: Notice to the provider may be oral or in writing.* *42 CFR 438.210(c)* Contract: Exhibit B—8.5.1	• Policy: Utilization Review Determinations, pg. 8	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor adheres to the following time frames for making standard and expedited authorization decisions: • For standard authorization decisions—as expeditiously as the member's condition requires and not to exceed 10 calendar days following the receipt of the request for service. • If the provider indicates, or the Contractor determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service. *42 CFR 438.210(d)(1–2)* Contract: Exhibit B—8.5.3.5; 8.5.3.7	• Policy: Utilization Review Determinations, Pg. 6	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor may extend the time frame for making standard or expedited authorization decisions by up to 14 additional calendar days if: • The member or the provider requests an extension, or • The Contractor justifies (to the Department, upon request) a need for additional information and how the extension is in the member's interest. *42 CFR 438.210(d)(1)(i–ii) and (d)(2)(ii)* Contract: Exhibit B—8.5.3.5.1-2; 8.5.3.7.1	• Policy: Utilization Review Determinations, Page 6	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
13. The Contractor provides telephonic or telecommunications response within 24 hours of a request for prior authorization of covered outpatient drugs. *42 CFR 438.210(d)(3)* *42 US Code 1396r-8(d)(5)(a)* Contract: Exhibit B—11.9.2.2.1	• See Pharmacy Prior Authorization And Utilization Management Process And Documentation - page 6 & pg. 20	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The notice of adverse benefit determination must be written in language easy to understand, available in state-established prevalent non-English languages in the region, and available in alternative formats for persons with special needs. *42 CFR 438.404(a)* Contract: Exhibit B—8.5.1.1-4	• Policy: Utilization Review Determinations, page 9	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to and copies of all documents and records relevant to the adverse benefit determination (includes medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits). • The member's (or member's designated representative's) right to request one level of appeal with the Contractor and the procedures for doing so. • The member's right to request a State review after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State review. • The circumstances under which an appeal process can be expedited and how to make this request. • The member's right to appeal under the Child and Youth Mental Health Treatment Act (CYMHTA), when applicable. *42 CFR 438.404(b)* Contract: Exhibit B—8.5.1.5-12	Inform CHP+ MCOs that federal rule changes in May 2016 for CHIP excluded the requirement that member information include "benefits will continue when the member files an appeal." The Department CHP+ MCO contract removed the requirement in July 2021. • Policy: Utilization Review Determinations, Page 9 & 10 • Policy Appeals Process pg. 11, section 4a	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: All CHP+ NABDs included information about continuation of benefits which no longer applies to the CHP+ line of business, and all CHP+ NABDs reviewed incorrectly stated that if the member submitted an appeal over the phone, the member would need to sign a copy and submit it to DHMP.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Members were informed that they may receive a complete copy of their file upon request; however, DHMP has an opportunity to clarify that these records are provided at no cost to the member. Files 1, 3, and 7 included a sentence where the date the appeal is due could be entered, but all of the appeal date fields were blank. Denial sample file 8 did not include the sentence. File 8 incorrectly stated that the member must ask for a State fair hearing within 120 calendar days of the *notice of action*, which should be 120 days after the *adverse appeal resolution*. In file 8, which was a denial regarding medical necessity, the wording "you may want to talk about this decision with your doctor to make sure that all of the information needed to support the request was given to us" and "the requesting provider/physician is carbon copied on this denial notification and has the right to discuss this decision with Denver Health Medical Plan Inc.'s Physician Reviewer and/or Medical Director (peer to peer conversation). If your provider wishes to discuss this decision, they should call the Utilization Management Department … to arrange for the conversation to take place within 10 days of the receipt of the oral and written request" may be misleading. DHMP should clarify that any additional peer-to-peer efforts after the NABD need to occur as part of the appeal process.		
Required Actions: DHMP must update its NABD template to revise or clarify all language noted in the finding and must develop a process to ensure that the updated NABD is used consistently.		
16. Notice of adverse benefit determination for denial of behavioral, mental health, or SUD benefits includes, in plain language: • A statement explaining that members are protected under the federal Mental Health Parity and Addiction Equity Act (MHPAEA), which provides that limitations placed on access to mental health and SUD benefits may be no greater than any limitations placed on access to medical and surgical benefits. • A statement providing information about contacting the office of the ombudsman for BH care if the member believes their rights under the MHPAEA have been violated. • A statement specifying that members are entitled, upon request to the Contractor and free of charge, to a copy of the medical necessity criteria for any behavioral, mental, and SUD benefit.	• Policy: Utilization Review Determinations, page 10	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
HB19-1269: Section 6—10-16-113 (I), and (II), and (III) Contract: Exhibit B—8.5.1.13.1-3		
17. The Contractor mails the notice of adverse benefit determination within the following time frames: • For termination, suspension, or reduction of previously authorized CHP+-covered services, as defined in 42 CFR 431.211, 431.213 and 431.214 (see below). • For denial of payment, at the time of any denial affecting the claim. • For standard service authorization decisions that deny or limit services, no later than 10 calendar days after receipt of request for service. • For expedited service authorization decisions, no later than 72 hours after receipt of request for service. • For extended service authorization decisions, no later than the date the extension expires. • For service authorization decisions not reached within the required time frames, on the date the time frames expire. *42 CFR 438.404(c)* *42 CFR 438.210(d)* Contract: Exhibit B—8.5.3.5-7	• Policy: Utilization Review Determinations Pag 6-8 • Job Aid: Duplicates and Decisioned Auth Changes	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.404(c) *42 CFR 431.211* *42 CFR 431.213* *42 CFR 431.214* Contract: Exhibit B—8.5.3.1-2 and 8.5.3.3.1-8		
19. If the Contractor extends the time frame for standard authorization decisions, it must give the member written notice of the reason for the extension and inform the member of the right to file a grievance if the member disagrees with that decision. *42 CFR 438.404(c)(4)* Contract: Exhibit B—8.5.3.5.2	• Policy: Utilization Review Determinations page 7	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
20. The Contractor provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42 CFR 438.210(e)* Contract: Exhibit B—11.12.6	• Policy: Utilization Review Determinations page 5	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
21. The Contractor defines emergency medical condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part. *42 CFR 438.114(a)* Contract: Exhibit B—2.1.37.1-3	• Member Handbook page 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
22. The Contractor defines emergency services as covered inpatient or outpatient services furnished by a provider that is qualified to deliver these services and are needed to evaluate or stabilize an emergency medical condition. *42 CFR 438.114(a)* Contract: Exhibit B—2.1.38	• Policy: Utilization Review Determinations, Page 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
23. The Contractor defines poststabilization care services as covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or provided to improve or resolve the member's condition. *42 CFR 438.114(a)* Contract: Exhibit B—2.1.87	• Policy: Utilization Review Determinations, Page 4 • Member Handbook page 23 & 24	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
24. The Contractor does not require prior authorization for emergency services or urgently needed services. *42 CFR 438.10(g)(2)(v)(B)* Contract: Exhibit B—11.9.4.8	• Services Requiring Prior Authorization • Member Handbook page 23	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
25. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. *42 CFR 438.114(c)(1)(i)* Contract: Exhibit B—11.9.4.2	• Services Requiring Prior Authorization; Policy Utilization Review Determinations, page 5 • Member handbook page 23 • Adjudication of Urgent Care, Emergency Care, Emergency Observation and Emergency Admission and Post Stabilization Claims pg. 2, section A	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
26. The Contractor may not deny payment for treatment obtained under either of the following circumstances: • A member had an emergency medical condition, including cases in which the absence of immediate medical attention would *not* have had the following outcomes: – Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; – Serious impairment to bodily functions; or – Serious dysfunction of any bodily organ or part. *(Note: The Contractor bases its coverage decisions for emergency services on the severity of the symptoms at the time of presentation and covers emergency services when the presenting symptoms are of*	• Member Handbook page 23 • Policy: Adjudication of Urgent Care, Emergency Care, Emergency Observation and Emergency Admission and Post Stabilization Claims pg. 2 & pg. 3 section A	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. 42 CFR 438.114—Preamble) • A representative of the Contractor's organization instructed the member to seek emergency services. *42 CFR 438.114(c)(1)(ii)* Contract: Exhibit B—11.9.4.4.1-2		
27. The Contractor does not: • Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms. • Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent failing to notify the member's primary care provider or the Contractor of the member's screening and treatment within 10 calendar days of presentation for emergency services. *42 CFR 438.114(d)(1)* Contract: Exhibit B—11.9.4.5 and 11.9.4.15.3	• Services Requiring Prior Authorization • Policy: Adjudication of Urgent Care, Emergency Care, Emergency Observation and Emergency Admission and Post Stabilization Claims pg. 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
28. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42 CFR 438.114(d)(2)* Contract: Exhibit B—11.9.4.6	• Services Requiring Prior Authorization • Policy: Adjudication of Urgent Care, Emergency Care, Emergency Observation and Emergency Admission and Post Stabilization Claims pg. 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
29. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment. *42 CFR 438.114(d)(3)* Contract: Exhibit B—11.9.4.9	• Member Handbook, Page 24 • Policy: Adjudication of Urgent Care, Emergency Care, Emergency Observation and Emergency Admission and Post Stabilization Claims pg. 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
30. The Contractor is financially responsible for poststabilization care services that are prior authorized by an in-network provider or the Contractor's representative, regardless of whether they are provided within or outside the Contractor's network of providers. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(i)* Contract: Exhibit B—11.9.4.10	• Member Handbook, Page 24 • Policy: Adjudication of Urgent Care, Emergency Care, Emergency Observation and Emergency Admission and Post Stabilization Claims pg. 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
31. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative but are administered to maintain the member's stabilized condition within one hour of a request to the organization for pre-approval of further poststabilization care services. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(ii)* Contract: Exhibit B—11.9.4.11	• Member Handbook, Page 24 • Policy: Adjudication of Urgent Care, Emergency Care, Emergency Observation and Emergency Admission and Post Stabilization Claims pg. 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
32. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the member's stabilized condition if: • The organization does not respond to a request for pre-approval within one hour. • The organization cannot be contacted. • The organization's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the organization must give the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with care of the patient until a plan provider is reached or one of the criteria in 422.113(c)(2)(iii) is met. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(iii)* Contract: Exhibit B—11.9.4.11.1-3	• Member Handbook, Page 24 • Policy: Adjudication of Urgent Care, Emergency Care, Emergency Observation and Emergency Admission and Post Stabilization Claims pg. 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
33. The Contractor's financial responsibility for poststabilization care services it has not pre-approved ends when: • A plan physician with privileges at the treating hospital assumes responsibility for the member's care, • A plan physician assumes responsibility for the member's care through transfer, • A plan representative and the treating physician reach an agreement concerning the member's care, or	• Member Handbook, Page 24 • Policy: Adjudication of Urgent Care, Emergency Care, Emergency Observation and Emergency Admission and Post Stabilization Claims pg. 3, section D & E	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The member is discharged. *42 CFR 438.114(e)* *42 CFR 422.113(c)(3)* Contract: Exhibit B—11.9.4.13.1-4		
34. If the member receives poststabilization care services from a provider outside the Contractor's network, the Contractor does not charge the member more than they would be charged if the member had obtained the services through an in-network provider. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(iv)* Contract: Exhibit B—11.9.4.12	• Member Handbook, Page 24 • Policy: Adjudication of Urgent Care, Emergency Care, Emergency Observation and Emergency Admission and Post Stabilization Claims pg. 3, section F	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	33	X	1.00	=	33
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	34	**Total Score**		=	33
				Total Score ÷ Total Applicable		=	97%

