CHP+

Child Health Plan *Plus*

Fiscal Year 2018–2019 Site Review Report

for

Friday Health Plans of Colorado

January 2019

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

Public Law 111-3, Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, requires that each state's Children's Health Insurance Program (CHIP) apply several provisions of Section 1932 of the Social Security Act in the same manner as the provisions apply under Title XIX of the Act. This requires managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to comply with provisions of the Code of Federal Regulations (CFR), Title 42—federal Medicaid managed care regulations published May 6, 2016. Revisions to federal Medicaid managed care regulations published May 6, 2016, became applicable to CHIP effective July 1, 2018. The CFR requires that states conduct a periodic evaluation of their MCOs and PIHPs to determine compliance with federal healthcare regulations and managed care contract requirements. The Department of Health Care Policy and Financing (the Department) has elected to complete this requirement for Colorado's Child Health Plan *Plus* (CHP+) managed care health plans by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

In order to evaluate the CHP+ health plans' compliance with new federal managed care regulations published May 2016, the Department determined that the review period for fiscal year (FY) 2018–2019 was July 1, 2018, through December 31, 2018. This report documents results of the FY 2018–2019 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 2018–2019 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the 2017–2018 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 credentialing and recredentialing record reviews. Appendix C lists HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process the health plan will be required to complete for FY 2018–2019 and the required template for doing so. Appendix E contains a detailed description of HSAG's site review activities consistent with the Centers for Medicare & Medicaid Services (CMS) final protocol.

Summary of Results

Based on conclusions drawn from the review activities, HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met, Not Met,* or *Not Applicable.* HSAG assigned required actions to any requirement receiving a score of *Partially Met* or *Not Met.* HSAG also identified opportunities for improvement with associated recommendations for some elements, regardless of the score.

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

Table 1-1—Summary of Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
III. Coordination and Continuity of Care	9	9	7	2	0	0	78%
IV. Member Rights and Protections	8	8	7	1	0	0	88%
VIII. Credentialing and Recredentialing	32	28	24	4	0	4	86%
X. Quality Assessment and Performance Improvement	18	18	15	1	2	0	83%
Totals	**67**	**63**	**53**	**8**	**2**	**4**	**84%***

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

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

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Credentialing	100	93	90	3	7	97%
Recredentialing	90	87	87	0	3	100%
Totals	**190**	**177**	**179**	**3**	**10**	**98%**

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

Standard III—Coordination and Continuity of Care

Summary of Strengths and Findings as Evidence of Compliance

At the time of the site review, **FHP**'s CHP+ population of approximately 2,200 members included very few members with ongoing complex medical or behavioral needs, due to the fact that members with such needs typically become Medicaid eligible. **FHP** integrated CHP+ members into processes applicable to all **FHP** lines of business, including medical management and coordination of services processes. **FHP**'s Medical Management Department included nurse clinicians who performed all utilization management and coordination of services activities for members.

Staff members described multiple mechanisms to ensure that each member has an ongoing source of care through a primary care provider (PCP) as well as a designated care coordinator through the health plan when indicated and that a mechanism exists for notifying the member of how to contact his or her designated PCP or care coordinator. **FHP**'s Health Risk Assessment (HRA) form included all required screening indicators to identify members with special healthcare needs and is administered to all members through a personal outreach call within 10 days of notification of enrollment. Staff members also described multiple additional "touch points" for **FHP** to identify individual members with special healthcare needs or needing continuity of care or coordination of services, including service authorization or referral requests, claims screening, the pharmacy benefits manager, or member inquiries to customer services. **FHP** defined "special health care needs" more broadly than the State definition—i.e., any member experiencing out-of-the-ordinary circumstances or need for services—which HSAG acknowledged as best practice for the generally healthy CHP+ population. **FHP** performed an in-depth comprehensive assessment, developed a service plan for all members identified to the medical management department as having special needs, and shared the assessment and service plan with providers and other entities involved in the member's care. The provider manual instructed providers to share results of assessments and members' treatment plans with other providers in order to coordinate care. **FHP** has multiple policies and procedures concerning Health Insurance Portability and Accountability Act of 1996 (HIPAA) rules and maintaining confidentiality of member information and has implemented secure mechanisms—i.e., secure electronic and fax exchanges—for sharing information. However, staff members stated that due to the small CHP+ population **FHP** widely uses interpersonal interactions and relationships with providers and other entities to manage care for members.

Summary of Findings Resulting in Opportunities for Improvement

During the on-site interview, staff members described procedures to coordinate services for members as outlined in several requirements, including: applying concurrent and prior authorization processes to identify members in need of continuity of care, using numerous other internal mechanisms to ensure that members are referred to medical management for follow-up, using discharge planning processes, coordinating with community service providers and agencies, and ensuring that providers maintain and share records with other providers and entities to coordinate care for members. However, HSAG noted that written procedures did not clearly delineate many of the procedures and processes described during

on-site interviews. HSAG recommends that **FHP** include in written procedures the processes applicable to several of the requirements listed in the tool, paying particular attention to:

- Requirement #2—how **FHP** ensures that each member has an ongoing source of care (i.e., PCP) and/or care coordinator and provides contact information to the member;
- Requirement #3—coordinating services between settings of care (e.g., discharge planning), with other managed care health plans and with community service organizations;
- Requirement #4—designating the time frame for conducting initial HRA screening;
- Requirements #5 and #6—sharing assessments and health records with other providers and entities.
- Requirement #8—components of developing a service plan for members with special healthcare needs, **FHP**'s definition of special healthcare needs, as well as all verbally-described internal mechanisms for ensuring that members are referred to medical management, as appropriate.

The requirement regarding member consent to medical treatment (Requirement #3 in the tool) is primarily executed through providers; therefore, HSAG recommended that **FHP** ensure that the provider manual or other provider communications clearly define this requirement to providers and consider implementing a mechanism, such as through medical record review, to monitor for documentation of member consent to medical treatment in the record.

Summary of Required Actions

FHP must define procedures to ensure that members and/or authorized family members are involved in treatment planning and consent to any medical treatment.

While staff members were able to verbally describe that **FHP** prefers to coordinate care with other healthcare plans through the member's provider, **FHP** must develop and implement procedures to directly coordinate services being received by members with other managed care and fee-for-service (FFS) health plans when indicated.

Standard IV—Member Rights and Protections

Summary of Strengths and Findings as Evidence of Compliance

FHP's Member Rights and Responsibilities policy and procedure required all employees and providers to comply with all applicable federal and State laws related to member rights. **FHP** listed specific CHP+ member rights as an attachment to the policy and included rights in the member handbook and provider manual. **FHP** requires that all employees participate in member rights training at time of hire. Additionally, during the on-site review, staff members explained that staff members who engage with members regularly (e.g., customer service) participate in weekly team meetings that include identifying and addressing any issues related to member rights. **FHP** notified providers about their responsibility to comply with member rights in the provider services contract and in the provider manual. **FHP** had a

robust HIPAA privacy policy and procedure that described procedures for ensuring appropriate protection of personal health information and which required that staff attend annual trainings.

FHP had a well-written, comprehensive desktop procedure that addressed requirements related to advance directives, including staff and member education. **FHP** notified providers of their responsibility to report conscientious objections to **FHP** and to document advance directives in member records. The procedure described processes to monitor laws and to update staff and members of any changes within 90 days. During the on-site interview, staff members stated that **FHP** conducts annual chart reviews that include review of advance directive requirements. Staff also described distributing advance directive pamphlets to area clinics, hospitals, and libraries.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to this standard.

Summary of Required Actions

The desktop procedure included no provisions for providing information regarding advance directives to a member's family or surrogate if the member is incapacitated at the time of initial enrollment and is unable to receive information. **FHP** must revise its processes to include provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and is unable to receive information. Additionally, as federal managed care requirements specify "written policies and procedures," **FHP** must convert its desktop procedure into a more formal policy and procedure.

Standard VIII—Credentialing and Recredentialing

Summary of Strengths and Findings as Evidence of Compliance

FHP's Credentialing Plan was compliant with National Committee for Quality Assurance (NCQA) guidelines and delineated the types of practitioners and facilities subject to credentialing and recredentialing, the criteria for joining the **FHP** network, and verification sources used. The plan described processes to ensure confidentiality of materials collected and that decisions are made in a non-discriminatory manner. The Credentialing Plan described the roles of credentialing staff, the medical director, and the credentialing committee (Physician Advisory Committee [PAC]).

FHP provided evidence of ongoing monitoring of practitioner sanctions, complaints, and quality issues between recredentialing cycles; and PAC meeting minutes demonstrated that the committee reviews issues and takes appropriate action against practitioners when warranted. The Professional Quality of Care/Quality of Service Concern Review policy described **FHP**'s practitioner appeal process compliant with regulations. While **FHP**'s Credentialing Plan described the processes related to delegation of credentialing or recredentialing activities, HSAG confirmed that **FHP** delegated no NCQA-required activities.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to this standard.

Summary of Required Actions

FHP policies and procedures required that providers submit a completed application for network participation that includes a signed attestation; however, one of the 10 initial credentialing records documented that **FHP** obtained the provider's signed attestation after the provider was approved by the medical director and accepted into the network. **FHP** must ensure that staff collect a signed attestation prior to accepting the provider into the network.

Two of 10 initial credentialing record reviews documented that, while primary source verification of federal sanctions was completed, **FHP** sent the letter accepting the provider into the network prior to federal sanction information being received. **FHP** must ensure that a provider is not accepted into the network prior to information from federal exclusion databases being received and reviewed.

FHP's policies and procedures described the processes for credentialing and recredentialing organizational providers consistent with regulations; however, documents submitted for review demonstrated that several organizations had not been recredentialed within the 36-month time frame. **FHP** must ensure that staff recredential organizational providers every 36 months.

On-site review of organizational credentialing files demonstrated that **FHP** staff members adhered to the requirement for using CMS or State quality reviews in lieu of site visits consistent with regulations;

however, this process was not documented in **FHP**'s Credentialing Plan. **FHP** must revise its credentialing processes to include the NCQA requirements related to on-site quality assessment for unaccredited organizational providers.

