CHP+

Child Health Plan *Plus*

Fiscal Year 2017–2018 Site Review Report

for

Friday Health Plans of Colorado

March 2018

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

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1. Executive Summary

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

In order to evaluate the health plan's progress toward compliance with new federal managed care regulations published May 2016, the Department determined that the review period for FY 2017–2018 was July 1, 2017, through December 31, 2017. This report documents results of the FY 2017–2018 site review activities for **Friday Health Plans of Colorado** (**FHP**). For each of the four standard areas reviewed this year, this section contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 2 describes the background and methodology used for the 2017–2018 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the 2016–2017 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the appeals and grievances record reviews. Appendix C lists HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process the health plan will be required to complete for FY 2017–2018 and the required template for doing so. Appendix E contains a detailed description of HSAG's site review activities consistent with the Centers for Medicare & Medicaid Services (CMS) final protocol.

Summary of Results

Based on conclusions drawn from the review activities, HSAG assigned each applicable requirement in the compliance monitoring tool a score of *Met*, *Partially Met, Not Met,* or *Not Applicable.* HSAG assigned required actions for any requirement within the compliance monitoring tool receiving a score of *Partially Met* or *Not Met.* Revisions to federal Medicaid managed care regulations published May 6, 2016, do not become applicable to CHIP until July 1, 2018; therefore, HSAG assigned each **revised** federal requirement a score of *Met* or *Not Scored*. HSAG identified opportunities for improvement and associated recommendations for those requirements that do not become effective until July 2018.

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

Table 1-1—Summary of Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
V. Member Information	24	12	11	1	0	12	92%
VI. Grievance System	35	22	18	4	0	13	82%
VII. Provider Participation and Program Integrity	16	15	14	1	0	1	93%
IX. Subcontracts and Delegation	4	0	0	0	0	4	NA
Totals	**79**	**49**	**43**	**6**	**0**	**30**	**88%**

Note: While the scoring of evidence related to individual, new federal requirements in the tool may indicate *Met* or *Not Scored*, all new requirements were scored *Not Applicable* in the total results; new federal requirements do not apply to CHP+ until July 1, 2018.

*The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements. (All elements representing revised requirements effective July 2018 were considered N/A.)

Table 1-2 presents the scores for **FHP** for the 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 Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Appeals	6	6	6	0	0	100%
Grievances	6	3	3	0	3	100%
Totals	**12**	**9**	**9**	**0**	**3**	**100%**

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

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Standard V—Member Information

Summary of Strengths and Findings as Evidence of Compliance

FHP provided information to members on its general website, including:

- Links to a PDF version of the member handbook and summary of benefits.
- A provider search feature.
- Information on how to locate and select a provider without using the provider search feature.
- The drug formulary.
- Grievance and appeals information.

During the on-site visit, **FHP** provided a demonstration of its new member portal, available through the website. The member portal provided parents of CHP+ members with some vital information, such as the member's primary care provider, benefits, and eligibility; however, much of information in the member portal was member-driven, meaning that members entered it themselves.

In addition to information provided on the website, **FHP** also mailed newly enrolled CHP+ members a member handbook, welcome letter, ID card, and information about the CHP+ ancillary vision and dental plans. **FHP** also reached out to new members through an introductory phone call and encouraged them to reach out to customer service via telephone or in person with any questions or concerns.

FHP's member handbook was comprehensive and easy to navigate. The member handbook included information on available benefits and how to access them. In addition, the member handbook outlined all member rights in easy-to-understand language, including the right to file a grievance or an appeal and how to do so. The member handbook outlined cost-sharing for the various CHP+ income tiers and informed members of their responsibility for services, whether in or out of network, including how to request a referral for an out-of-network provider when out-of-network care is warranted.

Summary of Findings Resulting in Opportunities for Improvement

FHP did not have taglines in large print (18-point font) describing how to request auxiliary aids and services, including written translation and oral interpretation, in either paper or electronic member materials, as required. HSAG reviewed various member materials available in PDF format; while the font appeared to be acceptable in size (not less than 12 font), HSAG was unable to directly confirm the font size due to the PDF format. HSAG recommends that **FHP** review all member documents to ensure that the general text of PDF versions of member materials is made available to members in at least a 12-point font. HSAG recommends that **FHP** include taglines in large print (18-point font) and in prevalent non-English languages that:

- Describe how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDD customer service numbers.
- State that materials are available in alternative formats.

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During the desk review process, HSAG conducted an accessibility check on a few **FHP** webpages using the Wave Web Accessibility Evaluation Tool. Using this tool, HSAG discovered general accessibility and contrast errors on various webpages. HSAG also discovered accessibility errors in **FHP**'s PDF documents using Adobe Acrobat Pro's accessibility checker. HSAG repeated these accessibility checks during the on-site review for educational purposes and discovered the same outcomes. HSAG recommends that **FHP** develop a process to ensure that all information on its website is readily accessible (i.e., complies with 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines).

HSAG was unable to locate notification on **FHP**'s website informing members that any electronic information presented on the website is available in paper form at no charge upon request, and would be provided within five business days. During the on-site interview, HSAG and **FHP** discussed where to place this notification on the website, especially considering that many members may not have a state-of-the-art cellular phone or access to sufficient bandwidth to search the website for this notice or to download the available PDF documents. HSAG recommends that **FHP** inform members in a prominent location on its website that any website information is available in paper form at no charge upon request, and would be provided within five business days.

At the time of the review, information provided to members through **FHP**'s provider search feature on its website did not include whether the provider had completed cultural competency training and whether the provider's office had accommodations for people with disabilities, including offices, exam rooms, and equipment. HSAG recommends that **FHP** update its website to include all required provider information. HSAG supplied **FHP** staff with a link to the Americans with Disabilities Act publication, *Access To Medical Care For Individuals With Mobility Disabilities*, which provides information on relevant exam room and physician office accessibility devices.[1-1]

Summary of Required Actions

At the time of the on-site review, **FHP** did not have a fully formatted, fully translated Spanish version of its member handbook available for review. **FHP** must ensure that all written information, including basic publications such as the member handbook, are available to members in the non-English prevalent language (Spanish).

[1-1] Americans with Disabilities Act. *Access To Medical Care For Individuals With Mobility Disabilities.* Available at: https://www.ada.gov/medcare_mobility_ta/medcare_ta.htm. Accessed on: Jan 16, 2018.

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Standard VI—Grievance System

Summary of Strengths and Findings as Evidence of Compliance

Much of the information in the CHP+ Grievance and Appeals desktop procedure (DTP) and member handbook was compliant with new federal regulations for CHP+ in advance of the July 1, 2018, effective date. Staff members stated that new federal requirements for CHP+ had previously been in place for other **FHP** lines of business, enabling ease of transition. During on-site interviews, staff members verbally articulated understanding of the new federal regulations related to grievances and appeals.

All procedures related to grievances and appeals were addressed in a single comprehensive document—the CHP+ Grievance and Appeals DTP—for easy reference by staff members. **FHP** had a single person assigned to process grievances and appeals who was able to describe processes compliant with written procedures. **FHP** appeared to process all grievances and appeal expeditiously. Staff members stated that a request for an expedited appeal was rarely denied, unless the service was retrospective to the appeal, and that nearly all grievances or appeals were related to claims payment issues. Both grievance and appeal resolution letters were written in easy-to-understand language. Staff members aided members in filing grievances, appeals, and State fair hearing (SFH) information, both in person and via phone. All information related to grievances or appeals was recorded in the Xpress data system and maintained 10 years or longer. **FHP** used a tracking log associated with the data system to monitor performance and was developing a workflow diagram to guide staff regarding time frame requirements.

FHP experienced only one grievance and one appeal during the review period. Both the grievance and appeal record reviews demonstrated 100 percent compliance with applicable requirements.

Summary of Findings Resulting in Opportunities for Improvement

HSAG noted that both the CHP+ Grievance and Appeals DTP and sections of the provider manual were written in language addressing the member (possibly copied from the member handbook). HSAG advised that documents should be written in language addressing the appropriate audience—instructions to grievance and appeals staff members or information to providers, respectively—not the member.

While **FHP** had addressed many of the new federal regulations that will become applicable to CHP+ on July 1, 2018, HSAG recommends that **FHP** update its policies and procedures and, as applicable, the member handbook prior to July 1, 2018, to address the following:

- Specify that "the denial of a member's right to dispute a member financial responsibility" is an adverse benefit determination.
- Include the *italicized* additional federal language used to define a "grievance":
  - 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

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respect the member's rights *regardless of whether remedial action is requested.* Grievance includes *a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision.*

- Specify the 60-day time frame for filing appeals.
- Thoroughly address all required procedures related to extending the time frame of either an expedited or standard appeal.
- Correct conflicting information in the CHP+ Grievances and Appeals DTP, as well as the member handbook, to clarify the time frame for requesting a SFH (within 120 calendar days from the date of the notice of appeal resolution).

HSAG provided additional recommendations related to current CHP+ requirements as follows:

- While staff members described adequate processes for handling a verbal appeal, the CHP+ Grievance and Appeals DTP did not specifically state that the member may file an appeal either orally or in writing, must follow an oral request with a written appeal, or that the verbal appeal establishes the filing date. The DTP also did not describe internal procedures for translating a verbal appeal into a written appeal. HSAG recommends that these instructions be added to the written DTP to ensure that all staff understand these requirements and the procedures for handling verbal appeals.
- The CHP+ Grievance and Appeals DTP addressed appeal requirements and SFH requirements in two separate sections. In some instances, requirements that relate to both appeals and SFH were documented in one section, but not the other. HSAG recommends that **FHP** review its DTP to ensure that all information applicable to both appeals and SFHs is addressed in each section. In addition, the SFH section used the terminology "appeal" when describing circumstances related to continued benefits. To avoid confusion, the term "SFH" might more appropriately be used in this section.
- Information in the CHP+ Grievance and Appeals DTP and member handbook was closely aligned; therefore, HSAG recommends that any changes in the DTP be similarly addressed in member communications.

Summary of Required Actions

The CHP+ Grievances and Appeals DTP, as well as the member handbook, stated that **FHP** would notify the member in writing within two working days if a member's request for an expedited appeal is denied. Neither the DTP nor the member handbook stated that the **FHP** would inform the member of the right to file a grievance if he or she disagrees with the denial of an expedited request. **FHP** must correct the CHP+ Grievances and Appeals DTP, as well as the member handbook, to specify that **FHP** will inform the member in writing within two *calendar* days of the reason for denying an expedited appeal request and will inform the member of the right to file a grievance if he or she disagrees with that decision. **FHP** must ensure that the notice to the member informs the member of the right to file a grievance, according to the requirement.

The CHP+ Grievances and Appeals DTP addressed all criteria related to continuation of benefits during an appeal *except* the requirement for requesting continued benefits within a 10-day time frame from notice of adverse benefit determination or intended effective date of termination for requesting continued benefits. The SFH section of the DTP stated that the member must request continued benefits within 10 calendar days "from the mailing date of the decision" but did not clarify whether this was the adverse benefit decision or appeal decision. The CHP+ Grievances and Appeals DTP must specify that the member may request continued benefits during an appeal within 10 days of the notice of adverse benefit determination. The DTP should also clearly specify that members must request continued benefits during a SFH within 10 days of *adverse appeal resolution*.

Both the appeals and SFH sections of the CHP+ Grievances and Appeals DTP, as well as the member handbook, included "the time period or service limits of a previously authorized service ends" as a criterion for how long member-requested benefits would continue while the appeal or SFH is pending. According to the regulation, this criterion is not applicable to how long benefits will continue. (It is applicable to the criteria for requesting continued benefits.) The SFH section of the DTP also stated that the criteria include "ten days pass after the MCO mails the notice providing the resolution of the appeal against the enrollee," which is an incomplete description of this criterion. **FHP** must remove the text "the time period or service limits of a previously authorized service ends" from the CHP+ Grievances and Appeals DTP and related documents as a criterion for how long benefits will continue while an appeal or SFH is pending. **FHP** must clarify in the SFH section of the DTP that the criterion "ten days pass after the MCO mails the notice providing the resolution of the appeal against the enrollee" includes "unless the member requests a SFH and continuation of benefits" (or similar language).

