CHP+

Child Health Plan *Plus*

Fiscal Year 2019–2020 Site Review Report

for

Friday Health Plans

March 2020

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

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Introduction

Public Law 111-3, Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, requires that each state's Children's Health Insurance Program (CHIP) apply several provisions of Section 1932 of the Social Security Act 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 federal managed care regulations and State contract requirements, the Department determined that the review period for fiscal year (FY) 2019–2020 was January 1, 2019, through December 31, 2019. This report documents results of the FY 2019–2020 site review activities for **Friday Health Plans** (**FHP**). For each of the standard areas reviewed this year, this section contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 2 describes the background and methodology used for the 2019–2020 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the 2018–2019 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 denials of authorization of services (denials) 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 2019–2020 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)
I. Coverage and Authorization of Services	36	32	20	6	6	4	63%
II. Access and Availability	16	16	13	3	0	0	81%
Totals	**52**	**48**	**33**	**9**	**6**	**4**	**69%**

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

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

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Denials	90	52	39	13	38	75%
Totals	**90**	**52**	**39**	**13**	**38**	**75%**

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

Standard I—Coverage and Authorization of Services

Summary of Strengths and Findings as Evidence of Compliance

FHP submitted, or provided on-site, procedures and written processes to demonstrate provision of medically necessary covered services to members. Policies and procedures and on-site interviews confirmed that systems were in place for review and authorization of initial and continuing services and covered benefits of the plan using adopted utilization management (UM) criteria (Milliman Care Guidelines and UpToDate.com clinical practice guidelines), an accurately defined CHP+ definition of "medical necessity," CHP+ covered benefit guidelines, and medical reviewers for potential denial decisions. The *UM Peer Review* policy and procedure documented processes for utilizing multidisciplinary medical peer reviewers qualified to render a clinical opinion about medical conditions and treatments being reviewed for authorization. **FHP** processes offered a peer-to-peer consultation with the requesting service provider prior to making a denial decision. The *Review Timeframes and Notification* policy accurately outlined the time frames for standard, expedited, and concurrent review decisions. Denial record reviews demonstrated compliance with required time frames and written notification to the member. Denial of a claim was communicated to members through the Explanation of Benefits (EOB) statement, which included an attachment to explain the appeal and State fair hearing (SFH) processes. The Notice of Adverse Benefit Determination (NOABD) template was available in English and Spanish. The template letter was written in language reasonably easy for the member to understand. The *CHP+ Extension of Standard and/or Expedited Decisions* desktop procedure (DTP) accurately outlined the reasons for extension of the review decision by up to 14 days, and the template extension letter included required information.

FHP's medical management procedures and CHP+ Member Handbook defined "emergency medical condition," "emergency services," and "post-stabilization services" according to the required definitions, and stated that prior authorization is not required for emergency services in or out of network. During on-site interviews, staff members described that the claims system is programmed to approve a number of pre-defined emergent conditions, and that all other emergency claims are reviewed and approved by the UM Nurse Manager and Medical Director. **FHP**'s *Medical Management—Availability of Emergency and Urgent Care Services* DTP stated that all CHP+ emergency service claims are evaluated using the definition of emergency medical condition consistent with the prudent layperson standard. **FHP** procedures also addressed requirements related to *not* limiting what constitutes a medical condition based on a diagnosis, *not* refusing to cover emergency services based on failure to notify the plan, and *not* holding the member liable for payment of emergency treatment. The procedures also stated that the treating physician determines when the member is clinically stabilized for transfer or discharge. Staff members stated that Milliman Care Guidelines include criteria for post-stabilization services that are applied by staff members to determine medical necessity of post-stabilization services.

Summary of Findings Resulting in Opportunities for Improvement

While **FHP** defined "medically necessary" in accordance with the definition in the CHP+ contract, the definition implied but did not explicitly address the criteria: "Not experimental, investigational, unproven, unusual, or not customary" and "Not solely for cosmetic purposes." HSAG recommends that **FHP** consider strengthening language in its CHP+ definition of "medically necessary" to specifically address these criteria.

While **FHP** must remove the opportunity for reconsideration of a pending denial—based on receiving additional information from the member—from its NOABD (see below), HSAG recommends that **FHP** develop an alternative method of communicating this opportunity to the member prior to making the authorization decision and sending the NOABD to the member.

HSAG recommends that **FHP** clarify language in its policies and procedures—*Precertification Procedures for Authorizations and Referrals*, *UM Concurrent Review Policy and Procedure*, and *Review Timeframes and Notification*—to specify that any decision to deny authorization of a service must be provided to the member in writing.

HSAG observed that the *CHP+ Expedited Requests/Determination* DTP (CHP+ "expedited" DTP) included confusing information regarding handling of expedited authorization decisions or expedited appeals. HSAG recommends that **FHP** review and clarify this document related to processes applicable to authorization decisions and those related to appeals.

The *Review Timeframes and Notification* policy and the *CHP+ Extension of Standard and/or Expedited Decisions* DTP (CHP+ "extension" DTP) included conflicting information. Whereas the CHP+ "extension" DTP clearly stated that standard or expedited review decisions may be extended up to 14 days, the *Review Timeframes and Notification* policy stated that "for prospective non-urgent (i.e., standard) reviews, **FHP** does not offer an extension for the UM review process." While verbally clarified by staff members during the on-site interview, HSAG recommends that **FHP** clarify language in the *Review Timeframes and Notification* policy to align with the CHP+ "extension" DTP.

While the CHP+ Member Handbook outlined all criteria for determining financial responsibility for post-stabilization services, the **FHP** Provider Manual did not include this information. Whereas the circumstances for determining payment of post-stabilization services impact the provider and are not in control of the member, HSAG suggests that **FHP** consider adding the requirements related to determining payment for post-stabilization services to the provider manual and consider removing similar detailed information from the member handbook.

FHP did not demonstrate that it had an oversight process to ensure that its pharmacy benefit manager (PBM) complied with regulations for providing notice within 24 hours of a request for authorization of covered outpatient drugs. HSAG recommends **FHP** ensure its PBM contract or delegation agreement includes the requirement for Magellan to comply with the 24-hour notice requirement and that **FHP** develop an oversight monitoring process to ensure compliance by the PBM.

Summary of Required Actions

While the *Review Timeframes and Notification* policy accurately stated the time frame for processing an expedited authorization request within 72 hours following receipt of the request, the CHP+ "expedited" DTP inaccurately stated the time frame for expedited authorization decisions as three business days. In addition, the CHP+ "extension" DTP inaccurately stated that notice of expedited authorization decisions must be provided within three business days of receipt of the request. **FHP** must correct both its CHP+ "expedited" DTP and CHP+ "extension" DTP and any related documents to include accurate time frames for making expedited authorization decisions and notifying the member.

The NOABD included no taglines informing the member of availability in alternative formats. In addition, HSAG found that in three denial record reviews, the information entered into the NOABD regarding the reason for denial was not easy for the member to understand. **FHP** must include taglines in its NOABD informing the member of the availability of the notice in alternative formats. **FHP** must also ensure that all information in the NOABD is written in language easy for the member to understand.

FHP's NOABD included numerous omissions or inaccuracies in the required content of the notice, including:

- Procedures for filing an appeal inaccurately stated that the member must request an appeal within 30 days of the NOABD (should be 60 days).
- The member's right to request an SFH included outdated regulatory information—"You have the right to request an SFH: instead of using **FHP**'s appeal process; at any time during your appeal with **FHP**; or if you are not happy with **FHP**'s decision about your appeal" (the member's right to request an SFH is only after receiving an appeal resolution notice from **FHP** that the adverse benefit determination [ABD] was upheld).
- Procedures for requesting an SFH inaccurately stated that a SFH must be requested within 30 days of the NOABD (should be within 120 days of receiving the appeal resolution notice from the health plan). It also inaccurately stated that a request for an SFH concerning previously approved services must be made within 10 working days of the NOABD.
- Does not inform the member on *how* to request that benefits continue during an appeal (i.e., call **FHP** to request continuation of benefits during the appeal).
- Offers a reconsideration process prior to an appeal, which equates to a second level of appeal within **FHP** and is non-compliant with "the member's right to request one level of appeal with the Contractor."
- No information on the member's right to appeal under the Child Mental Health Treatment Act (CMHTA), when applicable.

Due to these inaccuracies, all 10 denial record reviews were found *Not Met* for required content of the NOABD. **FHP** must revise the content of the NOABD to include all required content and accurate appeals information, per updated CHP+ federal and State regulations (effective July 1, 2018). In addition, **FHP** must remove the description of reconsideration (more than one level of appeal with the Contractor) from the NOABD.

FHP provided no evidence of operating procedures that addressed the notification time frames for: termination, suspension, or reduction of previously authorized services; extended service authorizations; or authorizations not reached within the required time frames. **FHP** must develop or enhance CHP+ operating procedures to address all required time frames for mailing the NOABD.

FHP had no operating procedures for staff members regarding the time frames for providing the NOABD for termination or reduction in previously authorized services or the exceptions to this time frame outlined in 42 CFR 431.211, 431.213, and 431.214. **FHP** must develop operating policies and procedures for staff members to address time frames for notice to the member regarding reduction, suspension, or termination of previously authorized services, as well as providing notice on or before the intended effective date for those circumstances outlined in the requirement. If, in fact, **FHP** never denies previously authorized services (as stated during on-site interviews), operating policies and procedures must clearly include this statement.

FHP's *Medical Management—Availability of Emergency and Urgent Care Services* DTP did not address mechanisms for reviewing or authorizing payment for emergency services "when a representative of **FHP** instructed the member to seek emergency services." **FHP** must enhance procedures for review of emergency claims to address the requirement to pay for emergency services if a representative of **FHP** instructed the member to seek emergency services.

FHP submitted the CHP+ Member Handbook, which outlined post-stabilization requirements verbatim, as evidence that requirements for financial responsibility of the Contractor for post-stabilization services had been met. However, the member handbook does not equate to internal operating procedures for staff members. **FHP** had no written operating procedures to guide staff members in the review of post-stabilization services considering the criteria outlined in 42 CFR 422.113(c). **FHP** must develop internal operating procedures or other documentation to guide staff members regarding **FHP**'s financial responsibility for payment of post-stabilization services as outlined in 42 CFR 422.113(c), including:

- Services that are prior authorized, whether provided in or out of network.
- Services that are not pre-approved but administered within one hour of request for approval.
- Services that are not pre-approved but the organization does not respond to request for approval, cannot be contacted, or when the treating physician and **FHP** cannot reach agreement.
- When financial responsibility for post-stabilization care that is not pre-approved ends.
- Member liability for payment of post-stabilization services received out of network as defined in 422.113(c)(3).

