Fiscal Year 2020–2021 Site Review Report

for

Friday Health Plans

January 2021

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

Public Law 111-3, Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, requires that each state's Children's Health Insurance Program (CHIP) apply several provisions of Section 1932 of the Social Security Act (the Act) in the same manner as the provisions apply under Title XIX of the Act. This requires managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to comply with provisions of the Code of Federal Regulations, Title 42 (42 CFR)—federal Medicaid managed care regulations published May 6, 2016. 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) 2020–2021 was January 1, 2020, through December 31, 2020. This report documents results of the FY 2020–2021 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 FY 2020–2021 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2019–2020 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for both the grievance and appeal record reviews. Appendix C lists HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan (CAP) process the health plan will be required to complete for FY 2020–2021 and the required template for doing so. Appendix E contains a detailed description of HSAG's site review activities consistent with the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[1-1]

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: July 15, 2020.

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

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
V. Member Information Requirements	21	21	14	6	1	0	67%
VI. Grievance and Appeal Systems	34	34	18	16	0	0	53%
VII. Provider Participation and Program Integrity	16	16	12	4	0	0	75%
IX. Subcontractual Relationships and Delegation	4	4	2	2	0	0	50%
Totals	**75**	**75**	**46**	**28**	**1**	**0**	**61%**

*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 grievance and appeal 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)
Grievances	NA	NA	NA	NA	NA	NA
Appeals	42	42	14	28	0	33%
Totals	**42**	**42**	**14**	**28**	**0**	**33%**

*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. Note: **FHP** reported no CHP+ grievances during the review period.

Standard V—Member Information Requirements

Summary of Strengths and Findings as Evidence of Compliance

FHP provided member informational materials through its website and the welcome kit (mailed to members) informed members that the information is available in written form upon request within five business days. The welcome kit included a benefit table that provided an overview of the majority of benefit categories and associated co-pays. This table was duplicated at the front of the member handbook. During the web-based interview, **FHP** staff members described the processes for ensuring the initial welcome packet is mailed within a few days of **FHP**'s notification of enrollment. Staff members also reported that customer service staff members were trained for immediate call resolution whenever possible to assist members in understanding the benefits and requirements of the CHP+ benefit package and address questions and requests at the point of contact.

Portions of the welcome kit were printed in English and Spanish and staff members reported that Spanish versions of the full welcome kit were available to members upon request. Both the provider directory and formulary were available on the Web in both a searchable format and in a Portable Document Format (PDF) format that could be retained and printed. The member handbook was also available on the website in PDF format and informed members of available aids and services; authorization requirements; how to obtain routine, urgent, and emergency services; member rights; grievance and appeal processes; and information about advance directives.

Summary of Findings Resulting in Opportunities for Improvement

While the welcome kit contained taglines in both English and Spanish, the taglines were on the second page of the welcome letter (the first document in the welcome kit). HSAG recommends that taglines be present on the first page of critical member informational materials.

In reviewing **FHP**'s website, HSAG found the website non-intuitive and difficult to navigate. HSAG noted that the welcome kit and member handbook only referred members to Fridayhealthplans.com; however, only after HSAG reviewers followed specific additional navigation instructions were they able to find the critical member materials. HSAG recommends that, until **FHP** is able to revise the website to be more intuitive in nature, more explicit instructions for finding materials, or more direct links, be provided to members in, at least, the welcome kit.

While **FHP** staff members reported that **FHP** had no physician incentive plans in place, the member handbook referenced only incentives for utilization management activities when informing members that no incentives existed. HSAG recommends that **FHP** consider any type of physician incentives, which could include payment for performance on key measures and other positive reward systems when determining if members should be notified about physician incentive plans.

Summary of Required Actions

Although staff members reported using the Flesch-Kincaid scale to test readability of member materials, HSAG found that **FHP**'s member handbook and welcome kit were written at a reading level much higher than sixth grade. Using the Flesch-Kincaid tool, testing selected pages revealed reading levels from 7.3 to 14.2. There were several instances in which **FHP** had copied either the federal regulation language or contract language verbatim into the member handbook, causing the document to be potentially not easily understood by an average CHP+ parent or guardian. Using the Adobe Acrobat accessibility tools, HSAG found that the member handbook, provider directory, and formulary showed multiple document reader, table, and contrast errors. **FHP** must develop a mechanism to use tools or mechanisms of **FHP**'s choice to ensure that member informational materials are in a format that may be easily understood—i.e., sixth grade reading level to the extent possible—and readily accessible based on Section 508 guidelines. HSAG recommends that **FHP** use tool kits for writing member materials developed by CMS.

In **FHP**'s CHP+ member handbook, there were a few definitions that were inconsistent with definitions outlined in **FHP**'s CHP+ contract with the Department. In addition, the care management discussion in the member handbook included a sentence that had not been completed. **FHP** must review how it is defining or using terms that are defined in the CHP+ contract and revise the handbook accordingly to ensure consistency. **FHP** should pay particular attention to the following terms: care management, care coordination, experimental/investigational, medical necessity, and utilization management.

Although the member handbook and welcome kit were primarily written in 12-point font, the benefits table was provided in 10-point font. **FHP** included a large font tagline in the welcome letter in English and Spanish; however, the tagline did not include information about how to request auxiliary aids other than through Teletypewriter/Telecommunications Device for the Deaf (TTY/TDD), written translation, or oral interpretation in any language. HSAG found no taglines in large print in the member handbook. Due to revisions to the Medicaid and CHIP managed care regulations posted November 13, 2020, there will be no required corrective actions related to the previous requirement for 18-point font. The definition of "large print" has been revised to be considered "conspicuously visible." **FHP** must ensure that member informational materials are written in, at a minimum, 12-point font and contain taglines written in a large font that include how to request auxiliary aids and services in addition to TTY/TDD, written translation, and oral interpretation.

HSAG found that the placement of the provider directory, member handbook, and formulary on **FHP**'s website was not prominent or easy to find as the website was difficult to navigate. In addition, the website was not compliant with Section 508 guidelines. Using the online tool at http://wave.webaim.org/, HSAG found numerous document content and contrast errors on **FHP**'s website. **FHP** must ensure that information available for members electronically is placed in a website location that is prominent and that the information is readily accessible in both the Hypertext Markup Language (HTML) and PDF versions (complies with Section 508 guidelines).

Neither **FHP**'s PDF version of the provider directory, nor the provider search feature on **FHP**'s website included information about whether the providers have completed cultural competency training or

whether the providers' offices have accommodations for members with physical disabilities. Due to revisions to the Medicaid and CHIP managed care regulations posted November 13, 2020, there will be no required corrective action related to findings regarding the provider directory not including information regarding whether or not the provider has completed cultural competency training. **FHP** must ensure that its provider directory includes information about whether the providers' offices have accommodations for members with physical disabilities.

FHP's member handbook contained information about grievances and appeals that included how to file, authority to file, and time frames and requirements. However, the time frames and requirements related to the continuation of services during an appeal and State fair hearing (SFH) were inaccurate and did not reflect the changes depicted in the 2016 revisions of the Medicaid managed care regulations (effective for CHP+ health plans beginning in July 2018). In addition, the examples provided for when to file an appeal were not entirely clear and could be interpreted inaccurately. **FHP** must revise the member handbook information about the grievances and appeals to ensure that members understand that:

- The right to file an appeal continues 60 days following the adverse benefit determination whether or not the member is requesting continuation of services during the appeal.
- If a member requests continuation of services during the appeal, the request for the continued services (not the appeal filing) must be submitted before the effective date of the advance notice to terminate, suspend, or reduce the previously authorized services.
- If the member has continued services during the appeal and requests continued services during the SFH, the member has 10 calendar days following the notice of appeal resolution to request the SFH and request the continued services (otherwise the member has 120 days following appeal resolution to request a SFH if continued services during the SFH is not being requested).
- If the member continued services during the appeal but does not request continued services during the SFH within 10 calendar days following the appeal resolution, the continued services will then end.

FHP must also clarify in its examples of appealable situations that appeals may only be filed in response to notices of adverse benefit determination (NABDs).

Standard VI—Grievance and Appeal Systems

Summary of Strengths and Findings as Evidence of Compliance

The member handbook, provider manual, and desktop procedure demonstrated compliance with some required definitions and timelines related to grievance and appeal systems. **FHP** accurately described a member's right to file a grievance verbally or in writing at any time and the right to appoint an authorized representative. Staff members were able to explain their efforts to inform members of their right to submit documentation, and appeals coordinators described their efforts to pursue appeals when submitted orally.

Although no grievances were reported for calendar year (CY) 2020, **FHP** documentation accurately described the timelines for sending grievance acknowledgement, resolution, and extension letters when applicable. Clinical staff members with appropriate expertise who were not previously involved in cases were available to make decisions on grievances and appeals.

Customer service staff members were available to assist with grievances and appeals in English and Spanish. When support in other languages was needed, **FHP** staff members used services from the vendor Translation Plus to dial in translators. Customer service training manuals outlined a member-centered and empathetic approach to dealing with complaints, emphasizing listening skills and empowering the customer service representative to take additional steps to help resolve the member's issue.

FHP's compliance management staff members were able to detect inadequacies (i.e., timely acknowledgement and resolution letters for appeals) within the current grievance and appeals internal processes in the summer of 2020. Upon detection of these inadequacies, **FHP** implemented an internal CAP to begin correcting the identified issues and to ensure timeliness of appeal processing. New appeals coordinators were hired in CY 2020 to provide additional support. Current grievance and appeal software systems were not completely interconnected, and information was commonly stored in Microsoft Excel spreadsheets. In an effort to update current systems and enhance timeliness oversight, **FHP** staff members reported that management staff were in the process of exploring new software systems.

Summary of Findings Resulting in Opportunities for Improvement

FHP did not submit sufficient policies, procedures, or workflows in advance of the audit to demonstrate overall strong compliance with grievance and appeal requirements. The single document submitted in advance for this standard was a desktop procedure that staff members agreed was a duplication of the member handbook, in which one section was repeated verbatim. This desktop procedure did not include detailed instructions to direct staff members in compliant grievance or appeal processing procedures or provide clear direction for monitoring for compliance with grievance and appeal requirements. The grievance and appeal department could benefit from additional procedural documents to clearly detail requirements and step-by-step details to help direct staff members. Additionally, stronger internal monitoring processes should be developed to ensure that the procedures are properly implemented and upheld consistently to ensure a compliant grievance and appeal system. For example, when describing the complaint logs kept by customer service, **FHP** stated the grievance and appeals team requested this information quarterly. HSAG recommends more frequent monitoring to ensure timeliness.

While **FHP**'s definition of "adverse benefit determination" was mostly accurate, **FHP**'s placement of a member's request to dispute financial liability was inaccurately placed in the definition as a sub-point. HSAG recommends that **FHP** update this list of bullet points to more accurately describe an adverse benefit determination. HSAG also recommends that **FHP** update documents to reflect the current terminology "adverse benefit determination" and "notice of adverse benefit determination" rather than the previous terminology "notice of action" (NOA) to better align with current State and federal definitions and provide clarity across documents.

Notably, for this FY 2020–2021 audit cycle, **FHP** did not report any grievances. Previously, in FY 2017–2018, **FHP** reported only one grievance. Despite **FHP**'s description of staff member orientation training and ongoing ad-hoc trainings to highlight the grievance process, there has been no increase in documented grievances. **FHP** described that there is a separate process in which complaints, if received, would be documented by customer service and collected by the grievance department quarterly. While no complaints had been logged, HSAG cautions that this quarterly process may not allow grievance staff members the opportunity to ensure timely acknowledgements, resolutions, or internal monitoring for compliance with grievance processing requirements.

Staff members described processing oral appeals; however, during the web-based interview, there was some confusion expressed regarding whether or not staff members would wait to receive additional documents before working on the appeal. HSAG recommends that **FHP** further outline procedures regarding the appeal process to include supporting members and authorized representatives when submitting additional evidence and a description of staff members' responsibility.

While **FHP** submitted additional documents regarding expedited appeals after the audit session, HSAG recommends that **FHP** clarify within internal procedural documents that the denial of an expedited appeal request should be reviewed by a clinically appropriate staff member. HSAG also recommends preparing a template expedited request denial letter to ensure that these notices consistently include the required content.

Lastly, HSAG also recommends a clearer heading to differentiate the "continuation of benefits during the appeal" section.

Summary of Required Actions

HSAG found that **FHP** did not meet many requirements regarding grievance and appeal systems. **FHP** submitted one procedural document related to grievance and appeal systems; however, this document appeared to be a duplication of the member handbook section for grievances and appeals and did not include details for how **FHP** staff members should process, monitor, or resolve cases. Additionally, overall appeal record scores demonstrated compliance with only roughly one-third of the requirements. **FHP** must update and expand its grievance and appeal policies, procedures, and letter templates to more clearly define both grievance and appeal and delineate processes. Additionally, **FHP** must develop detailed procedures to better train and monitor staff members to ensure that grievances and appeals are being collected, processed, and resolved in compliance with federal and State requirements.