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor maintains and monitors a network of providers sufficient to provide access to all covered services to all members, including those with limited English proficiency or physical or mental disabilities. The provider network includes the following provider types: primary care (adult and pediatric), OB/GYN providers, specialists, hospitals, pharmacies, and behavioral health (mental and substance use disorder, adult and pediatric). *42 CFR 438.206(b)(1)* Contract: Exhibit B—9.1.1; 9.3.1; 9.5.1.1	• Provider Directory Screenshot • DHMP_CHP_21-22_Q3 - example of report used to monitor the network • DHMP_CHP_21-22_Q3 Narrative -example of report used to monitor the network • DH_NetworkPln_FY22-23 • CHP_Provider_Directory_Tips_English	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor ensures that its primary care and specialty care provider network complies with time and distance standards as follows: • Pediatric primary care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Pediatric specialty care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—100 miles or 100 minutes • Obstetrics or gynecology: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes	• DHMP_CHP_21-22_Q3 - example of report used to monitor the network • DHMP_CHP_21-22_Q3 Narrative -example of report used to monitor the network • Policy- Access to Care and Service Standards	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Physical therapy/occupational therapy/speech therapy: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—100 miles or 100 minutes • Pharmacy: – Urban counties—10 miles or 10 minutes – Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes • Acute care hospitals: – Urban counties—20 miles or 20 minutes – Rural counties—30 miles or 30 minutes – frontier counties—60 miles or 60 minutes *42 CFR 438.206(a)* Contract: Exhibit B—9.3.10		