Standard X—Quality Assessment and Performance Improvement

Summary of Strengths and Findings as Evidence of Compliance

FHP's 2018 Quality Assurance Plan (applicable to all **FHP** lines of business), documented that **FHP** has an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) program applicable to CHP+ members. **FHP** had many resources dedicated to QAPI activities, an established structure and processes related to each component of the program, and oversight by both the PAC and the Quality Management Program Committee (QMPC). Staff members explained that the PAC was the vehicle for input of providers into the various quality assessment activities, and the QMPC provided the ultimate oversight and accountability for all components of the program. Due to the relatively small CHP+ population, **FHP** integrated CHP+ members into all of its health plan-wide QAPI activities. PAC minutes reviewed on-site indicated that the PAC was actively involved in performing oversight and providing practitioner input into QAPI program components such as peer review, medical record review, credentialing, review of authorization outcomes, assessment of quality of care concerns (QOCs), review of grievance and appeal activity, and clinical input into quality improvement activities. However, most review processes were documented as case-specific reviews and routinely structured activities. In addition, due to the short time frame of the review period—July 2018 through the date of on-site review—HSAG was unable to verify in PAC or QMPC minutes implementation of all the required oversight processes and assessments.

FHP participated in performance improvement projects (PIPs) and Healthcare Effectiveness Data and Information Set (HEDIS®)[1-1] and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-2] performance measures as defined by the State. As part of its other EQRO responsibilities, HSAG had previously determined these activities were compliant with all related requirements. However, **FHP** lacked statistical significance of many CHP+ performance measures due to the small CHP+ population; therefore, **FHP** included CHP+ members in the broader health plan population for most components of the QAPI program. **FHP** had a mechanism for adopting and disseminating practice guidelines in compliance with requirements. Staff members stated that the QMPC, composed of senior management, reviewed results of member surveys, grievances, and HEDIS measures and initiated internal corrective action plans as indicated. The Quality Assurance Plan outlined well-defined criteria for annual evaluation of overall effectiveness of the QAPI program, which staff members confirmed would be performed at the end of the calendar year and henceforth documented in meeting minutes.

[1-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[1-2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

FHP used the Monument Systems Xpress information system to support its claims and data management functions. **FHP** submitted numerous documents—primarily State-generated encounter electronic data interchange guides and Xpress information system user guides—and provided on-site data demonstrations to verify that its Xpress system collects, integrates, analyzes, and reports data in compliance with health information system federal requirements. **FHP** demonstrated that components of the data system included claims, authorizations and referrals, denials and appeals, provider demographic files, and member enrollment files. **FHP**'s claims processing systems collect data on provider and member characteristics, rendering provider, and services furnished to members in the required coding and formatting to enable encounter data submission to the Department in the ANSI X12N 837 format. Staff members stated that **FHP** submits batch CHP+ encounter data monthly to the Department and is considering submitting data weekly. Staff members described a two-level process to conduct screening for accuracy, timeliness, completeness, and coding logic through Xpress system edits as well as referral to an external claims screening entity for more detailed review of coding accuracy and payments. At the time of on-site review, **FHP**'s system was adequately performing all required health information functions. Staff reported that **FHP** was in process of transitioning to a new health plan-wide information system.

Summary of Findings Resulting in Opportunities for Improvement

HSAG noted that while the QAPI activities were comprehensive and regularly performed through operations and the PAC, the program lacked documentation of periodic analysis of overall trends in performance such as utilization, types of grievances, QOCs, and medical record reviews. In addition, while the Quality Assurance Plan outlined the role of the PAC in the QAPI program, it did not address the role of the QMPC—neither distinct activities nor the oversight and accountability role of the QMPC. Through on-site interviews, HSAG observed that the distinct roles and activities of the QMPC were unclear and appeared duplicative of the PAC. HSAG recommended that **FHP** include the defined role and responsibilities of the QMPC in its Quality Assurance Plan. HSAG also suggested on-site that **FHP** might consider defining the role of the QMPC to include analysis of overall trends in performance—e.g., types of grievances and appeals, utilization patterns, HEDIS and CAHPS results, QOCs, and annual evaluation of the effectiveness of the overall QAPI program—to distinguish those responsibilities from the more cursory case review activities performed by the PAC.

Summary of Required Actions

HSAG acknowledges that the low number of members with "special health care needs" in the small CHP+ population presents a challenge in defining an effective mechanism to assess the overall quality and appropriateness of care for these members. While **FHP** applied other internal individualized processes to these members' care—i.e., coordination of services—staff members acknowledged that no mechanism exists within the formal QAPI program to assess the overall quality and appropriateness of care furnished to these members. Despite the small population, **FHP** must implement a mechanism within its QAPI program to periodically assess quality and appropriateness of care for members with special healthcare needs.

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While **FHP** has a well-defined approach for adopting and disseminating clinical practice guidelines in compliance with requirements, **FHP** did not have an internal process for ensuring that other decisions to which the guidelines apply are consistent with adopted practice guidelines. **FHP** must define and implement a process to ensure that utilization management decisions, member education materials, and other areas to which practice guidelines apply are consistent with adopted practice guidelines.

While **FHP** demonstrated having the capability to produce on-demand utilization data trending reports, **FHP** must define and implement mechanisms to systematically detect and determine, as a component of its QAPI program, concerns regarding both underutilization and overutilization of services.

2. Overview and Background

Overview of FY 2018–2019 Compliance Monitoring Activities

For the FY 2018–2019 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement. Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of 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+ credentialing and recredentialing.

HSAG also reviewed a sample of the health plan's administrative records related to CHP+ credentialing and recredentialing to evaluate implementation of federal healthcare regulations and compliance with National Committee for Quality Assurance (NCQA) requirements effective July 2018. 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 CHP+ credentialing and recredentialing records that occurred between July 1, 2018, and December 31, 2018. 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 VIII—Credentialing and Recredentialing. HSAG also separately calculated a credentialing record review score, a recredentialing 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.[2-3] 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 2018–2019 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

Objective of the Site Review

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

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

[2-3] 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, 2018.

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

FY 2017–2018 Corrective Action Methodology

As a follow-up to the FY 2017–2018 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 2017–2018 compliance monitoring site review.

Summary of FY 2017–2018 Required Actions

For FY 2016–2017, HSAG reviewed Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

Related to member information, **FHP** was required to ensure that all written information was readily available in Spanish.

Related to provider participation, **FHP** was required to implement written policies and procedures for the retention of providers.

Related to the grievance system, **FHP** was required to address four elements related to expedited appeals and continuation of benefits.

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

Summary of Corrective Action/Document Review

FHP submitted a proposed CAP in April 2018. HSAG and the Department reviewed and approved the proposed plan and responded to **FHP**. **FHP** was given until October 2018 to submit documents as evidence of completion of its proposed interventions. As of November 16, **FHP**'s 2016–2017 CAP submission remained outstanding.

Summary of Continued Required Actions

As of the date of this 2018–2019 compliance report, all required 2017–2018 required actions were continued pending review of CAP documents submitted by **FHP**. HSAG will review **FHP**'s CAP submission with the Department and work with the health plan to ensure full implementation of all corrective actions.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements procedures to deliver care to and coordinate services for all members. These procedures meet State requirements, including: • Ensuring timely coordination with any of a member's providers, including mental health providers, for the provision of covered services. • Addressing those members who may require services from multiple providers, facilities, and agencies; and who require complex coordination of benefits and services. • Ensuring that all members and authorized family members or guardians are involved in treatment planning and consent to any medical treatment. • Criteria for making referrals and coordinating care with specialists, subspecialists, and community-based organizations. • Providing continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services. *42 CFR 438.208(b)* Contract: Exhibit B—10.5.1, 10.5.2, 10.5.3.3, 10.5.3.5, 10.5.3.6	**Documents:** 1. Policy 3504 UM Precertification Review 2. Policy 3516 UM Concurrent Review 3. Case Management Policy (#3000) **Narrative:** Friday Health Plans, Policy 3516, UM Concurrent Review helps to establish coordination with any of a member's providers as this policy is followed in providing services to members while members are inpatient. The Case Management Policy outlines the requirements around ensuring timely coordination with any of a member's providers, all providers (including mental health providers). Case Management Policy outlines the requirements around addressing those members who may require services from multiple providers, facilities, and agencies and who require complete coordination of benefits and services, as ensuring that all members and authorized family members or guardians are involved in treatment planning and consent to any medical treatment. Criteria for making referrals and coordinating care with specialists, subspecialists, and community-based organizations is covered under Policy 3504, UM Precertification Review. Friday Health Plans outlines in Policy 3504, UM Precertification Review that monitoring for medical necessity and appropriateness of services is completed which helps to provide continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Findings:

FHP's Care Management policy outlined processes for ensuring delivery of care and coordination of services that meet all State requirements except the requirement that all members or family members consent to the medical treatment plan. As this requirement is primarily executed through providers, HSAG recommended that FHP ensure that the provider manual or other provider communication clearly defines this requirement to providers and that FHP consider implementing a mechanism such as medical record review to monitor the record for documentation of member consent to medical treatment.

<table>
<tr><th colspan="3">Standard III—Coordination and Continuity of Care</th></tr>
<tr><th>Requirement</th><th>Evidence as Submitted by the Health Plan</th><th>Score</th></tr>
<tr><td colspan="3">Required Actions:
FHP must define procedures to ensure that members and/or authorized family members are involved in treatment planning and consent to any medical treatment.</td></tr>
<tr><td>2. The Contractor ensures that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member.
• The member must be provided information on how to contact the designated person or entity.
42 CFR 438.208(b)(1)
Contract: Exhibit B—1.1.79, 7.11.1.2</td><td>Documents:
1. CM Policy # 3000
Narrative:
In following the process as outlined in the Case Management Policy, #3000, Once a member is identified and placed in case management, these members have an ongoing source of care appropriate to his or her needs and a Primary Care Physician that would be the main point of contact for the member, the member is also assigned a case manager within the plan who will also be available to assist the member.</td><td>☒ Met
☐ Partially Met
☐ Not Met
☐ Not Applicable</td></tr>
<tr><td>3. The Contractor implements procedures to coordinate services the Contractor furnishes the member:
• Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays.
• With the services the member receives from any other managed care plan.
• With the services the member receives in fee-for-service (FFS) Medicaid.
• With the services the member receives from community and social support providers.
42 CFR 438.208(b)(2)
Contract—Exhibit B—10.5.3.3.1</td><td>Documents:
1. Policy 3504 UM Precertification Review
2. Policy 3516 UM Concurrent Review
3. Policy #3100 Pharmacy/Formulary Management
Narrative:
Our concurrent review policy lays out how we communicate with facilities who have our members as patients, and how we coordinate care and needs of our member based on the conversations and documentation we receive from these facilities during the members stay. It is during the concurrent review process that we are able to assist with any future needs for the member whether it be medication, home health, long term care etc.
This is also one way that we would be able to capture someone new with us that has come from another plan whether it be Medicaid or any other health insurance plan so that we can coordinate past care with current care and make sure we have no lag in our members continuity of care.</td><td>☐ Met
☒ Partially Met
☐ Not Met
☐ Not Applicable</td></tr>
</table>