The definitions for "appeal" provided within the member handbook, provider manual, and desktop procedure were all aligned with the federal definition. However, when staff members described the differences between member and provider appeals, staff members reported that any appeal submitted by a provider was considered a provider appeal. **FHP** must update and expand its internal grievance and appeal documentation to more clearly define both "grievance" and "appeal." **FHP** must develop detailed procedures to better train and monitor staff members and ensure that grievances and appeals are being collected, processed, and resolved in compliance with federal and State requirements. The record review contained multiple instances of durable medical equipment (DME) denials, in which the member was

denied insulin pumps and the provider was informed the member had reached the maximum benefit limit. HSAG clarified that any issue not related to provider procedural issues should be processed as a CHP+ member appeal. On November 13, 2020, CMS revisions to the definition of an "adverse benefit determination" further clarified that an appeal is anything other than "a denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a clean claim." Additionally, examples provided within the member handbook did not accurately describe an appeal. The appeal example stated, "You are told you are being discharged from the hospital and don't feel ready to go." However, this example is not entirely clear. If the authorized stay has expired, and no new request submitted, the member may not appeal. If a provider submitted a request for authorizing additional hospital days that was denied, then an NABD would be sent, which the member could appeal. The end of an authorization period does not trigger an NABD or appeal rights. **FHP** must update and expand its internal appeal documentation to more clearly define appeals. **FHP** must develop detailed procedures to better train and monitor staff members and ensure that appeals are being collected, processed, and resolved in compliance with federal and State requirements. **FHP** must update the member handbook to clarify that members may appeal the denial of services once an NABD has been received.

Definitions throughout the member handbook, provider manual, and desktop procedure included separate definitions for "complaints" and "grievances," which could be misleading to members and staff. For example, the provider manual stated that "The terms 'complaint' and 'grievance' are sometimes used interchangeably. A complaint may be resolved without further action." It goes on to say, "A grievance usually invokes the organization determination process through documented action and is generally considered more formal than a complaint."

Within the desktop procedure *Tracking Suggestions/Inquiries/Complaints/Grievances/Appeals/Provider Disputes*, the terms were also used incorrectly: "In the event that the complaint is actually a grievance the grievance policy is followed. In the event that the issue is still categorized as a complaint and it is unable to be resolved during the first call, **FHP** will ensure that all complaints are resolved within 7 days from receipt. Verbal notice is given to the member within 24 hours from resolution." This direction is out of compliance with federal grievance and appeal regulations. Additional training evidence submitted post-audit included a training manual that outlined how customer service should handle a "complaint call" and did not include any reference to a complaint being a grievance, nor the need to alert the grievance and appeal department, log the grievance, or follow up with an acknowledgement or resolution letter. **FHP** must update and clarify this information in all related documents (included procedures and training materials) to align the definition of "grievance" with the federal definition. These updates must clarify that "complaints" are the same as "grievances" and must be treated the same way. **FHP** must remove references that there are differences between formal and informal grievances or complaints.

While the supporting documents did outline that **FHP** staff members would help in filing efforts, the language in the grievance section did not include specifics about auxiliary aids and interpreter services. **FHP** must update related grievance and appeal documents to clarify that auxiliary aids and interpreter services are available at no cost to the member in order to help members with completing any forms or other procedural steps related to grievances and appeals.

FHP's *Quick Reference Guid*e detailed second-level appeal rights and did not clarify that CHP+ members only have one level of appeal. **FHP** must update documents to clarify that for the CHP+ line of business there is only one level of appeal for CHP+ members.

The member handbook, provider manual, and desktop procedure all included accurate language describing the time frame for mailing members appeal acknowledgement letters. Staff members reported during the virtual interview that internal monitoring over the summer of 2020 had identified an issue regarding acknowledgement letters and an internal corrective action plan was developed in July 2020. However, record review findings indicated that none of the seven appeals included acknowledgement letters for members or providers. **FHP** must develop a mechanism to ensure that member acknowledgement letters for each appeal are sent in a timely manner.

Despite having the expedited appeal resolution time frames accurately outlined in the desktop policy, **FHP**'s documents did not include language regarding a member's right to file a grievance in response to the denial of an expedited appeal. **FHP** must update grievance and appeal documents to include the member's right to file a grievance in response to a denial of an expedited appeal request.

Appeal resolution timelines were accurately described in the member handbook, provider manual, and desktop procedure, but not within the *Quick Reference Guide*. The *Quick Reference Guide* depicted "10 days" instead of the "10 working day" requirement. And although the 10 calendar days would be a greater benefit to the CHP+ member, the policy was not consistently applied in practice. Record review findings showed that appeal resolution letters were not sent to members in six of the seven samples. In the one case in which a letter was sent to the member, it was mailed over 60 days after the appeal was submitted. **FHP** must update documents to reflect the 10-working day timeline and develop a mechanism to ensure appeals are resolved and members are notified within timeliness standards.

While **FHP**'s documents did include language regarding the 72-hour expedited appeal timeline, the desktop procedure *Expedited Determinations* also referred to a three-business day timeline. **FHP** must remove references to three business days and update all time frames to reflect that both verbal and written notice must take place within the 72-hour time frame.

Although **FHP**'s extension process and samples included the correct time frames and described efforts to provided prompt oral notice, the documents did not include the member's right to file a grievance if the member disagrees with the extension. **FHP** must update documents to include the member's right to file a grievance in response to an extension if the member disagrees with the extension.

Sections of **FHP**'s member handbook, desktop procedure, and provider manual included inaccurate timelines regarding SFHs (60 days from the notice of action instead of 120 days from the notice of appeal resolution). Also, although the request for continued services was accurately outlined as 10 days from the adverse appeal determination, the language regarding "or before the effective date of the termination or changes in services" does not apply during a SFH, only appeals. **FHP** must update the SFH timelines to reflect that the member has 120 days from the appeal resolution to request a SFH unless the member is also requesting continuation of the disputed services, in which case both the continued services and the SFH must be requested within 10 days following the appeal resolution. **FHP**

must also remove the reference to the original effective date of the termination of the services from the SFH section of its documents.

In regard to SFH, **FHP**'s documents did not clearly indicate that the member must request both the continuation of benefits and SFH within 10 days of the adverse appeal determination. **FHP** must also clarify that the provider may not request continued benefits on behalf of the member due to the potential financial liability for the member. **FHP** must update all related grievance and appeal systems documents to clearly indicate the timelines for requesting continuation of benefits during appeals and SFH and who may request such benefits.

While parts of **FHP**'s desktop procedure, member handbook, and provider manual included partially accurate information, this language should be under the appeals section, not SFH: "A total of ten (10) calendar days pass after we mail the original notice to you that we are denying your appeal. If you request a State fair hearing within those ten (10) calendar days, your benefits will continue until the hearing is finished." Lastly, the authorization period for services does not trigger the end of services once the services have been continued during the SFH as the authorization may have since expired during the appeal or SFH. **FHP** must update all related documentation to clarify the duration of continued benefits during an appeal and SFH.

Although the **FHP** member handbook, provider manual, and desktop procedure accurately described the member's responsibility for continued services during the appeal, the SFH section did not include that the member may also be financially liable for services delivered during the SFH. **FHP** must clarify within the SFH section related to continued benefits that the member may be held liable for services delivered during the appeal and SFH.

Documentation stated that "Friday maintains procedures to collect, track and report suggestions, inquiries, complaints, grievances and appeals received." While the appeals records did include key documentation, the 2020 Complaint Log did not include the minimum required elements (i.e., name of the person for whom the grievance was filed and a general description of the reason for the grievance). HSAG also noted there was not a section in the complaint log to include additional dates or information regarding resolution letters (when applicable). **FHP** must enhance policies, procedures, and monitoring practices to ensure that all required grievance information is maintained.

Within the provider manual, the terms "complaint" and "grievance" were defined separately, which did not clearly convey that the terms mean the same thing based on federal regulations. Additionally, the manual included other inaccuracies regarding appeal and SFH timelines and continuation of benefits. **FHP** must ensure that updates to other requirements are accurately implemented in the provider manual and associated materials so that providers and subcontractors receive accurate information about grievances, appeals, and SFHs at the time they enter into a contract.

Standard VII—Provider Participation and Program Integrity

Summary of Strengths and Findings as Evidence of Compliance

FHP's network access management plan laid out efforts to recruit and retain a fully developed, contracted network of professional, institutional, and ancillary providers within its service area. **FHP**'s contracting strategy was described as "broad-based yet personalized" to account for the rural area served. While specialists may at times be hard to find, **FHP** described the use of telehealth when possible and monitoring for contract opportunities in bordering counties. **FHP**'s documents described the Quality Assurance Committee (QAC) as responsible for reviewing, providing input, and approving the Network Management Program at least annually and also for assessing provider network performance and making any improvement recommendations to the chief executive officer (CEO). **FHP** staff members reported that single case agreements (SCAs) were utilized occasionally for instances such as continuity of care with a new CHP+ enrollee, specific sub-specialties, post-acute discharge needs, or out-of-state emergent cases. **FHP** did not report any retention issues with providers and described retention efforts built into structured contracts.

Documentation and interviews supported compliance with provider screening, contracting, file maintenance, and efforts toward provider relations even through the coronavirus disease 2019 (COVID-19) barriers. Notably, **FHP**'s sample credentialing denial letter showed due diligence in screening providers and notifying providers of any adverse decisions made by the credentialing committee. Provider agreements were tracked through the Health Rules Payer (HRP) system and staff members reported that 25 percent of the directory was monitored each quarter to verify data accuracy.

FHP reported ongoing communication with providers through email blasts, mailings for more formal topics, and recently through webinars. In addition to usual billing questions and answers, **FHP** also used these meetings to introduce providers to applicable quality improvement projects. These efforts were supported by **FHP**'s Network team and Provider Operations team. Credentialing staff members ensured that all network providers were enrolled with the State and showed an *Application Report* workflow as evidence of consistent screening and enrollment review processes.

Program Integrity documents provided evidence that requirements were operationalized by the compliance manager who regularly reviewed statues and rule changes, and monitored for Health Insurance Portability and Accountability Act (HIPAA) breach notifications. The Compliance Committee reportedly met quarterly. Training for staff members occurred annually and for new hires, with additional communications sent through email for ad-hoc updates.

FHP comprehensively outlined provisions for prompt reporting of overpayments. Staff members described multiple methods for reviewing for overpayment, including general claims reconciliation; monitoring high dollar claims, such as inpatient; and also quality improvement projects involving medical record reviews, which targeted accurate documentation.

HIPAA training took **FHP**'s organizational culture into consideration as evidenced by the focus on "need to know." While the **FHP** staff member count had grown from approximately 30 employees to

over 100 employees during the review period, **FHP**'s compliance team reinforced that current role assignments are used for system controls. Additionally, **FHP** reported updating physical security measures such as key fobs and increasing awareness reminders. Phishing and fraud emails had also been implemented as newer focuses to training content with consideration to the new work-at-home conditions imposed by COVID-19.

Summary of Findings Resulting in Opportunities for Improvement

FHP's member handbook and provider agreements generally outlined that providers are not restricted from communicating with members about the following as long as the provider is doing so while acting within the lawful scope of his or her practice. HSAG recommends that **FHP** expand the provider agreement language to include all the criteria within 42 CFR 438.102(a)(1):

- The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered.
- Any information the member needs in order to decide among all relevant treatment options.
- The risks, benefits, and consequences of treatment or non-treatment.
- The member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions.

Although **FHP** does not object to providing any of the CHP+ covered services, **FHP** did not have a process for providers to notify **FHP** if the provider objected to providing any CHP+ services based on any moral or religious grounds. HSAG recommends that **FHP** clarify within the provider manual or provider contracts that if any contractor objects to providing CHP+ covered services, whether for religious or moral reasons, **FHP** should be notified. **FHP** should also consider outlining proactive measures to inform members of any provider objections.

Summary of Required Actions

The *Compliance Program* description conveyed **FHP**'s commitment to comply with all applicable federal and State requirements; designated a chief compliance officer; and described the Compliance Committee structure, participants, and duties in alignment with regulations. However, the plan lacked details regarding the specific training for the compliance officer and health plan managers. Staff interviews confirmed that no specific training plans were in place for compliance leadership beyond the general internal staff-level training. **FHP** must further develop training and education requirements for the compliance officer and compliance management staff members.

The False Claims Act was accurately described within the *Compliance Program* description; however, it did not include specific details regarding staff members' rights to be protected. Furthermore, the description did not consistently outline details about how staff members should make a prompt referral (i.e., reporting timelines, appropriate method for reporting). In addition, page 20 of the plan stated, "The Companies and Applicable Persons may be required to comply with the following federal and state

laws." The training manual submitted did not contain additional information regarding compliance, fraud, waste, abuse, or reporting hotlines. While **FHP** did describe that suspension of payments would be processed through the Physician Advisory Committee (PAC), **FHP** did not submit written procedures regarding provisions for suspension of payments to a network provider for which the State determines there is a credible allegation of fraud. **FHP** must update its *Compliance Program* description and supporting documents to further detail staff members' right to be protected under the False Claims Act and include additional details (i.e., reporting methods, contact methods, timelines, etc.) for prompt referral of fraud, waste, and abuse both internally and also to the State as applicable.