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor ensures that its BH provider network complies with time and distance standards as follows: • Acute care hospitals: – Urban counties—20 miles or 20 minutes – Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes • Psychiatrists and psychiatric prescribers for children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes • Mental health providers for children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes • SUD providers for children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes *Note: If there are no BH providers that meet the BH provider standards within the defined area for a specific member, then the Contractor shall not be bound by the time and distance requirements. (Exhibit B—9.3.11.2)* *42 CFR 438.206(a)* Contract: Exhibit B-1—10.2.1.12, 10.2.1.13.1	• DHMP_CHP_21-22_Q3 - example of report used to monitor the network • DHMP_CHP_21-22_Q3 Narrative -example of report used to monitor the network	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor provides female members with direct access to a women's health care specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health care specialist. *42 CFR 438.206(b)(2)* Contract: Exhibit B—9.3.13	• CHP+ Member Handbook- Pg. 15 & 32 • Policy- Access to Care and Service Standards	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Contractor provides for a second opinion from a network provider or arranges for the member to obtain one outside the network (if there is no qualified provider within the network), at no cost to the member. *42 CFR 438.206(b)(3)* Contract: Exhibit B—9.3.22	• CHP+ Member Handbook- Pg. 23 • Policy- Access to Care and Service Standards • Provider Manual 2022- Pg. 53	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. If the provider network is unable to provide necessary covered services to a particular member in network, the Contractor must cover the services (timely and without compromising the member's quality of care or health) out of network for as long as the Contractor is unable to provide them. *42 CFR 438.206(b)(4)* Contract: Exhibit B—9.3.23.1	• Policy- Access to Care and Service Standards • Policy- Utilization Review Determinations • CHP+ Member Handbook- Pg. 21	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor requires out-of-network providers to coordinate with the Contractor for payment and ensures that the cost to the member is no greater that it would be if the services were furnished within the network. *42 CFR 438.206(b)(5)* Contract: Exhibit B—9.3.23.2	• Policy- Access to Care and Service Standards • OTA Template 2022- Pg. 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor must meet, and require its providers to meet, the State standards for timely access to care and services, taking into account the urgency of the need for services. The Contractor ensures that services are available as follows: • Emergency BH care: – By phone within 15 minutes of the initial contact. – In-person within 1 hour of contact in urban and suburban areas. – In-person within 2 hours of contact in rural and frontier areas. • Urgent care within 24 hours from the initial identification of need. • Non-urgent symptomatic care visit within 7 calendar days after member request. • Non-urgent medical or non-symptomatic well care within one month after member request (unless required sooner to ensure the American Academy of Pediatrics Bright Futures Schedule). • Outpatient follow-up appointments within seven days after discharge from hospitalization.	• Policy- Access to Care and Service Standards • CHP+ Member Handbook- Pg. 27	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Members may not be placed on waiting lists for initial routine BH services. *42 CFR 438.206(c)(1)(i)* Contract: Exhibit B—9.3.17		
Findings: The DHMP CHP+ handbook included both physical and behavioral health appointment timeliness content but did not clarify that well-visits may be sooner than one month if indicated by the Bright Futures Periodicity schedule. Additionally, the Network Plan stated that urgently needed services are available within 48 hours of request by the member or the member's provider(s).		
Required Actions: DHMP must update its CHP+ member handbook to include the Bright Futures Periodicity schedule in regard to well-care appointment timeliness standards and the Network Plan to include the 24-hour urgent care timeliness requirement.		
9. The Contractor and its providers offer hours of operation that are no less than the hours of operation offered to commercial members or that are comparable to other CHP+ providers. The Contractors network provides: • Minimum hours of provider operation from 8:00 a.m. to 5:00 p.m. Mountain Time, Monday through Friday. • Extended hours on evenings and weekends, including access to clinical staff, not just an answering service or referral service staff. • Alternatives for emergency department visits for after-hours urgent care. *42 CFR 438.206(c)(1)(ii)* Contract: Exhibit B—7.3.4.2; 9.3.5-9.3.6.1	• Policy- Access to Care and Service Standards- shows the Nurseline as available to members for extended hours and after hours urgent care • CHP+ Member Handbook- Pg. 56 • Contract Template 2022- Pg. 11	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor makes services included in the contract available 24 hours a day, 7 days a week, when medically necessary. *42 CFR 438.206(c)(1)(iii)* Contract: Exhibit B—9.3.8; 9.3.9; 9.3.17.1; 11.9.4.7	• Policy- Access to Care and Service Standards • CHP+ Member Handbook- Pg. 25	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor ensures timely access by: • Establishing mechanisms to ensure compliance with access (e.g., appointment) standards by network providers. • Monitoring network providers regularly to determine compliance, including research to determine solutions for any causal systemic issues. • Taking corrective action and notifying the Department if there is failure to comply. *42 CFR 438.206(c)(1)(iv)–(vi)* Contract: Exhibit B—9.3.17-9.3.19	• DH_NetworkPln_FY22-23 • Policy- Access to Care and Service Standards	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. This includes: • Developing and/or providing cultural competency training programs, as needed, to network providers and health plan staff regarding: – Health care attitudes, values, customs, and beliefs that affect access to and benefit from health care services.	• Policy- Cultural and Linguistic Appropriate Services -CLAS • Policy- Access to Care and Service Standards • Policy-Evaluating Members Non-English Language Needs for Language Translation Services • Contract Template 2022- Pg. 7 • DH Annual Training	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Medical risks associated with the member population's racial, ethnic, and socioeconomic conditions. • Identifying members whose cultural norms and practices may affect their access to health care. These efforts shall include, but are not limited to, inquiries conducted by the Contractor of the language proficiency of individual members during orientation or while being served by providers. *42 CFR 438.206(c)(2)* Contract: Exhibit B—2.1.27; 7.2		
13. The Contractor must ensure that network providers have the ability to provide physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities. *42 CFR 438.206(c)(3)* Contract: Exhibit B—9.1.6.7	• CHP_Provider_Directory_Tips • Contract Template 2022- Pg. 9 • Policy- Access to Care and Service Standards	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor submits to the State (in a format specified by the State) documentation to demonstrate that the Contractor offers an appropriate range of preventive, primary care, and specialty services that is adequate in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. • A *Network Adequacy Plan* is submitted to the State annually. • A *Network Report* is submitted to the State quarterly. • A *Network Changes and Deficiencies Report* is submitted to the State within five days after the Contractor's knowledge of an unexpected or anticipated material change to the network or a	• DHMP_CHP_22-23_Q1 • DHMP_CHP_22-23_Q1 Narrative • DHMP_CHP_21-22_Q4 • DHMP_CHP_21-22_Q4 Narrative • DHMP_CHP_21-22_Q3 Narrative • DHMP_CHP_21-22_Q3 • DHMP_CHP+ 21-22-Q2 • DHMP_CHP+ 21-22-Q2 Narrative • DH_NetworkPln_FY22-23	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
network deficiency that could affect service delivery, availability, or capacity within the network. *42 CFR 438.207(b)* Contract: Exhibit B—9.4-9.5		

Results for Standard II—Adequate Capacity and Availability of Services							
Total	Met	=	13	X	1.00	=	13
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	14	**Total Score**		=	13
				Total Score ÷ Total Applicable		=	93%