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Pg. 1 of policy #3516 lays out the purpose which is to ensure that the continued care is appropriate and is provided in an effective and efficient manner, and that are care is appropriate for our members clinical needs. Pg. 2 of this policy lines out some of the processes in which we perform these tasks. Policy # 3504 precertification review also lines out the process we use is to ensure that we are monitoring appropriate utilization of services and health care resources. We have a process in place which allows us to effectively review requests coming in and process those requests in a timely fashion to ensure that the member's necessary care is not being delayed. This is another area in which we can capture if someone is new to us via the requests that come in either for medical services or pharmacy requests. Policy#3100 lays out how we manage our formulary as well as requests for medications. Our prior authorizations are managed through our PBM (pharmacy benefit manager). There is continuous communication between them and our onsite staff here at FHPs.	
Findings: FHP staff members were able to verbally describe procedures for coordinating members' services between settings of care, including discharge planning from institutional stays as well as coordinating members' service needs with community organizations and agencies. Staff members described that coordinating care for members transitioning between healthcare plans was performed through the member's primary care provider as a more effective conduit for ensuring that the member's care was coordinated with other health plans. While HSAG acknowledges that this approach represents "good practice," FHP must also develop and implement procedures to directly coordinate needed member services with other managed care and FFS health plans, particularly when the member is transitioning between health plans. In addition, HSAG observed that the processes verbally described during on-site interviews were not clearly delineated in written procedures and recommends that FHP do so.		
Required Actions: FHP must develop and implement procedures to coordinate services being received by members with other managed care and FFS health plans when indicated.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor provides best efforts to conduct an initial screening of each new member's needs within 90 days of enrollment, including subsequent attempts if the initial attempt to contact the member is unsuccessful. • Assessment includes screening for special health care needs including mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems. *42 CFR 438.208(b)(3)* Contract: Exhibit B—10.5.3.1.1	**Documents:** 1. Health Risk Assessment Form **Narrative:** We have a designated employee in our Government Programs department who reaches out to each new CHP+ member and completes a Health Risk Assessment and then sends this information to medical department. A nurse reviews these and will reach out to those she feels are medically necessary. All others are touched again with a phone call from a non-clinical personnel.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Contractor shares with other entities serving the member the results of identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR 438.208(b)(4)* Contract: Exhibit B—10.6.1	**Documents:** 1. Policy 3504 UM Precertification Review 2. Policy 3516 UM Concurrent Review 3. Case Management Policy(#3000)\ **Narrative:** Our precertification process as well as our concurrent review process are ways that we are able to identify duplication of services. When a UM nurse processes the request for services or is working with an IP using our concurrent review process they also monitor claims data within our system and ensure that there are no duplication of services. Another way we capture this is if we have a member who has met the requirements and have been placed into Case Management. These members receive more coordination of care from us than the other members due to the acuity of their diagnosis. In our case management processes duplication of services would be caught and appropriately	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	managed in order to consolidate these services and ensure the member is getting the best care possible.	
6. The Contractor ensures that each provider furnishing services to members maintains and shares, as appropriate, a member health record, in accordance with professional standards. *42 CFR 438.208(b)(5)* Contract: Exhibit B—14.1.6.6–7	**Documents:** 1. Provider Contract 2. Policy 3516, Concurrent Review Process **Narrative:** This is met through our Concurrent Review Process (Policy#3516) and the information is exchanged via either secure fax or secure email. There is also information in the provider contracts that ensures to us that they maintain an appropriate medical record that is shared with us upon request.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The Contractor ensures that, in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent applicable. *42 CFR 438.208(b)(6)* Contract: Exhibit B—10.5.1.1	**Documents:** 1. Provider Contract 2. Policy#9308- HIPAA Privacy and Security Training 3. Policy #9305- HIPAA Safeguarding PHI on Paper 4. Policy 9303- HIPAA Workforce Security and Verbal Use of PHI 5. Policy #9300 HIPAA Confidentiality Uses/Disclosures of PHI **Narrative:** We strictly adhere to all HIPAA requirements for PHI with all employee training yearly. The protection of, use of, and disclosure of PHI is clearly outlined in our policies as well as in the mandatory training all staff has to take in regards to HIPAA. Our Provider Contract also outlines the expectation that all providers we work with are to maintain each member's privacy and protection of PHI.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor produces a treatment or service plan for members with special health care needs who are determined, through assessment, to need a course of treatment or regular care monitoring. The treatment plan must be: • Developed by the member's primary care provider with member participation, and in consultation with any specialists caring for the enrollee. • Approved by the Contractor in a timely manner (if such approval is required by the Contractor). • In accordance with any applicable State quality assurance and utilization review standards. • Reviewed and revised upon reassessment of functional need, at least every 12 months, when the member's circumstances or needs change significantly, or at the request of the member. *42 CFR 438.208(c)(3)* Contract: Exhibit B—10.5.3.2.1–4	**Documents:** 1. MM –Assessment-Care Management General **Narrative:** When a clinical review indicates that member requires CM intervention, a treatment or service plan is established to develop regular care monitoring.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. For members with special health care needs determined to need a course of treatment or regular care monitoring, the Contractor must have a mechanism in place to allow members direct access to a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. *42 CFR 438.208(c)(4)* Contract: Exhibit B—10.5.3.5; 10.6.3	**Documents:** 1. Standing Referrals Policy and Procedure, No. 3506. Friday Health Plans, follows the standing referrals policy and procedure to allow members direct access to a specialist, as appropriate for the member's condition and identified needs.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	7	X	1.00	=	7
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	9	**Total Score**		=	7
					Total Score ÷ Total Applicable	=	78%

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has written policies regarding the member rights specified in this standard. *42 CFR 438.100(a)(1)* Contract: Exhibit B—14.1.1.2	**Documents:** 1. Member Rights and Responsibilities Policy & Procedure, No. 2100 **Narrative:** Friday Health Plans of Colorado follows the Member Rights and Responsibilities Policy and Procedure, No. 2100 with regard to member rights specified in the standard.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor complies with any applicable federal and State laws that pertain to member rights and ensures that its employees and contracted providers observe and protect those rights. *42 CFR 438.100(a)(2)* Contract: Exhibit B—14.1.1.1	**Documents:** 1. Member Rights and Responsibilities Policy & Procedure, No. 2100 2. Professional Services Agreement **Narrative:** Friday Health Plans of Colorado follows the Member Rights and Responsibilities Policy and Procedure, No. 2100 with regard to member rights and the compliance with any applicable federal and state laws that pertain to member rights. Friday Health Plans of Colorado also has the Professional Services Agreement that providers sign acknowledging that they will adhere to member rights as well.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor's policies and procedures ensure that each member is guaranteed the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for 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.	**Documents:** 1. Member Rights and Responsibilities Policy & Procedure, No. 2100 2. Professional Services Agreement, page **Narrative:** Friday Health Plans follows the Member Rights and Responsibilities policy and procedure to ensure that each member receives information	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Participate in decisions regarding his or her health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. • Request and receive a copy of his or her medical records and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210). *42 CFR 438.100(b)(2) and (3)* Contract: Exhibit B—14.1.1.2.1–5; 14.1.1.3	pertaining to their rights and that members are afforded those rights in a respectful manner.	
4. The Contractor ensures that each member is free to exercise his or her rights and that the exercise of those rights does not adversely affect how the Contractor, its network providers, or the State Medicaid agency treat(s) the member. *42 CFR 438.100(c)* Contract: Exhibit B—14.1.1.2.6	**Documents:** 1. Member Rights and Responsibilities Policy and Procedure 2. Professional Services Agreement **Narrative:** Friday Health Plans of Colorado follows the Member Rights and Responsibilities Policy and Procedure to ensure that members are free to exercise their rights and that the exercise of those rights does not adversely affect the member.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. Member's rights and responsibilities are included in the member handbook and provided to all enrolled members. *42 CFR 438.10(2)(ix)* Contract: Exhibit B—14.1.3.10	**Documents:** 1. CHP+ Member Handbook **Narrative:** Friday Health Plans members are provided a CHP+ Member Handbook that outlines their rights and responsibilities.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor complies with any other federal and State laws that pertain to member rights, including Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975, as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and Section 1557 of the Patient Protection and Affordable Care Act. *42 CFR 438.100(d)* Contract: 21.A	**Documents:** 1. Member Rights and Responsibilities Policy and Procedure **Narrative:** Friday Health Plans follows the Member Rights and Responsibilities Policy and Procedure including federal and state laws that pertain to member rights.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. For medical records and any other health and enrollment information which identify a particular member, the Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42 CFR 438.224* Contract: Exhibit B—14.1.6.7	**Documents:** 1. HIPAA Privacy Policies and Procedures, Appendix A **Narrative:** Friday Health Plans follows the HIPAA Privacy Policies and Procedures regarding the use and disclosure of individually identifiable health information.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor maintains written policies and procedures and provides written information to individuals concerning advance directives with respect to adult members receiving care by or through the Contractor. Advance directives policies and procedures include:	**Documents:** 1. DTP: Notification of Advance Directives **Narrative:**	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• A clear statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience. • The difference between institution-wide conscientious objections and those raised by individual physicians. • Identification of the State legal authority permitting such objection. • Description of the range of medical conditions or procedures affected by the conscientious objection. • Provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and unable to receive information. • Provisions for providing advance directive information to the incapacitated member once he or she is no longer incapacitated. • Provisions for documenting in a prominent part of the member's medical record whether the member has executed an advance directive. • Provisions that the decision to provide care to a member is not conditioned on whether the member has executed an advance directive and that members are not discriminated against based on whether they have executed an advance directive. • Provisions for ensuring compliance with State laws regarding advance directives.	Friday Health Plans follows the DTP: Notification of Advance Directives for providing information to members concerning advance directives.	