While the *Compliance Program* description spoke in general terms about **FHP**'s "formal, systematic, and structured approach" which "involves planning, sampling, testing, and validating," there were no specific procedures to verify regularly, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. Methodology discussed by staff members included financial and claims review and general reconciliation processes but did not include a proactive way of validating services with members directly. **FHP** must develop a method, such as member sampling, to assess regularly whether billed member services have been supplied by a provider.

While **FHP** did submit evidence regarding how excess payments were addressed, **FHP** did not submit evidence of internal procedures for providing written disclosures of ownership and control or prohibited affiliations. **FHP** must create and implement procedures to outline how **FHP** provides disclosures of ownership and control as well as prohibited affiliations to the State.

Standard IX—Subcontractual Relationships and Delegation

Summary of Strengths and Findings as Evidence of Compliance

During the web-based interviews, **FHP** staff members reported that the **FHP** delegates were Magellan for pharmacy services; Vision Services Plan (VSP) for vision services; and UST Global Inc. (UST) for fulfillment of distributing the member welcome kits, ID cards, and explanations of benefits. Through the web-based interviews and policy/procedure statements, **FHP** demonstrated an understanding of the regulation pertaining to maintaining ultimate responsibility for adhering to, and otherwise fully complying with, all terms and conditions of its CHP+ contract with the State. **FHP** submitted evidence of having a written agreement with each delegation subcontractor.

Summary of Findings Resulting in Opportunities for Improvement

While **FHP** provided a policy/procedure related to subcontracts and delegation, the policy had not been updated to reflect changes in the Medicaid and CHIP managed care rule that were released in 2016 and effective for CHP+ health plans beginning in July 2018. HSAG recommends that **FHP** review policies, procedures, and any organizational processes to ensure that internal company documents reflect the most recent federal regulations.

Although **FHP** staff members reported that delegation monitoring was reported to the quality committee and ultimately has board oversight, **FHP** was unable to provide evidence of such practices. HSAG recommends that **FHP** ensure that monitoring and oversight of delegates is consistent with internal policies and procedures and organized in a way to ensure consistent and activity-specific oversight.

Summary of Required Actions

Only the Magellan agreement specified reporting responsibilities. All agreements provided included the subcontractor's agreement to perform the duties under the contract, provisions for remedies for instances of subcontractor nonperformance of the subcontracted activities, and agreement to comply with all regulations and laws pertaining to work under the contract. The UST agreement provided did not have the statement of work attached and, therefore, the document provided did not include the delegated activities or the reporting responsibilities. **FHP** must amend the UST and VSP contracts to ensure that the delegation agreements specify the delegate's activities or obligations and related reporting responsibilities.

Both the VSP and Magellan contracts were missing the required provisions that the State, CMS, and Health and Human Services (HHS) personnel have the right to audit, evaluate, and inspect books, records, or premises as deemed necessary by the applicable agency. The contracts also required retention of records for only six years, which would not be sufficient to allow for agency audits through 10 years following the final date of the contract or agreement. None of the agreements provided for review included specific provisions related to CMS rights to audit based on suspicion of fraud. **FHP** must amend all delegation agreements to ensure inclusion of the required contract provisions related to State, CMS, and HHS rights to audit. Amendments must include all required provisions and timelines.

2. Overview and Background

Overview of FY 2020–2021 Compliance Monitoring Activities

For the FY 2020–2021 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard V—Member Information Requirements, Standard VI—Grievance and Appeal Systems, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontractual Relationships and Delegation. Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Site Review Methodology

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

HSAG also requested to review a sample of the health plan's administrative records related to CHP+ grievances and CHP+ appeals to evaluate implementation of federal healthcare regulations. However, **FHP** did not have any reported grievances for this review period and only seven member appeals. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records (to the extent that a sufficient number existed) for each of grievances and appeals. Using a random sampling technique, HSAG selected the sample from all CHP+ appeal records that occurred between January 1, 2020, and December 31, 2020. For the record review, the health plan received a score of *Met (M)*, *Not Met (NM)*, or *Not Applicable (NA)* for each required element. Results of record reviews were considered in the review of applicable requirements in Standard VI—Grievance and Appeal Systems. HSAG separately calculated a record review score for each record review requirement and an overall record review score.

The site review processes were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS EQR protocol. The four standards chosen for the FY 2020–2021 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement.

Objective of the Site Review

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

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

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

FY 2019–2020 Corrective Action Methodology

As a follow-up to the FY 2019–2020 site review, each health plan that received one or more *Partially Met* or *Not Met* scores was required to submit a CAP to the Department addressing those requirements found not to be fully compliant. If applicable, the health plan was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the health plan and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **FHP** until it completed each of the required actions from the FY 2019–2020 compliance monitoring site review.

Summary of FY 2019–2020 Required Actions

For FY 2019–2020, HSAG reviewed Standard I—Coverage and Authorization of Services and Standard II—Access and Availability.

Related to coverage and authorization of services, **FHP** was required to complete 12 required actions, including:

- Correct documents to include accurate time frames (72 hours) for making expedited authorization decisions and notifying the member.
- 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. In addition, develop or enhance **FHP** policies and procedures to address review and notification.
- Update NABD taglines informing the member of availability of the notice in alternative formats. **FHP** must also ensure that all information in the NABD is written in language easy for the member to understand.
- Update NABDs to include accurate appeal information and remove the description of reconsiderations.
- Enhance or develop operating procedures to ensure NABDs are mailed within required time frames.
- Develop policies and procedures for NABDs regarding reduction, suspension, or termination of a previously authorized service, or, clarify within policies and procedures that **FHP** never denies previously authorized services.
- Enhance procedures for reviewing emergency claims and address the requirement to pay for emergency services if a representative of **FHP** instructed the member to seek emergency services.

- Develop policies or procedures to guide staff members regarding financial responsibility for post-stabilization services (this action covers five related requirements).

Related to access and availability, **FHP** was required to complete three required actions, including:

- 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** was required to 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.
- 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.
- Develop and implement mechanisms to ensure staff members are provided cultural competency training programs regarding cultural factors affecting access to care or medical risks.

Summary of Corrective Action/Document Review

FHP submitted a proposed CAP in February 2020. HSAG and the Department reviewed and approved portions of the proposed plan and responded to **FHP**. **FHP** submitted initial documents as evidence of completion in July 2020. **FHP** resubmitted final CAP documents in November 2020.

Summary of Continued Required Actions

FHP successfully completed the FY 2019–2020 CAP, resulting in no continued corrective actions.

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor provides all required member information to members in a manner and format that may be easily understood and is readily accessible by enrollees. *Note: Readily accessible means electronic information which complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines.* *42 CFR 438.10(b)(1)* CHP Contract: Section 21.A.	**Documents:** 1. Member Handbook 2. Provider Directory 3. CHP+ Formulary -these are all found on our website at www.fridayhealthplans.com 4. Welcome Kits -also a copy of member's welcome kit, that includes member ID, Summary of benefit information, etc., is saved to their account and if requested can be emailed to member, or members parent/guardian.	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: FHP's member handbook and welcome kit were written at a reading level much higher than sixth grade. Using the Flesch-Kincaid tool, testing selected pages revealed reading levels from 7.3 to 14.2. There were several instances in which FHP had copied either the federal regulation language or contract language verbatim into the member handbook, causing the document to be potentially not easily understood by an average CHP+ parent or guardian. Using the Adobe Acrobat accessibility tools, HSAG found that the member handbook, provider directory, and formulary showed multiple document reader, table, and contrast errors.		
Required Actions: FHP must develop a mechanism to use tools or mechanisms of FHP's choice to ensure that member informational materials are in a format that may be easily understood—i.e., sixth grade reading level to the extent possible—and readily accessible based on Section 508 guidelines. HSAG recommends that FHP use tool kits for writing member materials developed by CMS.		

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor has in place a mechanism to help members understand the requirements and benefits of the plan. *42 CFR 438.10(c)(7)* CHP+ Contract: Exhibit B1—6.3.1.15	**Documents:** 1) Member Handbook, **Narrative:** Friday Health Plans maintains a Member Handbook that helps members understand the requirements and benefits of the plan. This member handbook is distributed to all new members upon enrollment with the plan. The member handbook functions as the Evidence of Coverage. The Member Handbook contains a CHP+ Comparison Benefit Form that outlines the covered services and copayments offered by the managed care plan. The Member Handbook additionally provides members with additional information regarding the benefits and services covered under the managed care plan. Members are encouraged to contact our Customer Service department for any questions or clarification in services offered under their plan. Customer Service representatives use this member handbook as its guide in explaining requirements and benefits of the plan to members. Members are encouraged to call customer service with any questions or concerns that may arise.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. For consistency in the information provided to members, the Contractor uses the following as developed by the State: • Definitions for managed care terminology, including appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. • Model member handbooks and member notices. *42 CFR 438.10(c)(4)* CHP+ Contract: Exhibit B1—2.8.4	This terminology is used throughout the member handbook/ EOC. Documents: Member Handbook - (section XIII. DEFINITIONS, Pg. 99-115)	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: In FHP's CHP+ member handbook, there were a few definitions that were inconsistent with definitions outlined in FHP's CHP+ contract with the Department. In addition, the care management discussion in the member handbook included a sentence that had not been completed.		
Required Actions: FHP must review how it is defining or using terms that are defined in the CHP+ contract and revise the handbook accordingly to ensure consistency. FHP should pay particular attention to the following terms: care management, care coordination, experimental/investigational, medical necessity, and utilization management.		

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • All written materials for members must: – Use easily understood language and format. – Use a font size no smaller than 12 point. – Be available in alternative formats and through provision of auxiliary aids and service that takes into consideration the special needs of members with disabilities or limited English proficiency. – Include taglines in large print (18 point) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service number, and availability of materials in alternative formats. *42 CFR 438.10(d)(3) and (d)(6)* CHP+ Contract: Exhibit B1—6.3.1.14, 14.1.3.1, 14.1.3.2, 14.1.3.4, 14.1.3.5	Written materials that are critical to obtaining services include: provider directories, member handbooks, appeal and grievance notices, and denial and termination notices. All Documentation that is mailed to members is in 12 point Font and available in other formats as requested. Documents: Welcome kit for new and reinstating members. (Page 2, of the letter. & page 27&28 which state #'s for other non-English languages)	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Findings:
FHP informed members that materials were available in Spanish and FHP staff members stated during the web-based interview that Spanish materials were sent upon request by the member. Although the member handbook and welcome kit were primarily written in 12-point font, the benefits table was provided in 10-point font. FHP included a tagline in the welcome letter in English and Spanish; however, the tagline did not include information about how to request auxiliary aids other than TTY/TDD, written translation, or oral interpretation. HSAG found no taglines in large print in the member handbook.

Due to revisions to the Medicaid and CHIP managed care regulations posted November 13, 2020, there will be no required corrective actions related to the previous requirement for 18-point font. The definition of "large print" has been revised to be considered "conspicuously visible."

Required Actions:
FHP must ensure that member informational materials are written in, at a minimum, 12-point font and contain taglines written in a large font that include how to request auxiliary aids and services in addition to TTY/TDD, written translation, and oral interpretation.

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. If the Contractor makes information available electronically—Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of readily accessible above). • The information is placed in a website location that is prominent and readily accessible. • The information can be electronically retained and printed. • The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge upon request and is provided within five (5) business days. *42 CFR 438.10(c)(6)* CHP+ Contract: Exhibit B1—14.1.3.13.2	All our Electronic information is available in paper form without Charge upon request and is provided within five business days. It is also downloadable and printable from our website www.fridayhealthplans.com Now with the newest version of our website you will click on member hub select Colorado, then click health plans at the top and select Child Health Plans Plus. Pg. 1 and 2 of the welcome kit for New and reinstating members contain this information. References: - Documents: - Welcome kit - Website: - www.fridayhealthplans.com	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: FHP provided member informational materials through its website and the welcome kit (mailed to members) informed members that the information is available in written form upon request within five business days. HSAG found that the provider directory, member handbook, and the formulary were on the website in PDF format which could be retained and printed. HSAG, however, found that the placement of these documents was not prominent as the website was difficult to navigate. The website was not compliant with Section 508 guidelines. Using the online tool at http://wave.webaim.org/, HSAG found numerous document content and contrast errors on FHP's website.		
Required Actions: FHP must ensure that information available for members electronically is placed in a website location that is prominent and that the information is readily accessible (complies with Section 508 guidelines).		