The provider manual description of CHP+ grievances and appeals was a copy of the entire CHP+ Grievances and Appeals DTP. As such, all DTP noncompliance issues noted in the above requirements apply to the provider manual, including lack of time frame for filing appeals, two different time frames for filing a SFH, and any issues noted in continuation of benefits information. Once necessary corrections are made to the CHP+ Grievances and Appeals DTP, **FHP** must address similar changes in the provider manual, and ensure that providers are notified of applicable changes to the manual.

Standard VII—Provider Participation and Program Integrity

Summary of Strengths and Findings as Evidence of Compliance

HSAG reviewed **FHP**'s Compliance Plan and fraud, waste and abuse policies and procedures. The Compliance Plan expressed **FHP**'s intent to operate within compliance of pertinent laws and delineated processes for adhering to regulations; monitoring providers; monitoring payments; and acting as a resource for members, employees, or providers to report suspected fraud, waste, and abuse directly to the compliance officer or anonymously through **FHP**'s hotline. The Compliance Plan described the role of the compliance officer as well as the composition and the duties of the compliance committee.

Prior to hiring, **FHP** conducted initial searches of federal databases to ensure that it does not employ or contract with providers, employees, or other individuals or entities excluded from participation in federal healthcare programs. Following initial hire, **FHP** conducts monthly monitoring of providers and employees on these same databases.

FHP monitored for suspected fraud, waste, and abuse. Monitoring processes were ongoing and included a review of medical claims and utilization management (UM) reviews. If needed, **FHP** would conduct an audit of a billing code or a provider. During the on-site review, **FHP** discussed a hypothetical situation detailing the investigation of suspected noncompliance. **FHP** staff members were able to walk through the process of investigation and discovery, including corrective actions, termination, reporting to appropriate entities including the State of Colorado, and recovery of overpayment if applicable.

Compliance training occurred upon hire and then annually during in-person in-services conducted by the compliance and privacy officer. **FHP** noted during the on-site review that this method requires multiple sessions, as staff numbers have grown and cannot all fit into one training room. In addition, it is not feasible to train all staff at once as certain functions (e.g., customer service) require continuous coverage. To make annual compliance training more efficient, **FHP** intends to invest in learning management software in the future.

During the on-site interview, **FHP** discussed new compliance events or "fairs," spearheaded by the compliance and policy officer. These fairs, held periodically (i.e., during compliance week and Health Insurance Portability and Accountability Act of 1996 [HIPAA] week), interactively engaged **FHP** staff members to encourage, educate, and engage staff on various topics of compliance, including the use of games and prizes. **FHP** reported enthusiastic participation from its staff. HSAG commends this activity and encourages its continuation.

Summary of Findings Resulting in Opportunities for Improvement

During the on-site review, HSAG noted that all **FHP** policies were still written on Colorado Choice letterhead. **FHP** explained that the new ownership had adopted all policies and procedures as they were written and that **FHP** focused on transitioning all member-facing documents from Colorado Choice headers and branding, prior to open enrollment. Once those documents were updated, policies and procedures would be updated next. HSAG recommends that **FHP** carefully review its policies for accuracy and applicability, prior to transitioning them to the new branding and headers, especially regarding the recent changes to federal regulations.

While **FHP**'s written credentialing plan included provisions indicating that it does not discriminate against providers seeking qualification as a participating provider, the language was vague in relation to the requirement. HSAG recommends that **FHP** enhance and describe in more detail this policy language, to include that **FHP** does not discriminate against providers for acting within the scope of their license or against providers who serve high-risk populations or specialize in conditions that require costly treatment.

Summary of Required Actions

FHP supplied HSAG with its Network Management Program Description following the on-site review. This document contained information on **FHP**'s provider selection criteria; however, it did not include information on provider retention. **FHP** must implement written policies and procedures for the retention of providers.

Standard IX—Subcontracts and Delegation

Summary of Strengths and Findings as Evidence of Compliance

FHP staff members stated that **FHP** delegated the following activities related to the CHP+ contract—pharmacy benefit management, specialty medical review, and vision services. **FHP** delegated to Vision Services Plan (VSP) the following activities related to vision services: maintaining a provider network, provision of defined benefits and services, credentialing and recredentialing of providers, marketing, benefit authorization (UM), claims adjudication, and customer services (including grievances). **FHP** provided the VSP agreement as an example of the template agreement used with all delegates. The Delegation Oversight policy outlined procedures for a predelegation assessment/scoring/corrective action plan; ongoing monitoring and assessment/CAPs; and termination for nonperformance.

Summary of Findings Resulting in Opportunities for Improvement

Documents related to subcontracts and delegation, including the sample agreement with VSP, had not been updated to reflect the new **FHP** ownership and name change. As subcontractor agreements are legal documents between entities, HSAG recommends that **FHP** prioritize updating the agreements to reflect the appropriate legal entity—Friday Health Plans.

Prior to July 1, 2018, **FHP** should update its policies and existing delegation agreements applicable to CHP+ as follows:

- State that **FHP** is ultimately accountable for complying with the terms of the contract with the State (not just oversight of delegated functions).
- State that the delegate must comply with all applicable Medicaid laws and regulations and contract provisions.
- Ensure that detailed reporting responsibilities are of sufficient detail and scope to enable **FHP** to monitor and determine the delegate's compliance with the delegated responsibilities.
- Strengthen the language and detail regarding described performance audits to be conducted by **FHP**.
- Include the specific elements of the requirements related to the right of CMS or the U.S. Department of Health & Human Services (HHS) Inspector General to audit, the right to audit for 10 years after the contract end date, the types of documents or records to be made available, and other specifics outlined in the language of 42 CFR 438.230(c)(3).

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Summary of Required Actions

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

2. Overview and Background

Overview of FY 2017–2018 Compliance Monitoring Activities

For the fiscal year (FY) 2017–2018 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation. Compliance with applicable federal managed care regulations and managed care contract requirements was evaluated through review of all four standards.

Compliance Monitoring Site Review Methodology

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

HSAG also reviewed a sample of the health plan's administrative records related to CHP+ appeals and grievances to evaluate implementation of managed care contract requirements for processing grievances and appeals. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records (to the extent that a sufficient number existed). Using a random sampling technique, HSAG selected the samples from all applicable CHP+ appeals and grievances that occurred between July 1, 2017, and December 31, 2017. For the record review, the health plan received a score of *M* (met), *NM* (not met), or *NA* (not applicable) for each required element. Results of record reviews were considered in the review of applicable requirements in Standard VI—Grievance System. HSAG also separately calculated a grievances record review score, an appeals record review score, and an overall record review score.

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[2-1] Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The four standards chosen for the FY 2017–2018 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement.

Objective of the Site Review

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

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

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Sep 26, 2017.

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

FY 2016–2017 Corrective Action Methodology

As a follow-up to the FY 2016–2017 site review, each health plan that received one or more *Partially Met* or *Not Met* scores was required to submit a corrective action plan (CAP) to the Department addressing those requirements found not to be fully compliant. If applicable, the health plan was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the health plan and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **FHP** until it completed each of the required actions from the FY 2016–2017 compliance monitoring site review.

Summary of FY 2016–2017 Required Actions

For the FY 2016–2017, HSAG reviewed Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. **FHP** was required to develop plans to address the following issues related to coverage and authorization of services:

- Develop a procedure to determine when an expedited authorization review is warranted and how an expedited review request will be processed.
- Develop and implement a process for extending standard and expedited authorization decisions up to 14 calendar days.
- Include in the process for extending authorization decisions that written notice will be provided to the member and that the member will be informed of the right to file a grievance if he or she disagrees with the decision.

FHP was required to develop plans to address the following issues related to access and availability:

- Amend its provider handbook and Network Access Plan to reflect accurate, timely access standards for diagnosis and treatment of a mental health condition.
- Develop a mechanism to regularly monitor provider compliance with timely access requirements and have in place a system for corrective actions in cases of noncompliance.
- Have policies, procedures, provider training, and member communications related to its efforts to deliver services in a culturally competent manner.

Summary of Corrective Action/Document Review

FHP submitted a proposed CAP in June 2017. After reviewing the proposed plan, HSAG and the Department required that **FHP** revise two of its proposed interventions or monitoring procedures. **FHP** was given until January 24, 2018, to submit evidence of having implemented its corrective actions. HSAG completed this 2017–2018 compliance monitoring report prior to receiving and processing **FHP**'s 2016–2017 CAP submission and is unable to comment on the completeness of the corrective actions.

Summary of Continued Required Actions

HSAG will review **FHP**'s CAP submission with the Department when received and work with the plan to ensure full implementation of all corrective actions.

Appendix A. Compliance Monitoring Tool

The completed compliance monitoring tool follows this cover page.