FHP policies and procedures did not address requirements for providing 24-hour notice to the requestor of authorization determinations regarding covered outpatient drugs. **FHP** delegated PBM to Magellan Health (Magellan). Magellan's "procedures for conducting reviews for drug service requests" inaccurately documented that the turnaround times for conducting initial prior authorization drug service requests (applicable to managed care plans) was within 72 hours of receipt for expedited requests and within 15 calendar days of receipt for standard requests. **FHP** must ensure that its PBM has accurate policies and procedures regarding the time frame for providing notice of authorization for covered

outpatient drugs and complies with the requirement to provide telephonic or telecommunications notice of the authorization decision within 24 hours of receiving complete information from the prescriber/requestor for making the authorization decision. In addition, **FHP** must develop or enhance **FHP** policies and procedures to address review and notification of authorization for covered outpatient drugs.

Standard II—Access and Availability

Summary of Strengths and Findings as Evidence of Compliance

FHP demonstrated having an active process for analysis and oversight of network adequacy. **FHP**'s executive team reviewed **FHP**'s geo-access maps, utilization of services data, the latest census data, recent claims, customer services statistics, and key performance indicators weekly to continuously monitor network access. Annual evaluation of the Network Access Plan was conducted by the Quality Assurance Committee, executive team, Chief Executive Officer, and Board of Directors. Assessment included achievement of the Network Access Plan goals and objectives and revising the Network Access Plan prior to submitting it to the Department.

FHP developed and utilized various assessment checklists, tools, and platforms to evaluate network access standards routinely. A Scheduling Wait Times Log was used to sample 20 percent of the providers in network quarterly to determine compliance with scheduling standards. **FHP** used the Office Site Quality Checklist to evaluate physical accessibility, equipment accessibility, and Americans with Disabilities Act (ADA) compliance of provider offices. Staff members weekly examined the Provider Network Disruption Analysis to pinpoint any disruptions to access that occurred and required follow up by the provider relations team or executive team to alleviate the disruption. **FHP** obtained geo-access maps comparing the number of members and provider types by service area to quarterly evaluate alterations in network access and to annually assess compliance with required time and distance standards throughout the service area.

FHP maintained written policies related to cultural competency that addressed provision of services to members in accordance with cultural beliefs and affiliations and to members with disabilities. **FHP**'s *Provider Relations—Cultural Competency* DTP included a list of resources where providers could obtain additional cultural competency training, continuing education, and other beneficial documents for providing culturally sensitive care. **FHP** confirmed that network providers had participated in cultural competency training. **FHP** offered translation services to members through Translation Plus and provided written materials in other languages and alternative formats, if requested.

FHP completed quarterly and annual reviews, utilizing geo-access maps, to oversee that members had direct access to in-network women's healthcare specialists and family planning providers. **FHP** utilized single case agreements in instances when the provider network was unable to deliver necessary covered services and out-of-network services were necessary. **FHP** network providers offered standard hours of operation from at least 8 a.m. to 5 p.m., Monday through Friday, which **FHP** monitored no less than annually.

Summary of Findings Resulting in Opportunities for Improvement

While **FHP** was able to describe the process for providing a member with a second opinion in or out of network, **FHP** did not have a written internal procedure outlining this process. HSAG recommends that **FHP** develop a written procedure outlining the process for providing members with second opinions (in network and out of network), at no cost to the member.

Summary of Required Actions

FHP provided standards for timely access to care and services for all required elements, except for: *emergency* behavioral healthcare by phone or in person; ensuring that members were not placed on waiting lists for initial routine behavioral health services; and outpatient follow-up appointments within seven days after discharge. Similarly, **FHP** did not have a mechanism to monitor providers for compliance with these three missing standards. **FHP** must update or expand its standards for timely access to include emergency behavioral healthcare by phone and in person, outpatient follow-up appointments, and not placing members on waiting lists for initial routine behavioral health services. Additionally, **FHP** must expand the Scheduling Wait Times Log to including monitoring of these additional standards for timely access or develop an alternative mechanism for doing so.

FHP provided its Scheduling Wait Times Log, which was used to audit timely access standards; however, **FHP** did not have a written procedure outlining the entire process for ensuring timely access standards are met. **FHP** must develop a written procedure that outlines the full process for monitoring timely access standards and addresses all elements of the requirement—e.g., mechanism for monitoring, frequency of monitoring, and taking corrective action.

While **FHP** network providers are provided resources for cultural competency training programs, there was no established method by which **FHP** ensured health plan staff members were provided with cultural competency training programs. **FHP** must develop and implement mechanisms to ensure **FHP** staff members are provided cultural competency training programs regarding cultural factors affecting access to care or medical risks.

2. Overview and Background

Overview of FY 2019–2020 Compliance Monitoring Activities

For the FY 2019–2020 site review process, the Department requested a review of two areas of performance. HSAG developed a review strategy and monitoring tools consisting of two standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of the two standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the two 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+ denial of authorization.

HSAG also reviewed a sample of the health plan's administrative records related to CHP+ denials to evaluate implementation of federal healthcare regulations. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records (to the extent that a sufficient number existed). Using a random sampling technique, HSAG selected the sample from all CHP+ denial records that occurred between January 1, 2019, and December 31, 2019. 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 I—Coverage and Authorization of Services. HSAG separately calculated a record review score for each record and an overall record review score.

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[2-1] Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The two standards chosen for the FY 2019–2020 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VI—Grievances and Appeals, Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, and Standard X—Quality Assessment and Performance Improvement.

Objective of the Site Review

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

- The health plan's compliance with federal healthcare regulations and managed care contract requirements in the two 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.

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Aug 5, 2019.

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

FY 2018–2019 Corrective Action Methodology

As a follow-up to the FY 2018–2019 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 2018–2019 compliance monitoring site review.

Summary of FY 2018–2019 Required Actions

For FY 2018–2019, HSAG reviewed 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.

Related to coordination and continuity of care, **FHP** was required to complete two corrective actions, including:

- Coordinating services with other managed care and fee-for-service (FFS) plans.
- Ensuring members of family members consent to medical treatment plan.

Related to member rights and protections, **FHP** was required to include in its written advance directives policies provisions for providing advance directive information to the member's family or surrogate if the member is incapacitated at the time of initial enrollment.

Related to credentialing and recredentialing, **FHP** was required to complete four corrective actions, including:

- Two elements related to ensuring the provider is not accepted into the network prior to all required information being received and reviewed.
- Ensuring credentialing of organizational providers every 36 months.
- Including in written processes requirements related to on-site quality assessment of organizational providers.

Related to quality assessment and performance improvement, **FHP** was required to complete three corrective actions, including:

- Systematically detecting and determining concerns regarding over- and underutilization.
- Assessing quality of care for members with special healthcare needs.
- Implementing a process to ensure UM and other decisions are consistent with clinical practice guidelines.

Summary of Corrective Action/Document Review

FHP submitted a proposed CAP in February 2019. HSAG and the Department reviewed and approved the proposed plan and responded to **FHP**. **FHP** submitted initial documents as evidence of completion in July 2019. **FHP** subsequently provided resubmission of specific documents in September 2019. Following review by HSAG and the Department, **FHP** was required to resubmit additional documentation and was given until December 20, 2019, to resubmit documents as evidence of completion for two outstanding proposed interventions.

Summary of Continued Required Actions

As of the date of this FY 2019–2020 compliance report, **FHP** had two continued required actions pending review of CAP documents to be resubmitted by **FHP**. HSAG will review **FHP**'s CAP resubmission with the Department and work with the health plan to ensure full implementation of all corrective actions.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor ensures that the services are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished. *42 CFR 438.210(a)(3)(i)* Contract: Exhibit B-1—8.3	**Documents:** 1. CHP+ Member Handbook –Summary Comparison Benefit Form, pages 6-14; Your Friday Health Plans Benefits and Services, pages 37-70 2. P&P #3504 UM Precertification Review Policy 3. Network Access Plan **Narrative:** Friday Health Plans has a Member Handbook that includes benefits and services offered to members. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Friday Health Plans when providing information to members and furnishing services. Friday Health Plans follows policy 3504 in assuring that services provided to plan members are covered benefits that are medically necessary, appropriate, and applicable to the diagnosis or condition being treated. The Network Access Plan is also incorporated in order maintain a network of Providers and facilities sufficient to assure that all covered benefits are available to Members without unreasonable delay as is possible.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42 CFR 438.210(a)(3)(ii)* Contract: Exhibit B-1—8.11	**Documents:** 1. CHP+ Member Handbook– Section I, Summary Comparison Benefit Form, Pages 6 – 14; Section VII. Your Friday Benefits and Services, Pages 37 – 70. 2. Policy 3504 UM Pre-Certification Review **Narrative:** Friday affords all CHP+ members the benefits as listed in the CHP+ comparison benefit form covered services and co-payments. CHP+ members receive the summary comparison benefit form in their member handbook. The handbook also has a section that provides detailed information about benefits and services. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Friday when dealing with members and furnishing services. Policy 3504 outlines Friday's procedures to ensure that services provided to plan members are covered benefits that are medically necessary, appropriate and applicable to the diagnosis or condition being treated.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor may place appropriate limits on services— • On the basis of criteria applied under the State plan (such as medical necessity). • For the purpose of utilization control, provided that: – The services furnished can reasonably achieve their purpose. – Family planning services are provided in a manner that enables the member to be free from coercion and choose the method of family planning to be used. – Long-term services and supports (LTSS) supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the member's ongoing need for such services. *42 CFR 438.210(a)(4)* Contract: Exhibit B-1—8.15.8.1	**Documents:** 1. CHP+ Member Handbook – Section III. Process for Getting Covered Services, Pages 19-23 2. Utilization Management Program **Narrative:** Friday has a Member Handbook that includes utilization review process for members. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Friday when dealing with members and furnishing services. Friday has a Utilization Management Program that is used for monitoring, evaluating, and improving the quality appropriateness of health services provided to members.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. The Contractor may place appropriate limits on services for utilization control, provided that any financial requirement or treatment limitation applied to mental health or SUD benefits in any classification is no more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to members (whether or not the benefits are furnished by the same Contractor). *HB19-1269: Section 3—10-16-104(3)(B)* Contract: Exhibit B-1—8.15.4.1	**Documents:** 1. CHP+ Member Handbook – Section III. Process for Getting Covered Services, Pages 19-23 2. Utilization Management Program **Narrative:** Friday has a Member Handbook that includes utilization review process for members. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Friday when dealing with members and furnishing services. Friday has a Utilization Management Program that is used for monitoring, evaluating, and improving the quality appropriateness of health services provided to members.	*For Information Only*

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor must ensure that the diagnosis of an intellectual or developmental disability, a neurological or neurocognitive disorder, or a traumatic brain injury does not preclude an individual from receiving a covered behavioral health (BH) service. *HB19-1269: Section 12—25.5-5-402(3)(h)*	**Documents:** 1. CHP+ Member Handbook – Section III. Process for Getting Covered Services, Pages 19-23 2. Utilization Management Program **Narrative:** Friday has a Member Handbook that includes utilization review process for members. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Friday when dealing with members and furnishing services. Friday has a Utilization Management Program that is used for monitoring, evaluating, and improving the quality appropriateness of health services provided to members. Friday health plans treats all members the same and therefore would not preclude an individual from received a covered behavioral health (BH) service.	*For Information Only*
6. The Contractor covers all medically necessary covered treatments for covered BH diagnoses, regardless of any co-occurring conditions. *HB19-1269: Section 12—25.5-5-402(3)(i)*	**Documents:** 1. CHP+ Member Handbook – Section III. Process for Getting Covered Services, Pages 19-23 2. Utilization Management Program **Narrative:** Friday has a Member Handbook that includes utilization review process for members. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Friday when dealing with members and furnishing services.	*For Information Only*