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor makes available to members in electronic or paper form information about its formulary: • Which medications are covered (both generic and name brand). • What tier each medication is on. • Formulary drug list must be available on the Contractor's website in a machine readable file and format. *42 CFR 438.10(i)* CHP+ Contract Amendment 3: Exhibit B1—6.7.1.5	This information is available on our website and mailed to member upon member request. The formulary is updated annually as needed. And is in an Adobe PDF format. Documents: CHP+ Formulary 2020-2021	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The Contractor makes interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and how to access them. • This includes oral interpretation and use of auxiliary aids such as TTY/TDY and American Sign Language. *42 CFR 438.10(d)(4)* CHP+ Contract: Exhibit B1—7.5, 14.1.3.3, 14.1.7.6	This information is listed on every Document, In the Formulary on the bottom of page 1. In member hand book it is mentioned multiple times. Pg 2, 6, 16, 17, 32, 33, 34, 39, 46, and on pg 126 in many languages.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor notifies members that auxiliary aids and services are available upon request and at no cost for members with disabilities, and how to access them. *42 CFR 438.10(d)(5)* CHP+ Contract: Exhibit B1—14.1.3.5, 14.1.3.10.1.3	**Documents:** Welcome kit for new & reinstated members. First page on the bottom states where the information is available online.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor provides each member with a member handbook in both electronic and paper format within a reasonable time after receiving notification of the member's enrollment. *42 CFR 438.10(g)(1)* CHP+ Contract Amendment 3: Exhibit B1—6.7.1	When a member is enrolled the welcome kit states where the member handbook is found on our website, and as always if requested they will receive one via mail (if hardcopy is requested) or email (if digital copy is requested.)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor gives members written notice of any significant change (as defined by the State) in the information required at 438.10(g) at least 30 days before the intended effective date of the change. *42 CFR 438.10(g)(4)* CHP+ Contract: Exhibit B1—6.7.2, 14.1.3.13.3	**Documents:** 1. Member Handbook **Narrative:** The Member Handbook outlines that Friday Health Plans will provide written notice of any significant changes at least 30 days before the intended effective date.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. *42 CFR 438.10(f)(1)* CHP+ Contract: Exhibit B1—7.12.2, 14.1.8.1	When provider relations terminates providers that have CHP+ members who have selected this provider as a primary care physician, a letter is sent out to the members advising them of the termination and whether there is a replacement provider available and giving members the option to choose a new PCP.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, pharmacies, and behavioral health providers, and LTSS providers (as applicable): • The provider's name and group affiliation, street address(es), telephone number(s), website URL, specialty (as appropriate),	This information is also available on our website including the provider directory. **Documents:** 1) CHP+ Provider Directory 2) Member Handbook	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
whether the providers will accept new enrollees. • The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training. • Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment. *Note: Information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after the Contractor receives updated provider information.* *42 CFR 438.10(h)(1-3)* CHP+ Contract: Exhibit B1—14.1.3.6-7	**Narrative:** Members have up-to-date real time data regarding network providers for CHP+ through their Member Portal search. Members are informed in the member handbook that they can call customer service to have a provider directory mailed to them.	
Findings: Neither FHP's PDF version of the provider directory, nor the provider search feature on FHP's website included information about whether the providers have completed cultural competency training or whether the providers' offices have accommodations for members with physical disabilities. Due to revisions to the Medicaid and CHIP managed care regulations posted November 13, 2020, there will be no required corrective action related to findings regarding the provider directory not including information regarding whether or not the provider has completed cultural competency training.		
Required Actions: FHP must ensure that its provider directory includes information about whether the providers' offices have accommodations for members with physical disabilities.		

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. Provider directories are made available on the Contractor's website in a machine readable file and format. *42 CFR 438.10(h)(4)* CHP+ Contract: Exhibit B1—14 1.3.8	Found on website this is mention in welcome letter for enrollment to our plan. Document: Welcome Kit(page 1 at the bottom of the page states where to find this information online.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: FHP's provider directory was available on the FHP website in a PDF format; however, the PDF document was not compliant with Section 508 guidelines.		
Required Actions: FHP must develop a mechanism to ensure that the provider directory is available in a machine readable format (compliant with Section 508 guidelines).		
14. The member handbook provided to members following enrollment includes: • The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled. • Procedures for obtaining benefits, including authorization requirements and/or referrals for specialty care and for other benefits not furnished by the member's primary care provider. • The extent to which and how members may obtain benefits, including family planning services, from out-of-network providers. This includes an explanation that the Contractor cannot require the member to obtain a referral before choosing family planning provider. • The process of selecting and changing the member's primary care provider. • Any restrictions on the member's freedom of choice among network providers. • In the case of a counseling or referral service or CHP+ covered	**Documents:** Member Handbook & EOC -Pages 6-17 include the summary of benefits. -Additionally, Benefits and services is outlined in Section VII. Your Friday Health Plans Benefits and Services. Pgs 43-80	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
benefit that the Contractor does not cover due to moral or religious objections, the Contractor informs the member that the service is not covered because of moral or religious objections and how and where the member can obtain the services. *42 CFR 438.10(g)(2)(iii, iv, vi, vii, x) and (g)(ii)(A-B)* CHP+ Contract: Exhibit B1—14.1.3.10 14.1.3.13.3.7 Exhibit K—1.1.4.1–3, 1.1.14, 1.1.30 Amendment 3: Exhibit K—1.1.7		
15. The member handbook provided to members following enrollment includes the following member rights and protections as specified in 42 CFR 438.100. Members have the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for his or her dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding his or her health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. • Request and receive a copy of his or her medical records, and request that they be amended or corrected. • Be furnished health care services in accordance with	**Documents:** The Member Handbook & EOC -Section V. MEMBER RIGHTS AND RESPONSIBILITES (Pgs. 29-32) -this covers the member's rights and responsibilities. -Specifically please see page 29 and 30 for all Member rights listed in this section.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
requirements for access, coverage, and coordination of medically necessary services. • Freely exercise his or her rights, and the exercising of those rights will not adversely affect the way the Contractor, its network providers, or the State Medicaid agency treats the member. *42 CFR 438.10(g)(2)(ix)* CHP+ Contract: Exhibit B1—14.1.3.10, 14.1.1.2.1-6, 14.1.1.3 Exhibit K—1.1.2		
16. The member handbook provided to members following enrollment includes the following information regarding the grievance, appeal, and fair hearing procedures and time frames: • The right to file grievances and appeals. • The requirements and time frames for filing a grievance or appeal. • The right to a request a State fair hearing after the Contractor has made a determination on a member's appeal which is adverse to the member. • The availability of assistance in the filing process. • The fact that, when requested by the member: – Benefits that the Contractor seeks to reduce or terminate will continue if the member files an appeal or a request for State fair hearing is filed within the time frames specified for filing. – If benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of	**Documents:** Member Handbook/EOC -Section VI Grievances and Appeals Process -(Pages 33-42)	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
services while the appeal or State fair hearing is pending if the final decision is adverse to the member. *42 CFR 438.10(g)(2)(xi)* CHP+ Contract: Exhibit B1—14.1.3.10 Exhibit K—1.1.18, 1.1.18.1, 1.1.18.1.1, 1.1.18.1.3, 1.1.18.2.1		

Findings:

FHP's member handbook contained information about grievances and appeals that included how to file, authority to file, and time frames and requirements. However, the time frames and requirements related to the continuation of services during an appeal and SFH were inaccurate and did not reflect the changes depicted in the 2016 revisions of the Medicaid managed care regulations. In addition, the examples provided for when to file an appeal were not entirely clear and could be interpreted inaccurately.

Required Actions:

FHP must revise the member handbook information about the grievances and appeals to ensure that members understand that:

- The right to file an appeal continues 60 days following the adverse benefit determination whether or not the member is requesting continuation of services during the appeal.
- If a member requests continuation of services during the appeal, the request for the continued services (not the appeal filing) must be submitted before the effective date of the advance notice to terminate, suspend, or reduce the previously authorized services.
- If the member has continued services during the appeal and requests continued services during the SFH, the member has 10 calendar days following the notice of appeal resolution to request the SFH and request the continued services (otherwise the member has 120 days following appeal resolution to request the SFH if continued services during the SFH is not being requested).
- If the member continued services during the appeal but does not request continued services during the SFH within 10 calendar days following the appeal resolution, the continued services will then end.

FHP must also clarify in its examples of appealable situations that appeals may only be filed in response to NABDs.

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The member handbook provided to members following enrollment includes the extent to which and how after-hours and emergency coverage are provided, including: • What constitutes an emergency medical condition and emergency services. • The fact that prior authorization is not required for emergency services. • The fact that the member has the right to use any hospital or other setting for emergency care. *42 CFR 438.10(g)(2)(v)* CHP+ Contract: Exhibit B1—14.1.3.10 Exhibit K—1.1.10.1, 1.1.10.1.1, 1.1.10.2, 1.1.10.5	**Documents:** Member Handbook: - Section VII. Your Friday Health Plans Benefits and Services, "Emergency Care" beginning on Page 53	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
18. The member handbook provided to members following enrollment includes: • Cost-sharing, if any is imposed under the State plan. • How and where to access any benefits that are available under the State plan but not covered under the Medicaid managed care contract. • How transportation is provided. • The toll-free telephone number for member services, medical management, and any other unit providing services directly to members. • Information on how to report suspected fraud or abuse. • How to access auxiliary aids and services, including information in alternative formats or languages.	**Documents:** Member Handbook Cost-sharing is found under Section XII. Definitions - page 109 "Out-Of-Pocket Annual Max" Access of Benefits - this is not in the book as we only cover what is required. Transportation - Found beginning pg 56 of Section VII. Your Friday Health Plans benefits and serviced. Ambulance and Transportation Services. - Toll-free telephone numbers	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.10(g)(2)(ii, viii, xiii, xiv, xv) CHP+ Contract: Exhibit B1—14.1.3.10 Exhibit K—1.1.3, 1.1.19	- Our Toll free number is at the bottom of every page throughout this Handbook. Also on pgs. 2, 18, 19, 20, 24, 27, 28, 30, 39, 75, 76, 77, 78, 81, 91, 92, 93, 95, 122. How to report Fraud How to access Auxiliary aids and services -this is found on several pages, Auxiliary aids and services do include TTY which we do provide in all documentation mailed or otherwise. Staring on page 2, 6, 16, 17, 32, 33, 34, 39, 46, 71, & 123.	
19. The member handbook provided to members following enrollment includes how to exercise an advance directive as required in 438.3 (j): • The member's right under the State law to make decisions regarding medical care and to formulate advance directives, including the right to accept or refuse medical or surgical treatment. • The Contractor's policies and procedures respecting implementation of advance directives, with a clear statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience. • Informing members that grievances concerning noncompliance with the advance directive requirements may be filed with the State Department of Public Health and Environment. *42 CFR 438.10(g)(2)(xii)* CHP+ Contract: Exhibit B1—14.1.1.2.7, 14.1.1.2.7.1, 14.1.9 Exhibit K—1.1.24	**Documents:** Member Handbook - Section V. Member Rights and Responsibilities - Pgs. 29-32.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
20. The Contractor provides member information by either: • Mailing a printed copy of the information to the member's mailing address. • Providing the information by email after obtaining the member's agreement to receive the information by email. • Posting the information on the Contractor's website and advising the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost. • Providing the information by any other method that can reasonably be expected to result in the member receiving that information. *42 CFR 438.10(g)(3)* CHP+ Contract: Exhibit B1—14.1.3.10.1	Member enrollment information is provided by mail. All non- PHI documents are located electronically on our website at www.fridayhealthplans.com, this info is also available in hard copy as requested when requested.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
21. The Contractor must make available to members, upon request, any physician incentive plans in place. *42 CFR 438.10(f)(3)* CHP+ Contract: None	**Documents:** 1. Member Handbook **Narrative:** The Member Handbook informs members that no financial incentives exist. If they were to exist the member handbook would specifically be changed to include that members could request a copy of any physician incentive plan by calling Customer Service to request a copy. Any physician incentive plans would be posted to the website as well.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard V—Member Information Requirements							
Total	Met	=	14	X	1.00	=	14
	Partially Met	=	6	X	.00	=	0
	Not Met	=	1	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	21	**Total Score**		=	14
				Total Score ÷ Total Applicable		=	67%

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an internal grievance and appeal system in place for members. A grievance and appeal system means the processes the Contractor implements to handle grievances and appeals of an adverse benefit determination, as well as processes to collect and track information about grievances and appeals. *42 CFR 438.400(b)* *42 CFR 438.402(a)* CHP+ Contract: Exhibit B1—7.9.1 10 CCR 2505-10—8.209.1	**Documents:** Grievance and Appeal DTP Member Hand book	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: HSAG found that FHP did not meet many requirements regarding grievance and appeal systems. FHP submitted one procedural document related to grievance and appeal systems; however, this document appeared to be a duplication of the member handbook section for grievances and appeals and did not include details for how FHP staff members should process, monitor, or resolve cases. Additionally, overall appeal record scores demonstrated compliance with only around one-third of the requirements.		
Required Actions: FHP must update and expand its grievance and appeal policies, procedures, and letter templates to more clearly define both grievance and appeal and delineate processes. Additionally, FHP must develop detailed procedures to better train and monitor staff members to ensure that grievances and appeals are being collected, processed, and resolved in compliance with federal and State requirements.		
2. The Contractor defines adverse benefit determination as: • The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. • The reduction, suspension, or termination of a previously authorized service. • The denial, in whole, or in part, of payment for a service.	**Documents:** Member Handbook & EOC - Section III. Process for getting Covered services on page 24. - Section V. Member's Rights and Responsibilities on page 29. - Section VI. Grievances and Appeals Process on pages 33, 35, 36, 37, 39, & 41. - Section XII. Definitions pgs.99, 100, 105, &	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The failure to provide services in a timely manner, as defined by the State. • The failure to act within the time frames defined by the State for standard resolution of grievances and appeals. • The denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other). • For a resident of a rural area with only one managed care plan, the denial of a Medicaid member's request to exercise his or her rights to obtain services outside of the network under the following circumstances: – The service or type of provider (in terms of training, expertise, and specialization) is not available within the network. – The provider is not part of the network, but is the main source of a service to the member—provided that: – The provider is given the opportunity to become a participating provider. – If the provider does not choose to join the network or does not meet the Contractor's qualification requirements, the member will be given the opportunity to choose a participating provider and then will be transitioned to a participating provider within 60 days. *42 CFR 438.400(b)* *42 CFR 438.52(b)(2)(ii)* CHP+ Contract: Exhibit B1—1.1.3 10 CCR 2505-10—8.209.2.A	118. -These pages all reference adverse benefit determinations.	