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor provides all required member information to members in a manner and format that may be easily understood **and is readily accessible by members.** *(Note: Readily accessible means electronic information which complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines.)* *42 CFR 438.10(b)(1)* Contract: Section 21.A.	**Documents:** 1) Member Handbook **Narrative:** Once Friday Health Plans is notified of an enrollment, it is processed and an enrollment kit is mailed to each member that contains the required member information. Members are provided instructions in the member handbook on how to request alternative format materials (readily accessible.	☒ Met ☐ Not Scored
2. The Contractor has in place a mechanism to help members understand the requirements and benefits of the plan. *42 CFR 438.10(c)(7)* Contract: Exhibit B—6.3.1.15	**Documents:** 1) Member Handbook, Pages 6 -13, and pages 37-67 **Narrative:** Friday Health Plans maintains a Member Handbook that helps members understand the requirements and benefits of the plan. This member handbook is distributed to all new members upon enrollment with the plan. The member handbook functions as the Evidence of Coverage. The Member Handbook contains a CHP+ Comparison Benefit Form that outlines the covered services and copayments offered by the managed care plan. The Member Handbook additionally provides members with additional information regarding the benefits and services covered under the managed care plan. Members	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	are encouraged to contact our Customer Service department for any questions or clarification in services offered under their plan.	
3. **For consistency in the information provided to members, the Contractor uses the following as developed by the State:** • **Definitions for managed care terminology, including appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care.** • **Model member handbooks and member notices.** *42 CFR 438.10(c)(4)*	**Documents:** 1) Member Handbook, pages 85-98 **Narrative:** Friday Health Plans provides definitions to members in the Member Handbook. Friday Health Plans obtains the definitions from the Contract with the State and also from the Code of Colorado Regulations referenced in the Contract.	☐ Met ☒ Not Scored
Findings: HSAG is aware and the Department acknowledges that, for the 2017–2018 compliance review period, the State has neither developed nor communicated to health plan contractors a consensus list of managed care definitions to be incorporated into information provided to members. HSAG has therefore scored this element *Not Applicable.*		
Recommendations: HSAG recommends that all contractors maintain awareness of this requirement and, when received, incorporate State-defined managed care definitions into all applicable member communications, as directed by the Department.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • Written materials must use easily understood language and format. *42 CFR 438.10(d)(3) and (d)(6)(i)* Contract: Exhibit B—10.8.2.5	**Documents:** 1) CHP+ Welcome Letter 2) Member Handbook 3) VSP Vision Benefits Summary 4) Selection of PCP Form 5) Health Assessment Survey **Narrative:** Members are notified of the availability of written information in alternate formats and how to request the alternate information in the Member Handbook (Page 4). Friday Health Plans sends out an English, Spanish version of certain forms, such as the VSP Vision Benefits Summary, the Selection of PCP Form and the Health Assessment Survey.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: At the time of the on-site review, Friday Health Plans (FHP) did not have a fully formatted, fully Spanish version of its member handbook available for review.		
Required Actions: FHP must ensure that all written information, including basic publications such as the member handbook, are available to members in the non-English prevalent language (Spanish).		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. **Written materials that are critical to obtaining services include: provider directories, member handbooks, appeal and grievance notices, and denial and termination notices.** **All written materials for members must:** • **Use a font size no smaller than 12 point.** • Be available in alternative formats **and through provision of auxiliary aids and service** that takes into consideration the special needs of members **with disabilities** or limited English proficiency. • **Include taglines in large print (18 point) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service number, and availability of materials in alternative formats.** *42 CFR 438.10(d)(3) and (d)(6)(ii–iv)*	**Documents:** 1) DTP-Marketing-Plain Language for Member Materials 2) Member Handbook, Page 106 **Narrative:** In preparing written materials to members, Friday Health Plans follows the DTP: Marketing Plain Language for Member Materials which includes using a font of 12-point. The Member Handbook has taglines in 16 languages informing members that if they speak a certain language, language assistance services, free of charge, are available to you and a number they should call for those services.	☐ Met ☒ Not Scored
Findings: FHP did not have taglines in large print (18-point font) describing how to request auxiliary aids and services, including written translation and oral interpretation, in either paper or electronic member materials, as required.		
Recommendations: HSAG reviewed various member materials available in PDF format; while the font appeared to be acceptable in size, HSAG was unable to directly confirm the font size due to the PDF format. HSAG recommends that FHP review all member documents to ensure that the general text of PDF versions of member materials is made available to members in at least a 12-point font. HSAG recommends that FHP include taglines in large print (18-point font) and prevalent non-English languages that (1) describe how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDD customer service numbers, and (2) state that materials are available in alternative formats.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. **If the Contractor makes information available electronically—Information provided electronically must meet the following requirements:** • **The format is readily accessible (see definition of readily accessible above).** • **The information is placed in a Web site location that is prominent and readily accessible.** • **The information can be electronically retained and printed.** • **The information complies with content and language requirements.** • **The member is informed that the information is available in paper form without charge upon request, and is provided within five (5) business days.** *42 CFR 438.10(c)(6)*	**Documents:** 1) CHP+ Website information **Narrative:** Contractor maintains a website that contains the plan information for CHP+ members. There is a specific tab for CHP+ and all documents that are on the website can be opened as a PDF that can be printed. Members are able to call customer service to request a copy be sent to them.	☐ Met ☒ Not Scored
Findings: During the desk review process, HSAG conducted an accessibility check on a few general FHP webpages using the Wave Web Accessibility Evaluation Tool. Using this tool, HSAG discovered general accessibility errors and contrast errors on various webpages. HSAG also discovered accessibility errors in FHP's PDF documents using the Adobe Acrobat Pro accessibility checker. HSAG repeated these accessibility checks during the on-site review for educational purposes, and the same outcomes were discovered. HSAG was unable to locate notification on FHP's website informing members that any electronic information presented on the website is available in paper form at no charge upon request, and would be provided within five business days. During the on-site interview, HSAG and FHP discussed where to place this notification on the website, especially considering that many members may not have a state-of-the-art cellular phone or access to sufficient bandwidth to search the website for this notice or to download the available PDF documents.		
Recommendations: HSAG recommends that FHP develop a process to ensure that all information on its website is readily accessible (i.e., complies with 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines). HSAG recommends that FHP inform members in a prominent location on its website that any website information is available in paper form at no charge upon request, and would be provided within five business days.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. **The Contractor makes available to members in electronic or paper form information about its formulary:** • **Which medications are covered (both generic and name brand).** • **What tier each medication is on.** • **Formulary drug list must be available on the Contractor's Web site in a machine readable file and format.** *42 CFR 438.10(i)*	**Documents:** 1) CHP+ Formulary **Narrative:** Friday Health Plans provides the formulary based on SMCN. CHP+ members may call customer service to request a copy.	☒ Met ☐ Not Scored
8. The Contractor makes interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and how to access them. *42 CFR 438.10(d)(4) and (d)(5)* Contract: Exhibit B—7.5, 14.1.3.4, 14.1.7.4–6	**Documents:** 1) Member Handbook 2) Translation Services Procedure **Narrative:** Oral interpretation services are available free to all members through contract with Translation Plus. Customer Services representatives would follow the procedures for how to connect a member through Translation Plus. Members are notified of the availability of interpretation services in the Member handbook and are provided information on how to access those services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. **Interpretation services include oral interpretation and use of auxiliary aids such as TTY/TDY and American Sign Language.** • The Contractor notifies members that **auxiliary aids and services are available upon request and at no cost for members with disabilities**, and how to access them. *42 CFR 438.10(d)(4) and (d)(5)*	**Documents:** 1) Member Handbook 2) DTP: Telephone Services for Special Needs **Narrative:** Oral interpretation services are available free to all members through contract with Translation Plus. Customer Services representatives would follow the procedures for how to connect a member through Translation Plus and also follow the DTP: Telephone Services for Special Needs. Members are notified of the availability of interpretation services in the Member handbook and are provided information on how to access those services.	☒ Met ☐ Not Scored
10. **The Contractor provides each member with a member handbook within a reasonable time after receiving notification of the member's enrollment.** *42 CFR 438.10(g)(1)*	Note: The State generally defines "a reasonable time" as 30 days. **Narrative:** Friday Health Plans enrollment procedure consists of Government Programs CHP+ Specialist processing the enrollments as they are received, making telephone calls for primary care physicians, the member enrollment information is then forwarded to Enrollment and Billing Specialist for input and ID Card processing, the ID Cards are provided to Sales Support for mailing. Sales support mails the ID Cards to the	☒ Met ☐ Not Scored

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Member with the Welcome Kit. The internal goal for completion is currently 14 days.	
11. The Contractor gives members written notice of any significant change (as defined by the State) in the information required at 438.10(g) at least 30 days before the intended effective date of the change. *42 CFR 438.10(g)(4)* Contract: Exhibit B—14.1.3.13	**Documents:** 1) Member Handbook **Narrative:** In the member handbook members are notified that if benefits or services change, notification will be provided at least 30 days before the intended effective date of the change and will also be posted on our website.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. *42 CFR 438.10(f)(1)* Contract: Exhibit B—7.12.2, 14.1.8.1	**Documents:** 1) CHP Network PCP Changes **Narrative:** When provider relations terminates providers that have CHP+ members who have selected this provider as a primary care physician, a letter is sent out to the members advising them of the termination and whether there is a replacement provider available and giving members the option to choose a new PCP.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. The Contractor makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals**, pharmacies, and behavioral health providers, and long-term services and supports (LTSS) providers:**	**Documents:** 1) CHP+ Provider Directory 2) Member Handbook	☐ Met ☒ Not Scored

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The provider's name and **group affiliation**, street address(es), telephone number(s), **Web site URL, specialty (as appropriate),** and whether the providers will accept new members. • **The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training.** • **Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment.** *(Note: Information included in a paper provider directory must be updated at least monthly, and electronic provider directories must be updated no later than 30 calendar days after the Contractor receives updated provider information.)* *42 CFR 438.10(h)(1–3)*	**Narrative:** Members have up-to-date real time data regarding network providers for CHP+ through their Member Portal. Members are informed in the member handbook that they can call customer service to have a provider directory mailed to them.	
Findings: At the time of the review, information provided to members through FHP's provider search feature on its website did not include whether the provider had completed cultural competency training and whether the provider's office had accommodations for people with disabilities, including offices, exam rooms, and equipment.		
Recommendations: HSAG recommends that FHP update its website to include all required provider information. HSAG supplied FHP staff with a link to the Americans with Disabilities Act publication, *Access To Medical Care For Individuals With Mobility Disabilities,* which provides information on relevant exam room and physician office accessibility devices.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. **Provider directories are made available on the Contractor's Web site in a machine readable file and format.** *42 CFR §438.10(h)(4)*	**Documents:** 1) Website Screenshot **Narrative:** The Website screenshot has a placeholder for the CHP+ Provider Directory. The Provider Directory will be added prior to the onsite.	☒ Met ☐ Not Scored
15. The member handbook provided to members following enrollment includes: • The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled. • Procedures for obtaining benefits, including authorization requirements and/or referrals for specialty care and for other benefits not furnished by the member's primary care provider. • Any restrictions on the member's freedom of choice among network providers. • In the case of a counseling or referral service that the Contractor does not cover due to moral or religious objections, the Contractor informs the member that the service is not covered and how the member can obtain information from the State about how to access such services. *42 CFR 438.10 (g)(2)(iii, iv, vi) and (g)(ii)(A-B)* Contract: Exhibit B—14.1.3.13.1–3, 14.1.3.14.4, Exhibit K—1.1.4.1–3, 1.1.7, 1.1.16.3.11, 1.1.28	**Documents:** 1) Member Handbook **Narrative:** Contractor maintains a Member Handbook that helps members understand the benefits to which they are entitled, the procedures for obtaining benefits, including authorization requirements and use of network providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The member handbook provided to members following enrollment includes: • The extent to which and how members may obtain benefits, including family planning services, from out-of-network providers. **This includes an explanation that the Contractor cannot require the member to obtain a referral before choosing family planning provider.** • **The process of selecting and changing the member's primary care provider.** *42 CFR 438.10(g)(2)(vii, x)*	**Documents:** 1) Member Handbook **Narrative:** Contractor maintains a Member Handbook that helps members understand the benefits to which they are entitle, the procedures for obtaining benefits, including authorization requirement and use of network providers. Member rights on page 25 outline that members have the right to obtain family planning services directly from any provider that is duly licensed or certified to provide such services without referral and these member rights on page 25 also inform members that they have the right to choose or change a PCP within the network.	☒ Met ☐ Not Scored
17. The member handbook provided to members following enrollment includes the following member rights and protections as specified in 42 CFR 438.100. Each member has the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for his or her dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding his or her healthcare, including the right to refuse treatment.	**Documents:** 1) Member Handbook **Narrative:** Members are provided a Member Handbook along with their ID Cards upon enrollment. The member handbook on pages 25-26 informs members of their rights and protections.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. • Request and receive a copy of his or her medical records, and request that they be amended or corrected. • Be furnished healthcare services in accordance with requirements for access, coverage, and coordination of medically necessary services. • Freely exercise his or her rights; and the exercising of those rights will not adversely affect the way the Contractor, its network providers, or the State agency - treats the member. *42 CFR 438.10(g)(2)(ix)* Contract: Exhibit B—14.1.3.6.1, Exhibit K—1.1.2		
18. The member handbook provided to members following enrollment includes the following information regarding the grievance, appeal, and fair hearing procedures and timeframes: • The right to file grievances and appeals. • The requirements and timeframes for filing a grievance or appeal. • The right to a request a State fair hearing after the Contractor has made a determination on a member's appeal which is adverse to the member. • The availability of assistance in the filing process. • The fact that, when requested by the member:	**Documents:** 1) Member Handbook **Narrative:** The CHP+ Member Handbook, which is provided upon enrollment and updated at renewal, fully explains the grievance, appeal and State Fair Hearing procedures. The information outlines a member's right to file grievances and appeals, appropriate timeframes, right to a state fair hearing, availability of assistance in the filing process, DPRs, and continuance of benefits and	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Benefits that the Contractor seeks to reduce or terminate will continue if the member files an appeal or if a request for State fair hearing is filed within the time frames specified for filing. – If benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal or State fair hearing is pending if the final decision is adverse to the member. *42 CFR 438.10(g)(2)(xi)* Contract: Exhibit B—1.1.16.6, 1.1.16.6.1, 1.1.16.6.3	when the member may be required to pay for those benefits.	
19. The member handbook provided to members following enrollment includes the extent to which and how after-hours and emergency coverage are provided, including: • What constitutes an emergency medical condition and emergency services. • The fact that prior authorization is not required for emergency services. • The fact that the member has the right to use any hospital or other setting for emergency care. *42 CFR 438.10(g)(2)(v)* Contract: Exhibit K—1.1.10.1, 1.1.10.1.1–2, and 5	**Documents:** 1) Member Handbook **Narrative:** Member Handbook, pages 45-48, explains to members what constitutes an emergency medical condition as well as emergency services, provides that prior authorization is not required for emergency services and the fact that the member has the right to use any hospital or other setting for emergency care.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
20. The member handbook provided to members following enrollment includes: • That cost-sharing, if any, is imposed under the State plan. • How and where to access any benefits that are available under the State plan but not covered under the CHP+ managed care contract. • How transportation is provided. *42 CFR 438.10(g)(2)(ii, viii)* Contract: Exhibit K—1.1.3	**Documents:** 1) Member Handbook **Narrative:** The member handbook pages 6-13 outlines the member cost-shares, if any for services. The member handbook also outlines how and where to access benefits and outlines transportation options.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
21. The member handbook provided to members following enrollment includes: • **The toll-free telephone number for member services, medical management, and any other unit providing services directly to members.** • **Information on how to report suspected fraud or abuse.** • **How to access auxiliary aids and services, including information in alternative formats or languages.** *42 CFR 438.10(g)(2)(xiii, xiv, xv)*	**Documents:** 1) Member Handbook **Narrative:** The member handbook provides the toll-free telephone number in the footer. The member handbook provides information to members about how to report suspected fraud and how to access additional information, through calling Customer Service (Page 2).	☒ Met ☐ Not Scored