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an established internal grievance and appeal system in place for members, or providers acting on their behalf, or designated member representatives. A grievance and appeal system means the processes the Contractor implements to handle grievances and appeals of an adverse benefit determination, as well as processes to collect and track information about grievances and appeals. *42 CFR 438.400(b)* *42 CFR 438.402(a)* CHP+ Contract: Exhibit B—8.1 10 CCR 2505-10 8.209.1	• Appeals Process • Grievance Process	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor defines adverse benefit determination as: • The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. • The reduction, suspension, or termination of a previously authorized service. • The denial, in whole, or in part, of payment for a service. • The failure to provide services in a timely manner, as defined by the State. • The failure to act within the time frames defined by the State for standard resolution of grievances and appeals. • The denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other).	• Appeals Process – Page 1, ABD definition	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Note: A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a ''clean claim'' at 42 CFR §447.45(b) is not an adverse benefit determination. *42 CFR 438.400(b)* CHP+ Contract: Exhibit B—2.1.1 10 CCR 2505-10 8.209.2.A		
3. The Contractor defines "appeal" as a review by the Contractor of an adverse benefit determination. *42 CFR 438.400(b)* CHP+ Contract: Exhibit B—2.1.3 10 CCR 2505-10 8.209.2.B	• Appeals Process– Page 1, appeal definition	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor defines "grievance" as an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. A grievance includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision. *42 CFR 438.400(b)* CHP+ Contract: Exhibit B—2.1.50 10 CCR 2505-10 8.209.2.D, 8.209.4.A.3.c.i	• Grievances Process, Page 2 Grievance definition. • CHP+ Member handbook, page 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor has provisions for who may file: • A member may file a grievance, a Contractor-level appeal, and may request a State fair hearing. • With the member's written consent, a provider or authorized representative may file a grievance, a Contractor-level appeal, and may request a State fair hearing on behalf of a member. *Note: Throughout this standard, when the term "member" is used, it includes providers and authorized representatives acting on behalf of the member.* *42 CFR 438.402(c)* CHP+ Contract: Exhibit B—8.5.1.7; 8.6.5	• Appeals Process, page 3 (B) and Page 7 (M). • Grievance Process, page 3 (C).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, providing interpreter services and toll-free numbers that have adequate TeleTYpe/Telecommunications Device for the Deaf (TTY/TTD) and interpreter capability. *42 CFR 438.406(a)* CHP+ Contract: Exhibit B—8.2 10 CCR 2505-10 8.209.4.C	• Appeals Process– Page. 3 (C, 3, a) • Grievance Process– Page. 1 (B)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who: • Were not involved in any previous level of review or decision-making nor a subordinate of any such individual. • Have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding any of the following: – An appeal of a denial that is based on lack of medical necessity. – A grievance regarding the denial of expedited resolution of an appeal. – A grievance or appeal that involves clinical issues. *42 CFR 438.406(b)(2)* CHP+ Contract: Exhibit B—8.4.4; 8.6.3 10 CCR 2505-10 8.209.5.C, 8.209.4.E	• Appeals Process– Page. 6 (J). • Grievance Process– Page. 2 (E)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor ensures that the individuals who make decisions on grievances and appeals: • Take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. *42 CFR 438.406(b)(2)* CHP+ Contract: Exhibit B—8.5.2 10 CCR 2505-10 8.209.5.C, 8.209.4.E	• Appeals Process– Page. 6 (J). • Grievance Process– Page. 4 (H,1)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor accepts grievances orally or in writing. *42 CFR 438.402(c)(3)(i)* CHP+ Contract: Exhibit B—8.4.3 10 CCR 2505-10 8.209.5.D	• Grievance Process– Page. 3 (D)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. Members may file a grievance at any time. *42 CFR 438.402(c)(2)(i)* CHP+ Contract: Exhibit B—8.4.3 10 CCR 2505-10 8.209.5.A	• Grievance Process– Page. 3 (D)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor sends the member a written acknowledgement of each grievance within two working days of receipt. *42 CFR 438.406(b)(1)* CHP+ Contract: Exhibit B—8.4.5 10 CCR 2505-10 8.209.5.B	• Grievance Process– Page 4 (G).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor must resolve each grievance and provide written notice of the resolution as expeditiously as the enrollee's health condition requires, and within 15 working days of when the member files the grievance. • Notice to the member must be in a format and language that may be easily understood by the member. *42 CFR 438.408(a); (b)(1); and (d)(1)* Contract: Exhibit B—8.4.6; 8.4.8 10 CCR 2505-10 8.209.5.D	• Grievance Process - Page 1 (C) and Page 3 (E).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The written notice of grievance resolution includes: • Results of the disposition/resolution process and the date it was completed. *42 CFR 438.408(a)* CHP+ Contract: Exhibit B1—8.4.6. 10 CCR 2505-10 8.209.5.G	• Grievance Process– Page 4 (H,1) • Attachment F (GRIEVANCE DISPOSITION Letter)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor may have only one level of appeal for members. *42 CFR 438.402(b)* CHP+ Contract: None	• Appeals Process -Page 2, Policy.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. A member may file an appeal with the Contractor within 60 calendar days from the date on the adverse benefit determination notice. *42 CFR 438.402(c)(2)(ii)* CHP+ Contract: Exhibit B—8.6.5.1 10 CCR 2505 10 8.209.4.B	• Appeals Process– Page 3 (D)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. The member may file an appeal either orally or in writing, and the Contractor must treat oral appeals in the same manner as appeals received in writing. The Contractor may not require that oral requests for an appeal be followed with a written request. *42 CFR 438.402(c)(3)(ii)* *42 CFR 438.406 (b)(3)* CHP+ Contract: Exhibit B—8.6.5.2 10 CCR 2505 10 8.209.4.F	• Appeals Process– Page 3	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: On page 3, DHMP's Appeal Process stated the accurate time frame for a member to file an appeal set by the State. However, on page 5, the Appeal Process stated that a DHMP specialist would write the member's appeal and send it with the acknowledgement letter, and that the member is required to sign and return the written appeal within 10 working days. Additionally, page 60 of the CHP+ Member Handbook also stated that the member must sign and return a written appeal.		
Required Actions: DHMP must remove any language from both the Appeal Process and CHP+ Member Handbook that requires the member to sign and return a written appeal to DHMP.		
17. The Contractor sends written acknowledgement of each appeal within two working days of receipt, unless the member or designated representative requests an expedited resolution. *42 CFR 438.406(b)(1)* CHP+ Contract: Exhibit B—8.6.2.1 10 CCR 2505-10 8.209. 4.D	• Appeals Process– Page 5 (I, 8)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
18. The Contractor's appeal process must provide that included, as parties to the appeal, are: • The member and the member's representative, or • The legal representative of a deceased member's estate. *42 CFR 438.406(b)(3) and (6)* CHP+ Contract: Exhibit B—8.6.11 10 CCR 2505-10 8.209.4.I	• Appeals Process, Page 7 (J, 4)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
19. The Contractor's appeal process must provide: • The member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. (The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution time frame in the case of expedited resolution.) • The case file to the member and their representative, including medical records, other documents and records, and any new or additional documents considered, relied upon, or generated by the Contractor in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame. *42 CFR 438.406(b)(4-5)* CHP+ Contract: Exhibit B—8.6.8-8.6.10 10 CCR 2505-10 8.209. 4.G, 8.209.4.H	• Appeals Process– Page. 6 (J, 2-3)	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DHMP included accurate information in the Appeal Process and member appeal acknowledgement letters which informed members that they have reasonable opportunity to present evidence, testimony, and make legal and factual arguments and that they have limited time available for this sufficiently in advance of the resolution time frame in the case of an expedited resolution. While page 60 of DHMP's CHP+ Member Handbook, the "After you file an appeal" section of the CHP+ website, and DHMP's NABDs stated that the member or member's representative may "look at" the case file before and during the appeal process, DHMP did not inform the members that the request is free of charge.		
Required Actions: DHMP must update its NABDs, CHP+ Member Handbook, and CHP+ website to inform the member and member's representative that this information must be provided free of charge and sufficiently in advance of the appeal resolution time frame, upon request.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
20. The Contractor maintains an expedited review process for appeals when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. The Contractor's expedited review process includes that: • The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. *42 CFR 438.410(a–b)* CHP+ Contract: Exhibit B—8.6.12; 8.6.13.2 10 CCR 2505-10 8.209.4.Q-R	• Appeals Process– Page 4 (H, 1).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
21. If the Contractor denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the time frame for standard resolution. • Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and within two calendar days provide the member written notice of the reason for the decision and inform the member of the right to file a grievance if the member disagrees with that decision. *42 CFR 438.410(c)* CHP+ Contract: Exhibit B—8.6.13.2.2 10 CCR 2505-10 8.209.4.S	• Appeals Process– Page 4, H (2, a ,b, c)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
22. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)* *42 CFR 438.408(d)(2)(i)* *42 CFR 438.10* CHP+ Contract: Exhibit B—8.6.13.1 10 CCR 2505-10 8.209.4.J.1	• Appeals Process -Page 4, (F, 1) (H,2-d) • Page. 2, Policy section	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DHMP's appeal sample included one CHP+ appeal resolution letter that would not be easy for the member to understand. The resolution letter stated that the member was not responsible although DHMP was still denying the service due to a billing code error. DHMP staff reported that the paragraph stating the service was still denied was mistakenly included.		
Required Actions: DHMP must ensure that the member appeal resolution letters are written so that members can easily understand them and remove any language that is deemed confusing and that could potentially confuse the member.		
23. For expedited appeal, the Contractor must resolve the appeal and provide written notice of disposition to affected parties within 72 hours after the Contractor receives the appeal. • For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. *42 CFR 438.408(b)(3) and (d)(2)(ii)* CHP+ Contract: Exhibit B—8.6.13.2.3; 8.6.13.2.6 10 CCR 2505-10 8.209.4.J.2, 8.209.4.L	• Appeals Process -Page 4, (F, 2)	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: DHMP's website for CHP+ stated that expedited appeal decisions are to be made within three working days after receiving the appeal. However, federal and State regulation set forth the timeframe for expedited resolution to not exceed 72 hours.		
Required Actions: DHMP must update the CHP+ website sections "Filing an expedited (quick) appeal" and "After you file an appeal" to reflect the accurate time frame of 72 hours set forth by federal and State regulations.		
24. The Contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: • The member requests the extension; or • The Contractor shows (to the satisfaction of the Department, upon request) that there is need for additional information and how the delay is in the member's interest. *42 CFR 438.408(c)(1)* CHP+ Contract: Exhibit B—8.4.7; 8.6.13.2.4 10 CCR 2505-10 8.209.4.K, 8.209.5.E	• Appeals Process– Page 4 (G,1-2) • Grievance Process– Page 3 (F, 1-2)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
25. If the Contractor extends the time frames for a grievance or appeal, it must—for any extension not requested by the member: • Make reasonable efforts to give the member prompt oral notice of the delay. • Within two (2) calendar days, give the member written notice of the reason for the delay and inform the member of the right to file a grievance if the member disagrees with that decision. • Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension	• Grievance Process– Page 3 (F, a-b-c) • Appeals Process– Page 4 (G)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
expires (14 days following the expiration of the original grievance or appeal resolution time frame). *42 CFR 438.408(c)(2)* CHP+ Contract: Exhibit B—8.4.7.1; 8.6.13.2.5 10 CCR 2505-10 8.209.4.L, 8.209.4.K, 8.209.4.A. 3.C(ii), 8.209.5.E		
26. The written notice of appeal resolution must include: • The results of the resolution process, and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. *42 CFR 438.408(e)* CHP+ Contract: Exhibit B—8.6.13.3 10 CCR 2505-10 8.209.4.M	In May 2016, the federal rule changes for CHIP excluded from the requirement that member information must include "benefits will continue when the member files an appeal." However, the Department removed the statement from the CHP+ MCO contract requirement in July 2021. • Appeals Process– Page 7, K,1 (a,b,c)	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DHMP inaccurately stated in its CHP+ appeal resolution letters, CHP+ Member Handbook, and on its CHP+ website that the member can request continued services while the State fair hearing is pending and how to make that request.		
Required Actions: DHMP must remove all language that references continuation of benefits in its CHP+ appeal resolution letters, CHP+ Member Handbook, and on its CHP+ website as this does not apply to the CHP+ line of business. If documents are used across multiple lines of business, they must clarify that continuation of benefits during appeals and State fair hearings does not apply to CHP+.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
27. The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of appeal resolution. • If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. *42 CFR 438.408(f)(1–2)* CHP+ Contract: Exhibit B—8.6.14.1 10 CCR 2505-10 8.209.4.N and O	• Appeals Process– Page 8 (M, 1)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
28. The parties to the State fair hearing include the Contractor as well as the member and their representative or the representative of a deceased member's estate. *42 CFR 438.408(f)(3)* CHP+ Contract: Exhibit B—8.6.14.3	• Appeals Process– Page 8 (M, 5).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
29. Effectuation of reversed appeal resolutions: • If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. *42 CFR 438.424*	• Appeals Process– Page 9 (5, a ,i)	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
CHP+ Contract: Exhibit B—8.6.13.4 10 CCR 2505-10 8.209.4.W		
Findings: DHMP's Provider Manual and CHP+ website do not include that the Contractor must provide the disputed services as promptly and as expeditiously as the member's health condition requires *but no later than 72 hours* from the date it receives notice reversing the determination.		
Required Actions: DHMP must update the "State Fair Hearing" section of its CHP+ website and the "Effectuation of Appeal Resolutions" section of its Provider Manual to inform the member that the Contractor must provide the disputed services as promptly and as expeditiously as the member's health condition requires *but no later than 72 hours* from the date it receives notice reversing the determination.		
30. The Contractor maintains records of all grievances and appeals. The records must be accurately maintained in a manner accessible to the State and available on request to CMS. • The record of each grievance and appeal must contain, at a minimum, all of the following information: – A general description of the reason for the grievance or appeal. – The date received. – The date of each review or, if applicable, review meeting. – Resolution at each level of the appeal or grievance. – Date of resolution at each level, if applicable. – Name of the person for whom the appeal or grievance was filed. • The Contractor must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the Department's quality strategy. • The Contractor quarterly submits to the Department a Grievance and Appeals report including this information.	• Appeals Process– page 10, O (1,2,3,4,5 and 6) • Appeals Process– Page 10, P (1) • Grievance Process– Page 4, J	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.416 CHP+ Contract: Exhibit B—8.1; 8.7 10 CCR 2505-10 8.209.3.C		
31. The Contractor provides the information about the grievance, appeal, and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. *42 CFR 438.414* CHP+ Contract Exhibit B—8.3 10 CCR 2505-10 8.209.3.B	• Appeals Process– Page 7 (L, 1-2-3-4) • Provider manual, SECTION XIV: MEMBER GRIEVANCES, DENIALS AND APPEALS, page 37	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DHMP's Provider Manual stated an inaccurate time frame for expedited appeals. DHMP also stated that the member has 120 days from the date of notice of adverse action to request a hearing. However, it should state that the member has 120 days from the date of the appeal resolution letter to request a hearing. Additionally, the Provider Manual did not separate CHP+ and Medicaid when discussing continuation of benefits.		
Required Actions: DHMP must update its Provider Manual to: • Remove references to continuation of benefits related to CHP+ or clarify that this only applies to Medicaid.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Update the time frame of a decision for an expedited appeal, which is 72 hours from the request. • Clarify that the time frame to file a State fair hearing is 120 days from the adverse *appeal* resolution.		