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor defines "appeal" as a review by the Contractor of an adverse benefit determination. *42 CFR 438.400(b)* CHP+ Contract: Exhibit B1—1.1.4 10 CCR 2505-10—8.209.2.A.7	**Documents:** Member Handbook - Section XIII. Definitions page 100.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Findings:

The definitions for "appeal" provided within the member handbook, provider manual, and desktop procedure were all aligned with the federal definition. However, when staff members described the differences between member and provider appeals, staff members reported that any appeal submitted by a provider was considered a provider appeal. The record review contained multiple instances of durable medical equipment (DME) denials, in which the member was denied insulin pumps and the provider was informed the member had reached the maximum benefit limit. HSAG clarified that any issue not related to provider procedural issues should be processed as a CHP+ member appeal, regardless of whether the member filed the appeal, or the provider on behalf of the member. On November 13, 2020, CMS revisions to the definition of an adverse benefit determination further clarified that an appeal is anything other than "a denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a clean claim."

Additionally, examples provided within the member handbook did not accurately describe an appeal. The appeal example stated, "You are told you are being discharged from the hospital and don't feel ready to go." However, this example is not entirely clear. If the authorized stay has expired, and no new request submitted, the member may not appeal. If a provider submitted a request for authorizing additional hospital days that was denied, then an NABD would be sent, which the member could appeal. The end of an authorization period does not trigger an NABD or appeal rights.

Required Actions:

FHP must update and expand its internal appeal documentation to more clearly define appeals. FHP must develop detailed procedures to better train and monitor staff members and ensure that appeals are being collected, processed, and resolved in compliance with federal and State requirements. FHP must update the member handbook to clarify that members may appeal the denial of services once an NABD has been received.

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor defines "grievance" as an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. A grievance includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision. *42 CFR 438.400(b)* CHP+ Contract: Exhibit B1—1.1.44 10 CCR 2505-10—8.209.2.D, 8.209.4.A.3.c.i	**Documents:** Member Handbook Section XIII. Definitions page 105.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Findings:
Definitions throughout the member handbook, provider manual, and desktop procedure included separate definitions for "complaints" and "grievances," which could be misleading to members and staff. For example, the provider manual stated that "The terms 'complaint' and 'grievance' are sometimes used interchangeably. A complaint may be resolved without further action." It goes on to say, "A grievance usually invokes the organization determination process through documented action and is generally considered more formal than a complaint."

Within the desktop procedure *Tracking Suggestions/Inquiries/Complaints/Grievances/Appeals/Provider Disputes*, the terms were also used incorrectly: "In the event that the complaint is actually a grievance the grievance policy is followed. In the event that the issue is still categorized as a complaint and it is unable to be resolved during the first call, FHP will ensure that all complaints are resolved within 7 days from receipt. Verbal notice is given to the member within 24 hours from resolution." This direction is out of compliance with federal grievance and appeal regulations. Additional training evidence submitted post-audit included a training manual that outlined how customer service should handle a "complaint call" and did not include any reference to a complaint being a grievance, nor the need to alert the grievance and appeal department, log the grievance, or follow-up with an acknowledgement or resolution letter.

Required Actions:
FHP must update and clarify this information in all related documents (included procedures and training materials) to align the definition of "grievance" with the federal definition. These updates must clarify that "complaints" are the same as "grievances" and must be treated the same way. FHP must remove references that there are differences between formal and informal grievances or complaints.