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Friday has a Utilization Management Program that is used for monitoring, evaluating, and improving the quality appropriateness of health services provided to members. Friday health plans treats all members the same and therefore would not preclude an individual from receiving all medically necessary covered treatments for covered BH diagnoses, regardless of any co-occurring conditions.	
7. The Contractor specifies what constitutes "medically necessary" in a manner that is: • Consistent with the symptom, diagnosis, and treatment of a member's medical condition. • Widely accepted by the practitioner's peer group as effective and reasonably safe based on scientific evidence. • Not experimental, investigational, unproven, unusual, or not customary. • Not solely for cosmetic purposes. • Not solely for the convenience of the member, subscriber, physician, or other provider. • The most appropriate level of care that can be safely provided to the member, and failure to provide the service would adversely affect the member's health. • When applied to inpatient care—medically necessary services cannot be safely provided in an ambulatory setting. Contract: Exhibit B-1—1.1.62.1–8	**Documents:** 1. CHP+ Member Handbook – Section III. Process for Getting Covered Services, Pages 20 2. Utilization Management Program **Narrative:** Friday has a Member Handbook that includes our utilization review processes for services to members that are medically necessary services. The handbook also addresses the extent of services available to the members. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Friday when dealing with members and furnishing services. Friday has established a Utilization Management Program in order to focus on appropriate utilization of health care resources for its entire plan membership.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor and its subcontractors have in place and follow written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42 CFR 438.210(b)(1)* Contract: Exhibit B-1—11.1.5	**Documents:** 1. Policy 3504 – Precertification Procedures for Authorizations and Referrals 2. Policy 3516, UM Concurrent Review Policy and Procedure **Narrative:** Friday follows Policy 3504 and Policy 3516 in processing the requests for initial and continuing authorization of services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor and its subcontractors have in place mechanisms to ensure consistent application of review criteria for authorization decisions. *42 CFR 438.210(b)(2)(i)* Contract: Exhibit B-1—11.1.6	**Documents:** 1. Policy 3504 – Precertification Procedures for Authorizations and Referrals **Narrative:** Friday follows Policy 3504 in processing the requests for initial and continuing authorization of services that includes consistent application of review criteria for authorization decisions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. The Contractor and its subcontractors have in place mechanisms to consult with the requesting provider for medical services when appropriate. *42 CFR 438.210(b)(2)(ii)* Contract: Exhibit B-1—11.1.6	**Documents:** 1. Policy 3504 – Precertification Procedures for Authorizations and Referrals **Narrative:** Friday follows Policy 3504 in processing the requests for initial and continuing authorization of services. The processes include a mechanism to consult with the requesting provider when appropriate.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by an individual who has appropriate expertise in treating the member's medical or BH needs. *42 CFR 438.210(b)(3)* Contract: Exhibit B-1—11.1.3	**Documents:** 1. Policy 3504 – Precertification Procedures for Authorizations and Referrals **Narrative:** Friday follows Policy 3504 in processing the requests for initial and continuing authorization of services, including a process that any decision to deny a service authorization request is made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor notifies the requesting provider and gives the member written notice of any decision by the Contractor to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. *Note: Notice to the provider may be oral or in writing.* *42 CFR 438.210(c)* Contract: Exhibit B-1—11.1.8	**Documents:** 1. Policy 3504 – Precertification Procedures for Authorizations and Referrals **Narrative:** Friday follows Policy 3504 in processing the requests for initial and continuing authorization of services. The processes include notifying the requesting provider and giving the member written notice of any decision.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. The Contractor adheres to the following time frames for making standard and expedited authorization decisions: • For standard authorization decisions—as expeditiously as the member's condition requires and not to exceed 10 calendar days following the receipt of the request for service. • If the provider indicates, or the Contractor determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited	**Documents:** 1. P&P #3514 UM Review Timeframes and Notification 2. CHP+ Expedited Review Workflow/Desktop procedure **Narrative:** Friday follows Policy 3514 in processing the requests for initial and continuing authorization of services including	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service. *42 CFR 438.210(d)(1–2)* Contract: Exhibit B-1—11.1.10–11.1.12	the following time frames for making standard and expedited authorization decisions.	
Findings: FHP's policies and procedures were inconsistent regarding the time frames for processing an expedited authorization request. While the *Review Timeframes and Notification* policy accurately stated the time frame for processing an expedited authorization request within 72 hours following receipt of the request, the *CHP+ Expedited Requests/Determinations* DTP (CHP+ "expedited" DTP) inaccurately stated the time frame for expedited authorization decisions as three business days. Similarly, the *CHP+ Extension of Standard and/or Expedited Decisions* DTP (CHP+ "extension" DTP) inaccurately stated that notice of expedited authorization decisions must be provided within three business days of receipt of the request.		
Required Actions: FHP must correct both its *CHP+* "expedited" DTP and CHP+ "extension" DTP and any related documents to include accurate time frames (72 hours) for making expedited authorization decisions and notifying the member.		
14. The Contractor may extend the time frame for making standard or expedited authorization decisions by up to 14 additional calendar days if: • The member or the provider requests an extension, or • The Contractor justifies a need for additional information and how the extension is in the member's interest. *42 CFR 438.210(d)(1)(i–ii) and (d)(2)(ii)* Contract: Exhibit B-1—11.1.10.1–2; 11.1.12.1–2	**Documents:** 1. DTP: CHP+ Extension of Standard and/or Expedited Decisions 2. Review Timeframes/Notification policy **Narrative:** Friday Health Plans follows the CHP+ Extension of Standard and/or Expedited Decisions DTP as well as the Review Timeframes/Notification Policy with regard to extension of the time frame for making standard or expedited authorization decisions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The Contractor provides telephonic or telecommunications notice within twenty-four (24) hours of a request for prior authorization of covered outpatient drugs. *42 CFR 438.210(d)(3)* *42 US code 1396r-8(d)(5)(a)* Contract: Exhibit B-1—8.18.3.1	Through our PBM, telephonic or telecommunications notice is provided within twenty-four (24) hours of a request for prior authorization of covered outpatient drugs.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Findings:

FHP's policies and procedures did not address requirements for providing 24-hour notice to the requestor of authorization determinations regarding covered outpatient drugs. FHP delegated PBM to Magellan Health (Magellan). Magellan's *Medicaid* (i.e., CHP+) *Service Authorization Determination* policy stated that, for covered outpatient drugs, Magellan provides notice (defined as response by telephone or other telecommunication device) within 24 hours of a request for prior authorization. However, Magellan's *Initial Determination Reviews for Medical Necessity* procedures for "conducting reviews for drug service requests" inaccurately documented that the turnaround times for conducting initial prior authorization for managed care plans was within 72 hours of receipt for expedited requests and within 15 calendar days of receipt for standard requests. FHP did not demonstrate that it had an oversight process to ensure that its PBM complied with regulations for providing notice within 24 hours of a request for authorization of covered outpatient drugs.

Required Actions:

FHP must ensure that its PBM has accurate policies and procedures regarding the time frame for providing notice of authorization for covered outpatient drugs and complies with the requirement to provide telephonic or telecommunications notice of the authorization decision within 24 hours of receiving complete information from the prescriber/requestor for making the authorization decision. In addition, FHP must develop or enhance FHP policies and procedures to address review and notification of authorization for covered outpatient drugs. HSAG recommends FHP ensure its PBM contract or delegation agreement includes the requirement for Magellan to comply with the 24-hour notice requirement and that FHP develop an oversight monitoring process to ensure compliance by the PBM.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The notice of adverse benefit determination must be written in language easy to understand, available in prevalent non-English languages in the region, and available in alternative formats for persons with special needs. *42 CFR 438.404(a)* *42 CFR 438.10(c)* Contract: Exhibit B-1—14.1.3.15.1.1–4	**Documents:** 1. Notice of Adverse Benefit Determination **Narrative:** Friday Health Plans maintains denial letters (notice of adverse benefit determination) and distributes them to members and providers as required. Friday Health Plans makes every attempt to provide the material in prevalent non-English languages in the region (Spanish) and in alternative formats for persons with special needs.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The NOABD template was written in language easy to understand and was available in Spanish. However, the NOABD included no taglines informing the member of availability in alternative formats. In addition, HSAG found that in three denial record reviews, the information to the member regarding the reason for denial was not easy for the member to understand.		
Required Actions: FHP must include in its NOABD taglines informing the member of availability of the notice in alternative formats. FHP must also ensure that all information in the NOABD is written in language easy for the member to understand.		
17. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to and copies of all documents and records relevant to the adverse benefit determination (includes medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits).	**Documents:** 1. Notice of Adverse Benefit Determination **Narrative:** Friday maintains denial letters (notice of action) specific to CHP+ members and distributes them to members and providers as required. Rights to appeal are included with in the notice that is provided to members.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The member's (or member's designated representative's) right to request one level of appeal with the Contractor and the procedures for doing so. • The member's right to request a State review after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State review. • The circumstances under which an appeal process can be expedited and how to make this request. • The member's rights to have benefits/services continue (if applicable) pending the resolution of the appeal, how to request that benefits continue, and the circumstances under which the member may be required to pay the cost of these services. • The member's right to appeal under the Child Mental Health Treatment Act (CMHTA), when applicable. *42 CFR 438.404(b)* Contract: Exhibit B-1—14.1.3.15.1.5–12		

Findings:
FHP's NOABD included numerous omissions or inaccuracies in the required content of the letter, including:

- Procedures for filing an appeal inaccurately stated that the member must request an appeal within 30 days of the NOABD (should be 60 days).
- The member's right to request an SFH included outdated regulatory information—"You have the right to request an SFH: instead of using FHP's appeal process; at any time during your appeal with FHP; or if you are not happy with FHP's decision about your appeal" (the member's right to request an SFH is only after receiving an appeal resolution notice from FHP that the adverse benefit determination was upheld).
- Procedures for requesting an SFH inaccurately stated that an SFH must be requested within 30 days of the NOABD (should be within 120 days of receiving the appeal resolution notice from the health plan). It also inaccurately stated that a request for an SFH concerning previously approved services must be made within 10 working days of the NOABD.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Does not inform the member on how to request that benefits continue during an appeal (i.e., call FHP to request continuation of benefits during the appeal). • No information on the member's right to appeal under CMHTA, when applicable. Furthermore, the letter included information inviting the member to submit additional information to demonstrate the requested services should be covered and that FHP will reevaluate the request based on additional information. During on-site interviews, staff members confirmed that this is a reconsideration process offered to the member prior to the adverse benefit determination. HSAG noted that, while this reconsideration process may be appropriate, a reconsideration offered in the NOABD (i.e., after the service has been denied) equates to a second level of appeal within FHP, which is out of compliance with "the member's right to request one level of appeal with the Contractor." Due to these numerous errors and omissions in the NOABD, all 10 denial record reviews were found *Not Met* for required content of the NOABD.		
Required Actions: FHP must revise the content of the NOABD to include all required content and accurate appeals information, per updated (effective July 1, 2018) CHP+ federal and State regulations. In addition, FHP must remove the description of reconsideration (more than one level of appeal with the Contractor) from the NOABD. HSAG recommends that FHP determine an alternative method of communicating with the member to offer a reconsideration prior to the determination to deny services.		
18. Notice of adverse benefit determination for denial of behavioral, mental health, or SUD benefits includes, in plain language: • A statement explaining that members are protected under the federal Mental Health Parity and Addiction Equity Act (MHPAEA), which provides that limitations placed on access to mental health and SUD benefits may be no greater than any limitations placed on access to medical and surgical benefits. • A statement providing information about contacting the office of the ombudsman for BH care if the member believes his or her rights under the MHPAEA have been violated.	**Documents:** 1. Notice of Adverse Benefit Determination **Narrative:** Friday maintains denial letters (notice of action) specific to CHP+ members and distributes them to members and providers as required. Rights to appeal are included with in the notice that is provided to members.	*For Information Only*

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• A statement specifying that members are entitled, upon request to the Contractor and free of charge, to a copy of the medical necessity criteria for any behavioral, mental, and SUD benefit. *HB19-1269: Section 6—10-16-113 (I), and (II), and (III)* Contract: None		
19. The Contractor mails the notice of adverse benefit determination within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, as defined in 42 CFR 431.211, 431.213 and 431.214 (see below). • For denial of payment, at the time of any denial affecting the claim. • For standard service authorization decisions that deny or limit services, no later than 10 calendar days after receipt of request for service. • For expedited service authorization decisions, no later than 72 hours after receipt of request for service. • For extended service authorization decisions, no later than the date the extension expires. • For service authorization decisions not reached within the required time frames, on the date the time frames expire. *42 CFR 438.404(c)* Contract: Exhibit B-1—14.1.3.15.2.1–7	**Documents:** 1. Notice of Adverse Benefit Determination **Narrative:** Denials (notice of action) are mailed within one business day of the decision to deny. The decision to approve or deny is made within 10 days of receipt of the request. Approvals are generated by the computer system and are faxed immediately or mailed out to the member and the provider the day following the approval.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The *Review Timeframes and Notification* policy accurately addressed time frames for providing an NOABD for standard, expedited, and concurrent reviews. During on-site interviews, staff members stated that denials of claims are auto-generated by the claims system and a notice is sent to the member by the system simultaneously with the denial. However, FHP provided no evidence of procedures that addressed the notification time frames for: termination, suspension, or reduction of previously authorized services; extended service authorizations; or authorizations not reached within the required time frames.		
Required Actions: FHP must develop or enhance CHP+ operating procedures to address all required time frames for mailing the NOABD.		
20. For reduction, suspension, or termination of a previously authorized CHP+-covered service, the Contractor gives notice at least ten (10) days before the intended effective date of the proposed adverse benefit determination except: • The Contractor gives notice on or before the intended effective date of the proposed adverse benefit determination if: – The Agency has factual information confirming the death of a member. – The Agency receives a clear written statement signed by the member that he/she no longer wishes services, or gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information. – The member has been admitted to an institution where he/she is ineligible under the plan for further services. – The member's whereabouts are unknown, and the post office returns Agency mail directed to him/her indicating no forwarding address. – The Agency establishes that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.	**Documents:** 1. Notice of Adverse Benefit Determination **Narrative:** Denials (notice of action) are mailed within one business day of the decision to deny. The decision to approve or deny is made within 10 days of receipt of the request. Approvals are generated by the computer system and are faxed immediately or mailed out to the member and the provider the day following the approval.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– A change in the level of medical care is prescribed by the member's physician. – The notice involves an adverse benefit determination made with regard to the preadmission screening requirements. • If probable member fraud has been verified, the Contractor gives notice five (5) calendar days before the intended effective date of the proposed adverse benefit determination. *42 CFR 438.404(c)* *42 CFR 431.211* *42 CFR 431.213* *42 CFR 431.214* Contract: Exhibit B-1—14.1.3.15.2.1–3		
Findings: During on-site interviews, staff members stated that FHP never denies previously authorized services. However, FHP provided no documentation to verify this statement and FHP had no operating procedures for staff members regarding the time frame for providing the NOABD for termination or reduction in previously authorized services or the exceptions to this time frame outlined in this requirement.		
Required Actions: FHP must develop operating policies and procedures for staff members to address time frames for notice to the member regarding reduction, suspension, or termination of previously authorized services, as well as providing notice on or before the intended effective date for those circumstances outlined in the requirement. If, in fact, FHP "never denies previously authorized services," operating policies and procedures must include such a statement.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
21. If the Contractor extends the time frame for standard authorization decisions, it must give the member written notice of the reason for the extension and inform the member of the right to file a grievance if he or she disagrees with that decision. *42 CFR 438.404(c)(4)* Contract: Exhibit B-1—14.1.3.15.2.5.2	**Documents:** 1. Extension Letter **Narrative:** If Friday Health Plans extends the time frame for standard authorization decisions, Friday Health Plans provides an extension letter to the member providing the reason for the extension and informs the members of the right to file a grievance if the member disagrees with the decision.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
22. The Contractor provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42 CFR 438.210(e)* Contract: Exhibit B-1—11.1.1	**Documents:** 1. Utilization Management Program, Page 14 **Narrative:** As outlined in Friday Health Plans Utilization Management Program Friday Health Plans does not have a system for reimbursement, bonuses or incentives to staff or providers that is based directly on consumer utilization of health care services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
23. The Contractor defines emergency medical condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part.	**Documents:** 1. CHP+ Member Handbook, Page 46 **Narrative:** Friday has a Member Handbook that defines emergency medical condition for members. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.114(a) Contract: Exhibit B-1—1.1.31	Friday when dealing with members and furnishing services.	
24. The Contractor defines emergency services as covered inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title and are needed to evaluate or stabilize an emergency medical condition. *42 CFR 438.114(a)* Contract: Exhibit B-1—1.1.32	**Documents:** 1. CHP+ Member Handbook, Page 46 **Narrative:** Friday has a Member Handbook that defines emergency services for members. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Friday when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
25. The Contractor defines poststabilization care services as covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition or provided to improve or resolve the member's condition. *42 CFR 438.114(a)* Contract: Exhibit B-1—1.1.75	**Documents:** 1. CHP+ Member Handbook, pages 47 **Narrative:** Friday has a Member Handbook that defines post-stabilization care services as related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or to improve or resolve the member's condition. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Friday when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
26. The Contractor does not require prior authorization for emergency services or urgently needed services. Contract: Exhibit B-1—8.17.1.3	**Documents:** 1. CHP+ Member Handbook, Page 46 **Narrative:** Friday has a Member Handbook that includes a section of covered services for emergency care for members not requiring prior authorization for emergency or urgently needed services. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Friday when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
27. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. *42 CFR 438.114(c)(1)(i)* Contract: Exhibit B-1—8.17.1.4	**Documents:** 1. CHP+ Member Handbook, pages 46 **Narrative:** Friday has a Member Handbook that includes covered services and payment for emergency services for members that states the contractor covers and pays for emergency services regardless of whether the emergency care is provided by in-network and out-of-network provider. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Friday when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
28. The Contractor may not deny payment for treatment obtained under either of the following circumstances: • A member had an emergency medical condition, including cases in which the absence of immediate medical attention would *not* have had the following outcomes: – Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; – Serious impairment to bodily functions; or – Serious dysfunction of any bodily organ or part. *(Note: The Contractor bases its coverage decisions for emergency services on the severity of the symptoms at the time of presentation and covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. 42 CFR 438.114—Preamble)* • A representative of the Contractor's organization instructed the member to seek emergency services. *42 CFR 438.114(c)(1)(ii)* Contract: Exhibit B-1—8.17.1.4, 8.17.1.6	**Documents:** 1. CHP+ Member Handbook, pages 46 - 48 **Narrative:** Friday has a Member Handbook that states an emergency medical condition will not be denied for payment. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Friday when dealing with members and furnishing services.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: FHP's *Medical Management—Availability of Emergency and Urgent Care Services* DTP stated that all CHP+ emergency service claims will be evaluated using this definition and the prudent layperson standard. However, the procedures did not address providing payment if a representative of FHP instructed the member to seek emergency services.		
Required Actions: FHP must enhance procedures for review of emergency claims to address the requirement to pay for emergency services if a representative of FHP instructed the member to seek emergency services.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
29. The Contractor does not: • Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms. • Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent failing to notify the member's primary care provider or the Contractor of the member's screening and treatment within 10 calendar days of presentation for emergency services. *42 CFR 438.114(d)(1)* Contract: Exhibit B-1—8.17.3.3, 8.20.1, 8.17.1.7	**Documents:** 1. CHP+ Member Handbook, pagers 46-48 **Narrative:** Friday has a member handbook that states that Friday covers emergency services necessary to screen and stabilize a member without precertification. The handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Friday when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
30. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42 CFR 438.114(d)(2)* Contract: Exhibit B-1—8.17.1.8	**Documents:** 1. CHP+ Member Handbook, pages 48 **Narrative:** Friday has a Member Handbook that states contractor covers emergency services necessary to screen and stabilize a member as well as post stabilization services. The handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Friday when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
31. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment. *42 CFR 438.114(d)(3)* Contract: Exhibit B-1—8.17.1.5	**Documents:** 1. CHP+ Member Handbook, pages 47-48 **Narrative:** Friday has a member handbook that defines post stabilization care services when obtained in or out of network and administered to maintain a member's stabilized condition. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Friday when dealing with members and furnishing services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
32. The Contractor is financially responsible for poststabilization services that are prior authorized by an in-network provider or Contractor representative, regardless of whether they are provided within or outside the Contractor's network of providers. *42 CFR 438.114(e)* *42 CFR 422.113(c)(i)* Contract: Exhibit B-1—8.17.4.1, 8.17.4.3, 8.17.4.5	**Documents:** 1. CHP+ Member Handbook, pages 47 and 48 **Narrative:** Friday has a Member Handbook that states contractor is responsible for post-stabilization care services obtained in or out of network if those services are pre-approved. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Friday when dealing with members and furnishing services.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: While the CHP+ Member Handbook (submitted for this requirement) informs the member that FHP is responsible for pre-approved post-stabilization care services obtained in or out of network, the member handbook does not equate to operating procedures for staff members. FHP had no internal operating procedures related to this requirement.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: FHP must develop written operating procedures or provide other documentation to guide staff members regarding FHP's financial responsibility for post-stabilization services, as outlined in this requirement. HSAG also recommends that FHP consider omitting this language from the CHP+ Member Handbook, as financial responsibilities of the Contractor are not pertinent to the member and may be confusing.		
33. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative but are administered to maintain the member's stabilized condition within one (1) hour of a request to the organization for pre-approval of further poststabilization care services. *42 CFR 438.114(e)* *42 CFR 422.113(c)(ii)* Contract: Exhibit B-1—8.17.4.6	**Documents:** 1. CHP+ Member Handbook, pages 47-48 **Narrative:** Friday has a Member Handbook that states contractor is responsible for post-stabilization care services obtained in or out of network if those services are not pre-approved, but are administered to maintain, improve, or resolve the member's stabilized condition. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Friday when dealing with members and furnishing services.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: While the member handbook (submitted for this requirement) included this language verbatim, the CHP+ Member Handbook does not equate to operating procedures for staff members to determine financial responsibility for post-stabilization services that have not been pre-approved. FHP had no internal operating procedures related to this requirement.		
Required Actions: FHP must develop written operating procedures or provide other documentation to guide staff members regarding FHP's financial responsibility for post-stabilization services, as outlined in this requirement. HSAG also recommends that FHP consider omitting this language from the CHP+ Member Handbook, as financial responsibilities of the Contractor are not pertinent to the member and may be confusing.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
34. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the member's stabilized condition if: • The organization does not respond to a request for pre-approval within 1 hour. • The organization cannot be contacted. • The organization's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the organization must give the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with care of the patient until a plan provider is reached or one of the criteria in 422.113(c)(3) is met. *42 CFR 438.114(e)* *42 CFR 422.113(c)(iii)* Contract: Exhibit B-1—8.17.4.7	**Documents:** 1. CHP+ Member Handbook, pages 47-48 **Narrative:** Friday has a Member Handbook that states contractor is responsible for post-stabilization care services obtained in or out of network if those services are not pre-approved, but are administered to maintain, improve, or resolve the member's stabilized condition. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Friday when dealing with members and furnishing services.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: While the CHP+ Member Handbook (submitted for this requirement) included this language verbatim, the CHP+ Member Handbook does not equate to operating procedures for staff members to determine financial responsibility for post-stabilization services that have not been pre-approved. FHP had no internal operating procedures related to this requirement.		
Required Actions: FHP must develop written operating procedures or provide other documentation to guide staff members regarding FHP's financial responsibility for post-stabilization services, as outlined in this requirement. HSAG also recommends that FHP consider omitting this language from the CHP+ Member Handbook, as financial responsibilities of the Contractor are not pertinent to the member and may be confusing.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
35. The Contractor's financial responsibility for poststabilization care services it has not pre-approved ends when: • A plan physician with privileges at the treating hospital assumes responsibility for the member's care, • A plan physician assumes responsibility for the member's care through transfer, • A plan representative and the treating physician reach an agreement concerning the member's care, or • The member is discharged. *42 CFR 438.114(e)* *42 CFR 422.113(c)(3)* Contract: Exhibit B-1—8.17.4.9	**Documents:** 1. CHP+ Member Handbook, pages 47-48 **Narrative:** Friday has a member handbook that includes not covered/excluded post-stabilization services informing members that Friday is no longer financially responsible. This handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Friday when dealing with members and furnishing services.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: FHP had no internal operating procedures related to criteria for determining when financial responsibility for post-stabilization services it has not pre-approved ends.		
Required Actions: FHP must develop written operating procedures or provide other documentation to guide staff members regarding FHP's financial responsibility for post-stabilization services, as outlined in this requirement.		
36. If the member receives poststabilization services from a provider outside the Contractor's network, the Contractor does not charge the member more than he or she would be charged if he or she had obtained the services through an in-network provider. *42 CFR 438.114(e)* *42 CFR 422.113(c)(iv)* Contract: Exhibit B-1—8.17.4.8	**Documents:** 1. Network Access Plan 2. CHP+ Member Handbook, pages 47-48 **Narrative:** Friday's Network Access Plan states that Prior Authorization is not required, regardless of whether the emergency services facility or Provider is a Participating facility or Provider, or is considered out-of-network. CO	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Choice will ensure that the member obtains the covered emergency services benefit at no greater cost to the Member than if the benefit had been obtained through a Participating Provider or facility. Friday Health Plans is responsible for post-stabilization care services when the services were administered to maintain, improve, or resolved the Member's stabilized condition.	
Findings: FHP provided no internal policies or procedures or other evidence that it does not charge members any more for out-of-network post-stabilization services than it would for post-stabilization services obtained in network.		
Required Actions: FHP must develop written operating procedures or provide other documentation to guide staff members regarding FHP's policy related to charging members for out-of-network post-stabilization services, as outlined in this requirement.		