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Provisions for informing members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. • Provisions for educating staff concerning policies and procedures about advance directives. • Provisions for community education regarding advance directives, to include: − What constitutes an advance directive. − Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. − Description of applicable State law concerning advance directives. *42 CFR 438.3(j)* *42 CFR 422.128* Contract: Exhibit B—14.1.9.1		

Findings:
FHP's Medical Management Notification of Advance Directives desktop procedure described a member's right to declare and FHP's commitment to honoring advance directives. The document described the processes to monitor the laws and to update staff, members, and providers of any changes; educate staff and providers; and conduct annual chart reviews to confirm provider compliance. FHP included advance directive information in the member handbook and distributed pamphlets to area hospitals, clinics, and libraries. The desktop procedure included no provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and is unable to receive information.

Required Actions:
FHP must revise its processes to include provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and is unable to receive information. Additionally, in order to address the requirement for written policies and procedures, FHP must convert its desktop procedure into a more formal policy and procedure.

Results for Standard IV—Member Rights and Protections							
Total	Met	=	7	X	1.00	=	7
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	8	**Total Score**		=	7
					Total Score ÷ Total Applicable	=	88%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. • The Contractor's credentialing program complies with the standards of the National Committee on Quality Assurance (NCQA) for initial credentialing and re-credentialing of participating providers. *42 CFR 438.214(a)* Contract: Exhibit B—14.2.1.3	**Documents:** 1. Credentialing Plan **Narrative:** Friday Health plans follows the credentialing plan for evaluating and selecting licensed independent practitioners to provide care to its members. The credentialing plan complies with the standards for URAC for initial credentialing and recredentialing of participating providers. While NCQA standards are similar, we recognize that there may be some elements that differ.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: • The types of practitioners it credentials and recredentials. This includes all physicians and non-physician practitioners who have an independent relationship with the Contractor. (Examples include MDs, DOs, podiatrists, nurse practitioners, and each type of behavioral health provider.) NCQA CR1—Element A1	**Documents:** 1. Credentialing Plan, Page 1, 1. Who is Credentialed: **Narrative:** Friday follows the credentialing plan that outlines the types of practitioners to credential and recredential. Friday does not discriminate in its willingness to credential providers. Friday is dedicated to expanding our provider network and maintaining provider relationships.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor's written policies and procedures for the selection and retention of providers specify: • The verification sources it uses. NCQA CR1—Element A2	**Documents/Sources:** 1. Credentialing Plan, Pages 5-6, 5. Primary and Secondary Verification Sources: a. National Practitioner Data Bank - http://www.npdb-hipdb.hrsa.gov/ b. CMS Sanctions - http://exclusions.oig.hhs.gov/search.aspx c. ABMS - http://www.certifacts.org/	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	d. DO Certification - https://www.doprofiles.org/ e. P.A. Certification – https://www.nccpa.net/pa/CredentialPublicSend.aspx f. Colorado License & Discipline Action - https://www.colorado.gov/dora/licensing/ **Narrative:** Friday follows the Credentialing Plan regarding verification sources used for the selection and retention of providers. The above sources are used to verify credentialing and recredentialing information. In following the credentialing plan, credentialing staff shall use accepted primary sources to verify the following for all individual providers: Licensure (licensing board), Certification for PA-Cs (National Commission on the Certification of Physician Assistants), Education (licensing board if the board primary-source verifies education prior to issuing a license; or from the school/program directly); Board certification (American Board of Medical Specialties or AOA) and Medicare/Medicaid sanctions and exclusions from Federal programs (OIG and GSA's EPLS websites)	
4. The Contractor's written policies and procedures for the selection and retention of providers specify: • The criteria for credentialing and recredentialing. NCQA CR1—Element A3	**Documents:** 1. Credentialing Plan, Guidelines Page 8, 8. Credentialing Guidelines **Narrative:** Friday follows criteria found in its Credentialing Plan for selection and retention of providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for making credentialing and recredentialing decisions.	**Documents:** 1. Credentialing Plan, Page 3, 3. Initial Credentialing: and Page 4, 4. Recredentialing	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
NCQA CR1—Element A4	**Narrative:** Friday follows criteria found in its Credentialing Plan when making credentialing and recredentialing decisions during the selection and retention of provider process. Upon completion of credentialing application, it is reviewed by the "PAC" for final approval or denial of providers.	
6. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for managing credentialing and recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	**Documents:** 1. Credentialing Plan, Page 9, 11. Credentialing File Maintenance and Confidentiality **Narrative:** Friday follows the Credentialing Plan, for managing credentialing/recredentialing files that meet the established criteria. The credentialing specialist utilizes a checklist, to ensure that all files are complete, accurate and do not contain conflicting information, before the files are presented to the Physician Advisory Committee (PAC).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for delegating credentialing or recredentialing (if applicable). NCQA CR1—Element A6	**Documents:** 1. Credentialing Plan, Page 10, 12. Credentialing Delegation **Narrative:** Friday follows the Credentialing Plan in delegating credentialing or recredentialing.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for ensuring that credentialing and recredentialing are conducted in a non-discriminatory manner, (i.e., must describe the steps the Contractor takes to ensure that it does not make credentialing and recredentialing decisions based solely on an applicant's	**Documents:** 1. Credentialing Plan, Page 2 2. Non-Discrimination Statement **Narrative:** Friday outlines in its credentialing plan that it does not discriminate against any provider seeking qualification as a participating provider with Friday. Members of the Physician Advisory Committee also sign a	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
race, ethnic or national identity, gender, age, sexual orientation, or patient type in which the practitioner specializes). NCQA CR1—Element A7	Non-Discrimination Statement outlining that credentialing review follows the Credentialing Plan.	
9. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for notifying practitioners if information obtained during the Contractor's credentialing/recredentialing process varies substantially from the information provided to the Contractor. NCQA CR1—Element A8	**Documents:** 1. Credentialing Plan, Page 11, 15. Discrepancies and Missing Information **Narrative:** Friday follows the Credentialing Plan process for notifying practitioners if information obtained during the Contractor's credentialing/recredentialing process varies substantially from the information they provided to the Contractor. Friday will contact the provider to explain the discrepancy.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for ensuring that practitioners are notified of credentialing and recredentialing decisions within 60 calendar days of the committee's decision. NCQA CR1—Element A9	**Documents:** 1. Credentialing Plan, Page 4, 3. Initial Credentialing **Narrative:** Friday follows the Credentialing Plan for notification of credentialing decisions. Initial Providers are 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. The Credentialing Plan also outlines that providers may consider themselves recredentialed unless otherwise notified.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor's written policies and procedures for the selection and retention of providers specify: • The medical director's or other designated physician's direct responsibility and participation in the credentialing/recredentialing program. NCQA CR1—Element A10	**Documents:** 1. Credentialing Plan, Page 7, Medical Director Oversight 2. Physician Advisory Committee (PAC) Charter **Narrative:** Friday follows the Credentialing Plan regarding medical director direct responsibility and participating in the credentialing/recredentialing program. Medical Director reviews the credentialing or recredentialing application and signs the internal checklist. The Medical Director is also a member of the PAC Committee, and as such conducts the meetings, signs and reviews the letters sent to providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for ensuring the confidentiality of all information obtained in the credentialing/recredentialing process. NCQA CR1—Element A11	**Documents:** 1. Credentialing, Plan, Page 9, 11. Credentialing File Maintenance and Confidentiality **Narrative** Credentialing files are kept electronically, and only approved staff can access these files. These files are made available for the PAC and Medical Director to review.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
13. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for ensuring that listings in provider directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty. NCQA CR1—Element A12	**Documents:** 1. DTP: Provider Directory Maintenance **Narrative:** Friday follows the Desktop Procedure: Provider Directory Maintenance for maintaining the Provider Directory.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor notifies practitioners about their rights: • To review information submitted to support their credentialing or recredentialing application. • To correct erroneous information. • To receive the status of their credentialing or recredentialing application, upon request. NCQA CR1—Element B	**Documents:** 1. Credentialing Plan, Page 10, Provider Review of Credentialing Information and Request for Status. 2. Provider Manual, Page 20, Right to Review or Correct Credentials Information **Narrative:** Friday follows the Credentialing Plan in its credentialing and recredentialing process. Providers are informed of their right to review, correct erroneous information, and receive status of the credentialing via the Provider Manual which is posted online and made available to any provider.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing and recredentialing decisions. The committee uses participating practitioners to provide advice and expertise for credentialing decisions. NCQA CR2—Element A1	**Documents:** 1. Credentialing Plan, pages 6, 7. PAC Credentialing Program Oversight 2. Physician Advisory Committee (PAC) Charter, page 2 Membership **Narrative:** Friday follows the Credentialing Plan in designating a Committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions. Friday's committee is the Physician Advisory Committee. Friday has outlined in the Physician Advisory Committee how the membership is comprised. Membership of the committee includes the Friday Medical Director, Participating Community Providers, and Nurse Manager (who is a non-voting member).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The Credentialing Committee: • Reviews credentials for practitioners who do not meet established thresholds. • Ensures that files which meet established criteria are reviewed and approved by a medical director or designated physician. NCQA CR2—Element A2 and A3	**Documents:** 1. Credentialing Plan, page 4 **Narrative:** Providers are listed on the "PAC" Meeting Agenda and are reviewed by the Committee. Approved files are signed off by the Medical Director (Committee Chair).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
17. The Contractor verifies credentialing and recredentialing information through primary sources to ensure that practitioners have the legal authority and relevant training and experience to provide quality care. Verification is within the prescribed time limits and includes: • A current, valid license to practice (verification time limit=180 calendar days). • A current, valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (verification time limit=prior to the credentialing decision). • Education and training—highest level obtained—e.g., medical/ professional school graduate; residency (verification time limit=prior to the credentialing decision). Required at initial credentialing only. • Board certification—if the practitioner states on the application that he or she is board certified (board certification time limit=180 calendar days). • Work history—most recent five years—if less, from time of initial licensure—from practitioner's application	**Documents:** 1. Credentialing Plan, Page 5, Primary and Secondary Verification Sources **Narrative:** Friday follows the Credentialing Plan in regards to primary sources to ensure practitioners have a valid license, education, DEA (if applicable), board certification, work history and history of malpractice.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
or curriculum vitae (CV) (verification time limit=365 calendar days). Required at initial credentialing only. • History of malpractice settlements—most recent five years (verification time limit=180 calendar days). NCQA CR3—Element A		
18. The Contractor verifies the following sanction information for credentialing and recredentialing (verification time limit=180 days): • State sanctions, restrictions on licensure, or limitations on scope of practice. • Medicare and Medicaid sanctions. NCQA CR3—Element B	**Documents:** 1. Credentialing Plan, page 3 **Narrative:** Friday follows the Credentialing Plan and verifies license and CMS sanctions for the initial credentialing and recredentialing process.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: On-site record reviews demonstrated that FHP timely verified State sanctions; however, two records demonstrated that, while FHP verified federal sanctions within the required time fame, the letter accepting the provider into the network was sent prior to federal sanction information being received. NCQA instructs that the credentialing file must contain sufficient documentation to demonstrate all primary source verification information was present at the time of the credentialing decision.		