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor has provisions for who may file: • A member may file a grievance, a Contractor-level appeal, and may request a State fair hearing. • With the member's written consent, a provider or authorized representative may file a grievance, a Contractor-level appeal, and may request a State fair hearing on behalf of a member. *Note: Throughout this standard, when the term "member" is used it includes providers and authorized representatives (with the exception that providers cannot exercise the member's right to request continuation of benefits under 42 CFR 438.420).* *42 CFR 438.402(c)* CHP+ Contract: Exhibit B1—14.1.4.1.1, 14.1.5.1	**Documents:** 1) Member Handbook 2) Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals **Narrative:** The Member Handbook outlines that members or their DCR may file a grievance and/or appeal. Friday Health Plans has a member complaint/grievance policy outlining its objective to meet all federal and state statutes and regulations as well as contractual requirements and internal policies and procedures in processing grievances and appeals for CHP+ members. Internally, Friday Health Plans follows the Member Complaint Grievance Policy/DTP: CHP+ Grievances and Appeals.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. *42 CFR 438.406(a)(1)* CHP+ Contract: Exhibit B1—None 10 CCR 2505-10—8.209.4.C	**Documents:** - Section VI Grievances And Appeals Process - Subsection "Getting help filing an Appeal on pg. 39, second sentence.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: While the supporting documents did outline that FHP staff members would assist in filing efforts, the language in the grievance section did not include specifics about auxiliary aids and interpreter services.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: FHP must update related grievance and appeal documents to clarify that auxiliary aids and interpreter services are available at no cost to the member in order to help members with completing any forms or other procedural steps related to grievances and appeals.		
7. The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who: • Were not involved in any previous level of review or decision-making nor a subordinate of any such individual. • Have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding any of the following: – An appeal of a denial that is based on lack of medical necessity. – A grievance regarding the denial of expedited resolution of an appeal. – A grievance or appeal that involves clinical issues. *42 CFR 438.406(b)(2)* CHP+ Contract: Exhibit B1—14.1.4.1.6, 14.1.5.8 10 CCR 2505-10 8.209.5.C, 8.209.4.E	**Documents:** 1. DTP: Govt Programs/CHP+Appeals&Grievances **Narrative:** Friday Health Plans follows the DTP in the processing of grievances and appeals. Friday Health Plans will take into account all comments, documents, records or other information you or your DCR submit without regard to whether such information was submitted or considered in the initial adverse benefit determination	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor ensures that the individuals who make decisions on grievances and appeals: • Take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. *42 CFR 438.406(b)(2)* CHP+ Contract: None 10 CCR 2505-10—8.209.5.C, 8.209.4.E	**Documents:** 1. DTP: Govt Programs/CHP+Appeals&Grievances **Narrative:** Friday Health Plans follows the DTP in the processing of grievances and appeals. Friday Health Plans will take into account all comments, documents, records or other information you or your DCR submit without regard to whether such information was submitted or considered in the initial adverse benefit determination	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor accepts grievances orally or in writing. *42 CFR 438.402(c)(3)(i)* CHP+ Contract: Exhibit B1—14.1.5.6 10 CCR 2505-10—8.209.5.D	**Documents:** 1. DTP: Govt Programs/CHP+Appeals&Grievances **Narrative:** Friday Health Plans follows the DTP in the processing of grievances and appeals. Friday Health Plans outlines How a Member May File a Grievance With CHP+ Offered by Friday Health Plans of Colorado: The CHP+ member or member's DCR can call or write Friday Health Plans of Colorado Grievance and Appeals Department at any time: Friday Health Plans of Colorado Grievance and Appeals Department	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	700 Main Street Alamosa, Colorado 81101 Phone: (719) 589-3696, toll free 1-800-475-8466, TTY 1-800-659-2656 Email: Appeals@fridayhealthplans.com or fax it to (719) 589-4901	
10. Members may file a grievance at any time. *42 CFR 438.402(c)(2)(i)* CHP+ Contract: Exhibit B1—14.1.5.4 10 CCR 2505-10—8.209.5.A	**Documents:** 1. DTP: Govt Programs/CHP+Appeals&Grievances **Narrative:** Friday Health Plans follows the DTP in the processing of grievances and appeals. Friday Health Plans outlines How a Member May File a Grievance With CHP+ Offered by Friday Health Plans of Colorado: The CHP+ member or member's DCR can call or write Friday Health Plans of Colorado Grievance and Appeals Department at **any time:**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor sends the member a written acknowledgement of each grievance within two (2) working days of receipt. *42 CFR 438.406(b)(1)* CHP+ Contract: Exhibit B1—14.1.5.5 10 CCR 2505-10 8.209.5.B	**Documents:** 1. DTP: Govt Programs/CHP+Appeals&Grievances **Narrative:** Friday Health Plans follows the DTP in the processing of grievances and appeals. Friday Health Plans outlines After receiving the phone call or letter,	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	the Grievance and Appeal Coordinator will send the member a letter within two (2) working days. The letter will say we received your grievance.	
12. The Contractor must resolve each grievance and provide notice as expeditiously as the enrollee's health condition requires, and within 15 working days of when the member files the grievance. • Notice to the member must be in a format and language that may be easily understood by the member. *42 CFR 438.408(a) and (b)(1)and (d)(1)* Contract: Exhibit B1—14.1.5.7, 14.1.5.9, 14.1.3.1 10 CCR 2505-10 8.209.5.D	**Documents:** 1. DTP: Govt Programs/CHP+Appeals&Grievances **Narrative:** Friday Health Plans follows the DTP in the processing of grievances and appeals. Friday Health Plans outlines "Within fifteen (15) working days after we receive the member's grievance, the Grievance and Appeal Coordinator or Medical Management will send the member a letter saying what we found and how we fixed it.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
13. The written notice of grievance resolution includes: • Results of the disposition/resolution process and the date it was completed. CHP+ Contract: Exhibit B1—14.1.5.11 10 CCR 2505-10 8.209.5.G	**Documents:** 1. DTP: Govt Programs/CHP+Appeals&Grievances **Narrative:** Friday Health Plans follows the DTP in the processing of grievances and appeals. Friday Health Plans outlines "The member will get a letter from us after finish the review letting the member know the results and the date the review was completed."	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor may have only one level of appeal for members. *42 CFR 438.402(b)* CHP+ Contract: None	**Documents:** 1. DTP: Govt Programs/CHP+ Appeals&Grievances **Narrative:** Friday Health Plans follows the DTP in the processing of grievances and appeals. Friday Health Plans outlines "A CHP+ member or DCR has the right to appeal. When Friday Health Plans of Colorado takes an action (Adverse Benefit Determination), the member and his/her provider will get a Notice of Action (Adverse Benefit Determination) letter explaining why the action was taken and how to appeal if the member wants to request one."	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: FHP's *Quick Reference Guide* detailed second-level appeal rights and did not clarify that CHP+ members only have one level of appeal.		
Required Actions: FHP must update documents to clarify that for the CHP+ line of business there is only one level of appeal for CHP+ members.		
15. A member may file an appeal with the Contractor within 60 calendar days from the date on the adverse benefit determination notice. *42 CFR 438.402(c)(2)(ii)* CHP+ Contract: Exhibit B1—14.1.4.1.1 10 CCR 2505 10 8.209.4.B	**Documents:** 1. DTP: Govt Programs/CHP+ Appeals&Grievances **Narrative:** Friday Health Plans follows the DTP in the processing of grievances and appeals. Friday Health Plans outlines that "A member may file an appeal within 60 calendar days from the date on the adverse benefit determination notice."	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The member may file an appeal either orally or in writing, and must follow the oral request with a written, signed appeal (unless the request is for expedited resolution). *42 CFR 438.402(c)(3)(ii)* *42 CFR 438.406 (b)(3)* CHP+ Contract: Exhibit B1—14.1.4.1.2, 14.1.4.1.8.2 10 CCR 2505 10 8.209.4.B	**Documents:** 1. DTP: Govt Programs/CHP+ Appeals&Grievances **Narrative:** Friday Health Plans follows the DTP in the processing of grievances and appeals. Friday Health Plans outlines that "Any oral requests must be followed with a written, signed appeal. No written, signed appeal is necessary for a request for expedited resolution."	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
17. The Contractor sends written acknowledgement of each appeal within two (2) working days of receipt, unless the member or designated representative requests an expedited resolution. *42 CFR 438.406(b)(1)* CHP+ Contract: Exhibit B1—14.1.4.1.3 10 CCR 2505-10 8.209. 4.D	**Documents:** 1. DTP: Govt Programs/CHP+ Appeals&Grievances **Narrative:** Friday Health Plans follows the DTP in the processing of grievances and appeals. What Happens With An Appeal: After we receive your phone call or letter, you will get a letter within two (2) working days. This letter will tell you that we got your request for an appeal.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The member handbook, provider manual, and desktop procedure all included accurate language describing the time frame for mailing members appeal acknowledgement letters. However, record review findings indicated that none of the seven appeals included acknowledgement letters for members or providers.		
Required Actions: FHP must develop a mechanism to ensure that member acknowledgement letters for each appeal are sent in a timely manner.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. The Contractor's appeal process must provide: • That oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date). • That if the member orally requests an expedited appeal, the Contractor shall not require a written, signed appeal following the oral request. • That included, as parties to the appeal, are: – The member and his or her representative, or – The legal representative of a deceased member's estate. *42 CFR 438.406(b)(3-5)* CHP+ Contract: Exhibit B1—14.1.4.1.5.1, 14.1.4.1.8.2, 14.1.4.1.5.4 10 CCR 2505-10 8.209. 4.F, 8.209.4.I	**Documents:** 1. DTP: Govt Programs/CHP+ Appeals&Grievances **Narrative:** Friday Health Plans follows the DTP in the processing of grievances and appeals. The member or member's DCR can ask for an expedited "fast" appeal. If an expedited appeal is requested, there is no need to submit a written, signed appeal following the oral request.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
19. The Contractor's appeal process must provide: • The member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. (The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution time frame in the case of expedited resolution.) • The member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional documents considered, relied upon, or generated by the Contractor in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame.	**Documents:** 1. DTP: GovtPrograms/CHP+ Appeals & Grievances **Narrative:** Friday Health Plans follows the DTP in the processing of grievances and appeals. The DTP outlines that You or your DCR can also give us any information or records that you think would help your appeal, including evidence and testimony and make legal and factual arguments. Friday Health Plans of Colorado will take into account all comments, documents, records or other information you or your DCR submit without regard to whether	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.406(b)(3-5) CHP+ Contract: Exhibit B1—14.1.4.1.5.2-3 10 CCR 2505-10 8.209. 4.G, 8.209.4.H	such information was submitted or considered in the initial adverse benefit determination. You or your DCR can look at Friday Health Plans of Colorado's member's case file, including medical records, other documents and records, and any new or additional documents considered, relied upon, or generated by Friday Health Plans of Colorado in connection with the appeal. This information will be provided by Friday Health Plans of Colorado free of charge.	
20. The Contractor maintains an expedited review process for appeals when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life; physical or mental health; or ability to attain, maintain, or regain maximum function. The Contractor's expedited review process includes that: • The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. *42 CFR 438.410(a–b)* CHP+ Contract: Exhibit B1—14.1.4.1.8.1, 14.1.4.1.8.5 10 CCR 2505-10 8.209.4.Q-R	**Documents:** 1. DTP: GovtPrograms/CHP+ Appeals & Grievances **Narrative:** Friday Health Plans follows the DTP in the processing of grievances and appeals. If the member feels that waiting for an appeal would seriously affect his or her life or health, they may need a decision from Friday Health Plans of Colorado CHP+ fast. The member or member's DCR can ask for an expedited "fast" appeal.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
21. If the Contractor denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the time frame for standard resolution. • Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and within two (2) calendar days provide the member written notice of the reason for the decision and inform the member of the right to file a grievance if he or she disagrees with that decision. *42 CFR 438.410(c)* CHP+ Contract: Exhibit B1—14.1.4.1.8.4.1 10 CCR 2505-10 8.209.4.S	**Documents:** 1. DTP: Govt Programs/CHP+ Appeals&Grievances **Narrative:** Friday Health Plans follows the DTP in the processing of grievances and appeals. If the member's request for a fast appeal is denied, Friday Health Plans of Colorado CHP+ will call the member or their DCR as soon as possible to let them know. Friday Health Plans of Colorado will also send the member a letter within two (2) working days. Then we will review the appeal the regular way	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Despite having the time frames accurately outlined in the desktop policy, FHP's documents did not include language regarding a member's right to file a grievance in response to the denial of an expedited appeal.		
Required Actions: FHP must update grievance and appeal documents to include the member's right to file a grievance in response to a denial of an expedited appeal request.		
22. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)*	**Documents:** 1. DTP: GovtProgams/CHP+ Appeals&Grievances **Narrative:** Friday Health Plans follows the DTP in the processing of grievances and appeals. Standard resolution of appeals within 10 working days.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.408(d)(2) *42 CFR 438.10* CHP+ Contract: Exhibit B1—14.1.4.1.4, 14.1.3.1 10 CCR 2505-10 8.209.4.J.1		
Findings: Appeal resolution timelines were accurately described in the member handbook, provider manual, desktop procedure, but not within the *Quick Reference Guide.* The *Quick Reference Guide* depicted "10 days" instead of the "10 working day" requirement. And although the 10 calendar days would be a greater benefit to the CHP+ member, the policy was not consistently applied in practice. Record review findings showed that appeal resolution letters were not sent to members in six of the seven samples. In the one case in which a letter was sent to the member, it was mailed over 60 days after the appeal was submitted.		
Required Actions: FHP must update documents to reflect the 10-working day timeline and develop a mechanism to ensure appeals are resolved and members are notified within timeliness standards.		
23. For expedited appeal, the Contractor must resolve the appeal and provide written notice of disposition to affected parties within 72 hours after the Contractor receives the appeal. • For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. *42 CFR 438.408(b)(3) and (d)(2)(ii)* CHP+ Contract: Exhibit B1—14.1.4.1.8.4.2, 14.1.4.1.8.4.5 10 CCR 2505-10 8.209.4.J.2, 8.209.4.L	**Documents:** 1. DTP: GovtProgams/CHP+ Appeals&Grievances **Narrative:** Friday Health Plans follows the DTP in the processing of grievances and appeals. The DTP outlines resolution of expedited appeals within 72 hours. Reasonable efforts will be made to provide oral notice of resolution.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: While FHP's documents did include language regarding the 72-hour expedited appeal timeline, the desktop procedure *Expedited Determinations* also referred to a three-business day timeline.		
Required Actions: FHP must remove references to three business days and update all time frames to reflect that both verbal and written notice must take place within the 72-hour time frame.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
24. The Contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: • The member requests the extension; or • The Contractor shows (to the satisfaction of the Department, upon request) that there is need for additional information and how the delay is in the member's interest. *42 CFR 438.408(c)(1)* CHP+ Contract: Exhibit B1—14.1.4.1.4.1, 14.1.4.1.8.4.3 10 CCR 2505-10 8.209.4.K, 8.209.5.E	**Documents:** 1. DTP: GovtPrograms/CHP+ Appeals&Grievances **Narrative:** Friday Health Plans follows the DTP in the processing of grievances and appeals. The DTP outlines that FHP may extend the time frames for resolution of grievances or appeals.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
25. If the Contractor extends the time frames, it must—for any extension not requested by the member: • Make reasonable efforts to give the member prompt oral notice of the delay. • Within two (2) calendar days, give the member written notice of the reason for the delay and inform the member of the right to file a grievance if he or she disagrees with that decision. • Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. *42 CFR 438.408(c)(2)* CHP+ Contract: Exhibit B1—14.1.4.1.4.2, 14.1.4.1.8.4.4–5	**Documents:** 1. DTP: GovtPrograms/CHP+ Appeals&Grievances **Narrative:** Friday Health Plans follows the DTP in the processing of grievances and appeals. Friday Health Plans shall make reasonable efforts to give the member prompt oral notice of the delay and within two (2) calendar days, give the member written notice of the reason for the delay and inform the member of the right to file a grievance if he or she disagrees with that decision.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Although FHP's extension process and samples included the correct time frames and described efforts to provide prompt oral notice, the documents did not include the member's right to file a grievance if the member disagrees with the extension.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: FHP must update documents to include the member's right to file a grievance in response to an extension if the member disagrees with the extension.		
26. The written notice of appeal resolution must include: • The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. – The right to request that benefits/services continue* while the hearing is pending, and how to make the request. – That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's adverse benefit determination. **Continuation of benefits applies only to previously authorized services for which the Contractor provided 10-day advance notice to terminate, suspend, or reduce. In addition, to be eligible for continued benefits during a State fair hearing, the member must have received continued benefits during the Contractor appeal process.* *42 CFR 438.408(e)* CHP+ Contract: Exhibit B1—14.1.4.1.7 10 CCR 2505-10 8.209.4.M	**Documents:** 1. DTP: GovtPrograms/CHP+ Appeals&Grievances **Narrative:** Friday Health Plans follows the DTP in the processing of grievances and appeals. Friday Health Plans of Colorado will notify the Member in writing of the resolution of an appeal and the date it was completed. Reasonable efforts will be made to provide oral notice. If the appeal was not resolved wholly in favor of the member the following should be included in the notification to the member: ☐ The right to request a State fair hearing and how to do so ☐ The right to request and to receive benefits while the hearing is pending, and how to make the request; and ☐ That the member may be held liable for the cost of those benefits if the hearing decision upholds the MCO's action.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
27. The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of resolution. • If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. *42 CFR 438.408(f)(1–2)* CHP+ Contract: Exhibit B1—14.1.4.1.10.1-2 10 CCR 2505-10 8.209.4.N and O	**Documents:** 1. DTP: GovtPrograms/CHP+ Appeals&Grievances **Narrative:** Friday Health Plans follows the DTP in processing grievances and appeals. The member shall request a State Fair Hearing within one hundred and twenty (120) calendar days from the date of the notice of Appeal determination. If the Friday Health Plans of Colorado fails to adhere to the notice and timing requirements regarding resolution and notification of an Appeal, the member is deemed to have exhausted the Appeals process and may request a State Fair Hearing.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Sections of FHP's member handbook, desktop procedure, and provider manual included inaccurate timelines regarding SFHs (60 days from the notice of action instead of 120 days from the notice of appeal resolution). Also, although the request for continued services was accurately outlined as 10 days from the adverse appeal determination, the language regarding "or before the effective date of the termination or changes in services" does not apply during a SFH, only appeals.		
Required Actions: FHP must update the SFH timelines to reflect that the member has 120 days from the appeal resolution to request a SFH unless the member is also requesting continuation of the disputed services, in which case both the continued services and the SFH must be requested within 10 days following the appeal resolution. FHP must also remove the reference to the original effective date of the termination of the services from the SFH section of its documents.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
28. The parties to the State fair hearing include the Contractor as well as the member and his or her representative or the representative of a deceased member's estate. *42 CFR 438.408(f)(3)* CHP+ Contract: Exhibit B1—14.1.4.1.10.3	**Documents:** 1. DTP: GovtPrograms/CHP+ Appeals&Grievances **Narrative:** Friday Health Plans follows the DTP in processing grievances and appeals. The parties to the State fair hearing will include Friday Health Plans of Colorado as well as the member and the representative or the representative of a deceased member's estate.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
29. The Contractor provides for continuation of benefits/services (when requested by the member) while the Contractor-level appeal is pending if: • The member files in a timely manner* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the Contractor mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal within 60 days of the notice of adverse benefit determination.	**Documents:** 1. DTP: GovtPrograms/CHP+ Appeals&Grievances **Narrative:** Friday Health Plans follows the DTP in processing grievances and complaints. Continuation of benefits will be continued if: ▪ The enrollee or the provider files the appeal timely ▪ The appeal involved the termination, suspension, or reduction of a previously authorized course of treatment ▪ The services were ordered by an authorized provider ▪ The original period covered by	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
**This definition of timely filing only applies for this scenario—i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced. (Note: The provider may not request continuation of benefits on behalf of the member.)* The Contractor provides for continuation of benefits/services (when requested by the member) while the State fair hearing is pending if: • The member requests a State fair hearing with a request for continuation of benefits in a timely manner—defined as on or before the following: – Within 10 days of the Contractor mailing the notice of appeal resolution not in favor of the member. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment (and the member requested and received continued benefits during the Contractor appeal). • The services were ordered by an authorized provider. *42 CFR 438.420(a) and (b)* CHP+ Contract: Exhibit B1—14.1.4.1.9.1 10 CCR 2505-10 8.209.4.T	the original authorization has not expired; and ▪ The enrollee requests extension of benefits	
Findings: In regard to SFH, FHP's documents did not clearly indicate that the member must request both the continuation of benefits and SFH within 10 days of the adverse appeal determination. FHP must also clarify that the provider may not request continued benefits on behalf of the member due to the potential financial liability for the member.		
Required Actions: FHP must update all related grievance and appeal systems documents to clearly indicate the timelines for requesting continuation of benefits during appeals and SFH and who may request such benefits.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
30. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal is pending, the benefits must be continued until one of the following occurs: • The member withdraws the appeal. • The member does not request continued benefits during a State fair hearing within 10 calendar days after the Contractor sends the notice of an appeal resolution not in the member's favor. If, at the member's request, the Contractor continues or reinstates the benefits while the State fair hearing is pending, the benefits must be continued until one of the following occurs: • The member withdraws the request for a State fair hearing. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR 438.420(c)* CHP+ Contract: Exhibit B1—14.1.4.1.9.2 10 CCR 2505-10 8.209.4.U	**Documents:** 1. DTP: GovtPrograms/CHP+ Appeals&Grievances **Narrative:** Friday Health Plans follows the DTP in the processing of grievances and appeals. Duration of continued benefits ☐ If benefits are continued while the appeal is pending, the benefits must be continued until one of the following occurs: • The enrollee withdraws the appeal. • Ten days pass after the MCO mails the notice, providing the resolution of the appeal against the enrollee. • A State fair hearing Office issues a hearing decision adverse to the enrollee. The time period or service limits of a previously authorized service has been met	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: While parts of FHP's desktop procedure, member handbook, and provider manual included partially accurate information, this language should be under the appeals section, not SFH: "A total of ten (10) calendar days pass after we mail the original notice to you that we are denying your appeal. If you request a State fair hearing within those ten (10) calendar days, your benefits will continue until the hearing is finished." Lastly, the authorization period for services does not trigger the end of services once the services have been continued during the SFH as the authorization may have since expired during the appeal or SFH.		
Required Actions: FHP must update all related documentation to clarify the duration of continued benefits during an appeal and SFH.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
31. Member responsibility for continued services: • If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's adverse benefit determination, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. *42 CFR 438.420(d)* CHP+ Contract: Exhibit B1—14.1.4.1.9.3 10 CCR 2505-10 8.209.4.V	**Documents:** 1. DTP: GovtPrograms/CHP+ Appeals&Grievances **Narrative:** Friday Health Plans follows the DTP in processing grievances and appeals. If you are getting services that have already been approved by Friday Health Plans of Colorado, you may be able to keep getting those services while you are waiting for the Judge's decision. But if you lose at the State Fair Hearing, you may have to pay for services that you get while you are appealing. If you win, you will not have to pay	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Although the FHP member handbook, provider manual, and desktop procedure accurately described the member's responsibility for continued services during the appeal, the SFH section did not include that the member may also be financially liable for services continued during the SFH.		
Required Actions: FHP must clarify within the SFH section related to continued benefits that the member may be held liable for services continued during the appeal and SFH.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
32. Effectuation of reversed appeal resolutions: • If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than seventy-two (72) hours from the date it receives notice reversing the determination. • If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the Contractor must pay for those services. *42 CFR 438.424* CHP+ Contract: Exhibit B1—14.1.4.1.9.4–5 10 CCR 2505-10 8.209.4.W-X	**Documents:** 1. DTP: GovtPrograms/CHP+ Appeals&Grievances **Narrative:** Friday Health Plans follows the DTP in processing grievances and appeals and outlines the following with regard to reverse resolutions. Services not furnished while the appeal is pending. If the MCO or State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. Services furnished while the appeal is pending. If the MCO or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO or the State must pay for those services, in accordance with State policy and regulations	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
33. The Contractor maintains records of all grievances and appeals. The records must be accurately maintained in a manner accessible to the State and available on request to CMS. • The record of each grievance and appeal must contain, at a minimum, all of the following information: – A general description of the reason for the grievance or appeal. – The date received. – The date of each review or, if applicable, review meeting. – Resolution at each level of the appeal or grievance. – Date of resolution at each level, if applicable. – Name of the person for whom the appeal or grievance was filed. • The Contractor quarterly submits to the Department a Grievance and Appeals report including this information. *42 CFR 438.416* CHP+ Contract: Exhibit B1—14.1.4.1.12, 15.5.1 10 CCR 2505-10 8.209.3.C	**Documents:** 1. Tracking log **Narrative:** Friday Health Plans maintains a Tracking Log as its record of grievances and appeals. This tracking log outlines the general description of the reason for the grievance or appeal, the date received, resolution and date of resolution. The Quarterly grievances and appeals report is provided on a quarterly basis to the state.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Documentation stated that "Friday maintains procedures to collect, track and report suggestions, inquiries, complaints, grievances and appeals received." While the appeals records did include key documentation, the 2020 Complaint Log did not include the minimum required elements (i.e., name of the person for whom the grievance was filed and a general description of the reason for the grievance). HSAG also noted there was not a section in the complaint log to include additional dates or information regarding resolution letters (when applicable).		
Required Actions: FHP must enhance policies, procedures, and monitoring practices to ensure that all required grievance information is maintained.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
34. The Contractor provides the information about the grievance, appeal, and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing.* – The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member. * *Time frames specified for filing:* *During an appeal: Request continued benefits within 10 days of the notice of adverse benefit determination.* *During a State fair hearing: Request continued benefits within 10 days of the notice of adverse appeal resolution.* *42 CFR 438.414* *42 CFR 438.10(g)(xi)*	**Documents:** 1) Provider Manual (Page 11) **Narrative:** Providers are provided with a Provider Manual. This manual outlines the grievances and appeals process that are specific to the CHP+ line of business.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
CHP+ Contract Amendment 3: Exhibit B1—14.1.4.1.1.1, 14.1.5.1.1 10 CCR 2505-10 8.209.3.B		
Findings: Within the provider manual, the terms "complaint" and "grievance" were defined separately, which did not clearly convey that the terms mean the same thing based on federal regulations. Additionally, the manual included other inaccuracies regarding appeal and SFH timelines and continuation of benefits.		
Required Actions: FHP must ensure that updates to other requirements are accurately implemented in the provider manual and associated materials so that providers and subcontractors receive accurate information about grievances, appeals, and SFHs at the time they enter into a contract.		