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	20	X	1.00	=	20
	Partially Met	=	6	X	.00	=	0
	Not Met	=	6	X	.00	=	0
	Not Applicable	=	4	X	NA	=	NA
Total Applicable		=	32	**Total Score**		=	20
				Total Score ÷ Total Applicable		=	63%

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor maintains and monitors a network of providers sufficient to provide access to all covered services to all members, including those with limited English proficiency or physical or mental disabilities. The provider network includes the following provider types: • Physicians • Specialists • Hospitals • Pharmacies • BH providers • LTSS providers, as appropriate *42 CFR 438.206(b)(1)* Contract: Exhibit B-1—7.13.1, 14.1.3.6	**Documents:** 1. Network Access Plan 2. Physician Advisory Committee, P&P #3700, page 12 **Narrative:** Friday Health Plans network development team follows a Network Access Plan in developing a network of providers sufficient to assure that all covered benefits are available to Members without unreasonable delay as is possible. Friday Health Plans believes that its members have the right to receive quality health care services as close to home as possible but know the pathways to care require networks that include Providers located in the rural communities as well as across the Front Range and into Denver, Colorado Springs, and Pueblo. The Network Access Plan is reviewed and approved by the Physician Advisory Committee. The Physician Advisory Committee also as a standing item of their meeting review Network Management Criteria.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. In establishing and maintaining the network adequacy standards, the Contractor considers: • The anticipated CHP+ enrollment. • The expected utilization of services, taking into consideration the characteristics and health care needs of specific CHP+ populations represented in the Contractor's service area. • The numbers, types, and specialties of network providers required to furnish the contracted CHP+ services. • The number of network providers accepting/not accepting new CHP+ members. • The geographic location of providers in relationship to where CHP+ members live, considering distance, travel time, and means of transportation used by members. • The ability of providers to communicate with limited-English-proficient members in their preferred language. • The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for members with physical or mental disabilities. • The availability of triage lines or screening systems, as well as use of telemedicine, e-visits, and/or other technology solutions. *42 CFR 438.206(a); 438.68(c)(i)–(ix)* Contract: Exhibit B-1—7.13.2.2.1	**Documents:** 1. Network Access Plan 2. CAQH Application 3. Supplier Demographic Request **Narrative:** Friday Health Plans employs a number of means to ensure network adequacy to meet the needs of FHP members. FHP uses reasonable criteria including, but not limited to: Ratio of Primary Care Providers (PCPs) to Members; Ratio of Key Specialty Providers (KSPs) to members; Geographic accessibility including proximity of acute care hospitals; Waiting times for appointments; Hours of operation; and Volume of technological and specialty services available to serve the needs of Members. Members and providers are mapped utilizing ESRI ArcMap. All providers apply to be contracted through a uniform application. Providers list all languages other than English (including sign language and type) available in their office, page 6. Providers also include information regarding handicapped access, services for the disabled and accessibility by public transportation, page 18. Provider relations team has been doing an ongoing provider demographic confirmation. Through this Supplier Demographic Request provider offices have been called to confirm hours and languages and physical location.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor ensures that its primary care and specialty care provider network complies with time and distance standards as follows: • Pediatric primary care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Pediatric specialty care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—100 miles or 100 minutes • Obstetrics or gynecology: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Physical therapy/occupational therapy/speech therapy: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—100 miles or 100 minutes • Pharmacy: – Urban counties—10 miles or 10 minutes – Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes • Acute care hospitals: – Urban counties—20 miles or 20 minutes	**Documents:** 1. Network Access Plan **Narrative:** Friday Health Plans follows the Network Access Plan in establishing a network to meet the provider network time and distance standards as well as routine monitoring of complaints and grievances related to access, routine monitoring of coordination of care as part of the Quality Management process, periodic claims review to identify trends in claims payments and customer satisfaction data.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Rural counties—30 miles or 30 minutes – frontier counties—60 miles or 60 minutes *42 CFR 438.206(a); 438.68(b)* Contract: Exhibit B-1—10.2.1.10		
4. The Contractor ensures that its BH provider network complies with time and distance standards as follows: • Acute care hospitals: – Urban counties—20 miles or 20 minutes – Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes • Psychiatrists and psychiatric prescribers for children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes • Mental health providers for children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes • SUD providers for children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes	**Documents:** 1. Network Access Plan **Narrative:** Friday Health Plans treats all providers the same regardless of provider type. Friday Health Plans follows the Network Access Plan in establishing a network to meet the provider network time and distance standards as well as routine monitoring of complaints and grievances related to access, routine monitoring of coordination of care as part of the Quality Management process, periodic claims review to identify trends in claims payments and customer satisfaction data.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Note: If there are no BH providers that meet the BH provider standards within the defined area for a specific member, then the Contractor shall not be bound by the time and distance requirements. (Exhibit B1—10.2.1.11.1) *42 CFR 438.206(a); 438.68(b)* Contract: Exhibit B-1—10.2.1.12, 10.2.1.13.1		
5. The Contractor provides female members with direct access to a women's health care specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health care specialist. *42 CFR 438.206(b)(2)* Contract: Exhibit B-1—10.2.1.15	**Documents:** 1. Network Access Plan, Page 6 **Narrative:** FHP makes a good faith effort to maintain contracts with all Specialty Care Providers in the service area and maintain contracts with an adequate number of specialists and subspecialists in the most accessible urban areas and nearby counties. Female Members may obtain routine and preventive reproductive or gynecological care from Participating obstetricians, gynecologists, or certified nurse midwives without a Referral for the office visit.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
6. The Contractor provides for a second opinion from a network provider or arranges for the member to obtain one outside the network (if there is no qualified provider within the network), at no cost to the member. *42 CFR 438.206(b)(3)* Contract: Exhibit B-1—10.2.1.16	**Documents:** 1. CHP+ Member Handbook, page 46 2. Provider Manual, page 41 **Narrative:** Friday Health Plans has a Member Handbook that includes members' right to a second opinion. This	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	handbook is provided to all members upon enrollment with the plan so that they are informed of their benefits and services. This handbook is also a reference guide that is followed by Friday Health Plans when dealing with members and furnishing services. Providers are notified through the Provider Manual of the rights afforded to CHP+ Members including the right to a second opinion. Members will pay no greater cost than they would with in-network pricing, including copays.	
7. If the provider network is unable to provide necessary covered services to a particular member in network, the Contractor must adequately and in a timely manner cover the services out of network for as long as the Contractor is unable to provide them. *42 CFR 438.206(b)(4)* Contract: Exhibit B-1—10.2.2.1	**Documents:** 1. Network Access Plan, Page 6 **Narrative:** The content of the Network Access Plan, which is followed by Friday Health Plans in its network development, outlines that in the rare case where no Participating Provider or facility provides a covered services (e.g., if necessary to accommodate independent living of homebound members with disabilities), Friday Health Plans will arrange for a Referral to a provider or facility with the necessary expertise and ensure that the Members obtains the covered benefit at no greater costs to the Member than if the benefit had been obtained through a Participating Provider or facility. To maintain continuity of care and obtain the lowest out-of-pocket costs for the Member, every attempt is made to secure	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	a single-case agreement with the specific Provider or facility.	
8. The Contractor requires out-of-network providers to coordinate with the Contractor for payment and ensures that the cost to the member is no greater that it would be if the services were furnished within the network. *42 CFR 438.206(b)(5)* Contract: Exhibit B-1—10.2.2.2	**Documents:** 1. Network Access Plan, Pages 6-7 **Narrative:** The content of the Network Access Plan, which is followed by Friday Health Plans in its network development, outlines that in the rare case where no Participating Provider or facility provides a covered services (e.g., if necessary to accommodate independent living of homebound members with disabilities), Friday Health Plans will arrange for a Referral to a provider or facility with the necessary expertise and ensure that the Members obtains the covered benefit at no greater costs to the Member than if the benefit had been obtained through a Participating Provider or facility. To maintain continuity of care and obtain the lowest out-of-pocket costs for the Member, every attempt is made to secure a single-case agreement with the specific Provider or facility.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services. *42 CFR 438.206(b)(7)* Contract: None	**Documents:** 1. Network Access Plan **Narrative:** Friday Health Plans primary care and OB/GYN providers provide family planning services to members. Any provider who does not provide planning services (i.e. beliefs) have colleagues in their practice who are available for providing family planning services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. The Contractor must meet, and require its providers to meet, the State standards for timely access to care and services, taking into account the urgency of the need for services. The Contractor ensures that services are available as follows: • Emergency BH care: – By phone within 15 minutes of the initial contact. – In-person within 1 hour of contact in urban and suburban areas. – In-person within 2 hours of contact in rural and frontier areas. • Urgent care within 24 hours from the initial identification of need. • Non-urgent symptomatic care visit within 7 calendar days after member request. • Non-urgent medical or non-symptomatic well care within 30 calendar days after member request.	**Documents:** 1. Network Access Plan, page 11 2. Provider Manual, page 26 3. Professional Services Agreement, page 7 **Narrative:** Friday Health Plans follows the Network Access Plan and strives to ensure that its Members have adequate access to services within a reasonable length of time. It is the policy of Friday Health Plans that Participating Providers adopt the access standards in their appointment scheduling practices.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Outpatient follow-up appointments within 7 days after discharge from hospitalization. • Members may not be placed on waiting lists for initial routine BH services. *42 CFR 438.206(c)(1)(i)* Contract: Exhibit B-1—10.2.1.23.1–7, 10.2.1.23.7.2		