Required Actions: FHP must ensure that a provider is not accepted into the network prior to information from federal exclusion databases being received and reviewed.		
19. Practitioners complete an application for network participation (at initial credentialing and recredentialing) that includes a signed attestation (attestation verification time limit=365 days). The application addresses the following: • Reasons for inability to perform the essential functions of the position.	**Documents**: 1. Credentialing Plan, pages 2, 2. Credentialing Application 2. Colorado Health Care Professional Credentials Application, Pages 17, 19, 21, 25 and 26 **Comments:** Friday follows the Credentialing Plan for credentialing and recredentialing practitioners. The Colorado Health Care Professional	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Lack of present illegal drug use. • History of loss of license and felony convictions. • History of loss or limitation of privileges or disciplinary actions. • Current malpractice or professional liability insurance coverage (minimums=physician—0.5mil/1.5mil; facility—0.5mil/3mil). • Attestation confirming the correctness and completeness of the application. NCQA CR3—Element C	Credentials Application is the credentialing application used by Friday. Page 26 covers reasons for inability to perform the essential functions of the position. Page 25 covers lack of present illegal drug use, Page 20, covers history of loss of license and felony convictions, Page 17 covers history of loss or limitation of privileges or disciplinary actions and current insurance coverage. Page 21, outlines the attestation for correctness and completeness of the application.	
Findings: FHP policies and procedures required that providers submit a completed application for network participation that includes a signed attestation; however, one of the 10 initial credentialing records reviewed on-site documented that FHP obtained the provider's signed attestation after the provider was approved by the medical director and accepted into the network.		
Required Actions: FHP must ensure that staff members collect signed attestations from provider applicants prior to accepting those providers into the network.		
20. The Contractor formally recredentials practitioners at least every 36 months. NCQA CR4	**Documents:** 1. Credentialing Plan, page 5 **Narrative:** The Credentialing Plan outlines that providers are recredentialed at least every 36 months.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
21. The Contractor has and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints, and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identifies issues related to poor quality. Monitoring includes: • Collecting and reviewing Medicare and Medicaid sanctions. • Collecting and reviewing sanctions or limitations on licensure. • Collecting and reviewing complaints. • Collecting and reviewing information from identified adverse events. • Implementing appropriate interventions when it identifies instances of poor quality related to the above. NCQA CR5—Element A		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
22. The Contractor has policies and procedures for taking action against a practitioner for quality reasons, reporting the action to the appropriate authorities, and offering the practitioner a formal appeal process. Policies and procedures address: • The range of actions available to the Contractor to improve practitioner performance before termination. • Procedures for reporting to National Practitioner Data Bank (NPDB), State agency, or other regulatory body, as appropriate. NCQA CR6—Element A1 and A2	**Documents:** 1. Credentialing Plan, page 10, 13. Notification of Terminations to Regulatory Agencies 2. Policy 6000, Professional Quality of Care/Quality of Service Concern **Narrative:** Friday follows the Credentialing Plan for reporting to regulatory agencies and uses Policy 6000 for the range of actions available to improve practitioner performance before termination.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
23. When taking action against a practitioner for quality reasons, the Contractor offers the practitioner a formal appeal process. Policies and procedures address: • A well-defined practitioner appeal process, including: – Written notification when a professional review action has been brought against a practitioner, reasons for the action, and a summary of the appeal rights and process. – Allowing practitioners to request a hearing and the specific time period for submitting the request. – Allowing at least 30 calendar days, after notification for practitioners, to request a hearing. – Allowing practitioners to be represented by an attorney or another person of their choice. – Appointing a hearing officer or a panel of individuals to review the appeal. – Notifying practitioners of the appeal decision in writing, including specific reasons for the decision. • Making the appeal process known to practitioners. NCQA CR6—Element A3 and A4	**Documents:** 1. Provider Manual 2. Policy 6000, Professional Quality of Care/Quality of Service Concern **Narrative:** Friday follows the Professional Quality of Care/Quality of Service Concern in notifying the providers of the action taken for quality reasons and to notify them of the appeal process for those instances. The Medical Director notifies the practitioner in writing, by certified mail, of the recommendation of the PAC. This notification informs the practitioner that they may submit a written request, within thirty (30) business days of the date of the letter for a first-level appeal panel hearing. Friday, after setting the date, requests that practitioner notify the plan of any attorney he/she intends to have at the hearing. Medical Director will select a panel of three qualified individuals for the hearing process. Within fifteen (15) business days after the completion of the hearing the Medicare Director notifies the practitioner in writing, by certified mail, of the findings and recommendation of the first level panel. The appeal process is made known to practitioners as the policy is contained in the Provider Manual.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
24. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of *organizational* providers with which it contracts, which include: • The Contractor confirms—initially and at least every three years—that the provider is in good standing with State and federal regulatory bodies. − Policies specify the sources used to confirm—which may only include applicable State or federal agency, agent of the applicable State or federal agency, or copies of credentials (e.g., state licensure) from the provider. NCQA CR7—Element A1	**Documents:** 1. Credentialing Plan, Page 11, Item 17., Institutional Credentialing **Narrative:** Friday follows the Credentialing Plan for the initial and ongoing assessment of (organizational) providers. Friday confirms that the provider is in good standing with state and federal regulatory bodies.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: FHP's policies and procedures described the processes for credentialing and recredentialing organizational providers consistent with regulations; however, documents submitted for review demonstrated that several organizations had not been recredentialed within the 36-month time frame.		
Required Actions: FHP must ensure that staff recredential organizational providers every 36 months.		
25. The Contractor confirms, initially and at least every three years, provider review and approval by an accrediting body. • Policies specify the sources used to confirm—which may only include applicable State or federal agency or applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, or copies of credentials—e.g., licensure, accreditation report or letter—from the provider. NCQA CR7—Element A2	**Documents:** 1. Credentialing Plan, Page 11, Item 17., Institutional Credentialing **Narrative:** Friday follows the Credentialing Plan and collects copies of accreditation information from organizational providers initially and at least every three years.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
26. The Contractor conducts, initially and at least every three years, an on-site quality assessment if the provider is not accredited. • Polices include: on-site quality assessment criteria for each type of unaccredited organizational provider; a process for ensuring that that the provider credentials its practitioners. • The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: – The CMS or state review is no more than three years old. – The organization obtains a survey report or letter from CMS or the State, from either the provider or from the agency, stating that the facility was reviewed and passed inspection. – The report meets the organization's quality assessment criteria or standards. NCQA CR7—Element A3	**Documents:** 1. Credentialing Plan, Pages 11, Item 17., Institutional Credentialing **Narrative:** Friday follows the Credentialing Plan and collects accreditation information and CMS or state reviews from organizational providers	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: On-site review of organizational credentialing files demonstrated that FHP staff members adhered to the requirement for using CMS or State quality reviews in lieu of site visits consistent with regulations; however, this process was not documented in FHP's credentialing plan.		
Required Actions: FHP must revise its credentialing processes to include the NCQA requirements related to on-site quality assessment for unaccredited organizational providers.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
27. The Contractor's organizational provider assessment policies and processes include assessment of at least the following medical providers: • Hospitals • Home health agencies • Skilled nursing facilities • Freestanding surgical centers NCQA CR7—Element B	**Documents:** 1. Credentialing Plan, Pages 11-12, Item 17., Institutional Credentialing **Narrative:** Friday's credentialing plan lists Hospitals, home health agencies, skilled nursing facilities, and freestanding surgical centers as well as many other types of organizational providers that are assessed.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
28. The Contractor has documentation that it has assessed contracted medical health care (organizational) providers. NCQA CR7—Element D	**Documents:** 1. Organizational provider files **Narrative:** Friday keeps credentialing files of organizational providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
29. If the Contractor delegates any NCQA-required credentialing or recredentialing activities, the Contractor has a written delegation document with the delegate that: • Is mutually agreed upon. • Describes the delegated activities and responsibilities of the Contractor and the delegated entity. • Requires at least semiannual reporting by the delegated entity to the Contractor. • Describes the process by which the Contractor evaluates the delegated entity's performance. • Specifies that the organization retains the right to approve, suspend, or terminate individual practitioners, providers, and sites—even if the organization delegates decision making.	**Documents:** 1. Credentialing Delegation Addendum **Narrative:** Friday has a written Credentialing Delegation Addendum for those delegates who provide any NCQA-required credentialing activities. These agreements are mutually agreed upon (Page 4, C.). The Delegation Addendum describes the delegated activities (credentialing). The Delegation Addendum Exhibit 1 outlines that the provider will submit to performance The Delegation addendum also outlines that If provider fails to comply with Plan's credentialing requirements, PLAN reserves the right to assume credentialing of providers.	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Describes the remedies available to the Contractor (including revocation of the contract) if the delegate does not fulfill obligations. NCQA CR8—Element A		
Findings: FHP delegated no NCQA-required credentialing or recredentialing activities; therefore, this element is scored Not Applicable.		
30. If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes the following provisions: • The allowed uses of PHI. • A description of delegate safeguards to protect the information from inappropriate use or further disclosure. • A stipulation that the delegate will ensure that subdelegates have similar safeguards. • A stipulation that the delegate will provide members with access to their PHI. • A stipulation that the delegate will inform the Contractor if inappropriate use of information occurs. • A stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends. NCQA CR8—Element B	**Documents:** HIPAA Privacy Policies and Procedures, Page 56 of PDF **Narrative:** In order to ensure that the Business Associates of Company agree to safeguard and respect the confidentiality of PHI and to set forth the procedure Company will follow in entering into and managing Business Associate Agreement, FHP has signed BAAs in place.	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Findings: FHP delegated no NCQA-required credentialing or recredentialing activities; therefore, this element is scored Not Applicable.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
31. For new delegation agreements in effect fewer than 12 months, the Contractor evaluated delegate capacity to meet NCQA requirements before delegation began. NCQA CR8—Element C	**Documents:** N/A **Narrative:** Friday has no new delegation agreements that have been entered into in the last 12 months.	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Findings: FHP delegated no NCQA-required credentialing or recredentialing activities; therefore, this element is scored Not Applicable.		
32. For delegation agreements in effect 12 months or longer, the Contractor: • Annually reviews its delegates' credentialing policies and procedures. • Annually audits credentialing and recredentialing files against NCQA standards for each year that delegation has been in effect. • Annually evaluates delegate performance against NCQA standards for delegated activities. • Semiannually evaluates delegate reports specified in the written delegation agreement. • At least once in each of the past two years, identified and followed up on opportunities for improvement, if applicable. NCQA CR8—Elements D and E	**Documents:** 1. Credentialing Delegation Addendum, page 3 Audits. **Narrative:** Friday reviews delegates' credentialing policies and procedures annually, performs credentialing/recredentialing audits every 3 years and receives reports from delegated entities.	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Findings: FHP delegated no NCQA-required credentialing or recredentialing activities; therefore, this element is scored Not Applicable.		