Results for Standard VI—Grievance and Appeal Systems							
Total	Met	=	18	X	1.00	=	18
	Partially Met	=	16	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	34	**Total Score**		=	18
				Total Score ÷ Total Applicable		=	53%

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements written policies and procedures for selection and retention of providers. *42 CFR 438.214(a)* CHP+ Contract: Exhibit B1—14.2.1.1	**Documents:** 1. Network Access Plan 2. Network Management Program Description **Narrative:** Friday Health Plans follows the Network Access Plan and the Network Management Program Description in the selection and retention of Providers. The Network Access Plan describes the process used to develop and assure adequate access to our Provider Network on behalf of our Members. The Network Management Program Description is used to ensure that all Friday Health Plans of Colorado (FHP) members have access to one or more fully developed, contracted networks of professional, institutional and ancillary providers within the FHP service area in the State of Colorado to obtain covered health services.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor follows a documented process for credentialing and recredentialing of providers that complies with the standards of the National Committee for Quality Assurance (NCQA). The Contractor shall assure that all laboratory-testing sites providing services under this contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration. *42 CFR 438.214(b) and (e)* CHP+ Contract: Exhibit B1—14.2.1.3, 14.2.1.5	**Documents:** 1. Credentialing Plan 2. Credentialing Application Review Workflow **Narrative:** Friday Health Plans utilizes its Credentialing Plan as its process for credentialing and recredentialing of providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's provider selection policies and procedures include provisions that the Contractor does not: • Discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. • Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42 CFR 438.12(a)(1) and (2)* *42 CFR 438.214(c)* CHP+ Contract: Exhibit B1—14.2.1.1.2.1—2	**Documents:** 1. Network Access Plan, page 4 2. Credentialing Plan, Page 2 3. PAC-Nondiscrimination Statement **Narrative:** The Network Access Plan outlines the Standards of Participation and Non-Discrimination of Providers The Credentialing Plan outlines that Friday Health Plans does not discriminate against any provider seeking qualification as a participating provider. Every member of the Physician Advisory Committee executes a Non-Discrimination Statement attesting that credentialing decisions will not be based on an applicant's race, ethnicity, national origin, religion, gender, age, or sexual orientation; or by the type of procedure or patient in which the practitioner specializes and that decisions will not be based upon and there shall be do discrimination related to any provider who is acting within the scope of their license or certification under applicable law, solely on the basis of that license or against providers that serve high-risk populations or specialize in conditions that require costly treatment.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This is not construed to: • Require the Contractor to contract with providers beyond the number necessary to meet the needs of its members. • Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. • Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members. *42 CFR 438.12(a-b)* CHP+ Contract: Exhibit B1—14.2.1.1.2.4, 14.2.1.1.5	**Documents:** 1. Credentialing Plan, Page 8 2. Credentialing Denial Letter **Narrative:** The credentialing plan, page 8, outlines that providers shall be notified whether they were approved or denied/terminated by the PAC within 10 business days of the meeting, or by the deadlines set forth in the appeals processes. Friday Health Plans provides the provider with a letter providing the written notice for the reason of its decision to decline to include the individual or group of providers in its network.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Contractor has a signed contract or participation agreement with each provider. *42 CFR 438.206(b)(1)* CHP+ Contract: Exhibit B1—10.1	**Documents:** 1. FHP_CO Facility Agreement 2. FHP_CO Ancillary Provider Agreement 3. FHP_CO Physician Agreement 4. CO – State Compliance Attachment **Narrative:** Friday Health Plans provides each provider with a Participating Provider Agreement that is executed by both Friday Health Plans and the provider.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor does not employ or contract with providers or other individuals or entities excluded for participation in federal health care programs under either Section 1128 or 1128 A of the Social Security Act. *(This requirement also requires a policy.)* *42 CFR 438.214(d)* *42 CFR 438.610* CHP+ Contract: Exhibit B1—14.2.1.6, 19.1.1	**Documents:** 1. Credentialing Plan 2. Compliance Plan **Narrative:** Friday Health Plans follows the credentialing plan in making provider participation decisions. The Credentialing Plan outlines that information pertaining to OIG, and GSA's Excluded Parties Listing System websites shall be queried to ensure providers have not been Medicare/Medicaid sanctioned or excluded from receiving Federal funds for any reason. These same queries are conducted for employees as well. The Compliance outlines that Friday Health Plans will not enter into contracts with ineligible individuals or entities, including those who are listed as debarred, suspended, and excluded, are ineligible for participation in federal health care programs; lawfully prohibited from participating in any public procurement activity; or from participating in non-procurement activities.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549. *42 CFR 438.610* CHP+ Contract: Exhibit B1—19.1.1 and 19.1.2	**Documents:** 1. Compliance Plan **Narrative:** Friday Health Plans follows its Compliance Plan in that Friday Health Plans prohibits the hiring or entering into contracts with ineligible individuals or entities, including those who have been recently convicted of a criminal	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	offense related to health care; who are listed as debarred, suspended, and excluded; are ineligible for participation in federal health care programs; lawfully prohibited from participating in any public procurement activity; or from participating in non-procurement activities. At the direction of the CCO, the Companies shall conduct screenings of all staff and applicable contractors prior to engagement and monthly thereafter to verify if they appear in the Social Security Administration Death Master File; the National Plan and Provider Enumeration System (NPPES); the Department of Health and Human Services Office or Inspector General List of Excluded Individuals / Entities (http://oig.hhs.gov/fraud/exclusions.html); the System for Award Maintenance (SAM.gov); and any other relevant state exclusion databases or other such information data bases. In addition, to insure compliance with ERISA Section 411, the Companies will conduct criminal background checks at point of engagement, and on a periodic basis afterwards, for all employees and contractors to determine if any individual has been convicted of crimes described in Section 411 (29 USC Section 1111). Any employee or contractor found to be ineligible will be immediately removed from his/her position at the Companies or have his/her contract terminated.	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: • The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered. • Any information the member needs in order to decide among all relevant treatment options. • The risks, benefits, and consequences of treatment or non-treatment. • The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. *42 CFR 438.102(a)(1)* CHP+ Contract: Exhibit B1—10.4.3	**Documents:** 1. FHP_CO Facility Agreement 2. FHP_CO Ancillary Provider Agreement 3. FHP_CO Physician Agreement 4. CO – State Compliance Attachment 5. Provider Manual **Narrative:** Friday Health Plans enters into an agreement with each provider. This agreement (Ancillary Provider) Section 7.2 outlines that Provider and Health Plan agree that nothing in this Agreement shall limit or otherwise restrict the Provider's medical judgment and ultimate responsibility for patient care in the provision of Covered Services. Nothing herein is intended to create any right for Health Plan to intervene in the medical decision-making regarding the Covered Person. Providers are also provided with a provider manual. This provider manual includes Attachment C, which outlines to providers the specific member's rights and responsibilities. Providers are notified that members have the following rights: • Talk with your PCP and receive information about your medical condition and the appropriate medically necessary treatment options available and any alternatives, regardless of the cost or what your benefits are. This information should be presented in a manner appropriate to the member's condition and ability to understand.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: • To the State upon contracting or when adopting the policy during the term of the contract. • To members before and during enrollment. • To members within 90 days after adopting the policy with respect to any particular service. *42 CFR 438.102(b)* CHP+ Contract: Exhibit B1—14.1.3.13.3.7 Amendment 3: Exhibit K—1.1.7	**Not Applicable** Friday Health Plans provides all covered services to its members. Friday Health Plans does not object to providing a service on moral or religious grounds.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor has administrative and management arrangements or procedures, including a compliance program to detect and prevent fraud, waste, and abuse and includes: • Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal, State, and contract requirements. • The designation of a compliance officer who is responsible for developing and implementing policies, procedures and practices to ensure compliance with requirements of the contract and reports directly to the CEO and Board of Directors. • The establishment of a Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program. • Training and education of the compliance officer, management, and organization's staff members for the federal and State	**Documents:** 1. Compliance Plan **Narrative:** Friday Health Plans has a compliance plan that outlines its commitment to conducting business in full compliance with the highest legal and ethical standards. The Companies have established this comprehensive Compliance Program to ensure that all organizational and operational areas of the Companies are, and remain, complaint with applicable legal (federal and state) and other compliance requirements, including, but not limited to the detection and prevention of fraud, waste and abuse ("FWA"). The Compliance Plan outlines the designation of a compliance officer and their role as well as reporting directly to the CEO and to the governing	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
standards and requirements under the contract. • Effective lines of communication between the compliance officer and the Contractor's employees. • Enforcement of standards through well-publicized disciplinary guidelines. • Implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks. • Procedures for prompt response to compliance issues as they are raised, investigation of potential compliance problems identified in the course of self-evaluation and audits, corection of such problems quickly and thoroughly to reduce the potential for reoccurence, and ongoing compliance with the requirements under the contract. *42 CFR 438.608(a)(1)* CHP+ Contract: Exhibit B1—14.2.5.2–3, 14.2.5.4.1–2, 14.2.5.4.9, 14.2.7.2–5	body. This plan outlines the compliance committee, annual compliance training, effective lines of communication, enforcement of standards through well-publicized disciplinary guidelines, routine internal monitoring and auditing of compliance risks and prompt response to compliance issues as they are raised, investigation of potential compliance problems.	
Findings: The *Compliance Program* description conveyed FHP's commitment to comply with all applicable federal and State requirements; designated a chief compliance officer; and described the Compliance Committee structure, participants, and duties in alignment with regulations. However, the plan lacked details regarding the specific training for the compliance officer and health plan managers. Staff interviews confirmed that no specific training plans were in place for compliance leadership beyond the general internal staff-level training.		
Required Actions: FHP must further develop training and education requirements for the compliance officer and compliance management staff members.		