Findings: FHP provided in its CHP+ Member Handbook and Provider Manual the "wait time" standards for "urgent care, non-urgent symptomatic care visits, non-urgent medical or non-symptomatic care visits, specialty care, prenatal care, behavioral health routine/non-urgent/non-emergency, mental health routine/non-urgent/non-emergency, and substance abuse care routine/non-urgent/non-emergency." FHP demonstrated using its Scheduling Wait Time Log Audit to routinely monitor compliance with these elements. However, FHP did not include in its timely access standards: *emergency* behavioral healthcare by phone or in person, ensuring that members were not placed on waiting lists for initial routine behavioral health services, and outpatient follow-up appointments within seven days after discharge. Similarly, FHP did not have a mechanism to monitor for compliance with these three missing standards.		
Required Actions: FHP must update or expand its standards for timely access to include emergency behavioral healthcare by phone and in person, outpatient follow-up appointments, and not placing members on waiting lists for initial routine behavioral health services. Additionally, FHP must expand the Scheduling Wait Time Log Audit to including monitoring of these additional standards for timely access or develop an alternative mechanism for doing so.		
11. The Contractor and its providers offer hours of operation that are no less than the hours of operation offered to commercial members or Medicaid members. The Contractors network provides: • Minimum hours of provider operation from 8 a.m. to 5 p.m. Monday through Friday. • Extended hours on evenings and weekends. • Alternatives for emergency department visits for after-hours urgent care.	**Documents:** 1. Professional Services Agreement, Page 4, 20 2. CHP+ Member Handbook, page 4 **Narrative:** Members are provided with office hours through the member handbook. Friday Health Plans office hours are Monday thru Friday 8:00 AM to 5:00 PM.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.206(c)(1)(ii) Contract: Exhibit B-1—10.2.1.5–7	Providers shall provide the same standards of care for Friday Health Plan CHP+ members as they do for all other patients. Friday Health Plans members are defined in the sample contract, regardless of whether the Member is commercial or CHP+, and it is defined that these members shall receive the same standard of care. Provider office hours are outlined on Page 20 of the Professional services Agreement. Emergency department is available to members on evenings and weekends.	
12. The Contractor makes services included in the contract available 24 hours a day, 7 days a week, when medically necessary. *42 CFR 438.206(c)(1)(iii)* Contract: Exhibit B-1—10.2.4.1	**Documents:** 1. CHP+ Member Handbook, Page 17 **Narrative:** Emergency services are available 24 hours a day, 7 days a week. Members are notified of this through the Member Handbook.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. The Contractor ensures timely access by: • Establishing mechanisms to ensure compliance with access (e.g., appointment) standards by network providers. • Monitoring network providers regularly to determine compliance. • Taking corrective action if there is failure to comply. *42 CFR 438.206(c)(1)(iv)–(vi)* Contract: Exhibit B-1—10.2.1.25.2	**Documents:** 1. Scheduling Wait Times Log **Narrative:** Provider relations ensures timely access by completion of a scheduling wait times log.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: FHP provided its Scheduling Wait Times Log, which was used to audit timely access and services standards. While FHP verbally described the process used to complete the Scheduling Wait Times Log, FHP did not have a written procedure that outlined the entire process for ensuring timely access standards are met—i.e., procedure for completing the Scheduling Wait Times Log, what is done with the information obtained, next steps following completion of the audit, how corrective actions are determined and implemented, etc.).		
Required Actions: FHP must develop a written procedure that outlines the full process for monitoring timely access standards and addresses all elements of the requirement—e.g., mechanism for monitoring, frequency of monitoring, and taking corrective action.		
14. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. This includes: • Maintaining policies to provide prevention, health education, and treatment for diseases prevalent in specific cultural or ethnic groups. • Maintaining policies to provide health care services to members that respect individual health care attitudes, beliefs, customs, and practices related to cultural affiliation. • Maintaining written policies and procedures to ensure compliance with requirements of the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973. • Making written materials that are critical to obtaining services available in prevalent non-English languages and alternative formats for the visually and reading-impaired. • Providing cultural competency training programs, as needed, to network providers and health plan staff regarding:	**Documents:** 1. DTP: Provider Relations Cultural Competency 2. Provider Manual, pages 8 -9 **Narrative:** Friday Health Plans follows the DTP: Provider Relations Cultural Competency to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. Providers are informed and educated about cultural competency through the Provider Manual.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Health care attitudes, values, customs, and beliefs that affect access to and benefit from health care services. – Medical risks associated with the member population's racial, ethnic, and socioeconomic conditions. • Identifying members whose cultural norms and practices may affect their access to health care. These efforts shall include, but are not limited to, inquiries conducted by the Contractor of the language proficiency of individual members. • Providing language assistance services for all Contractor interactions with members, including interpreter services and TDD. *42 CFR 438.206(c)(2)* Contract: Exhibit B-1—10.8.2.1-4, 10.8.2.9-10, 10.8.2.12-13		
Findings: FHP maintained written policies to provide resources to providers regarding prevention, health education, and treatment for diseases prevalent in specific cultural or ethnic groups. Policies also addressed providing healthcare services to members that respect individual healthcare attitudes, beliefs, customs, and practices, and ensuring compliance with ADA and Section 504 of the Rehabilitation Act of 1973. FHP demonstrated a mechanism for identifying members whose cultural norms and practices may affect their access to healthcare and written materials critical to members obtaining services were available in prevalent non-English languages and alternate formats for visually and reading impaired members. FHP offered language assistance services to members, at no cost, through Translations Plus. While FHP network providers were provided resources for cultural competency training programs, there was no established method by which FHP ensured health plan staff members were provided with cultural competency training programs.		
Required Actions: FHP must develop and implement mechanisms to ensure FHP staff members are provided cultural competency training programs regarding cultural factors affecting access to care or medical risks.		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The Contractor must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities. *42 CFR 438.206(c)(3)* Contract: Exhibit B-1—10.8.2.10	**Documents:** 1. CAQH Application **Narrative:** Providers include information regarding handicapped access, services for the disabled and accessibility by public transportation, page 18.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
16. The Contractor submits to the State (in a format specified by the State) documentation to demonstrate that the Contractor offers an appropriate range of preventive, primary care, and specialty services that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. • A Provider Network Strategic Plan is submitted to the State annually. • A Provider Network Capacity and Services Report is submitted to the State quarterly. *42 CFR 438.207(b)* Contract: Exhibit B-1—15.3.1, 15.3.2	**Documents:** 1. Network Access Plan (Network Strategic Plan) 2. Quarterly Report **Narrative:** Friday Health Plans provides its Network Access Plan to the State on an annual basis no later than September 30th of each year. Friday Health Plans also provides to the State quarterly (due March 31, June 30, September 30 and December 31 of each year) a provider network capacity and services report. The state reviews both documents and requests clarification on as needed basis.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard II—Access and Availability							
Total	Met	=	13	X	1.00	=	13
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	16	**Total Score**		=	13
				Total Score ÷ Total Applicable		=	81%

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Denials Record Review Tool
for Friday Health Plans

Review Period:	January 1, 2019–December 31, 2019
Date of Review:	November 7, 2019
Reviewer:	Kathy Bartilotta and Dara Dameron
Participating Plan Staff Member(s):	Manuela Heredia

Requirements	File 1	File 2	File 3	File 4	File 5
Member ID	****	****	****	****	****
Date of initial request	NA	2/7	NA	3/9	NA
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	CL	NR	CL	NR	CL
(Standard [S], Expedited [E], or Retrospective [R])	R	S	R	S	R
Date notice of adverse benefit determination (NABD) sent	1/18	2/7	3/8	3/26	3/29
Notice sent to provider and member? (Met [M] or Not Met [NM])*	M	M	M	M	M
Number of days for decision/notice	NA	1	NA	7	NA
Notice sent within required time frame? (M or NM) (S = 10 Cal days after; E = 72 hours after; T = 10 Cal days before)*	M	M	M	M	M
Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
If extended, extension notification sent to member? (M, NM, or NA)*	NA	NA	NA	NA	NA
If extended, extension notification includes required content? (M, NM, or NA)*	NA	NA	NA	NA	NA
NABD includes required content? (M or NM)*	NM	NM	NM	NM	NM
Authorization decision made by qualified clinician? (M, NM, or NA)*	NA	M	NA	M	NA
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (M, NM, or NA)*	NA	NA	NA	NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (M or NM)*	M	M	M	M	M
Was correspondence with the member easy to understand? (M or NM)*	M	NM	M	M	M
Total Applicable Elements	**5**	**6**	**5**	**6**	**5**
Total Met Elements	**4**	**4**	**4**	**5**	**4**
Score (Number Met / Number Applicable) = %	**80%**	**67%**	**80%**	**83%**	**80%**

***** = Reference Denial Record Review Instructions for Corresponding Requirement in Compliance Monitoring Tool

M = Met, **NM** = Not Met, **NA** = Not Applicable, **Cal** = Calendar, **Y** = Yes, **N** = No (Yes and No = not scored—informational only)

**** = Redacted Member ID

Comments:

File 1: In the attached appeals notification that is sent with the EOB, content missing includes "the member's right to be provided upon request access to copies of all documents relevant to the ABD," as well as how a member can request an expedited review.