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
22. The member handbook provided to members following enrollment includes **how to exercise** an advance directive as required in 438.3 (j): • The member's right under the State law to make decisions regarding medical care and to formulate advance directives, including the right to accept or refuse medical or surgical treatment. • The Contractor's policies and procedures respecting implementation of advance directives, with a clear statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience. • Instructions that complaints concerning noncompliance with advance directives requirements may be filed with the Colorado Department of Public Health and Environment. *42 CFR 438.10(g)(2)(xii)* Exhibit B—14.1.1.2.7, 14.1.1.2.7.1, 14.1.9	**Documents:** 1) Member Handbook **Narrative:** The member handbook, provided to all members upon enrollment outlines the member's rights to Advance Medical Directives. Explains the kinds of Advance Medical Directives available and how to exercise those rights as well as where to file a grievance for provider not following the advance directive.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
23. **The Contractor provides member information by any of:** • **Mailing a printed copy of the information to the member's mailing address.** • **Providing the information by email after obtaining the member's agreement to receive the information by email.** • **Posting the information on the Web site of the MCO and advising the member in paper or electronic form that the information is available on the Internet and including the applicable Internet address, provided**	**Documents:** **Narrative:** Upon enrollment, members are provided with an enrollment kit that includes printed copies of information, and this is mailed by U.S. Mail to the member's address that is provided in the enrollment report from the State.	☒ Met ☐ Not Scored

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost. • **Providing the information by any other method that can reasonably be expected to result in the member receiving that information.** *42 CFR 438.10(g)(3)*		
24. The Contractor must make available to members, upon request, any physician incentive plans in place. *42 CFR 438.10(f)(3)*	**Documents:** 1) Member Handbook **Narrative:** The Member Handbook informs members that no financial incentives exist (page 18). If they were to exist the member handbook would specifically be changed to include that members could request a copy of any physician incentive plan by calling Customer Service to request a copy.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Note: While scoring of evidence related to individual, new federal requirements in the tool may indicate *Met* or *Not Scored*, all new requirements were scored *Not Applicable* in the total results; new federal requirements do not apply to CHP+ until July 1, 2018.

Results for Standard V—Member Information							
Total	Met	=	11	X	1.00	=	11
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	12	X	NA	=	NA
Total Applicable		=	12	**Total Score**		=	11
				Total Score ÷ Total Applicable		=	92%

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. **The Contractor has established internal grievance procedures under which members, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance. The Contractor must have a grievance and appeal system in place to handle appeals of an adverse benefit determination and grievances, as well as processes to collect and track information about them.** • **The Contractor may have only one level of appeal for members (or providers acting on their behalf).** • **A member may request a State fair hearing after receiving an appeal resolution notice from the Contractor that the adverse benefit determination has been upheld.** • **If the Contractor fails to adhere to required timeframes for processing appeals, the member is deemed to have exhausted the Contractor's appeal process and the member may initiate a State fair hearing.** *42 CFR 438.400(a)(3)* *42 CFR 438.402(a-c)* *42 CFR 438.400(b)* 10 CCR 2505-10—8.209.3.A, 8.209.4.A.2.c, 8.208.4.N, and 8.209.4.O	**Documents:** 1) Member Handbook 2) Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals **Narrative:** The member handbook outlines the established grievance procedures under which members, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance. Internally, Friday Health Plans follows the Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals.	☒ Met ☐ Not Scored
Findings: The CHP+ Grievances and Appeals DTP describes the grievance and appeal system in place for members. Both the CHP+ Grievances and Appeals DTP and the member handbook addressed the updated federal regulations in advance of the July 1, 2018, effective date for CHP+.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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. • For a resident of a rural area with only one managed care plan, the denial of a CHP+ member's request to exercise his or her rights to obtain services outside of the network under the following circumstances: – The service or type of provider (in terms of training, expertise, and specialization) is not available within the network. – The provider is not part of the network, but is the main source of a service to the member—provided that: o The provider is given the opportunity to become a participating provider. o If the provider does not choose to join the network or does not meet the Contractor's qualification requirements, the member will be	**Documents:** 1) Member handbook 2) Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals **Narrative:** Page 31 of the member handbook provides the Contractors definition of adverse benefit determination. Members receive this handbook upon enrollment. Internally, Friday Health Plans follows the Member Complaint Grievance Policy/DTP+ CHP+ Grievances and Appeals.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
given the opportunity to choose a participating provider and then will be transitioned to a participating provider within 60 days. *42 CFR 438.400(b)* *42 CFR 438.52(b)(2)(ii)* Contract: Exhibit B—1.1.1		
3. The Contractor also defines **adverse benefit determination** as: • **The denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other).** *42 CFR 438.400(b)* *42 CFR 438.52(b)(2)(ii)* 10 CCR 2505-10—8.209.2.A.7	**Documents:** 1) Member Handbook 2) Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals **Narrative:** The Member Handbook, at page 31 defines an adverse benefit determination as the denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities. Internally, Friday Health Plans follows the Member Complaint Grievance Policy/DTP+ CHP+ Grievances and Appeals.	☐ Met ☒ Not Scored
Findings: The CHP+ Grievances and Appeals DTP included the definition of "adverse benefit determination" in two separate places, only one of which lists this element. The member handbook includes this element in the definition, but the information is misplaced under the circumstances applied to denial of access to an out-of-network provider in a rural area, and needs to be reformatted.		
Recommendations: Prior to July 1, 2018, FHP should specify in both the DTP and member handbook that "the denial of a member's right to dispute a member financial responsibility" is an adverse benefit determination.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor defines "Appeal" as "a review by the Contractor of an **adverse benefit determination**." *42 CFR 438.400(b)* Contract: Exhibit B—1.1.4	**Documents:** 1) Member Handbook 2) Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals **Narrative:** As is noted in the member handbook, page 30, an "appeal" is a request for review of an Adverse Benefit Determination.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. 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. 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)* 10 CCR 2505-10—8.209.2.D, 8.209.4.A.3.c.i	**Documents:** 1) Member Handbook 2) Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals **Narrative:** As noted in the member handbook, page 28, a grievance is defined as an oral or written expression of dissatisfaction about any matter other than an Adverse Benefit Determination, including but not limited to quality of care or services provided and aspects of interpersonal relationships such as rudeness of provider or employee, or failure to respect the Member's rights). Internally, Friday Health Plans follows the Member Compliant Grievance Policy/DTP: CHP+ Grievances and Appeals.	☐ Met ☒ Not Scored
Findings: The CHP+ Grievances and Appeals DTP and the member handbook include the definition of a "grievance," but the definition does not include the additional federal language (written in bold text) of the requirement.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Recommendations: Prior to July 1, 2018, FHP should address the additional federal language used to define "grievance" in the CHP+ Grievances and Appeals DTP and related documents.		
6. The Contractor has provisions for who may file: • A member may file a grievance or 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 or a Contractor-level appeal and may request a State fair hearing on behalf of a member. *42 CFR 438.402(c)* Contract: Exhibit B—14.1.4.5, 14.1.5.1	**Documents:** 1) Member Handbook 2) Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals **Narrative:** The Member Handbook outlines that members or their DCR may file a grievance and/or appeal. Friday Health Plans has a member complaint/grievance policy outlining its objective to meet all federal and state statutes and regulations as well as contractual requirements and internal policies and procedures in processing grievances and appeals for CHP+ members. Internally, Friday Health Plans follows the Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
7. The Contractor accepts grievances orally or in writing. *42 CFR 438.402(c)(3)(i)* Contract: Exhibit B—14.1.5.6	**Documents:** 1) Member Handbook 2) Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals **Narrative:** The Member Handbook, page 28 outlines that a grievance is an oral or written expression of	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	dissatisfaction and the section titled "who to contact to file a grievance" outlines that member or their DCR can call, fill out a grievance in writing or write a letter explaining the grievance. Internally, Friday Health Plans follows the Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals.	
8. Members may file a grievance **at any time.** *42 CFR 438.402(c)(2)(i)* 10 CCR 2505-10—8.209.5.A	**Documents:** 1) Member Handbook 2) Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals **Narrative:** The Member Handbook, page 28 outlines that members can file a grievance with Friday Health Plans at any time. Internally, Friday Health Plans follows the Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals.	☒ Met ☐ Not Scored
Findings: The CHP+ Grievances and Appeals DTP and the member handbook addressed the updated regulation for filing a grievance at any time in advance of the July 1, 2018, effective date for CHP+.		
9. The Contractor sends the member written acknowledgement of each grievance within two (2) working days of receipt. *42 CFR 438.406(b)(1)* Contract: Exhibit B—14.1.5.5	**Documents:** 1) Grievance Acknowledgement Letter 2) Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals **Narrative:** The member handbook outlines to members that they will receive an acknowledgement of each	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	grievance within two (2) working days of receipt. Internally, Friday Health Plans follows the Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals.	
10. The Contractor must resolve each grievance and provide notice as expeditiously as the member's health condition requires, and **within 15 working days of when the member files the grievance.** • **Notice to the member must be in a format and language that may be easily understood by the member.** *42 CFR 438.408(a) and (b)(1) and (d)(1)* Contract: Exhibit B—14.1.5.7, 14.1.5.9	Note: Changed in federal rules only. Same as existing Colorado requirement. **Documents:** 1) Member Handbook 2) Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals **Narrative:** The Member Handbook outlines to members that each grievance will be resolved within 15 working days of when the member files the grievance. Internally, Friday Health Plans follows the Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11. The written notice of grievance resolution includes: • Results of the disposition/resolution process and the date it was completed. Contract: Exhibit B—14.1.5.1.1	**Documents:** 1) Grievance determination letter 2) Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals **Narrative:** The grievance determination letter provides information to the members that includes the results of the disposition/resolution process and the date it was completed. Internally, Friday Health Plans	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	follows the Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals.	
12. 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**, as well as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. *42 CFR 438.406(a)(1)* 10 CCR 2505-10—8.209.4.C	**Documents:** 1) Member Handbook 2) Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals **Narrative:** Friday Health Plans follows the Grievances and Appeals Process that is outlined in the Member Handbook. The Member Handbook, informs members that if they want help with any part of the appeal process, to contact Friday Health Plans. Internally, Friday Health Plans follows the Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals.	☒ Met ☐ Not Scored
Findings: The CHP+ Grievances and Appeals DTP and the member handbook addressed the requirement, including provision of auxiliary aids and services, in advance of the July 1, 2018, effective date for CHP+.		
13. 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:	**Documents:** 1) Member Handbook 2) Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals **Narrative:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– 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)* Contract: Exhibit B—14.1.5.8	Friday Health Plans follows the Grievance and Appeals Section outlined in the Member Handbook. The Member Handbook informs the member that if the decision or action you are appealing is about a denial or change of services, a doctor will review your medical records and other information. This doctor will not be the same doctor who made the first decision. (Page 33) Members are notified that when a grievance is received (Page 29) someone who was not involved in the situation and who has the right experience, will review your grievance. Internally, Friday Health Plans follows the Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals.	
14. 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)* 10 CCR 2505-10—8.209.5.C, 8.209.4.E	**Documents:** 1) Member Handbook 2) Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals **Narrative:** The Member Handbook informs members at page 33 that Friday Health Plans will take into account all comments, documents, records or other information you or your DCR submit without regard to whether such information was submitted or considered in the initial adverse benefit determination. Internally, Friday Health Plans follows the Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals.	☒ Met ☐ Not Scored