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	24	X	1.00	=	24
	Partially Met	=	4	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	4	X	NA	=	NA
Total Applicable		=	28	**Total Score**		=	24
					Total Score ÷ Total Applicable	=	86%

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. *42 CFR 438.330(a)* Contract: Exhibit B—12.1	**Documents:** 1. QMPC Charter 2. PAC Charter **Narrative:** Per URAC standards we are required to have 2 Quality Improvement Projects (QIP) at all times that we are working on, and in such have included the CHP+ LOB in those projects. In addition to the QIPS we also participate in the PIP project through the state. We have a Quality Management Program Committee (QMPC) that oversees the quality efforts of the facility as well as our Physicians Advisory Committee (PAC). Our quality projects are approved by QMPC and then are reported to PAC who then provides additional guidance if necessary.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor's QAPI Program includes conducting and submitting (to the State) annually and when requested by the Department performance improvement projects (PIPs) that focus on both clinical and nonclinical areas. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. Each PIP includes the following: • Measurement of performance using objective quality indicators. • Implementation of interventions to achieve improvement in the access to and quality of care. • Evaluation of the effectiveness of the interventions based on the objective quality indicators. • Planning and initiation of activities for increasing or sustaining improvement.	**Documents:** 1. Medical Management Quality Management Program Description 2. QMPC Charter 3. PAC Charter **Narrative:** We actively participate in the PIP projects and ensure that these are completed on a continual basis as the state lays out for us. In doing these projects we use objective quality indicators to identify areas for improvement. We then implement our interventions and evaluate the effectiveness of those interventions. We use the PDSA method for our quality improvement efforts. This information is shared with our PAC as well as all department managers through QMPC.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.330(b)(1) and (d)(2) and (3) Contract: Exhibit B—12.3.1, 12 3.2, 12.3.4		
3. The Contractor's QAPI Program includes collecting and submitting (to the State) annually: • Performance measure data using standard measures identified by the State. • Data, specified by the State, which enable the State to calculate the Contractor's performance using the standard measures identified by the State. • A combination of the above activities. *42 CFR 438.330(b)(2) and (c)* Contract: Exhibit B—12.4.1, 12.4.2	**Documents:** 1. HEDIS template provided to HSAG annually 2. CAHPS report conducted by HSAG **Narrative:** We participate and submit data and interventions to the state through the state identified PIP. We also submit CAHPS and HEDIS data annually.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42 CFR 438.330(b)(3)* Contract: Exhibit B—12.4.4	**Documents:** 1. Policy # 3504 **Narrative:** Under and over utilization is monitored by our UM nursing staff. They do this through our claims history data that is housed in our Xpress system. Before approving a request they look through the system to see if there has been previous requests for this and if they suspect misuse. This is then taken to the medical director and a letter is sent out to the member. We utilize the same process for ED overuse. In the same manner we are able to see if someone should be using a service (such as PT) more than they are. This is often seen when there has been an	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	approval for visits and no claims have come in. We are able to run a report for those referrals in our Xpress system that have been approved and not used.	
Findings: Staff described that individual case reviews related to authorizations or focused on specific areas of utilization—e.g., emergency room visits—are used to determine whether a particular member is under- or overutilizing a service. In addition, FHP produced a tracking report which demonstrated that FHP's data system has the capability to produce query reports to determine frequency of utilization of specific services. However, HSAG found no evidence that these types of reports were reviewed or that data were sufficiently analyzed to conclude potential over- or underutilization of services as a component of the QAPI program. Furthermore, neither the 2018 Quality Assurance Plan nor the Physician Advisory Committee minutes addressed review of overall utilization data trends. HSAG recommended that FHP consider establishing some routine utilization parameters, produce periodic reports of those parameters showing trends over time, and ensure that the QAPI oversight committees analyze and make conclusions regarding potential underutilization or overutilization concerns.		
Required Actions: While FHP demonstrated having capability to produce on-demand utilization trending reports, FHP must define and implement mechanisms to systematically detect and determine concerns regarding both underutilization and overutilization of services as a component of its QAPI program.		
5. The Contractor's QAPI program includes investigation of any alleged quality of care concerns. Contract: Exhibit B—12.4.5.1	**Documents:** 1. Policy # 3700 Physician Advisory Committee **Narrative:** Page 5 of this policy stated that all cases identified for Quality of Care issues will be discussed. These are usually identified through concurrent review and are then taken to the medical director if she/he was not the one to discover the possible quality of care issue. It is then taken to the PAC committee and reviewed and discussed. Once a decision has been made then appropriate correspondence is sent to the provider in question. Any return information is taken back to pack until the issue is resolved.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. *Note: Persons with special health care needs means persons with ongoing heath conditions that: have lasted or are expected to last for at least one year; produce significant limitations in physical, cognitive, emotions, or—in the case of children—social growth or developmental function; or produce dependency on medical or assistive devices; or—in the case of children—unusual need for psychological, educational, or medical services or ongoing special treatments (e.g. medications, special diets, accommodations at home or at school).* *42 CFR 438.330(b)(4)* Contract: Exhibit B—None	**Documents:** 1. Medical Management Quality Management Program Description **Narrative:** In an effort to assess quality and appropriateness of care furnished to members, Friday Health Plans has documented its oversight and continuous quality improvement through its development of the Quality Management Program Description.	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: During on-site interviews, staff members stated that FHP defines members with special healthcare needs as any member requiring out-of-the-ordinary care—a broader definition than the State definition—due to the fact that CHP+ members are a relatively healthy population. While FHP applies other internal individualized processes to these members—i.e., coordination of services—staff members acknowledged that no mechanism exists within the formal QAPI program to assess the overall quality and appropriateness of care furnished to these members. Staff members speculated that, due to the exceedingly low number of these members, perhaps a case study analysis through the PAC would be an appropriate mechanism for such assessment.		
Required Actions: FHP must implement a mechanism within its QAPI program to periodically assess the quality and appropriateness of care for members with special healthcare needs.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program at least annually. *42 CFR 438.330(e)(2)* Contract: Exhibit B—12.4.7.1	**Documents:** 1. Medical Management Quality Management Program Description **Narrative:** This document is updated on an annual basis by the Director of Medical Management in conjunction with the QMPC. Once the document is updated it is presented the Board of Directors, QMPC and the PAC for reporting purposes.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor adopts practice guidelines that meet the following requirements: • Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. • Consider the needs of the Contractor's members. • Are adopted in consultation with participating providers. • Are reviewed and updated at least every two years. *42 CFR 438.236(b)* Contract: Exhibit B—12.2.1.2	This information is located on our website and maintained by our Medical Director. The information used is obtained through, but not limited to, the following: 1. Milliman's Care Guidelines- MCG 2. Up to Date- UTD 3. The BAA from our Pharmacy Benefit Manager Several different American Academies (Pediatric and Cardiology)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor develops practice guidelines for the following: • Perinatal, prenatal, and postpartum care. • Conditions related to persons with a disability or special health care needs. • Well-child care. Contract: Exhibit B—12.2.1.1	This information is located on our website and maintained by our Medical Director. The information used is obtained through, but not limited to, the following: 1. Milliman's Care Guidelines- MCG 2. Up to Date- UTD 3. The BAA from our Pharmacy Benefit Manager Several different American Academies (Pediatric and Cardiology).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor disseminates the guidelines to all affected providers and, upon request, members, non-members, and the public—at no cost. *42 CFR 438.236(c)* Contract: Exhibit B—12.2.1.3	This information is located on our website and maintained by our Medical Director. The information used is obtained through, but not limited to, the following: 1. Milliman's Care Guidelines- MCG 2. Up to Date- UTD 3. The BAA from our Pharmacy Benefit Manager Several different American Academies (Pediatric and Cardiology)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42 CFR 438.236(d)* Contract: Exhibit B—12.2.1.4	This information is located on our website and maintained by our Medical Director. The information used is obtained through, but not limited to, the following: 1. Milliman's Care Guidelines- MCG 2. Up to Date- UTD 3. The BAA from our Pharmacy Benefit Manager Several different American Academies (Pediatric and Cardiology)	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: FHP had a well-defined approach through the medical director and the PAC to adopt and disseminate practice guidelines in compliance with requirements. However, FHP did not have an internal process for ensuring that other decisions to which the guidelines apply are consistent with adopted practice guidelines.		
Required Actions: FHP must define and implement a process to ensure that utilization management decisions, member education materials, and other areas to which practice guidelines apply are consistent with those guidelines.		
12. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42 CFR 438.242(a)* Contract: Exhibit B—12.4.10.1	**Documents:** 1. N/A **Narrative:** Friday Health Plans utilizes the Monument Systems Xpress, Version 3.11.2.202 system. With this Xpress system FHP is able to collect, analyze, integrate and report data including information on utilization,	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	services, grievances, and appeals, providers, encounters, enrollment and demographics data.	
13. The Contractor's health information system provides information about areas including but not limited to utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility. *42 CFR 438.242(a)* Contract: Exhibit B—12.4.10.1	**Documents:** 1. N/A **Narrative:** Friday Health Plans utilizes the Monument Systems Xpress, Version 3.11.2.202 system. With this Xpress system FHP is able to collect, analyze, integrate and report data including information on utilization, services, grievances, and appeals, providers, encounters, enrollment and demographics data.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor's claims processing and retrieval systems collect data elements necessary to enable the mechanized claims processing and information retrieval systems operated by the State. • Contractor electronically submits encounter claims data in the interChange ANSI X12N 837 format directly to the Department's fiscal agent using the Department's data transfer protocol. The 837-format encounter claims (reflecting claims paid, adjusted, and/or denied by the Contractor) shall be submitted via a regular batch process. *42 CFR 438.242(b)(1)* Contract: Exhibit B—18.2.1	**Documents:** 1. N/A **Narrative:** Friday Health Plans utilizes the Monument Systems Xpress, Version 3.11.2.202 system. With this Xpress system FHP is able to collect, analyze, integrate and report data including information on utilization, services, grievances, and appeals, providers, encounters, enrollment and demographics data.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The Contractor collects data on member and provider characteristics and on services furnished to members through an encounter data system (or other methods specified by the State). *42 CFR 438.242(b)(2)* Contract: Exhibit B—12.4.10.2	**Documents:** 1. N/A **Narrative:** Friday Health Plans utilizes the Monument Systems Xpress, Version 3.11.2.202 system. With this Xpress system FHP is able to collect, analyze, integrate and report data including information on utilization, services, grievances, and appeals, providers, encounters, enrollment and demographics data.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. The Contractor ensures that data received from providers are accurate and complete by: • Verifying the accuracy and timeliness of reported data, including data from network providers compensated through capitation payments. • Screening the data for completeness, logic, and consistency. • Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies used for Medicaid quality improvement and care coordination efforts. *42 CFR 438.242(b)(3) and (4)* Contract: Exhibit B—12.4.10.3.1	We utilize a company by the name of Zelis who reviews our claims data to ensure that providers are billing us and we are paying them appropriately. They are monitoring things such as unbundling and bundling of charges to ensure they are being done correctly. We also utilize PAC for this process for review of charts. This is done on a random basis as well as any triggered reviews or quality of care issues.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The Contractor: • Collects and maintains sufficient member encounter data to identify the provider who delivers any items or services to members. • Submits member encounter data to the State in standardized ASC X12N 837, NCPDP, and ASC X12N 835 formats as appropriate. • Submits member encounter data to the State at the level of detail and frequency specified by the State. *42 CFR 438.242(c)* Contract: Exhibit B—18.2.6; 18.2.7, 18.2.8	**Documents:** 1. N/A **Narrative:** Friday Health Plans utilizes the Monument Systems Xpress, Version 3.11.2.202 system. With this Xpress system FHP is able to collect, analyze, integrate and report data including information on utilization, services, grievances, and appeals, providers, encounters, enrollment and demographics data.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
18. The Contractor monitors members' perceptions of accessibility and adequacy of services provided, including: • Member surveys. • Anecdotal information. • Grievance and appeals data. • Enrollment and disenrollment information. Contract: Exhibit B—12.4.3.2	**Documents:** 1. Policy #3403 **Narrative:** We meet this through a few different avenues. We use a vendor for our CAHPS surveys (member) and we have processes in place for grievance and appeals data (see policy #3403). We also have a designated employee in our Government Programs department who monitors and addresses all enrollment and disenrollment activities as well as the anecdotal information and disseminates as appropriate.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard X—Quality Assessment and Performance Improvement							
Total	Met	=	15	X	1.00	=	15
	Partially Met	=	1	X	.00	=	0
	Not Met	=	2	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	18	**Total Score**		=	15
Total Score ÷ Total Applicable						=	83%