File 2: The content in the NOABD letter sent to the member contains numerous inaccuracies and omissions in the required content. Specific inaccuracies and omissions are outlined in #17 of the Compliance Monitoring Tool. In addition, the

information was not easy for the member to understand as the reason for denial referred to TMJ surgery while the requested service was for TMJ physical therapy.

File 3: In the attached appeals notification that is sent with the EOB, content missing includes "the member's right to be provided upon request access to copies of all documents relevant to the ABD," as well as how a member can request an expedited review.

File 4: The content in the NOABD letter sent to the member contains numerous inaccuracies and omissions in the required content. Specific inaccuracies and omissions are outlined in #17 of the Compliance Monitoring Tool.

File 5: In the attached appeals notification that is sent with the EOB, content missing includes "the member's right to be provided upon request access to copies of all documents relevant to the ABD," as well as how a member can request an expedited review.

Requirements	File 6	File 7	File 8	File 9	File 10
Member ID	****	****	****	****	****
Date of initial request	NA	NA	NA	5/29	NA
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	CL	CL	CL	NR	CL
(Standard [S], Expedited [E], or Retrospective [R])	R	R	R	S	R
Date notice of adverse benefit determination (NABD) sent	4/5	5/10	5/24	5/29	6/7
Notice sent to provider and member? (Met [M] or Not Met [NM])*	M	M	M	M	M
Number of days for decision/notice	NA	NA	NA	0	NA
Notice sent within required time frame? (M or NM) (S = 10 Cal days after; E = 72 hours after; T = 10 Cal days before)*	M	M	M	M	M
Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
If extended, extension notification sent to member? (M, NM, or NA)*	NA	NA	NA	NA	NA
If extended, extension notification includes required content? (M, NM, or NA)*	NA	NA	NA	NA	NA
NABD includes required content? (M or NM)*	NM	NM	NM	NM	NM
Authorization decision made by qualified clinician? (M, NM, or NA)*	NA	NA	NA	NA	NA
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (M, NM, or NA)*	NA	NA	NA	NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (M or NM)*	M	M	M	M	M
Was correspondence with the member easy to understand? (M or NM)*	NM	NM	M	M	M
Total Applicable Elements	**5**	**5**	**5**	**5**	**5**
Total Met Elements	**3**	**3**	**4**	**4**	**4**
Score (Number Met / Number Applicable) = %	**60%**	**60%**	**80%**	**80%**	**80%**

***** = Reference Denial Record Review Instructions for Corresponding Requirement in Compliance Monitoring Tool

M = Met, **NM** = Not Met, **NA** = Not Applicable, **Cal** = Calendar, **Y** = Yes, **N** = No (Yes and No = not scored—informational only)

**** = Redacted Member ID

Comments:

File 6: In the attached appeals notification that is sent with the EOB, content missing includes "the member's right to be provided upon request access to copies of all documents relevant to the ABD," as well as how a member can request an expedited review.

The EOB letter is also not easy to understand as the denial reason states the denial code and the description states "no OON Benefits."

File 7: In the attached appeals notification that is sent with the EOB, content missing includes "the member's right to be provided upon request access to copies of all documents relevant to the ABD," as well as how a member can request an expedited review.

The EOB letter is also not easy to understand as the denial reason states the denial code and the description states "no OON Benefits."

File 8: In the attached appeals notification that is sent with the EOB, content missing includes "the member's right to be provided upon request access to copies of all documents relevant to the ABD," as well as how a member can request an expedited review.

File 9: The content in the NOABD letter sent to the member contains numerous inaccuracies and omissions in the required content. Specific inaccuracies and omissions are outlined in #17 of the Compliance Monitoring Tool. Denial reason was due to out-of-network provider, thus "authorization decision being made by a qualified clinician" is NA.

File 10: In the attached appeals notification that is sent with the EOB, content missing includes "the member's right to be provided upon request access to copies of all documents relevant to the ABD," as well as how a member can request an expedited review.

Total Record Review Score*	Total Applicable Elements:	Total Met Elements:	Total Record Review Score:
	52	39	75%

* Only requirements with an "*" in the tool were used to calculate the score. The total record review score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements.

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2019–2020 site review of **FHP**.

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

HSAG Review Team	Title
Katherine Bartilotta	Associate Director
Dara Dameron	Project Manager
FHP Participants	**Title**
Cassandra Van Zalinge	Team Lead Nurse Manager
Janet Hornig	Senior Director, Claims and Operations
Jennifer Mueller	Chief of Operations
Manuela Heredia	Director of Government Programs
Department Observers	**Title**
Russell Kennedy (teleconference)	Department of Health Care Policy and Financing
Teresa Craig (teleconference)	Department of Health Care Policy and Financing

Appendix D. Corrective Action Plan Template for FY 2019–2020

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

Table D-1—Corrective Action Plan Process

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

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

The CAP template follows.

Table D-2—FY 2019–2020 Corrective Action Plan for FHP

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
13. The Contractor adheres to the following time frames for making standard and expedited authorization decisions: • For standard authorization decisions—as expeditiously as the member's condition requires and not to exceed 10 calendar days following the receipt of the request for service. • If the provider indicates, or the Contractor determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service. *42 CFR 438.210(d)(1–2)* Contract: Exhibit B-1—11.1.10–11.1.12	FHP's policies and procedures were inconsistent regarding the time frames for processing an expedited authorization request. The *CHP+ Expedited Requests/Determinations* DTP (CHP+ "expedited" DTP) inaccurately stated the time frame for expedited authorization decisions as three business days. Similarly, the *CHP+ Extension of Standard and/or Expedited Decisions* DTP (CHP+ "extension" DTP) inaccurately stated that notice of expedited authorization decisions must be provided within three business days of receipt of the request.	FHP must correct both its *CHP+* "expedited" DTP and CHP+ "extension" DTP and any related documents to include accurate time frames (72 hours) for making expedited authorization decisions and notifying the member.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
15. The Contractor provides telephonic or telecommunications notice within twenty-four (24) hours of a request for prior authorization of covered outpatient drugs. *42 CFR 438.210(d)(3)* *42 US Code 1396r-8(d)(5)(a)* Contract: Exhibit B-1—8.18.3.1	FHP's policies and procedures did not address requirements for providing 24-hour notice to the requestor of authorization determinations regarding covered outpatient drugs. FHP delegated PBM to Magellan Health (Magellan). Magellan's *Initial Determination Reviews for Medical Necessity* procedures for "conducting reviews for drug service requests" inaccurately documented that the turnaround times for conducting initial prior authorization for managed care plans was within 72 hours of receipt for expedited requests and within 15 calendar days of receipt for standard requests. FHP also did not demonstrate that it had an oversight process to ensure that its PBM complied with regulations for providing notice within 24 hours of a request for authorization of covered outpatient drugs.	FHP must ensure that its PBM has accurate policies and procedures regarding the time frame for providing notice of authorization for covered outpatient drugs and complies with the requirement to provide telephonic or telecommunications notice of the authorization decision within 24 hours of receiving complete information from the prescriber/requestor for making the authorization decision. In addition, FHP must develop or enhance FHP policies and procedures to address review and notification of authorization for covered outpatient drugs. HSAG also recommends FHP ensure its PBM contract or delegation agreement includes the requirement for Magellan to comply with the 24-hour notice requirement and that FHP develop an oversight monitoring process to ensure compliance by the PBM.
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 I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
16. The notice of adverse benefit determination must be written in language easy to understand, available in prevalent non-English languages in the region, and available in alternative formats for persons with special needs. *42 CFR 438.404(a)* *42 CFR 438.10(c)* Contract: Exhibit B-1—14.1.3.15.1.1–4	The NOABD included no taglines informing the member of availability in alternative formats. In addition, HSAG found that in three denial record reviews, the information to the member regarding the reason for denial was not easy for the member to understand.	FHP must include in its NOABD taglines informing the member of availability of the notice in alternative formats. FHP must also ensure that all information in the NOABD is written in language easy for the member to understand.
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 I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
17. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to and copies of all documents and records relevant to the adverse benefit determination (includes medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits). • The member's (or member's designated representative's) right to request one level of appeal with the Contractor and the procedures for doing so. • The member's right to request a State review after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State review.	FHP's NOABD included numerous omissions or inaccuracies in the required content of the letter, including: • Procedures for filing an appeal inaccurately stated that the member must request an appeal within 30 days of the NOABD (should be 60 days). • The member's right to request an SFH included outdated regulatory information—"You have the right to request an SFH: instead of using FHP's appeal process; at any time during your appeal with FHP; or if you are not happy with FHP's decision about your appeal" (the member's right to request an SFH is only after receiving an appeal resolution notice from FHP that the adverse benefit determination was upheld). • Procedures for requesting an SFH inaccurately stated that an SFH must be requested within 30 days of the NOABD (should be within 120 days of receiving the appeal resolution notice from the health plan). It also inaccurately stated that a request for an SFH concerning previously approved services must be made within 10 working days of the NOABD. • Does not inform the member on how to request that benefits continue during an	FHP must revise the content of the NOABD to include all required content and accurate appeals information, per updated (effective July 1, 2018) CHP+ federal and State regulations. In addition, FHP must remove the description of reconsideration (more than one level of appeal with the Contractor) from the NOABD.