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The CHP+ Grievances and Appeals DTP and the member handbook have adequately addressed this requirement in advance of the July 1, 2018, effective date for CHP+.		
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)* 10 CCR 2505-10—8.209.4.B	**Documents:** 1) Member Handbook 2) Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals **Narrative:** The Member Handbook informs members at page 32 that an appeal must be requested within sixty (60) calendar days. Internally, Friday Health Plans follows the Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals. Internally, Friday Health Plans follows the Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals.	☐ Met ☒ Not Scored
Findings: The member handbook correctly states the 60-day time frame for filing an appeal. However, the CHP+ Grievances and Appeals DTP includes no specific time frame for filing an appeal.		
Recommendations: Prior to July 1, 2018, FHP must include the 60-day time frame for filing appeals in the CHP+ Grievances and Appeals DTP.		
16. The member may file an appeal either orally or in writing, and must follow the oral request with a written, signed appeal (unless the request is for expedited resolution). *42 CFR 438.402(c)(3)(ii)* *42 CFR 438.406 (b)(3)* Contract: Exhibit B—14.1.4.6, 14.1.4.16.1	**Documents:** 1) Member Handbook 2) Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals **Narrative:** The Member Handbook informs members that they may call to start an appeal, then to start the appeal	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	they must send a letter after the phone call. (page 32) Internally, Friday Health Plans follows the Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals.	
17. The Contractor sends written acknowledgement of each appeal within two (2) working days of receipt, unless the member or designated client representative requests an expedited resolution. *42 CFR 438.406(b)(1)* Contract: Exhibit B—14.1.4.7	**Documents:** 1) Appeal Acknowledgement Letter 2) Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals **Narrative:** The Member Handbook outlines that the written acknowledgement of each appeal is sent out within two (2) working days of receipt. Internally, Friday Health Plans follows the Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
18. The Contractor's appeal process must provide: • That oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date), and must be confirmed in writing unless the member or provider requests expedited resolution. • That if the member orally requests an expedited appeal, the Contractor shall not require a written, signed appeal following the oral request. • That included, as parties to the appeal, are: − The member and his or her representative, or	**Documents:** 1) Member Handbook (Pages 33-34) 2) Member Compliant Grievance Policy/DTP: CHP+ Grievances and Appeals **Narrative:** The Member Handbook provides information to members regarding the Expedited ("Fast") Appeals, including that parties of an appeal, shall include the member and his or her representative, or the legal representative of a deceased member's estate. Internally, Friday Health Plans follows the Member	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
− The legal representative of a deceased member's estate. *42 CFR 438.406(b)(3) and (6)* Contract: Exhibit B—14.1.4.9.3	Complaint Policy/DTP: CHP+ Grievances and Appeals.	
19. The Contractor's appeal process must provide: • The member a reasonable opportunity, in person and in writing, to present evidence **and testimony** and make legal and factual arguments. (**The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution time frame in the case of expedited resolution.**) • The member and his or her representative the member's case file, including medical records, other documents and records, and **any new or additional documents considered, relied upon, or generated by the Contractor in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame.** *42 CFR 438.406(b)(4-5)* 10 CCR 2505-10—8.209.4.F, 8.209.4.G, 8.209.4.H, 8.209.4.I	**Documents:** 1) Member Handbook (Page 33) 2) Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals **Narrative:** The Member Handbook informs members that they may give us any information or records that you think would help your appeal, including evidence and testimony and make legal and factual arguments and also informs members that members can look at the member's case file, including medical records, other documents and records, and any new or additional documents considered, relied upon, or generated by Friday Health Plans in connection with the appeal and the information will be provided free of charge. Internally, Friday Health Plans follows the Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals.	☒ Met ☐ Not Scored
Findings: The CHP+ Grievances and Appeals DTP and the member handbook have adequately addressed the updated regulations in advance of the July 1, 2018, effective date for CHP+.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
20. 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. *Note: If the written appeal is not signed by the member or designated client representative (DCR), the appeal resolution will remain pending until the appeal is signed. All attempts to gain a signature shall be included in the record of the appeal.* • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)* *42 CFR 438.408(d)(2)* *42 CFR 438.10* Contract: Exhibit B—14.1.4.8, 14.1.3.1	**Documents:** 1) Member Handbook 2) Appeal Determination Letter 3) Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals **Narrative:** The Member Handbook provides to the member that for standard service authorization decisions that deny or limit services, the notice of action letter should be sent within ten (10) calendar days. Internally, Friday Health Plans follows the Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
21. 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)*	**Documents:** 1) Member Handbook, page 34 2) Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals **Narrative:** The Member Handbook which is the Evidence of Coverage that outlines the benefits to members,	☒ Met ☐ Not Scored

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10 CCR 2505-10—8.209.4.J.2, 8.209.4.L	outlines that the plan will make a decision within seventy-two (72) hours and that the plan will provide oral and written notice of the expedited appeal resolution. Internally, Friday Health Plans follows the Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals.	
Findings: The CHP+ Grievances and Appeals DTP and the member handbook address the updated regulation (72-hour time frame) in advance of the July 1, 2018, effective date for CHP+.		
22. 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)* Contract: Exhibit B—14.1.5.10	**Documents:** 1) Member Handbook, page 34 2) Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals **Narrative:** The Member Handbook, which is the Evidence of Coverage that outlines the benefits to members, outlines that the plan can extend the timeframe by up to fourteen (14) calendar days if the delay is requested by the member or if the MCO shows that there is a need for additional information and that the delay is in the Member's best interest. Internally, Friday Health Plans follows the Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
23. If the Contractor extends the time frames, it must—for any extension not requested by the member: • Make reasonable efforts to give the member prompt oral notice of the delay. • **Within two (2) calendar days**, give the member written notice of the reason for the delay **and inform the member of the right to file a grievance if he or she disagrees with that decision.** • Resolve the appeal as expeditiously as the enrollees health condition requires and no later than the date that the extension expires. *42 CFR 438.408(c)(2)*	**Documents:** 1) Member Handbook, page 34 2) Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals **Narrative:** The Member Handbook, which is the Evidence of Coverage that outlines the benefits to members, outlines that the plan can extend the timeframe if the delay is requested by the member, if the MCO shows that there is need for additional information and that the delay is in the member's best interest. The MCO shall make reasonable efforts to give the member prompt oral notice of the delay and within two (2) calendar days, give the member written notice of the reason for the delay and inform the member of the right to file a grievance if he or she disagrees with that decision. Internally, Friday Health Plans follows the Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals.	☐ Met ☒ Not Scored
Findings: The CHP+ Grievances and Appeals DTP does not specify that the timeline for making a decision when the health plan extends the time frames is "no later than the date the extension expires." In addition, while the DTP correctly outlines the terms of providing verbal and written notice of an extension in relation to expedited appeals, it fails to completely describe these procedures in the standard appeals section of the DTP.		
Recommendations: Prior to July 1, 2018, FHP should thoroughly address all required procedures related to extending the time frame of either an expedited or standard appeal in its CHP+ Grievances and Appeals DTP, as well as any related documents.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
24. The written notice of appeal resolution must include: • The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: − The right to request a State fair hearing, and how to do so. − The right to request that benefits/services continue* while the hearing is pending, and how to make the request. o That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's adverse benefit determination. **Continuation of benefits applies only to previously authorized services for which the Contractor provides 10-day advance notice to terminate, suspend, or reduce.* *42 CFR 438.408(e)* Contract: Exhibit B—14.1.4.10	**Documents:** 1) Appeal Determination Letter 2) Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals **Narrative:** Friday Health Plans will send an appeal determination letter. The appeal determination letter provides the decision of Friday Health Plans regarding the appeal. Internally, Friday Health Plans follows the Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
25. **The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of resolution.** • If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is	**Documents:** 1) Member Handbook, Page 34 2) Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals **Narrative:** The Member Handbook, which is the Evidence of Coverage that outlines the benefits to members,	☐ Met ☒ Not Scored

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
deemed to have exhausted the appeal process and may request a State fair hearing. *42 CFR 438.408(f)(1–2)* 10 CCR 2505-10—8.209.4.N, 8.209.4.O	outlines that members have a right to request a State Fair Hearing. The member shall request a State Fair Hearing within one hundred and twenty (12) calendar days from the date of the MCO's notice of Appeal determination and if Friday Health Plans fails to adhere to the notice and timing requirements regarding resolution and notification of an Appeal, the member is deemed to have exhausted the Appeals process and may request a State Fair Hearing. Internally, Friday Health Plans follows the Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals.	
Findings: The CHP+ Grievances and Appeals DTP and the member handbook include two paragraphs to describe the time frame for requesting a State fair hearing (SFH), which specify information pertaining to both the new SFH rules (120 days after MCO appeal resolution) and the current rule (60 days from the notice of action). The conflicting information in these two paragraphs must be clarified. During on-site interviews, staff members stated that FHP is applying the 120-day time frame, and that the conflicting information in these documents was an oversight.		
Recommendations: Prior to July 1, 2018, FHP must correct the conflicting information in the CHP+ Grievances and Appeals DTP, as well as the member handbook, to clarify the time frame for requesting a SFH. HSAG recommends that this clarification be implemented as soon as possible.		
26. The parties to the State fair hearing include the Contractor as well as the member and his or her representative or the representative of a deceased member's estate. *42 CFR 438.408(f)(3)* Contract: Exhibit B—14.1.4.17.5	**Documents:** 1) Member Handbook, page 35 2) Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals **Narrative:** The Member Handbook, which is the Evidence of Coverage that outlines the benefits to members, outlines that the parties to the State Fair Hearing	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	will include Friday Health Plans as well as the member and or his or her representative or the representative of a deceased member's estate. Internally, Friday Health Plans follows the Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals.	
27. 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)* Contract: Exhibit B—14.1.4.16, 14.1.4.16.4	**Documents:** 1) Member Handbook, pages 33 and 34 2) Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals **Narrative:** The Member Handbook, which is the Evidence of Coverage that outlines the benefits to members, outlines that there is an Expedited ("Fast") Appeals process and that informs members that if they feel that waiting for a regular appeal would threaten their life or health they can request an expedited appeal (page 33) this process includes that Friday Health Plans will not take punitive action against a provider who requests an expedited resolution or supports a Member's appeal (page 34). Internally, Friday Health Plans follows the Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

<table>
<tr><th colspan="3">Standard VI—Grievance System</th></tr>
<tr><th>Requirement</th><th>Evidence as Submitted by the Health Plan</th><th>Score</th></tr>
<tr><td>28. If the Contractor denies a request for expedited resolution of an appeal, it must:
• Transfer the appeal to the time frame for standard resolution.
• Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and within two (2) calendar days provide the member written notice of the reason for the decision and inform the member of the right to file a grievance if he or she disagrees with that decision.
42 CFR 438.410(c)
Contract: Exhibit B—15.1.4.16.5</td><td>Note: Changed in federal rules only. Same as existing Colorado requirement.
Documents:
1) Member Handbook, page 34
2) Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals
Narrative:
The Member Handbook, which is the Evidence of Coverage that outlines the benefits to members, outlines that if your request for a fast appeal is denied, Friday Health Plans will call you as soon as possible to let you know and will send a letter within two (2) working days. Then we will review your appeal the regular way. Internally, Friday Health Plans follows the Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals.</td><td>☐ Met
☒ Partially Met
☐ Not Met
☐ N/A</td></tr>
<tr><td colspan="3">Findings:
CHP+ Grievances and Appeals DTP, as well as the member handbook, stated that “If the member’s request for a fast appeal is denied, Friday Health Plans of Colorado CHP+ will call the member or their DCR as soon as possible to let them know. Friday Health Plans of Colorado will also send the member a letter within two (2) working days. Then we will review the appeal the regular way.” HSAG noted that the requirement is two calendar days. In addition, neither the DTP nor the member handbook stated that the FHP would inform the member of the right to file a grievance if he or she disagrees with the denial of an expedited request. FHP did not submit an example of a letter to the member denying an expedited appeal request; therefore, HSAG could not confirm the content of the letter.</td></tr>
<tr><td colspan="3">Required Actions:
FHP must correct the CHP+ Grievances and Appeals DTP, as well as the member handbook, to specify that FHP will inform the member in writing within two calendar days of the reason for denying an expedited appeal request and will inform the member of the right to file a grievance if he or she disagrees with that decision. FHP must ensure that the notice to the member informs the member of the right to file a grievance, according to the requirement.</td></tr>
</table>

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**

29. The Contractor provides for continuation of benefits/services while the Contractor-level appeal and the State fair hearing are pending if:
• The member files timely* for continuation of benefits—defined as on or before the later of the following:
  − Within 10 days of the Contractor mailing the notice of adverse benefit determination.
  − The intended effective date of the proposed adverse benefit determination.
• The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
• The services were ordered by an authorized provider.
• The original period covered by the original authorization has not expired.
• The member requests an appeal in accordance with required timeframes.
 	