Review Period:	July 1, 2018–November 7, 2018
Date of Review:	November 7, 2018
Reviewer:	Kathy Bartilotta and Rachel Henrichs
Health Plan Participant:	None

Sample #	1	2	3	4	5
Provider ID	*****	*****	*****	*****	*****
Credentialing Date	08/30/18	08/31/18	09/17/18	09/19/18	10/02/18
The Contractor, using primary sources, verifies that the following are present:					
1. A current, valid license to practice with verification that no State sanctions exist	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
2. A valid DEA or CDS certificate (if applicable)	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐
3. Education and training	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
4. Board certification (if the practitioner states on the application that he or she is board certified)	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒
5. Work history (most recent 5 years or from time of initial licensure)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
6. History of malpractice settlements (most recent 5 years)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
7. Current malpractice insurance in required amount (physicians: 0.5mil/1.5mil)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
8. Verification that the provider has not been excluded from participation in federal programs	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☒	Y ☐ N ☒	Y ☒ N ☐
9. Signed application and attestation	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
10. Verification was within the allowed time limits (verification time limits are included below).	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Number of applicable elements	**10**	**10**	**10**	**10**	**9**
Number of compliant elements	**10**	**10**	**9**	**9**	**9**
Percentage compliant	**100%**	**100%**	**90%**	**90%**	**100%**

Verification time limits:

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

Comments:
None.

Sample #	6	7	8	9	10
Provider ID	*****	*****	*****	*****	*****
Credentialing Date	10/03/18	10/11/18	10/12/18	10/24/18	10/24/18
The Contractor, using primary sources, verifies that the following are present:					
1. A current, valid license to practice with verification that no State sanctions exist	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
2. A valid DEA or CDS certificate (if applicable)	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐
3. Education and training	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
4. Board certification (if the practitioner states on the application that he or she is board certified)	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐
5. Work history (most recent 5 years or from time of initial licensure)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
6. History of malpractice settlements (most recent 5 years)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
7. Current malpractice insurance in required amount (physicians: 0.5mil/1.5mil)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
8. Verification that the provider has not been excluded from participation in federal programs	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
9. Signed application and attestation	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☒	Y ☒ N ☐
10. Verification was within the allowed time limits (verification time limits are included below).	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Number of applicable elements	**10**	**8**	**8**	**8**	**10**
Number of compliant elements	**10**	**8**	**8**	**7**	**10**
Percentage compliant	**100%**	**100%**	**100%**	**88%**	**100%**

Verification time limits:

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

Comments:
Files 3 and 4 included no verification that the provider had not been excluded from participation in federal programs prior to acceptance into the network.
File 9 included an attestation dated 11/02/18; however, the provider was accepted into the network on 10/24/18.

Total number of elements	**100**
Total number of applicable elements	**93**
Total number of compliant elements	**90**
Overall percentage compliant	**97%**

Review Period:	July 1, 2018–November 7, 2018
Date of Review:	November 7, 2018
Reviewer:	Rachel Henrichs
Health Plan Participant:	None

Sample #	1	2	3	4	5
Provider ID	*****	*****	*****	*****	*****
Prior Credentialing or Recredentialing Date	09/11/15	09/15/15	09/15/15	09/18/15	10/15/15
Current Recredentialing Date	09/12/18	09/26/18	09/14/18	09/26/18	10/03/18
The Contractor, using primary sources, verifies that the following are present:					
1. A current, valid license to practice with verification that no State sanctions exist	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
2. A valid DEA or CDS certificate (if applicable)	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐
3. Board certification (if the practitioner states on the application that he or she is board certified)	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐
4. History of malpractice settlements (most recent 5 years)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
5. Current malpractice insurance in required amount (physicians: 0.5mil/1.5mil)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
6. Verification that the provider has not been excluded from participation in federal programs	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
7. Signed application and attestation	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
8. Verification was within the allowed time limits (verification time limits are included below).	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
9. Provider was recredentialed within 36 months of previous approval date.	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Number of applicable elements	**8**	**9**	**9**	**9**	**9**
Number of compliant elements	**8**	**9**	**9**	**9**	**9**
Percentage compliant	**100%**	**100%**	**100%**	**100%**	**100%**

Verification time limits:

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

Comments:
None.

Appendix B. Colorado Department of Health Care Policy and Financing FY 2018–2019 Recredentialing Record Review Tool for Friday Health Plans of Colorado

Sample #	6	7	8	9	10
Provider ID	*****	*****	*****	*****	*****
Prior Credentialing or Recredentialing Date	10/27/15	11/09/15	11/13/15	11/19/15	11/30/15
Current Recredentialing Date	09/19/18	08/23/18	08/29/18	10/10/18	10/16/18
The Contractor, using primary sources, verifies that the following are present:					
1. A current, valid license to practice with verification that no State sanctions exist	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
2. A valid DEA or CDS certificate (if applicable)	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐
3. Board certification (if the practitioner states on the application that he or she is board certified)	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐
4. History of malpractice settlements (most recent 5 years)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
5. Current malpractice insurance in required amount (physicians: 0.5mil/1.5mil)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
6. Verification that the provider has not been excluded from participation in federal programs	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
7. Signed application and attestation	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
8. Verification was within the allowed time limits (verification time limits are included below).	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
9. Provider was recredentialed within 36 months of previous approval date.	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Number of applicable elements	**9**	**7**	**9**	**9**	**9**
Number of compliant elements	**9**	**7**	**9**	**9**	**9**
Percentage compliant	**100%**	**100%**	**100%**	**100%**	**100%**

Verification time limits:

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

Comments:
None.

Total number of elements	**90**
Total number of applicable elements	**87**
Total number of compliant elements	**87**
Overall percentage compliant	**100%**

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2018–2019 site review of **FHP**.

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

HSAG Review Team	Title
Kathy Bartilotta	Associate Director
Rachel Henrichs	Compliance Auditor
FHP Participants	**Title**
Ashley Booth	CHP+ Specialist in Government Programs
Ashley Palmer	Director, Provider Relations
Carrie Howard	Manager, Provider Relations
DeeAnn Sierra	Director, Medical Management
Jennifer Mueller	Chief Operations Officer
Jodi Parrish	Manager, Information Technology
Manuela Heredia	Director, Government Programs
Department Observers	**Title**
Patricia Connally	Quality Unit

Appendix D. Corrective Action Plan Template for FY 2018–2019

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 <u>also</u> 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**
	At the health plan's request, HSAG will schedule an 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 2018–2019 Corrective Action Plan for FHP

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
1. The Contractor implements procedures to deliver care to and coordinate services for all members. These procedures meet State requirements, including: • Ensuring timely coordination with any of a member's providers, including mental health providers, for the provision of covered services. • Addressing those members who may require services from multiple providers, facilities, and agencies; and who require complex coordination of benefits and services. • Ensuring that all members and authorized family members or guardians are involved in treatment planning and consent to any medical treatment. • Criteria for making referrals and coordinating care with specialists, subspecialists, and community-based organizations. • Providing continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services. *42 CFR 438.208(b)* Contract: Exhibit B—10.5.1, 10.5.2, 10.5.3.3, 10.5.3.5, 10.5.3.6	FHP's Care Management policy outlined processes for ensuring delivery of care and coordination of services that meet all State requirements except the requirement that all members or family members consent to the medical treatment plan. As this requirement is primarily executed through providers, HSAG recommended that FHP ensure that the provider manual or other provider communication clearly defines this requirement to providers.	FHP must define procedures to ensure that members and/or authorized family members are involved in treatment planning and consent to any medical treatment.