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
• The circumstances under which an appeal process can be expedited and how to make this request. • The member's rights to have benefits/services continue (if applicable) pending the resolution of the appeal, how to request that benefits continue, and the circumstances under which the member may be required to pay the cost of these services. • The member's right to appeal under the Child Mental Health Treatment Act (CMHTA), when applicable. *42 CFR 438.404(b)* Contract: Exhibit B-1—14.1.3.15.1.5–12	appeal (i.e., call FHP to request continuation of benefits during the appeal). • No information on the member's right to appeal under CMHTA, when applicable. Furthermore, the letter included information inviting the member to submit additional information to demonstrate the requested services should be covered and that FHP will reevaluate the request based on additional information. A reconsideration offered in the NOABD (i.e., after the service has been denied) equates to a second level of appeal within FHP, which is out of compliance with "the member's right to request one level of appeal with the Contractor." Due to these numerous errors and omissions in the NOABD, all 10 denial record reviews were found *Not Met* for required content of the NOABD.	
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
19. The Contractor mails the notice of adverse benefit determination within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, as defined in 42 CFR 431.211, 431.213 and 431.214 (see below). • For denial of payment, at the time of any denial affecting the claim. • For standard service authorization decisions that deny or limit services, no later than 10 calendar days after receipt of request for service. • For expedited service authorization decisions, no later than 72 hours after receipt of request for service. • For extended service authorization decisions, no later than the date the extension expires. • For service authorization decisions not reached within the required time frames, on the date the time frames expire. *42 CFR 438.404(c)* Contract: Exhibit B-1—14.1.3.15.2.1–7	FHP provided no evidence of procedures that addressed the notification time frames for: termination, suspension, or reduction of previously authorized services; extended service authorizations; or authorizations not reached within the required time frames.	FHP must develop or enhance CHP+ operating procedures to address all required time frames for mailing the NOABD.

Standard I—Coverage and Authorization of Services		
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 I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
20. For reduction, suspension, or termination of a previously authorized CHP+-covered service, the Contractor gives notice at least ten (10) days before the intended effective date of the proposed adverse benefit determination except: • The Contractor gives notice on or before the intended effective date of the proposed adverse benefit determination if: – The Agency has factual information confirming the death of a member. – The Agency receives a clear written statement signed by the member that he/she no longer wishes services, or gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information. – The member has been admitted to an institution where he/she is ineligible under the plan for further services. – The member's whereabouts are unknown, and the post office returns Agency mail directed to	During on-site interviews, staff members stated that FHP never denies previously authorized services. However, FHP provided no documentation to verify this statement and FHP had no operating procedures for staff members regarding the time frame for providing the NOABD for termination or reduction in previously authorized services or the exceptions to this time frame outlined in this requirement.	FHP must develop operating policies and procedures for staff members to address time frames for notice to the member regarding reduction, suspension, or termination of previously authorized services, as well as providing notice on or before the intended effective date for those circumstances outlined in the requirement. If, in fact, FHP "never denies previously authorized services," operating policies and procedures must include such a statement.

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
him/her indicating no forwarding address. – The Agency establishes that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth. – A change in the level of medical care is prescribed by the member's physician. – The notice involves an adverse benefit determination made with regard to the preadmission screening requirements. • If probable member fraud has been verified, the Contractor gives notice five (5) calendar days before the intended effective date of the proposed adverse benefit determination. *42 CFR 438.404(c)* *42 CFR 431.211* *42 CFR 431.213* *42 CFR 431.214* Contract: Exhibit B-1—14.1.3.15.2.1–3		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
28. The Contractor may not deny payment for treatment obtained under either of the following circumstances: • A member had an emergency medical condition, including cases in which the absence of immediate medical attention would *not* have had the following outcomes: – Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; – Serious impairment to bodily functions; or – Serious dysfunction of any bodily organ or part. *(Note: The Contractor bases its coverage decisions for emergency services on the severity of the symptoms at the time of presentation and covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. 42 CFR 438.114—Preamble)* • A representative of the Contractor's organization instructed the member to seek emergency services. *42 CFR 438.114(c)(1)(ii)* Contract: Exhibit B-1—8.17.1.4, 8.17.1.6	FHP's *Medical Management—Availability of Emergency and Urgent Care Services* DTP stated that all CHP+ emergency service claims will be evaluated using this definition and the prudent layperson standard. However, the procedures did not address providing payment if a representative of FHP instructed the member to seek emergency services.	FHP must enhance procedures for review of emergency claims to address the requirement to pay for emergency services if a representative of FHP instructed the member to seek emergency services.

Standard I—Coverage and Authorization of Services		
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 I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
32. The Contractor is financially responsible for poststabilization services that are prior authorized by an in-network provider or Contractor representative, regardless of whether they are provided within or outside the Contractor's network of providers. *42 CFR 438.114(e)* *42 CFR 422.113(c)(i)* Contract: Exhibit B-1—8.17.4.1, 8.17.4.3, 8.17.4.5	FHP had no internal operating procedures related to this requirement.	FHP must develop written operating procedures or provide other documentation to guide staff members regarding FHP's financial responsibility for post-stabilization services, as outlined in this requirement.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
33. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative but are administered to maintain the member's stabilized condition within one (1) hour of a request to the organization for pre-approval of further poststabilization care services. *42 CFR 438.114(e)* *42 CFR 422.113(c)(ii)* Contract: Exhibit B-1—8.17.4.6	FHP had no internal operating procedures related to this requirement.	FHP must develop written operating procedures or provide other documentation to guide staff members regarding FHP's financial responsibility for post-stabilization services, as outlined in this requirement.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
34. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the member's stabilized condition if: • The organization does not respond to a request for pre-approval within 1 hour. • The organization cannot be contacted. • The organization's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the organization must give the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with care of the patient until a plan provider is reached or one of the criteria in 422.113(c)(3) is met. *42 CFR 438.114(e)* *42 CFR 422.113(c)(iii)* Contract: Exhibit B-1—8.17.4.7	FHP had no internal operating procedures related to this requirement.	FHP must develop written operating procedures or provide other documentation to guide staff members regarding FHP's financial responsibility for post-stabilization services, as outlined in this requirement.
Planned Interventions:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
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 I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
35. The Contractor's financial responsibility for poststabilization care services it has not pre-approved ends when: • A plan physician with privileges at the treating hospital assumes responsibility for the member's care, • A plan physician assumes responsibility for the member's care through transfer, • A plan representative and the treating physician reach an agreement concerning the member's care, or • The member is discharged. *42 CFR 438.114(e)* *42 CFR 422.113(c)(3)* Contract: Exhibit B-1—8.17.4.9	FHP had no internal operating procedures related to criteria for determining when financial responsibility for post-stabilization services it has not pre-approved ends.	FHP must develop written operating procedures or provide other documentation to guide staff members regarding FHP's financial responsibility for post-stabilization services, as outlined in this requirement.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
36. If the member receives poststabilization services from a provider outside the Contractor's network, the Contractor does not charge the member more than he or she would be charged if he or she had obtained the services through an in-network provider. *42 CFR 438.114(e)* *42 CFR 422.113(c)(iv)* Contract: Exhibit B-1—8.17.4.8	FHP provided no internal policies or procedures or other evidence that it does not charge members any more for out-of-network post-stabilization services than it would for post-stabilization services obtained in network.	FHP must develop written operating procedures or provide other documentation to guide staff members regarding FHP's policy related to charging members for out-of-network post-stabilization services, as outlined in this requirement.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard II—Access and Availability		
Requirement	**Findings**	**Required Action**
10. The Contractor must meet, and require its providers to meet, the State standards for timely access to care and services, taking into account the urgency of the need for services. The Contractor ensures that services are available as follows: • Emergency BH care: – By phone within 15 minutes of the initial contact. – In-person within 1 hour of contact in urban and suburban areas. – In-person within 2 hours of contact in rural and frontier areas. • Urgent care within 24 hours from the initial identification of need. • Non-urgent symptomatic care visit within 7 calendar days after member request. • Non-urgent medical or non-symptomatic well care within 30 calendar days after member request. • Outpatient follow-up appointments within 7 days after discharge from hospitalization. • Members may not be placed on waiting lists for initial routine BH services. *42 CFR 438.206(c)(1)(i)* Contract: Exhibit B-1—10.2.1.23.1–7, 10.2.1.23.7.2	FHP did not include in its timely access standards: *emergency* behavioral healthcare by phone or in person, ensuring that members were not placed on waiting lists for initial routine behavioral health services, and outpatient follow-up appointments within seven days after discharge. Similarly, FHP did not have a mechanism to monitor for compliance with these three missing standards.	FHP must update or expand its standards for timely access to include emergency behavioral healthcare by phone and in person, outpatient follow-up appointments, and not placing members on waiting lists for initial routine behavioral health services. Additionally, FHP must expand the Scheduling Wait Time Log Audit to including monitoring of these additional standards for timely access or develop an alternative mechanism for doing so.

Standard II—Access and Availability		
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 II—Access and Availability		
Requirement	**Findings**	**Required Action**
13. The Contractor ensures timely access by: • Establishing mechanisms to ensure compliance with access (e.g., appointment) standards by network providers. • Monitoring network providers regularly to determine compliance. • Taking corrective action if there is failure to comply. *42 CFR 438.206(c)(1)(iv)–(vi)* Contract: Exhibit B-1—10.2.1.25.2	While FHP verbally described the process used to complete the Scheduling Wait Times Log, FHP did not have a written procedure that outlined the entire process for ensuring timely access standards are met—i.e., procedure for completing the Scheduling Wait Times Log, what is done with the information obtained, next steps following completion of the audit, how corrective actions are determined and implemented, etc.).	FHP must develop a written procedure that outlines the full process for monitoring timely access standards and addresses all elements of the requirement—e.g., mechanism for monitoring, frequency of monitoring, and taking corrective 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 II—Access and Availability		
Requirement	**Findings**	**Required Action**
14. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. This includes: • Maintaining policies to provide prevention, health education, and treatment for diseases prevalent in specific cultural or ethnic groups. • Maintaining policies to provide health care services to members that respect individual health care attitudes, beliefs, customs, and practices related to cultural affiliation. • Maintaining written policies and procedures to ensure compliance with requirements of the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973. • Making written materials that are critical to obtaining services available in prevalent non-English languages and alternative formats for the visually and reading-impaired. • Providing cultural competency training programs, as needed, to network	FHP maintained written policies to address many of the elements of cultural competency requirements. However, there was no established method by which FHP ensured health plan staff members were provided with cultural competency training programs.	FHP must develop and implement mechanisms to ensure FHP staff members are provided cultural competency training programs regarding cultural factors affecting access to care or medical risks.

Standard II—Access and Availability		
Requirement	**Findings**	**Required Action**
providers and health plan staff regarding: – Health care attitudes, values, customs, and beliefs that affect access to and benefit from health care services. – Medical risks associated with the member population's racial, ethnic, and socioeconomic conditions. • Identifying members whose cultural norms and practices may affect their access to health care. These efforts shall include, but are not limited to, inquiries conducted by the Contractor of the language proficiency of individual members. • Providing language assistance services for all Contractor interactions with members, including interpreter services and TDD. *42 CFR 438.206(c)(2)* Contract: Exhibit B-1—10.8.2.1-4, 10.8.2.9-10, 10.8.2.12-13		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

Standard II—Access and Availability		
Requirement	**Findings**	**Required Action**
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review Protocol Activities

The following table describes the activities performed throughout the compliance monitoring process. The activities listed below are consistent with 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 two standards and on-site activities. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. • Documents submitted for the desk review and on-site review consisted of the completed desk review form, the compliance monitoring tool with the health plan's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The health plans also submitted a list of all denials of authorization of services (denials) records that occurred between January 1, 2019, and December 31, 2019 (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 denials. • 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 2019–2020 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 Department**
	• 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.