Results for Standard VI—Grievance and Appeal Systems							
Total	Met	=	24	X	1.00	=	24
	Partially Met	=	7	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	31	**Total Score**		=	24
				Total Score ÷ Total Applicable		=	77%

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor agrees to accept individuals eligible for enrollment into its MCO in the order in which they apply without restriction (unless authorized by CMS) up to the limits set under that contract. • The Contractor may not apply limits to newborns. • In the event that the Contractor reaches the enrollment limits, the Contractor shall notify the Department. *42 CFR 438.3(d)(1)* Contract: Exhibit B—6.3.3; 6.3.7	• Enrollment and Disenrollment Practices, page 4 section 2. Discrimination prohibited and other requirements of the Company, a – i	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor does not discriminate against individuals eligible to enroll or use any policy or practice that has the effect of discriminating against individuals, based upon health status or need for health care services, race, color, national origin, sex, sexual orientation, gender identity, or disability. *42 CFR 438.3(d)(3-4)* Contract: Exhibit B—6.3.3.1	• Enrollment and Disenrollment Practices, page 5 section 2. Discrimination prohibited and other requirements of the Company, C	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor may not request disenrollment of a member because of an adverse change in the member's health status or because of the member's: • Utilization of medical services • Diminished mental capacity or adverse changes in the member's health status. • Behavior (e.g., uncooperative or disruptive) resulting from the member's special needs (except when the member's continued	• Enrollment and Disenrollment Practices, page 10, section 5. Disenrollment for cause, a, b, c, d and e	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
enrollment seriously impairs the Contractor's ability to furnish services to the member or to other members). • Failure to pay a copayment if that member is a child. *42 CFR 438.56(b)(2)* Contract: Exhibit B—6.5.2.2		
4. The Contractor may initiate disenrollment of any member's participation in the MCO upon one or more of the following grounds: • Uncooperative or disruptive behavior such that continued enrollment would seriously impair the Contractor's ability to furnish services to the member or to other members. • For cause, at any time under the following circumstances: – The member has moved out of the Contractor's service area – The Contractor does not (due to moral or religious objections) cover the service the member needs – The member needs related services to be performed at the same time, not all related services are available from the Contractor's network, and the member's primary care provider (or another provider) determines that receiving the services separately would subject the member to unnecessary risk	• Enrollment and Disenrollment Practices, page 12, section b-i • Page 9, section b, i, ii, iii, iv, v, vi, and vii.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Administrative error on the part of the Department or its designee or the Contractor including, but not limited to, system error – Poor quality of care – Lack of access to covered services, or lack of access to providers experienced with dealing with the member's specific needs *42 CFR 438.56(b)(1)* Contract: Exhibit B—6.5.5.1		
5. To initiate disenrollment of a member's participation with the MCO, the Contractor must provide the Department with documentation justifying the proposed disenrollment. *42 CFR 438.56(b)(3)* Contract: Exhibit B—6.5.2.1.9.3.1	• Enrollment and disenrollment, page 7, B, 2.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The member may request disenrollment as follows: • For cause at any time, including: – The member has moved out of the Contractor's service area – The Contractor does not (due to moral or religious objections) cover the service the member needs – The member needs related services to be performed at the same time, not all related services are available from the	• Enrollment and Disenrollment Practices, page 9, section b Disenrollment for cause, sub section b, i, ii, iii, iv, v, vi, and vii. • Enrollment and Disenrollment Practices, page 8, b disenrollment without cause, sub section i, ii, iii, v and c-i	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contractor's network, and the member's primary care provider (or another provider) determines that receiving the services separately would subject the member to unnecessary risk – Administrative error on the part of the Department or its designee or the Contractor including, but not limited to, system error – Poor quality of care – Lack of access to covered services, or lack of access to providers experienced with dealing with the member's specific needs • Without cause at the following times: – During the 90 days following the date of the member's initial passive enrollment – At least once every 12 months thereafter – Upon automatic re-enrollment if temporary loss of eligibility has caused the member to miss the annual disenrollment opportunity – When the Department has imposed sanctions on the MCO (consistent with 42 CFR 438.702(a)(4) *42 CFR 438.56(c)-(d)(2)* Contract: Exhibit B—6.5.5		