Standard III—Coordination and Continuity of Care		
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 III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
3. The Contractor implements procedures to coordinate services the Contractor furnishes the member: • Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. • With the services the member receives from any other managed care plan. • With the services the member receives in fee-for-service (FFS) Medicaid. • With the services the member receives from community and social support providers. *42 CFR 438.208(b)(2)* Contract—Exhibit B—10.5.3.3.1	FHP staff members were able to verbally describe procedures for coordinating members' services between settings of care, including discharge planning from institutional stays as well as coordinating members' service needs with community organizations and agencies. Staff members described that coordinating care for members transitioning between healthcare plans was performed through the member's primary care provider as a more effective conduit for ensuring that the member's care was coordinated with other health plans. While HSAG acknowledges that this approach represents "good practice," FHP must also develop and implement procedures to directly coordinate needed member services with other managed care and FFS health plans, particularly when the member is transitioning between health plans. In addition, HSAG observed that the processes verbally described during on-site interviews were not clearly delineated in written procedures and recommends that FHP do so.	FHP must develop and implement procedures to coordinate services being received by members with other managed care and FFS health plans when indicated.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard IV—Member Rights and Protections		
Requirement	**Findings**	**Required Action**
8. The Contractor maintains written policies and procedures and provides written information to individuals concerning advance directives with respect to adult members receiving care by or through the Contractor. Advance directives policies and procedures include: • A clear statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience. • The difference between institution-wide conscientious objections and those raised by individual physicians. • Identification of the State legal authority permitting such objection. • Description of the range of medical conditions or procedures affected by the conscientious objection. • Provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and unable to receive information. • Provisions for providing advance directive information to the	FHP's Medical Management Notification of Advance Directives desktop procedure described a member's right to declare and FHP's commitment to honoring advance directives. The document described the processes to monitor the laws and to update staff, members, and providers of any changes; educate staff and providers; and conduct annual chart reviews to confirm provider compliance. FHP included advance directive information in the member handbook and distributed pamphlets to area hospitals, clinics, and libraries. The desktop procedure included no provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and is unable to receive information.	FHP must revise its processes to include provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and is unable to receive information. Additionally, in order to address the requirement for written policies and procedures, FHP must convert its desktop procedure into a more formal policy and procedure.

Standard IV—Member Rights and Protections		
Requirement	**Findings**	**Required Action**
incapacitated member once he or she is no longer incapacitated. • Provisions for documenting in a prominent part of the member's medical record whether the member has executed an advance directive. • Provisions that the decision to provide care to a member is not conditioned on whether the member has executed an advance directive and that members are not discriminated against based on whether they have executed an advance directive. • Provisions for ensuring compliance with State laws regarding advance directives. • Provisions for informing members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. • Provisions for educating staff concerning policies and procedures about advance directives. • Provisions for community education regarding advance directives, to include: – What constitutes an advance directive. – Emphasis that an advance directive is designed to enhance		

Standard IV—Member Rights and Protections		
Requirement	**Findings**	**Required Action**
an incapacitated individual's control over medical treatment. – Description of applicable State law concerning advance directives. *42 CFR 438.3(j)* *42 CFR 422.128* Contract: Exhibit B—14.1.9.1		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Findings**	**Required Action**
18. The Contractor verifies the following sanction information for credentialing and recredentialing (verification time limit=180 days): • State sanctions, restrictions on licensure, or limitations on scope of practice. • Medicare and Medicaid sanctions. NCQA CR3—Element B	On-site record reviews demonstrated that FHP timely verified State sanctions; however, two records demonstrated that, while FHP verified federal sanctions within the required time fame, the letter accepting the provider into the network was sent prior to federal sanction information being received. NCQA instructs that the credentialing file must contain sufficient documentation to demonstrate all primary source verification information was present at the time of the credentialing decision.	FHP must ensure that a provider is not accepted into the network prior to information from federal exclusion databases being received and reviewed.
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:		

<table>
<tr><th colspan="3">Standard VIII—Credentialing and Recredentialing</th></tr>
<tr><th>Requirement</th><th>Findings</th><th>Required Action</th></tr>
<tr><td>19. Practitioners complete an application for network participation (at initial credentialing and recredentialing) that includes a signed attestation (attestation verification time limit=365 days). The application addresses the following:
• Reasons for inability to perform the essential functions of the position.
• Lack of present illegal drug use.
• History of loss of license and felony convictions.
• History of loss or limitation of privileges or disciplinary actions.
• Current malpractice or professional liability insurance coverage (minimums=physician—0.5mil/1.5mil; facility—0.5mil/3mil).
• Attestation confirming the correctness and completeness of the application.

NCQA CR3—Element C</td><td>FHP policies and procedures required that providers submit a completed application for network participation that includes a signed attestation; however, one of the 10 initial credentialing records reviewed on-site documented that FHP obtained the provider's signed attestation after the provider was approved by the medical director and accepted into the network.</td><td>FHP must ensure that staff members collect signed attestations from provider applicants prior to accepting those providers into the network.</td></tr>
<tr><td colspan="3">Planned Interventions:</td></tr>
<tr><td colspan="3">Person(s)/Committee(s) Responsible and Anticipated Completion Date:</td></tr>
</table>

Standard VIII—Credentialing and Recredentialing		
Requirement	**Findings**	**Required Action**
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Findings**	**Required Action**
24. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of *organizational* providers with which it contracts, which include: • The Contractor confirms—initially and at least every three years—that the provider is in good standing with State and federal regulatory bodies. − Policies specify the sources used to confirm—which may only include applicable State or federal agency, agent of the applicable State or federal agency, or copies of credentials (e.g., state licensure) from the provider. NCQA CR7—Element A1	FHP's policies and procedures described the processes for credentialing and recredentialing organizational providers consistent with regulations; however, documents submitted for review demonstrated that several organizations had not been recredentialed within the 36-month time frame.	FHP must ensure that staff recredential organizational providers every 36 months.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Findings**	**Required Action**
26. The Contractor conducts, initially and at least every three years, an on-site quality assessment if the provider is not accredited. • Polices include: on-site quality assessment criteria for each type of unaccredited organizational provider; a process for ensuring that that the provider credentials its practitioners. • The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: − The CMS or state review is no more than three years old. − The organization obtains a survey report or letter from CMS or the State, from either the provider or from the agency, stating that the facility was reviewed and passed inspection. − The report meets the organization's quality assessment criteria or standards. NCQA CR7—Element A3	On-site review of organizational credentialing files demonstrated that FHP staff members adhered to the requirement for using CMS or State quality reviews in lieu of site visits consistent with regulations; however, this process was not documented in FHP's credentialing plan.	FHP must revise its written credentialing processes to include the NCQA requirements related to on-site quality assessment for unaccredited organizational providers.

Standard VIII—Credentialing and Recredentialing		
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 X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
4. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42 CFR 438.330(b)(3)* Contract: Exhibit B—12.4.4	Staff described that individual case reviews related to authorizations or focused on specific areas of utilization—e.g., emergency room visits—are used to determine whether a particular member is under- or overutilizing a service. In addition, FHP produced a tracking report which demonstrated that FHP's data system has the capability to produce query reports to determine frequency of utilization of specific services. However, HSAG found no evidence that these types of reports were reviewed or that data were sufficiently analyzed to conclude potential over- or underutilization of services as a component of the QAPI program. Furthermore, neither the 2018 Quality Assurance Plan nor the Physician Advisory Committee minutes addressed review of overall utilization data trends. HSAG recommended that FHP consider establishing some routine utilization parameters, produce periodic reports of those parameters showing trends over time, and ensure that the QAPI oversight committees analyze and make conclusions regarding potential underutilization or overutilization concerns.	While FHP demonstrated having capability to produce on-demand utilization trending reports, FHP must define and implement mechanisms to systematically detect and determine concerns regarding both underutilization and overutilization of services as a component of its QAPI program.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
6. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. *Note: Persons with special health care needs means persons with ongoing heath conditions that: have lasted or are expected to last for at least one year; produce significant limitations in physical, cognitive, emotions, or—in the case of children—social growth or developmental function; or produce dependency on medical or assistive devices; or—in the case of children—unusual need for psychological, educational, or medical services or ongoing special treatments (e.g. medications, special diets, accommodations at home or at school).* *42 CFR 438.330(b)(4)* Contract: Exhibit B—None	During on-site interviews, staff members stated that FHP defines members with special healthcare needs as any member requiring out-of-the-ordinary care—a broader definition than the State definition—due to the fact that CHP+ members are a relatively healthy population. While FHP applies other internal individualized processes to these members—i.e., coordination of services—staff members acknowledged that no mechanism exists within the formal QAPI program to assess the overall quality and appropriateness of care furnished to these members.	FHP must implement a mechanism within its QAPI program to periodically assess the quality and appropriateness of care for members with special healthcare needs.
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 X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
11. The Contractor ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42 CFR 438.236(d)* Contract: Exhibit B—12.2.1.4	FHP had a well-defined approach through the medical director and the PAC to adopt and disseminate practice guidelines in compliance with requirements. However, FHP did not have an internal process for ensuring that other decisions to which the guidelines apply are consistent with adopted practice guidelines.	FHP must define and implement a process to ensure that utilization management decisions, member education materials, and other areas to which practice guidelines apply are consistent with those guidelines.
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:		

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 managed care regulations and contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, on-site agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all site reviewers to ensure consistency in scoring across plans.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided group technical assistance and training, as needed. • Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the health plan in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four 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 credentialing and recredentialing records that occurred between July 1, 2018, and December 31, 2018 (to the extent available at the time of the site visit). HSAG used a random sampling technique to select records for review during the site visit. • The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct Site Visit**
	• During the on-site portion of the review, HSAG met with the health plan's key staff members to obtain a complete picture of the health plan's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan's performance. • HSAG reviewed a sample of administrative records to evaluate implementation of managed care regulations related to credentialing and recredentialing of providers. • While on-site, HSAG collected and reviewed additional documents as needed. • At the close of the on-site portion of the site review, HSAG met with health plan staff and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2018–2019 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.