** This definition of "timely filing" only applies for this scenario–i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced. Note: The provider may not request continuation of benefits on behalf of the member.)*
 	
42 CFR 438.420(a) and (b)
 	
Contract: Exhibit B—14.1.4.11
	Documents:
	1) Member Handbook
	2) Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals
	
	Narrative:
	The Member Handbook, which is the Evidence of Coverage that outlines the benefits to members, at page 35 outlines that continuation of benefits/services will be continued if:
	The enrollee or the provider files the appeal timely; The appeal involved the termination, suspension, or reduction of a previously authorized course of treatment;
	The services were ordered by an authorized provider;
	The original period covered by the original authorization has not expired; and the enrollee requests extension of benefits. Internally, Friday Health Plans follows the Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals.
		☐ Met
		☒ Partially Met
		☐ Not Met
		☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The CHP+ Grievances and Appeals DTP includes procedures related to continued benefits during an appeal, as well as continued benefits during a SFH. In the appeals section, the DTP addressed all criteria related to continuation of benefits *except* the requirement for requesting continued benefits within a 10-day time frame from notice of adverse benefit determination or intended effective date of termination for requesting continued benefits. The SFH section of the DTP addressed that members must request continued benefits within 10 calendar days "from the mailing date of the decision" but did not clarify whether this was the adverse benefit decision or appeal decision. (Because new federal and State regulations require that the request for a SFH must follow appeal resolution by the health plan, the member must request continuation of benefits within 10 days of adverse resolution of appeal.)		
Required Actions: The CHP+ Grievances and Appeals DTP must specify that the member may request continued benefits during an appeal within 10 days of the notice of adverse benefit determination. The DTP should also clearly specify that members must request continued benefits during a SFH within 10 days of adverse appeal resolution. FHP should also ensure that member communications include clear, accurate information concerning the requirements for requesting continued benefits during an appeal or SFH.		
30. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of the following occurs: • The member withdraws the appeal or request for a State fair hearing. • The member fails to request a State fair hearing and continuation of benefits within 10 calendar days after the Contractor sends the notice of an adverse resolution to the member's appeal. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR 438.420(c)* Contract: Exhibit B—14.1.4.12	**Documents:** 1) Member Handbook 2) Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals **Narrative:** The Member Handbook, which is the Evidence of Coverage that outlines the benefits to members, at page 35 outlines that if benefits are continued or reinstated while an appeal is pending, the benefits must be continued until one of the following occurs: The enrollee withdraws the appeal; ten days pass after the MCO mails the notice, providing the resolution of the appeal against the enrollee; and A state fair hearing Office issues a hearing decision adverse to the enrollee or the time period or service limits of a previously authorized service has been	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	met. Internally, Friday Health Plans follows the Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals.	
Findings: The CHP+ Grievances and Appeals DTP includes procedures related to continued benefits during an appeal, as well as continued benefits during a SFH. Both the appeals and SFH sections of the DTP, as well as the member handbook, addressed the criteria for how long benefits will continue according to the requirement, yet added a fourth criterion—*the time period or service limits of a previously authorized service ends.* According to regulation, this criterion is not applicable to how long member-requested benefits will continue while the appeal or SFH is pending. In addition, the SFH section of the DTP states that the criteria include "… ten days pass after the MCO mails the notice providing the resolution of the appeal against the enrollee," which is an incomplete description of this criterion. The language should be modified to include "unless the member requests a State Fair Hearing and continuation of benefits." HSAG also noted that the SFH section uses the terminology "appeal" rather than "SFH" in the description of the criteria applied to how long benefits will continue, and recommends that FHP consider replacing the word "appeal" with "SFH" to avoid confusing staff and/or members.		
Required Actions: FHP must remove the criterion "the time period or service limits of a previously authorized service ends" from the CHP+ Grievances and Appeals DTP and related documents as a qualification for how long benefits will continue while an appeal or SFH is pending. FHP must clarify in the SFH section of the DTP that the criterion "… ten days pass after the MCO mails the notice providing the resolution of the appeal against the enrollee" includes "unless the member requests a State Fair Hearing and continuation of benefits" (or similar language).		
31. Member responsibility for continued services: • If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's adverse benefit determination, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. *42 CFR 438.420(d)*	**Documents:** 1) Member Handbook (page 34) 2) Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals **Narrative:** The Member Handbook informs members that the member may be held liable for the cost of those benefits if the hearing decision upholds the MCO's	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract: Exhibit B—14.1.4.13	actions. Internally, Friday Health Plans follows the Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals.	
32. 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 MCO must authorize or 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. *42 CFR 438.424(a)* 10 CCR 2505-10—8.209.W	**Documents:** 1) Member Handbook 2) Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals **Narrative:** The Member Handbook provides to members that if the MCO or State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. Internally, Friday Health Plans follows the Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals.	☒ Met ☐ Not Scored
Findings: The CHP+ Grievances and Appeals DTP and the member handbook addressed the updated regulation (72-hour time frame) in advance of the July 1, 2018, effective date for CHP+.		
Recommendations: FHP has addressed this requirement within the SFH section of the DTP and the member handbook, and may want to consider adding it to the appeals section of each.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
33. If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCO or the State must pay for those services, in accordance with State policy and regulations. *42 CFR 438.424(b)* Contract: Exhibit B—14.1.4.15	**Documents:** 1) Member Handbook, page 36 2) Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals **Narrative:** The Member Handbook provides to members that if the MCO or State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO or the State must pay for those services, in accordance with State policy and regulations. Internally, Friday Health Plans follows the Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
34. 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.**	**Documents:** 1) Tracking log **Narrative:** Friday Health Plans maintains a Tracking Log that includes an action and reason code, the date it was received, the date closed (review date), the Final Disposition and subscriber id/name/call#. All grievances and appeals are also captured in or Xpress data system.	☒ Met ☐ Not Scored

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• **Name of the person for whom the appeal or grievance was filed.** *42 CFR 438.416* 10 CCR 2505-10—8.209.3.C		
35. 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. • The fact that, when requested by the member: − Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. − The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member.	**Documents:** 1) Provider Manual (Page 9) **Narrative:** Providers, upon contracting with Friday Health Plans will receive a Provider handbook. This provider handbook outlines the grievance and appeals process that are specific to the CHP+ line of business. Attachment D of the Provider handbook outlines the information necessary for providers to understand regarding the member's appeals and grievances and state fair hearing system.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.414 *42 CFR 438.10(g)(xi)* Contract: Exhibit B—11.1.12		
Findings: The provider manual description of CHP+ grievances and appeals was a copy of the entire CHP+ Grievances and Appeals DTP. As such, all DTP noncompliance issues noted in the above requirements apply to the provider manual, including lack of a time frame for filing appeals, two different time frames for filing a SFH, and any issues noted in continuation of benefits information. All other provider manual information was compliant with elements of this requirement. HSAG also noted that, like the DTP, some sections were written in language directed toward the member, not the provider. HSAG recommends that language be modified to address the provider rather than the member.		
Required Actions: Once necessary corrections are made to the CHP+ Grievances and Appeals DTP, FHP must address similar changes in the provider manual and ensure that providers are notified of applicable changes to the manual.		

Note: While scoring of evidence related to individual, new federal requirements in the tool may indicate *Met* or *Not Scored*, all new requirements were scored *Not Applicable* in the total results; new federal requirements do not apply to CHP+ until July 1, 2018.

Results for Standard VI—Grievance System							
Total	Met	=	18	X	1.00	=	18
	Partially Met	=	4	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	13	X	NA	=	NA
Total Applicable		=	22	**Total Score**		=	18
				Total Score ÷ Total Applicable		=	82%

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements written policies and procedures for selection and retention of providers. *42 CFR 438.214(a)* Contract: Exhibit B—14.2.1.1	**Documents:** 1) Credentialing Plan **Narrative:** Friday Health Plans follows the policies and procedures outlined in the Credentialing Plan for selection and retention of providers.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: FHP supplied HSAG with its Network Management Program Description following the on-site review. This document contained information on FHP's provider selection criteria; however, it did not include information on provider retention.		
Required Actions: FHP must implement written policies and procedures that address provider retention.		
2. The Contractor follows a documented process for credentialing and recredentialing that complies with the State's policies for credentialing. *State policies require compliance with National Committee for Quality Assurance (NCQA) standards.* *42 CFR 438.214(b)* Contract: Exhibit B—14.2.1.3	Note: New regulations require that State credentialing and recredentialing policies address **acute, primary, behavioral, substance use disorders, and LTSS providers, as appropriate**. **Documents:** 1) Credentialing Plan **Narrative:** Friday Health Plans follows the policies and procedures outlined in the Credentialing Plan for selection and retention of providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's provider selection policies and procedures include provisions that the Contractor does not: • Discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. • Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42 CFR 438.12(a)(1) and (2)* *42 CFR 438.214(c)* Contract: Exhibit B—14.4.1 and 14.2.1.6	**Documents:** 1) Credentialing Plan, page 2 2) Non-Discrimination Statement **Narrative:** The Credentialing Plan outlines that Friday Health Plans does not discriminate against any provider seeking qualification as a participating provider. Every member of the Physician Advisory Committee executes a Non-Discrimination Statement attesting that credentialing decisions will not be based on an applicant's race, ethnicity, national origin, religion, gender, age, or sexual orientation; or by the type of procedure or patient in which the practitioner specializes.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This is not construed to: • Require the Contractor to contract with providers beyond the number necessary to meet the needs of its members. • Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. • Preclude the Contractor from establishing measures that are designed to maintain quality of services and control	**Documents:** 1) Credentialing Plan **Narrative:** The credentialing plan, page 8, outlines that providers shall be notified whether they were approved or denied/terminated by the PAC within 10 business days of the meeting, or by the deadlines set forth in the appeals processes.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
costs and are consistent with its responsibilities to members. *42 CFR 438.12(a–b)* Contract: Exhibit B—14.4.1 and 14.4.1.1–3		
5. The Contractor has a signed contract or participation agreement with each provider. *42 CFR 438.206(b)(1)* Contract: Exhibit B—10.1	**Documents:** 1) Professional Services Agreement **Narrative:** Upon credentialing, the Contractor and provider execute a Professional Services Agreement.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
6. The Contractor does not employ or contract with providers or other individuals or entities excluded for participation in federal healthcare programs under either Section 1128 or 1128 A of the Social Security Act. *42 CFR 438.214(d)* *42 CFR 438.610* Contract: Exhibit B—19.1.1.1	**Documents:** 1) Credentialing Plan, page 4 **Narrative:** Friday Health Plans follows the credentialing plan in making provider participation decisions. The Credentialing Plan outlines that information pertaining to OIG, and GSA's Excluded Parties Listing System websites shall be queried to ensure providers have not been Medicare/Medicaid sanctioned or excluded from receiving Federal funds for any reason. These same queries are conducted for employees as well.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549. *42 CFR 438.610* Contract: Exhibit B—19.1.1 and 19.1.2	**Documents:** 1) Compliance Plan **Narrative:** Friday Health Plans, Human Resources department, pursuant to its Compliance Plan, makes reasonable inquiry into the status of each prospective employee and/or applicable contractor, which may include a review of the General Services Administration's List of Parties Excluded from Federal Programs, the HHS/OIG List of Excluded Individuals and Entities (LEIE), relevant state exclusion databases or other such information data bases. This is done prior to conducting any business or contracting with these persons. Human Resources representative, with the cooperation of the Compliance Officer may on an ongoing basis audit current employee and contractor lists against these lists. Any employee or contractor found to be included on either of these lists will be immediately removed from his/her position at Friday Health Plan or have his/her contract terminated.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: • The member's health status, medical care, or treatment options—including any alternative treatments that may be self-administered.	**Documents:** 1) Professional Services Agreement 2) Provider Manual **Narrative:** Upon credentialing, the contractor and provider execute a Professional Services Agreement. The	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Any information the member needs in order to decide among all relevant treatment options. • The risks, benefits, and consequences of treatment or non-treatment. • The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. *42 CFR 438.102(a)(1)* Contract: Exhibit B—10.4.3	Professional Services Agreement, Section 2.5, states that nothing in this agreement should be construed as encouraging PROVIDER to restrict Health Care Services or to limit clinical dialogue between PROVIDER and Members. PROVIDER may freely communicate with Members regarding the treatment options available to them, including medication treatment options, regardless of benefit coverage limitations. Upon execution of the Professional Services Agreement providers are given a Provider Manual. This provider manual, outlines to providers the specific member's rights and responsibilities, Attachment C, includes the CHP+ Member Rights and Responsibilities in which providers are notified that members have the right to make decisions about your health care, including the decision to stop treatment or services, or stop participating in a health management program.	
9. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: • To the State upon contracting or when adopting the policy during the term of the contract. • To members before and during enrollment. • To members within 90 days after adopting the policy with respect to any particular service. *42 CFR 438.102(b)* Contract: Exhibit B—14.1.3.14 and Exhibit K—1.1.7	**Not Applicable** Friday Health Plans provides all covered services and none are excluded due to moral, religious, or other reasons.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor has administrative and management arrangements or procedures, including a compliance program to detect and prevent fraud, waste, and abuse, and which includes: • Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal, State, and contract requirements. • The designation of a compliance officer who is responsible for developing and implementing policies, procedures and practices to ensure compliance with requirements of the contract and who reports directly to the CEO and Board of Directors. • The establishment of a compliance committee of the Board of Directors and at the senior management level charged with overseeing the organization's compliance program. • Training and education of the compliance officer, management, and organization's staff members for the federal and State standards and requirements under the contract. • Effective lines of communication between the compliance officer and the Contractor's employees. • Enforcement of standards through well-publicized disciplinary guidelines. • Implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks.	**Documents:** 1) Compliance Plan **Narrative:** Friday Health Plans has a compliance plan that outlines its commitment to comply with pertinent federal, state and managed care organization standards, outlines the designation of a compliance officer and their role as well as reporting directly to the CEO and indirectly to the board of directors. The Compliance Plan outlines the composition and duties of the compliance committee, training and education, effective lines of communication, enforcement of standards through well-publicized disciplinary guidelines, monitoring and auditing, and prompt responses to compliance issues.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Procedures for prompt response to compliance issues as they are raised, investigation of potential compliance problems identified in the course of self-evaluation and audits, correction of such problems quickly and thoroughly to reduce the potential for reoccurrence, and ongoing compliance with the requirements under the contract. *42 CFR 438.608(a)(1)* Contract: Exhibit B—14.2.5.2–4, 14.2.7.3—14.2.7.9		
11. The Contractor's administrative and management procedures to detect and prevent fraud, waste, and abuse include: • Written policies for all employees, contractors or agents that provide detailed information about the False Claims Act, including the right of employees to be protected as whistleblowers. • Provisions for prompt referral of any potential fraud, waste, or abuse to the State Medicaid program integrity unit and any potential fraud to the State Medicaid Fraud Control Unit. • Provisions for suspension of payments to a network provider for which the State determines there is credible allegation of fraud (in accordance with 455.12). *42 CFR 438.608(a)(6–8)* Contract: Exhibit B—14.2.6.1, 14.2.7.1, 14.2.7.7	**Documents:** 1) Compliance Plan **Narrative:** Friday Health Plans has a compliance plan that provides detailed information about the False Claims Act, reporting of potential fraud, waste, or abuse.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor's compliance program includes: • Provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying which overpayments are due to potential fraud. • Provision for prompt notification to the State about member circumstances that may affect the member's eligibility, including change in residence or member death. • Provision for notification to the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including termination of the provider agreement with the Contractor. • Provision for a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. *42 CFR 438.608(a)(2–5)* Contract: Exhibit B—14.2.5.4.3–7	**Documents:** 1) Compliance Plan **Narrative:** Friday Health Plans has a compliance plan that provides information regarding how the plan uses a number of avenues to educate employees, network providers, members and subcontractors as to the effects of fraud and appropriate contact persons to report suspected fraud or program waste and abuse.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. **The Contractor ensures that all network providers are enrolled with the State as CHP+ providers consistent with the provider disclosure, screening, and enrollment requirements of the State.** *42 CFR 438.608(b)*	**Documents:** 1) ATN Report template from State **Narrative:** Friday Health Plans is currently working on a method of comparing the ATN report from the State to its network providers for outreach.	☒ Met ☐ Not Scored