Results for Standard XII—Enrollment and Disenrollment							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	6	**Total Score**		=	6
				Total Score ÷ Total Applicable		=	100%

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2022–2023 External Quality Review
Denials Record Review
for Denver Health Medical Plan

Review Period:	January 1, 2022–December 31, 2022
Date of Review:	January 25, 2023
Reviewer:	Sarah Lambie, MA, CPHQ
Participating MCE Staff Member(s):	Dr. Seals and Darla Schmidt

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Member ID #	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****
Date of Initial Request [XX/XX/XXXX]	1/26/2022	1/31/2022	2/4/2022	2/15/2022	2/15/2022	4/26/2022	4/22/2022	6/9/2022	7/8/2022	10/20/2022					
Type of Denial: Termination (T), New Request (NR), Claim (CL)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR					
Type of Request: Standard (S), Expedited (E), Retrospective (R), SUD Inpatient/Residential (SUD), or SUD Inpatient/Residential Special Connections (SUD SC)	S	S	S	S	S	S	S	S	S	S					
Date of Decision for Adverse Benefit Determination [XX/XX/XXXX]	1/28/2022	2/2/2022	2/10/2022	2/21/2022	2/21/2022	4/27/2022	4/27/2022	6/10/2022	7/15/2022	10/24/2022					
Date Notice of Adverse Benefit Determination (NABD) Sent [XX/XX/XXXX]	1/28/2022	2/2/2022	2/10/2022	2/21/2022	2/21/2022	4/27/2022	4/27/2022	6/17/2022	7/15/2022	10/24/2022					
Notice Sent to Provider and Member? [I.10]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Number of Hours or Days for Decision (H/D)	2 D	2 D	6 D	6 D	6 D	1 D	5 D	8 D	7 D	4 D					
Number of Hours or Days for Notice (H/D)	2 D	2 D	6 D	6 D	6 D	1 D	5 D	8 D	7 D	4 D					
Adverse Benefit Determination Decision Made Within Required Time Frame? [I.11] Standard: 10 calendar days Expedited: 72 hours SUD: 72 hours (calendar) or 24 hours (calendar) for special connections	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Notice Sent Within Required Time Frame? [I.17] Standard: 10 calendar days Expedited: 72 hours SUD: 72 hours (calendar) or 24 hours (calendar) for special connections Termination: 10 calendar days before the date of action	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Was Authorization Decision Timeline Extended? Yes or No	No	No	No	No	No	No	No	No	No	No					
If Extended, Extension Notification Sent to Member? [I.19]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA					
If Extended, Extension Notification Includes Required Content? [I.19]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA					
NABD Includes Required Content [I.15-16]	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met					
Authorization Decision Made by Qualified Clinician? [I.9]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA					
If Denied for Lack of Information, Was the Requesting Provider Contacted for Additional Information or Consulted (if applicable)? [I.8]	NA	NA	NA	NA	NA	NA	NA	Met	NA	NA					
Was the Decision Based on Established Authorization Criteria (i.e., not arbitrary)? [I.2]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Was Correspondence With the Member Easy to Understand? [I.14]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					

Scoring	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Applicable Elements	6	6	6	6	6	6	6	7	6	6					
Compliant (Met) Elements	5	5	5	5	5	5	5	6	5	5					
Percent Compliant	83%	83%	83%	83%	83%	83%	83%	86%	83%	83%					
Overall Total Applicable Elements	**61**														
Overall Total Compliant Elements	**51**														
Overall Total Percent Compliant	**84%**														

Comments:
All files included continuation of benefit information in the NABD, which is no longer applicable to the CHP+ line of business.
Files 1, 2, 3, 5, and 9 included information that may be confusing to the member, stating "not a covered benefit" when the denial can be more clearly communicated as an out-of-network request.
File 4: Requested as urgent but was downgraded to standard.
File 8: DHMP had the opportunity to use an extension but did not. The NABD did not include the due date to file an appeal. The NABD did not include Child Mental Health Treatment Act (CMHTA) information; however, this is NA due to the type of service requested. Language regarding peer-to-peer is unclear.

Yes and No = not scored—for informational purposes only
**** = Redacted Member ID

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2022–2023 External Quality Review
Grievances Record Review
for Denver Health Medical Plan

Review Period:	January 1, 2022–December 31, 2022
Date of Review:	
Reviewer:	
Participating MCE Staff Member(s):	

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Member ID #															
Date Grievance Received [XX/XX/XXXX]															
Date of Acknowledgement Letter [XX/XX/XXXX]															
Days From Grievance Received to Acknowledgement															
Acknowledgement Letter Sent in 2 Working Days [VI.11]															
Date of Written Notice [XX/XX/XXXX]															
# of Days to Notice															
Resolved and Notice Sent in Time Frame* [VI.12,24] Standard: 15 working days Extension: 15 working days + 14 calendar days															
Decision-Maker Not Involved in Grievance [VI.7]															
Appropriate Level of Expertise (If Clinical) [VI.7]															
Resolution Letter Includes Required Content [VI.13]**															
Resolution Letter Easy to Understand [VI.12]															
Scoring	**File 1**	**File 2**	**File 3**	**File 4**	**File 5**	**File 6**	**File 7**	**File 8**	**File 9**	**File 10**	**File OS1**	**File OS2**	**File OS3**	**File OS4**	**File OS5**
Applicable Elements															
Compliant (Met) Elements															
Percent Compliant															
Overall Total Applicable Elements															
Overall Total Compliant Elements															
Overall Total Percent Compliant															

Comments: DHMP reported no grievances for CHP+ during the review period.

* Grievance timeline for resolution and notice sent is 15 working days (unless extended, then up to 14 calendar days).

**Grievance resolution letter required content includes (1) results of the disposition/resolution process and (2) the date the disposition/resolution process was completed.