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor has procedures to provide to the State: • Written disclosure of any prohibited affiliation (as defined in 438.610). • Written disclosure of ownership and control (as defined in 455.104). • Identification within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract. *42 CFR 438.608(c)* Contract: 21.B, Exhibit B—19.4.1, 19.1.1.1	**Documents:** 1) Ownership/Controlling Interest and Conviction Disclosure **Narrative:** A formal letter would be sent to HCPF providing any written disclosure of any prohibited affiliations, a form for written disclosure of ownership and control and the identification of any overpayments in excess of the amounts specified in the contract.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
15. The Contractor has mechanisms for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days of identifying the overpayment, and to notify the Contractor in writing of the reason for the overpayment. • The Contractor reports annually to the State on recoveries of overpayments. *42 CFR 438.608(d)(2) and (3)*	**Documents:** 1) Professional Services Agreement (section 5.5) **Narrative:** The Professional Services Agreement outlines that PLAN shall have the right to request a refund for any and all amounts owed by PROVIDER to PLAN against amounts owed by PLAN to PROVIDER.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The Contractor provides that CHP+ members are not held liable for: • The Contractor's debts in the event of the Contractor's insolvency. • Covered services provided to the member for which the State does not pay the Contractor. • Covered services provided to the member for which the State or the Contractor does not pay the health care provider that furnishes the services under a contractual, referral, or other arrangement. • Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. *42 CFR 438.106* Contract: Exhibit B—16.4.1–4	**Documents:** 1) Professional Services Agreement **Narrative:** Members are protected in the event of insolvency via coverage obtained through its reinsurance contract. Participating providers, in their professional services agreement agree members are not held liable for contractor's debts in the event of insolvency, (See section 3.13), covered services for which State or Contractor does not pay.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Note: While scoring of evidence related to individual, new federal requirements in the tool may indicate *Met* or *Not Scored*, all new requirements were scored *Not Applicable* in the total results; new federal requirements do not apply to CHP+ until July 1, 2018.

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

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. **Notwithstanding any relationship(s) with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State.** *42 CFR 438.230(b)(1)* Contract: Exhibit B—5.5.3.3	**Documents:** 1) Delegation Oversight Policy, page 2 **Narrative:** Friday Health Plans follows the Delegation Oversight Policy, No. 3702 in functions relating to delegation. Friday Health Plans retains ultimate responsibility and authority for providing oversight of the contracted delegate to assure delegated functions are delivered according to accreditation and other regulatory requirements.	☐ Met ☒ Not Scored

Findings:
The Delegation Oversight Policy (effective 2014; reviewed March 2017) stated that Colorado Choice (Friday Health Plans [FHP]) retains *ultimate responsibility and authority for providing oversight of the contracted delegate* to assure delegated functions are delivered according to accreditation and other regulatory requirements. The policy stated that delegated activities are monitored according to URAC[A-1] delegation standard requirements, and that the Quality Assurance Committee provides ongoing oversight of delegated activities, with reporting to the Colorado Choice (FHP) Board of Directors. FHP submitted the delegation agreement with Vision Service Plan (VSP) as the example of the template agreement used with all delegates. Neither the policy nor the VSP agreement (with delegation addendum) contained a statement that acknowledges FHP's ultimate accountability for complying with the terms and conditions of the contract with the State. Furthermore, HSAG found that the VSP agreement generally referenced responsibilities for *covered persons* but did not specify that the agreement applies to CHP+ beneficiaries. In addition, specific responsibilities and reporting requirements included information—e.g., timelines for authorizations and appeals—that were noncompliant with CHP+ contract requirements. According to 42 CFR 438.230(b)(1), FHP would therefore remain responsible for performing any activities to ensure compliance with the State contract.

Recommendations:
Prior to July 1, 2018, FHP should update its policies and existing delegation agreements applicable to CHP+ to state that FHP is ultimately accountable for complying with the terms of the contract with the State (not just oversight of delegated functions). FHP should review the VSP and other existing delegation agreements to ensure that specific delegated responsibilities are compliant with its CHP+ contract with the State *or* that the agreement outlines FHP's continued responsibilities to do so.

[A-1] Originally, URAC was incorporated under the name "Utilization Review Accreditation Commission." However, that name was shortened to just the acronym "URAC" in 1996 when URAC began accrediting other types of organizations such as health plans and preferred provider organizations.

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. All contracts or written arrangements between the Contractor and any subcontractor specify: • The delegated activities **or obligations** and related reporting responsibilities. • **That the subcontractor agrees to perform the delegated activities and reporting responsibilities** • Provision for revocation of the delegation of activities or obligation, or **specify other remedies in instances where the State or Contractor determines** that the subcontractor has not performed satisfactorily. *42 CFR 438.230(b)(2) and (c)(1)*	Note: Subcontractor requirements do not apply to network provider agreements. **Documents:** 1) Strategic Alliance and Administration Agreement, VSP 2) Delegation Addendum **Narrative:** Friday Health Plans has agreements in place with subcontractors outlining the delegated activities or obligations and related reporting responsibilities. The agreements contain language about contractor complying with all company requirements set forth in the Agreement including reporting responsibilities. Page 2 of the Agreement and the Delegation Addendum provide for the provision of revocation for unsatisfactory performance.	☐ Met ☒ Not Scored
Findings: The Delegation Oversight policy describes the content of written delegation agreements, to include a description of the activities and responsibilities to be delegated, requirements for the contracted delegate to submit periodic performance reports to Colorado Choice (FHP), and recourse and sanctions if the contracted delegate does not make corrections to identified issues. The sample VSP delegation agreement and delegation addendum outlined provisions for revocation or corrective action; the right to audit by FHP, state, or federal authorities; responsibilities for quarterly reporting of statistics related to contracted activities; and mutual agreement by the parties to the terms outlined in the agreement. However, HSAG noted that the VSP agreement and addendum failed to outline detailed FHP audit processes, and that reporting responsibilities were of insufficient detail to monitor the performance of the subcontractor responsibilities.		
Recommendations: Prior to July 1, 2018, FHP should review its agreement with VSP and other CHP+ delegated entities to ensure that detailed reporting responsibilities are of sufficient detail and scope to enable FHP to monitor and determine the delegate's compliance with the delegated responsibilities. In addition, HSAG recommends strengthening the language and detail of described performance audits to be conducted by FHP.		

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's written agreement with any subcontractor includes: • **The subcontractor's agreement to comply with all applicable Medicaid laws and regulations, including applicable sub-regulatory guidance and contract provisions.** *42 CFR 438.230(c)(2)*	**Documents:** 1) Strategic Alliance and Administration Agreement, VSP 2) Delegation Addendum **Narrative:** 1) The Agreement (page 12) and Delegation Addendum (page 1) both contain language regarding compliance with all federal, state and local laws, ordinances and regulations, including those pertaining to the acquisition of any permit, certificate or authorization, in connection with the performance of their duties under this Agreement.	☐ Met ☒ Not Scored
Findings: The VSP agreement and delegation addendum broadly states that "The parties shall … comply with all federal, state and local laws, ordinances and regulations…." HSAG finds that this language is too generalized to qualify as the delegate's agreement to comply with *Medicaid laws and regulations and contract provisions.*		
Recommendations: Prior to July 1, 2018, FHP should consider strengthening language in agreements applicable to the CHP+ line of business (LOB) to state "all applicable Medicaid laws and regulations and contract provisions."		

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The written agreement with the subcontractor includes: • **The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State.** – **The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, and computer or other electronic systems related to CHP+ members.** – **The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.** – **If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.** *42 CFR 438.230(c)(3)*	**Documents:** 1) Delegation Addendum **Narrative:** The Delegation Addendum on page 1 outlines that the Contractor will allow COMPANY, and any state or federal government or regulatory agency, or their designees, to conduct on-site reviews and audits of Contractor's performance of the Delegated Responsibilities in accordance with the audit provisions of the agreement and this Addendum.	☐ Met ☒ Not Scored
Findings: The delegation addendum contains the statement noted under "Narrative" above. However, the statement references "in accordance with the *audit provisions of the agreement and this Addendum*." HSAG noted that neither the VSP agreement nor delegation addendum outlined detailed audit provisions and did not specifically address the right of CMS or the HHS Inspector General to audit, the right to audit for 10 years after the contract end date, the types of documents or records to be made available, or other specifics outlined in the language of 42 CFR 438.230(c)(3).		

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Recommendations: Prior to July 1, 2018, FHP should update agreements applicable to the CHP+ LOB to include the specific elements of this requirement. HSAG recommends that FHP incorporate the detailed language outlined in the federal regulation.		

Note: While scoring of evidence related to individual, new federal requirements in the tool may indicate *Met* or *Not Scored*, all new requirements were scored *Not Applicable* in the total results; new federal requirements do not apply to CHP+ until July 1, 2018.