**** = Redacted Member ID

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2022–2023 External Quality Review
Appeals Record Review
for Denver Health Medical Plan

Review Period:	January 1, 2022–December 31, 2022
Date of Review:	February 7–8, 2023
Reviewer:	Crystal Brown, CCMA
Participating MCE Staff Member(s):	Dr. Seals and Rebecca Sundquist

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Member ID #	*****	*****	*****	*****	*****	*****									
Date Appeal Received [XX/XX/XXXX]	10/26/2022	10/27/2022	10/5/2022	4/15/2022	3/7/2022	1/31/2022									
Date of Acknowledgement [XX/XX/XXXX]	10/27/2022	10/29/2022	10/7/2022	4/19/2022	3/9/2022	2/1/2022									
Days From Appeal Received to Acknowledgement	1	1	2	2	2	1									
Acknowledgement Sent Within 2 Working Days? [VI.17]	Met	Met	Met	Met	Met	Met									
Decision-Maker Not Previous Level [VI.7]	Met	Met	Met	Met	Met	Met									
Decision-Maker—Clinical Expertise [VI.7]	NA	NA	NA	NA	Met	Met									
Expedited Appeal: Yes or No	No	No	No	No	No	No									
Time Frame Extended: Yes or No	Yes	No	No	No	No	No									
Date Resolution Notice Sent [XX/XX/XXXX]	11/21/2022	11/9/2022	10/7/2022	4/23/2022	3/11/2022	1/31/2022									
Hours or Days From Appeal Filed to Resolution Notice Sent	17 D	9 D	2 D	5 D	4 D	0 D									
Notice Sent Within Time Frame*? [VI.22-25] Standard Resolution: 10 working days Expedited Resolution: 72 hours Time Frame Extended: +14 calendar days	Met	Met	Met	Met	Met	Met									
Resolution Letter Includes Required Content [VI.26]**	Not Met	Not Met	Met	Not Met	Not Met	Not Met									
Resolution Letter Easy to Understand [VI.22]	Met	Met	Met	Met	Met	Met									

Scoring	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Applicable Elements	5	5	5	5	6	6									
Compliant (Met) Elements	4	4	5	4	5	5									
Percent Compliant	80%	80%	100%	80%	83%	83%									
Overall Total Applicable Elements	**32**														
Overall Total Compliant Elements	**27**														
Overall Total Percent Compliant	**84%**														

Comments:
Files 1, 2, 4, 5, and 6 included continuation of benefits in the appeal resolution letters.
The six files represent the entire available universe of appeals during the review period.

*__Appeal resolution letter time frame__ does not exceed 10 working days from the day the MCE receives the appeal (unless expedited—72 hours; or unless extended—+14 calendar days).

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

**** = Redacted Member ID

Appendix C. Compliance Review Participants

Table C-1 lists the participants in the FY 2022–2023 compliance review of **DHMP**.

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

HSAG Review Team	Title
Sarah Lambie	Senior Project Manager
Crystal Brown	Project Manager I
Barbara McConnell	Executive Director
DHMP Participants	**Title**
Jeremy Sax	Government Products Manager
Arjanea Williams	Health Plan Compliance Analyst
Jason Casey	Health Plan Compliance Analyst
Kaitlin Gaffney	Lead Health Plan Compliance Analyst
Lisa Artale Bross	Director of Health Plan Compliance—DHHA/Enterprise Compliance Services (ECS)
Dr. Christine Seals	Medical Director
Christina Porter	Health Plan Medical Management Quality Assurance Training Manager
Darla Schmidt	Director of Utilization Management
Robert Lodge	Pharmacy Manager
Aya Desouki	Pharmacist Clinical Specialist
Murielle Romine	Provider Relations & Contracts Analyst
Lucas Wilson	Associate Chief Operating Officer
Natalie Score	Director of Insurance Products
Mike Wagner	Chief Operating Officer
Greg McCarthy	Executive Director, Managed Care
James Buckley	Clinical Systems Analyst
Corie Culter	Manager of Utilization Management Operations
Alicia Persich	Marketing & Engagement Manager
Rebecca Sundquist	Supervisor of Grievances & Appeals
Christopher White	Enrollment Services Manager
Bryant Wiltrout	Director of Information Systems
Stacy Grein	Compliance Specialist—DHHA/ECS
Lucas Wilson	Associate Chief Operations Officer

Department Observers	Title
Russell Kennedy	Quality Program Manager
Jeff Helm	Program Design and Policy
Helen Desta	Quality Section Manager
Amy Ryan	CHP+ Contract and Program
Lindsey Folkerth	Contract Specialist/Health Programs Office

Appendix D. Corrective Action Plan Template for FY 2022–2023

If applicable, the MCE 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 MCE must identify the planned interventions, training, monitoring and follow-up activities, and proposed documents in order to 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 MCE 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 MCE will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final compliance review report via email or through the file transfer protocol (FTP) site, with an email notification to HSAG and the Department. The MCE 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, monitoring and follow-up activities, and final evidence to be submitted following the completion of the planned interventions.	
Step 2	**Prior approval for timelines exceeding 30 days**
If the MCE is unable to submit the CAP proposal (i.e., the outline of the plan to come into compliance) 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: • Review and approve the planned interventions and instruct the MCE to proceed with implementation, or • Instruct the MCE to revise specific planned interventions, training, monitoring and follow-up activities, and/or documents to be submitted as evidence of completion and also to proceed with resubmission.	
Step 4	**Documentation substantiating implementation**
Once the MCE has received Department approval of the CAP, the MCE will have a time frame of 90 days (three months) to complete proposed actions and submit documents. The MCE will submit documents as evidence of completion one time only on or before the 90-day deadline for all required actions in the CAP. If any revisions to the planned interventions are deemed necessary by the MCE during the 90 days, the MCE should notify the Department and HSAG. If the MCE is unable to submit documents of completion for any required action on or before the three-month deadline, it must obtain approval in advance from the Department to extend the deadline.	

Step	Action
Step 5	**Technical assistance**
At the MCE's request or at the recommendation of the Department and HSAG, technical assistance (TA) calls/webinars are available. The session may be scheduled at the MCE's discretion at any time the MCE 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 MCE 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 resubmission established by the Department. HSAG will continue to work with the MCE until all required actions are satisfactorily completed.	

The CAP template follows on the next page.

Table D-2—FY 2022–2023 Corrective Action Plan for DHMP

Standard I—Coverage and Authorization of Services
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
15. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to and copies of all documents and records relevant to the adverse benefit determination (includes medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits). • The member's (or member's designated representative's) right to request one level of appeal with the Contractor and the procedures for doing so. • The member's right to request a State review after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State review. • The circumstances under which an appeal process can be expedited and how to make this request. • The member's right to appeal under the Child and Youth Mental Health Treatment Act (CYMHTA), when applicable. *42 CFR 438.404(b)* Contract: Exhibit B—8.5.1.5-12
Findings
All CHP+ NABDs included information about continuation of benefits which no longer applies to the CHP+ line of business, and all CHP+ NABDs reviewed incorrectly stated that if the member submitted an appeal over the phone, the member would need to sign a copy and submit it to DHMP. Members were informed that they may receive a complete copy of their file upon request; however, DHMP has an opportunity to clarify that these records are provided at no cost to the member. Files 1, 3, and 7 included a sentence where the date the appeal is due could be entered, but the appeal date fields were blank. Denial sample file 8 did not include the sentence.

Standard I—Coverage and Authorization of Services
File 8 incorrectly stated that the member must ask for a State fair hearing within 120 calendar days of *the notice of action*, which should be 120 days after the *adverse appeal resolution*. In file 8, which was a denial regarding medical necessity, the wording "you may want to talk about this decision with your doctor to make sure that all of the information needed to support the request was given to us" and "the requesting provider/physician is carbon copied on this denial notification and has the right to discuss this decision with Denver Health Medical Plan Inc.'s Physician Reviewer and/or Medical Director (peer to peer conversation). If your provider wishes to discuss this decision, they should call the Utilization Management Department … to arrange for the conversation to take place within 10 days of the receipt of the oral and written request" may be misleading. DHMP should clarify that any additional peer-to-peer efforts after the NABD need to occur as part of the appeal process.
Required Actions
DHMP must update its NABD template to revise or clarify all language noted in the finding and must develop a process to ensure that the updated NABD is used consistently.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard II—Adequate Capacity and Availability of Services
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
8. The Contractor must meet, and require its providers to meet, the State standards for timely access to care and services, taking into account the urgency of the need for services. The Contractor ensures that services are available as follows: • Emergency BH care: – By phone within 15 minutes of the initial contact. – In-person within 1 hour of contact in urban and suburban areas. – In-person within 2 hours of contact in rural and frontier areas. • Urgent care within 24 hours from the initial identification of need. • Non-urgent symptomatic care visit within 7 calendar days after member request. • Non-urgent medical or non-symptomatic well care within one month after member request (unless required sooner to ensure the American Academy of Pediatrics Bright Futures Schedule). • Outpatient follow-up appointments within seven days after discharge from hospitalization. • Members may not be placed on waiting lists for initial routine BH services. *42 CFR 438.206(c)(1)(i)* Contract: Exhibit B—9.3.17
Findings
The DHMP CHP+ handbook included both physical and behavioral health appointment timeliness content but did not clarify that well-visits may be sooner than one month if indicated by the Bright Futures Periodicity schedule. Additionally, the Network Plan stated that urgently needed services are available within 48 hours of request by the member or the member's provider(s).
Required Actions
DHMP must update its CHP+ member handbook to include the Bright Futures Periodicity schedule in regard to well-care appointment timeliness standards and the Network Plan to include the 24-hour urgent care timeliness requirement.

Standard II—Adequate Capacity and Availability of Services
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
16. The member may file an appeal either orally or in writing, and the Contractor must treat oral appeals in the same manner as appeals received in writing. The Contractor may not require that oral requests for an appeal be followed with a written request. *42 CFR 438.402(c)(3)(ii)* *42 CFR 438.406 (b)(3)* CHP+ Contract: Exhibit B—8.6.5.2 10 CCR 2505 10 8.209.4.F
Findings
On page 3, DHMP's Appeal Process stated the accurate time frame for a member to file an appeal set by the State. However, on page 5, the Appeal Process stated that a DHMP specialist would write the member's appeal and send it with the acknowledgement letter, and that the member is required to sign and return the written appeal within 10 working days. Additionally, page 60 of the CHP+ Member Handbook also stated that the member must sign and return a written appeal.
Required Actions
DHMP must remove any language from both the Appeal Process and CHP+ Member Handbook that requires the member to sign and return a written appeal to DHMP.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:

Standard VI—Grievance and Appeal Systems
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
19. The Contractor's appeal process must provide: • The member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. (The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution time frame in the case of expedited resolution.) • The case file to the member and their representative, including medical records, other documents and records, and any new or additional documents considered, relied upon, or generated by the Contractor in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame. *42 CFR 438.406(b)(4-5)* CHP+ Contract: Exhibit B—8.6.8-8.6.10 10 CCR 2505-10 8.209. 4.G, 8.209.4.H
Findings
DHMP included accurate information in the Appeal Process and member appeal acknowledgement letters which informed members that they have reasonable opportunity to present evidence, testimony, and make legal and factual arguments and that they have limited time available for this sufficiently in advance of the resolution time frame in the case of an expedited resolution. While page 60 of DHMP's CHP+ Member Handbook, the "After you file an appeal" section of the CHP+ website, and DHMP's NABDs stated that the member or member's representative may "look at" the case file before and during the appeal process, DHMP did not inform the members that the request is free of charge.
Required Actions
DHMP must update its NABDs, CHP+ Member Handbook, and CHP+ website to inform the member and member's representative that this information must be provided free of charge and sufficiently in advance of the appeal resolution time frame, upon request.
Planned Interventions:

Standard VI—Grievance and Appeal Systems
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
22. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)* *42 CFR 438.408(d)(2)(i)* *42 CFR 438.10* CHP+ Contract: Exhibit B—8.6.13.1 10 CCR 2505-10 8.209.4.J.1
Findings
DHMP's appeal sample included one CHP+ appeal resolution letter that would not be easy for the member to understand. The resolution letter stated that the member was not responsible although DHMP was still denying the service due to a billing code error. DHMP staff reported that the paragraph stating the service was still denied was mistakenly included.
Required Actions
DHMP must ensure that the member appeal resolution letters are written so that members can easily understand them and remove any language that is deemed confusing and that could potentially confuse the member.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:

Standard VI—Grievance and Appeal Systems
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
23. For expedited appeal, the Contractor must resolve the appeal and provide written notice of disposition to affected parties within 72 hours after the Contractor receives the appeal. • For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. *42 CFR 438.408(b)(3) and (d)(2)(ii)* CHP+ Contract: Exhibit B—8.6.13.2.3; 8.6.13.2.6 10 CCR 2505-10 8.209.4.J.2, 8.209.4.L
Findings
DHMP's website for CHP+ stated that expedited appeal decisions are to be made within three working days after receiving the appeal. However, federal and State regulation set forth the timeframe for expedited resolution to not exceed 72 hours.
Required Actions
DHMP must update the CHP+ website sections "Filing an expedited (quick) appeal" and "After you file an appeal" to reflect the accurate time frame of 72 hours set forth by federal and State regulations.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:

Standard VI—Grievance and Appeal Systems
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
26. The written notice of appeal resolution must include: • The results of the resolution process, and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. *42 CFR 438.408(e)* CHP+ Contract: Exhibit B—8.6.13.3 10 CCR 2505-10 8.209.4.M
Findings
DHMP inaccurately stated in its CHP+ appeal resolution letters, CHP+ Member Handbook, and on its CHP+ website that the member can request continued services while the State fair hearing is pending and how to make that request.
Required Actions
DHMP must remove all language that references continuation of benefits in its CHP+ appeal resolution letters, CHP+ Member Handbook, and on its CHP+ website as this does not apply to the CHP+ line of business. If documents are used across multiple lines of business, they must clarify that continuation of benefits during appeals and State fair hearings does not apply to CHP+.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:

Standard VI—Grievance and Appeal Systems
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
29. Effectuation of reversed appeal resolutions: • If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. *42 CFR 438.424* CHP+ Contract: Exhibit B—8.6.13.4 10 CCR 2505-10 8.209.4.W
Findings
DHMP's Provider Manual and CHP+ website do not include that the Contractor must provide the disputed services as promptly and as expeditiously as the member's health condition requires *but no later than 72 hours* from the date it receives notice reversing the determination.
Required Actions
DHMP must update the "State Fair Hearing" section of its CHP+ website and the "Effectuation of Appeal Resolutions" section of its Provider Manual to inform the member that the Contractor must provide the disputed services as promptly and as expeditiously as the member's health condition requires *but no later than 72 hours* from the date it receives notice reversing the determination.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:

Standard VI—Grievance and Appeal Systems
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
31. The Contractor provides the information about the grievance, appeal, and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. *42 CFR 438.414* CHP+ Contract Exhibit B—8.3 10 CCR 2505-10 8.209.3.B
Findings
DHMP's Provider Manual stated an inaccurate time frame for expedited appeals. DHMP also stated that the member has 120 days from the date of notice of adverse action to request a hearing. However, it should state that the member has 120 days from the date of the appeal resolution letter to request a hearing. Additionally, the Provider Manual did not separate CHP+ and Medicaid when discussing continuation of benefits.
Required Actions
DHMP must update its Provider Manual to: • Remove references to continuation of benefits related to CHP+ or clarify that this only applies to Medicaid. • Update the time frame of a decision for an expedited appeal, which is 72 hours from the request. • Clarify that the time frame to file a State fair hearing is 120 days from the adverse appeal resolution.
Planned Interventions:

Standard VI—Grievance and Appeal Systems
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in 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 desk request forms, compliance 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 MCEs.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided MCEs with proposed review dates, group technical assistance, and training, as needed. • HSAG confirmed a primary MCE 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 MCE 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 MCE 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 MCE's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. • The MCEs also submitted lists denials, grievances, and appeals that occurred between January 1, 2022, and December 31, 2022 (to the extent available at the time of the review). MCEs 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 MCE 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 MCE's key staff members to obtain a complete picture of the MCE's compliance with federal healthcare regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the MCE's performance. • HSAG requested, collected, and reviewed additional documents as needed. • At the close of the review, HSAG provided MCE staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2022–2023 Department-approved Compliance 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 Compliance Review Report to the MCE and the Department for review and comment. • HSAG incorporated the MCE 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 MCE and the Department.