Results for Standard IX—Subcontracts and Delegation							
Total	Met	=	0	X	1.00	=	0
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	4	X	NA	=	NA
Total Applicable		=	0	**Total Score**		=	NA
				Total Score ÷ Total Applicable		=	NA

Appendix B. Record Review Tools

The completed record review tools follow this cover page.

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Appeals Record Review Tool
for Friday Health Plans of Colorado

Review Period:	July 1, 2017–December 31, 2017
Date of Review:	December 14, 2017
Reviewer:	Kathy Bartilotta
Participating Health Plan Staff Member:	Amanda Martinez

1	2	3	4	5	6	7	8	9	10	11	12
File #	**Member ID #**	**Date Appeal Received**	**Acknowledgment Sent Within 2 Working Days**	**Decision Maker Not Previous Level**	**Decision Maker Has Clinical Expertise**	**Expedited**	**Time Frame Extended**	**Date Resolution Letter Sent**	**Notice Sent Within Time Frame**	**Resolution Letter Includes Required Content**	**Resolution Letter Easy to Understand**
1	******	7/7/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	7/12/17	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: Column 6 was scored *Met* as no medical decision was required. There was an administrative override of an explanation of benefits (EOB) denial for a "typical" approved situation.											
2			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
3			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
4			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
5			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
6			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
7			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
8			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
9			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
10			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
OS1			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS2			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS3			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS4			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS5			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
Do not score shaded columns below.											
Column Subtotal of Applicable Elements			**1**	**1**	**1**				**1**	**1**	**1**
Column Subtotal of Compliant (M) Elements			**1**	**1**	**1**				**1**	**1**	**1**
Percent Compliant (Divide Compliant by Applicable)			**100%**	**100%**	**100%**				**100%**	**100%**	**100%**

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

Total Applicable Elements	**6**
Total Compliant (M) Elements	**6**
Total Percent Compliant	**100%**

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Grievance Record Review Tool
for Friday Health Plans of Colorado

Review Period:	July 1, 2017–December 31, 2017
Date of Review:	December 14, 2017
Reviewer:	Kathy Bartilotta
Participating Health Plan Staff Member:	Amanda Martinez

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame	Decision Maker Not Previous Level (If Clinical)	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
1	******	8/31/17	Y ☐ N ☐ N/A ☒	8/31/17	1	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments: The grievance was processed as expedited; services were previously approved through Colorado Access/SMCN. The member switched to FHP. The provider was able to identify the correct plan; however, the timely filing time frame had already expired. The provider claim was denied for administrative reasons; the member contacted FHP with concerns, and FHP reprocessed the claim.										
2			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
3			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
4			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
5			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
6			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
7			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
8			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
9			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
10			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame	Decision Maker Not Previous Level (If Clinical)	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
OS 1			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 2			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 3			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 4			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 5			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
Do not score shaded columns below.										
Column Subtotal of Applicable Elements			**0**			**1**	**0**	**0**	**1**	**1**
Column Subtotal of Compliant (Yes) Elements			**0**			**1**	**0**	**0**	**1**	**1**
Percent Compliant (Divide Compliant by Applicable)			**NA**			**100%**	**NA**	**NA**	**100%**	**100%**

Key: Y = Yes; N = No
N/A = Not Applicable

Total Applicable Elements	**3**
Total Compliant (Yes) Elements	**3**
Total Percent Compliant	**100%**

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2017–2018 site review of **FHP**.

Table C-1—HSAG Reviewers, and FHP and Department Participants

HSAG Review Team	Title
Kathy Bartilotta	Associate Director
Gina Stepuncik	Project Manager
FHP Participants	**Title**
Amanda Martinez	Grievance and Appeal Coordinator
Ashley Booth	CHP Specialist
Cynthia Palmer	CEO
DeeAnn Sierra	Director of Medical Management
Janet Hornig	Director of Operations
Jennifer Mueller	Vice President of Operations
Krystle Albert	Project Manager
Manuela Heredia	Manager of Government Programs
Martin S. Merlotto	Compliance and Privacy Officer
Department Observers	**Title**
Teresa Craig	Contract Manager

Appendix D. Corrective Action Plan Template for FY 2017–2018

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

Table D-1—Corrective Action Plan Process

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

Step	Action
Step 5	**Technical Assistance**
	HSAG will schedule with the health plan a one-time, interactive, verbal consultation and technical assistance session during the six-month time frame. The session may be scheduled at the health plan's discretion at any time the health plan determines would be most beneficial. HSAG will not document results of the verbal consultation in the CAP document.
Step 6	**Review and completion**
	Following a review of the CAP and all supporting documentation, the Department or HSAG will inform the health plan as to whether or not the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements. Any documentation that is considered unsatisfactory to complete the CAP requirements at the six-month deadline will result in assignment as a delinquent corrective action that will be continued into the following compliance review year. (HSAG will list delinquent actions in the annual technical report and the health plan's subsequent year's compliance site review report.)

The CAP template follows.

Table D-2—FY 2017–2018 Corrective Action Plan for FHP

Standard V—Member Information		
Requirement	**Findings**	**Required Action**
4. The Contractor makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • Written materials must use easily understood language and format. *42 CFR 438.10(d)(3) and (d)(6)(i)* Contract: Exhibit B—10.8.2.5	At the time of the on-site review, Friday Health Plans (FHP) did not have a fully formatted, fully Spanish version of its member handbook available for review.	FHP must ensure that all written information, including basic publications such as the member handbook, are available to members in the non-English prevalent language (Spanish).
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
28. If the Contractor denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the time frame for standard resolution. • **Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and within two (2) calendar days provide the member written notice of the reason for the decision and inform the member of the right to file a grievance if he or she disagrees with that decision.** *42 CFR 438.410(c)* Contract: Exhibit B—15.1.4.16.5	CHP+ Grievances and Appeals DTP, as well as the member handbook, stated that "If the member's request for a fast appeal is denied, Friday Health Plans of Colorado CHP+ will call the member or their DCR as soon as possible to let them know. Friday Health Plans of Colorado will also send the member a letter within two (2) working days. Then we will review the appeal the regular way." HSAG noted that the requirement is two *calendar* days. In addition, neither the DTP nor the member handbook stated that the FHP would inform the member of the right to file a grievance if he or she disagrees with the denial of an expedited request. FHP did not submit an example of a letter to the member denying an expedited appeal request; therefore, HSAG could not confirm the content of the letter.	FHP must correct the CHP+ Grievances and Appeals DTP, as well as the member handbook, to specify that FHP will inform the member in writing within two calendar days of the reason for denying an expedited appeal request and will inform the member of the right to file a grievance if he or she disagrees with that decision. FHP must ensure that the notice to the member informs the member of the right to file a grievance, according to the requirement.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
29. The Contractor provides for continuation of benefits/services while the Contractor-level appeal and the State fair hearing are pending if: • The member files timely* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the Contractor mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal in accordance with required timeframes. ** This definition of "timely filing" only applies for this scenario–i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced. Note: The*	The CHP+ Grievances and Appeals DTP includes procedures related to continued benefits during an appeal, as well as continued benefits during a SFH. In the appeals section, the DTP addressed all criteria related to continuation of benefits *except* the requirement for requesting continued benefits within a 10-day time frame from notice of adverse benefit determination or intended effective date of termination for requesting continued benefits. The SFH section of the DTP addressed that members must request continued benefits within 10 calendar days "from the mailing date of the decision" but did not clarify whether this was the adverse benefit decision or appeal decision. (Because new federal and State regulations require that the request for a SFH must follow appeal resolution by the health plan, the member must request continuation of benefits within 10 days of adverse resolution of appeal.)	The CHP+ Grievances and Appeals DTP must specify that the member may request continued benefits during an appeal within 10 days of the notice of adverse benefit determination. The DTP should also clearly specify that members must request continued benefits during a SFH within 10 days of adverse appeal resolution. FHP should also ensure that member communications include clear, accurate information concerning the requirements for requesting continued benefits during an appeal or SFH.

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
provider may not request continuation of benefits on behalf of the member.) *42 CFR 438.420(a) and (b)* Contract: Exhibit B—14.1.4.11		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
30. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of the following occurs: • The member withdraws the appeal or request for a State fair hearing. • The member fails to request a State fair hearing and continuation of benefits within 10 calendar days after the Contractor sends the notice of an adverse resolution to the member's appeal. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR 438.420(c)* Contract: Exhibit B—14.1.4.12	The CHP+ Grievances and Appeals DTP includes procedures related to continued benefits during an appeal, as well as continued benefits during a SFH. Both the appeals and SFH sections of the DTP, as well as the member handbook, addressed the criteria for how long benefits will continue according to the requirement, yet added a fourth criterion—*the time period or service limits of a previously authorized service ends.* According to regulation, this criterion is not applicable to how long member-requested benefits will continue while the appeal or SFH is pending. In addition, the SFH section of the DTP states that the criteria include "… ten days pass after the MCO mails the notice providing the resolution of the appeal against the enrollee," which is an incomplete description of this criterion. The language should be modified to include "unless the member requests a State Fair Hearing and continuation of benefits." HSAG also noted that the SFH section uses the terminology "appeal" rather than "SFH" in the description of the criteria applied to how long benefits will continue, and recommends that FHP consider replacing the word "appeal" with "SFH" to avoid confusing staff and/or members.	FHP must remove the criterion "the time period or service limits of a previously authorized service ends" from the CHP+ Grievances and Appeals DTP and related documents as a qualification for how long benefits will continue while an appeal or SFH is pending. FHP must clarify in the SFH section of the DTP that the criterion "… ten days pass after the MCO mails the notice providing the resolution of the appeal against the enrollee" includes "unless the member requests a State Fair Hearing and continuation of benefits" (or similar language).

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

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
35. 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. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. – The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final	The provider manual description of CHP+ grievances and appeals was a copy of the entire CHP+ Grievances and Appeals DTP. As such, all DTP noncompliance issues noted in the above requirements apply to the provider manual, including lack of a time frame for filing appeals, two different time frames for filing a SFH, and any issues noted in continuation of benefits information. All other provider manual information was compliant with elements of this requirement. HSAG also noted that, like the DTP, some sections were written in language directed toward the member, not the provider. HSAG recommends that language be modified to address the provider rather than the member.	Once necessary corrections are made to the CHP+ Grievances and Appeals DTP, FHP must address similar changes in the provider manual and ensure that providers are notified of applicable changes to the manual.

Standard VI—Grievance System		
Requirement	**Findings**	**Required Action**
decision is adverse to the member. *42 CFR 438.414* *42 CFR 438.10(g)(xi)* Contract: Exhibit B—11.1.12		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VII—Provider Participation and Program Integrity		
Requirement	**Findings**	**Required Action**
1. The Contractor implements written policies and procedures for selection and retention of providers. *42 CFR 438.214(a)* Contract: Exhibit B—14.2.1.1	FHP supplied HSAG with its Network Management Program Description following the on-site review. This document contained information on FHP's provider selection criteria; however, it did not include information on provider retention.	FHP must implement written policies and procedures that address provider retention.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix E. Compliance Monitoring Review Protocol Activities

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

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal CHP+ managed care regulations and contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, on-site agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all site reviewers to ensure consistency in scoring across plans.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Medical Quality Improvement Committee (MQuIC) meetings and provided group technical assistance and training, as needed. • Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the health plan in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the two standards and on-site activities. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. • Documents submitted for the desk review and on-site review consisted of the completed desk review form, the compliance monitoring tool with the health plan's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The health plans also submitted a list of all CHP+ appeals and grievances that occurred between July 1, 2017, and December 31, 2017 (to the extent possible). HSAG used a random sampling technique to select records for review during the site visit. • The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct Site Visit**
	• During the on-site portion of the review, HSAG met with the health plan's key staff members to obtain a complete picture of the health plan's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan's performance. • HSAG reviewed a sample of administrative records to evaluate implementation of managed care regulations related to CHP+ appeals and grievances. • Also while on-site, HSAG collected and reviewed additional documents as needed. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were confidential or proprietary, or were requested as a result of the pre-on-site document review.) • At the close of the on-site portion of the site review, HSAG met with health plan staff and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2017–2018 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. • HSAG analyzed the findings. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the State**
	• HSAG populated the report template. • HSAG submitted the draft site review report to the health plan and the Department for review and comment. • HSAG incorporated the health plan's and Department's comments, as applicable, and finalized the report. • HSAG distributed the final report to the health plan and the Department.