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor's administrative and management procedures to detect and prevent fraud, waste, and abuse include: • Written policies for all employees, contractors or agents that provide detailed information about the False Claims Act, including the right of employees to be protected as whistleblowers. • Provisions for prompt referral of any potential fraud, waste, or abuse to the Department and any potential fraud to the State Medicaid Fraud Control Unit. • Provisions for suspension of payments to a network provider for which the State determines there is credible allegation of fraud (in accordance with 455.12.) *42 CFR 438.608 (a)(6-8)* CHP+ Contract: Exhibit B1—14.2.6.1, 14.2.7.1, 14.2.7.6	**Documents:** 1. Compliance Plan **Narrative:** Friday Health Plans has a compliance plan that is provided to all employees upon update and at least annually as part of their annual compliance training. This compliance plan outlines the Federal False Claims Act, the Qui Tam(also called Whistleblower) provisions, t provides detailed information about the False Claims Act, reporting of potential fraud, waste, or abuse. Page 28 of the Plan outlines that potential FCA violation should be reported immediately to the direct supervisor, the Compliance Officer or through the confidential Compliance Hotline.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Findings:

The False Claims Act was accurately described within the *Compliance Program* description; however, it did not include specific details regarding staff members' rights to be protected. Furthermore, the description did not consistently outline details about how staff members should make a prompt referral (i.e., reporting timelines, appropriate method for reporting). In addition, page 20 of the plan stated, "The Companies and Applicable Persons may be required to comply with the following federal and state laws." The training manual submitted did not contain additional information regarding compliance, fraud, waste, abuse, or reporting hotlines. While FHP did describe that suspension of payments would be processed through the PAC, FHP did not submit written procedures regarding provisions for suspension of payments to a network provider for which the State determines there is a credible allegation of fraud.

Required Actions:

FHP must update its *Compliance Program* description and supporting documents to further detail staff members' rights to be protected under the False Claims Act and include additional details (i.e., reporting methods, contact methods, timelines, etc.) for prompt referral of fraud, waste, and abuse both internally and also to the State as applicable.

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor's *Compliance Program* includes: • Provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potenial fraud. • Provision for prompt notification to the State about member circumstances that may affect the member's eligibility, including change in residence and member death. • Provision for notification to the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including termination of the provider agreement with the Contractor. • Provision for a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. *42 CFR 438.608 (a)(2-5)* CHP+ Contract: Exhibit B1—14.2.5.4.3–7	**Documents:** 1. Compliance Plan **Narrative:** Friday Health Plans has a compliance plan that provides information regarding Reporting a violation, how to report a violation and where to report a violation. This compliance plan provides details regarding the core elements of the compliance program, administration of the program, including the elements around fraud.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: While the *Compliance Program* description spoke in general terms about FHP's "formal, systematic, and structured approach" which "involves planning, sampling, testing, and validating," there were no specific procedures to verify regularly, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. Methodology discussed by staff members included financial and claims review and general reconciliation processes but did not include a proactive way of validating services with members directly.		
Required Actions: FHP must develop a method, such as member sampling, to assess regularly whether billed member services have been supplied by a provider.		

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor ensures that all network providers are enrolled with the State as CHP+ providers consistent with the provider disclosure screening, and enrollment requirements of the State. • The Contractor may execute network provider agreements pending the outcome of the State's screening and enrollment process of up to one-hundred and twenty (120) days, but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one one-hundred and twenty (120)-day period without enrollment of the provider, and notify affected enrollees. *42 CFR 438.608 (b)* CHP+ Contract: None	**Documents:** 1. Application Report **Narrative:** Friday Health Plans provides the Application Report to the IT department for an upload of the status of the applications in HRP.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor has procedures to provide to the State: • Written disclosure of any prohibited affiliation (as defined in 438.610). • Written disclosure of ownership and control (as defined in 455.104) • Identification within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract. *42 CFR 438.608(c)* CHP+ Contract: Exhibit B1—19.4.1, 19.4.4	**Documents:** 1) HCPF Ownership and Control Disclosure Form 2) Instructions for Ownership and Control Disclosure **Narrative:** Friday Health Plans notifies the state of any written disclosure of any prohibited affiliation through a formal written letter. Friday Health Plans provides a written disclosure of ownership and control by using the HCPF Ownership and Control Disclosure Form, and identification of payments in excess directly by email. These disclosures are made to the account manager and/or the finance/rates division.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: While FHP did submit evidence regarding how excess payments were addressed, FHP did not submit evidence of internal procedures for providing written disclosures of ownership and control or prohibited affiliations.		
Required Actions: FHP must create and implement procedures to outline how FHP provides disclosures of ownership and control as well as prohibited affiliations to the State.		
15. The Contractor has a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days of identifying the overpayment, and to notify the Contractor in writing of the reason for the overpayment. • The Contractor reports annually to the State on recoveries of overpayments. *42 CFR 438.608(d)(2) and (3)* CHP+ Contract: Exhibit B1—16.3.4.1.6	**Documents:** 1. FHP_CO Facility Agreement 2. FHP_CO Ancillary Provider Agreement 3. FHP_CO Physician Agreement 4. CO – State Compliance Attachment **Narrative:** Friday Health Plans provides in its agreements with providers, in Section 5.6 Overpayments/Underpayments. Friday Health Plans and Provider have agreed that provider shall refund all overpayments or duplicate or erroneous payments regardless of the cause promptly upon discovery, and within thirty (30) days of notice by Health Plan. In lieu of a refund, Payor may offset other amounts owed Provider under this Agreement. Payor may make retroactive adjustments to any payments made under this Agreement for a period of up to twenty-four (24) months from the original date of payment or such other period as may be required or permitted under applicable Law; provided, however, that this time limitation does not apply to cases involving fraud and abuse. Health Plan shall provide Provider with a written notice explaining any adjustment and dispute resolution procedures.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The Contractor provides that members are not held liable for: • The Contractor's debts in the event of the Contractor's insolvency. • Covered services provided to the member for which the State does not pay the Contractor. • Covered services provided to the member for which the State or the Contractor does not pay the health care provider that furnishes the services under a contractual, referral, or other arrangement. • Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. *42 CFR 438.106* CHP+ Contract Amendment 3: Exhibit B1—16.4.1	**Documents:** 1. FHP_CO Facility Agreement 2. FHP_CO Ancillary Provider Agreement 3. FHP_CO Physician Agreement 4. CO – State Compliance Attachment **Narrative:** Friday Health Plans enters into an agreement with all Providers. As part of this agreement, there is a clause for Hold Harmless. This clause outlines that the agreed upon requirements wherein Provider shall not under any circumstances bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, engage in any collection activities against, or have any recourse against Covered Persons for amounts due under this Agreement by Health Plan. This prohibition applies to, but is not limited to, any delay in payment or any amounts not paid by a Payor due to: (a) Payor's insolvency; (b) Provider's breach of this Agreement; (c) Provider's failure to comply with the requirements of the Utilization Management Policies and Procedures; (d) failure to file a timely Claim or appeal; or (e) the application of coding and bundling rules. This provision shall not prohibit Provider's collection of applicable Cost Sharing Amounts nor prohibit Provider from billing Covered Persons for Non-Covered Services in compliance with the terms of this Agreement. This paragraph supersedes any oral or written agreement to	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	the contrary now existing or hereafter entered into between Provider and a Covered Person or persons acting on the Covered Person's behalf.	

Results for Standard VII—Provider Participation and Program Integrity							
Total	Met	=	12	X	1.00	=	12
	Partially Met	=	4	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	16	**Total Score**		=	12
Total Score ÷ Total Applicable						=	75%

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. Notwithstanding any relationship(s) with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. *42 CFR 438.230(b)(1)* CHP+ Contract: Exhibit B1—5.5.3.3	**Documents:** 1. Delegation Oversight Policy, C&Q #2003, Page 1 2. Delegation Addendum, page 1 **Narrative:** Friday Health Plans follows its Delegation Oversight Policy and in that policy outlines that Friday Health Plans retains ultimate responsibility and authority for providing oversight of the contracted delegate to assure delegated functions are delivered according to accreditation and other regulatory requirements. The Delegation Addendum is provided to the delegate and in such Friday Health Plans outlines that it maintains the responsibility for ensuring that the function meets or exceeds all applicable state and federal requirements as well as the established policies and procedures as set forth by the PLAN for that certain function.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. All contracts or written arrangements between the Contractor and any subcontractor specify— • The delegated activities or obligations and related reporting responsibilities. • That the subcontractor agrees to perform the delegated activities and reporting responsibilities. • Provision for revocation of the delegation of activities or obligations or specify other remedies in instances where the Contractor determines that the subcontractor has not performed satisfactorily.	**Documents:** 1. Delegation Addendum **Narrative:** The Delegation Addendum outlines the functions to be delegated in Article Four, Delegated Activities, agreement to perform delegated activities and remedies for non-performance.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Note: Subcontractor requirements do not apply to network provider agreements. In addition, wholly-owned subsidiaries of the health plan are not considered subcontractors. *42 CFR 438.230(b)(2) and (c)(1)* CHP+ Contract: Exhibit B1—2.3		
Findings: Only the Magellan agreement specified reporting responsibilities. All agreements provided included the subcontractor's agreement to perform the duties under the contract, provisions for remedies for instances of subcontractor nonperformance of the subcontracted activities, and agreement to comply with all regulations and laws pertaining to work under the contract. The UST agreement provided did not have the statement of work attached and, therefore, the document provided did not include the delegated activities or the reporting responsibilities.		
Required Actions: FHP must amend the UST and VSP contracts to ensure that the delegation agreements specify the delegate's activities or obligations and related reporting responsibilities.		
3. The Contractor's written agreement with any subcontractor includes: • The subcontractor's agreement to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions. *42 CFR 438.230(c)(2)* CHP+ Contract: Exhibit B1—20.B	**Documents:** 1. Delegation Addendum **Narrative:** The Delegation Addendum at Section 1.2.1 outlines that the Delegated Responsibility Requirements means collectively PLAN Requirements, URAC Standards, and the requirements of any applicable laws.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The written agreement with the subcontractor includes: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State. – The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems related to Medicaid enrollees. – The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. – If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. *42 CFR 438.230(c)(3)* CHP+ Contract: Exhibit B1—2.3	**Documents:** 1) Delegation Addendum **Narrative:** Delegation Addendum outlines requirements for audits.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Both the VSP and Magellan contracts were missing the required provisions that the State, CMS, and HHS personnel have the right to audit, evaluate, and inspect books, records, or premises as deemed necessary by the applicable agency. The contracts also required retention of records for only six years, which would not be sufficient to allow for agency audits through 10 years following the final date of the contract or agreement. None of the agreements provided for review included specific provisions related to CMS rights to audit based on suspicion of fraud.		

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: FHP must amend all delegation agreements to ensure inclusion of the required contract provisions related to State, CMS, and HHS rights to audit. Amendments must include all required provisions and timelines.		

Results for Standard IX—Subcontractual Relationships and Delegation							
Total	Met	=	2	X	1.00	=	2
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	4	**Total Score**		=	2
				Total Score ÷ Total Applicable		=	50%

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Appeals Record Review Tool
for Friday Health Plans

Review Period:	January 1, 2020–December 31, 2020
Date of Review:	November 2, 2020–November 3, 2020
Reviewer:	Erica Arnold-Miller
Participating Health Plan Staff Member(s):	Manuela Heredia and Shoshanna Montoya

1	2	3	4	5	6	7	8	9	10	11	12
File #	**Member ID #**	**Date Appeal Received**	**Acknowledgment Sent Within 2 Working Days**	**Decision Maker Not Previous Level**	**Decision Maker Has Clinical Expertise**	**Expedited**	**Time Frame Extended**	**Date Resolution Letter Sent**	**Notice Sent Within Time Frame***	**Resolution Letter Includes Required Content****	**Resolution Letter Easy to Understand**
1	****	02/25/20	M ☐ N ☒ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	Not sent	M ☐ N ☒	M ☐ N ☒	M ☐ N ☒
Comments: No acknowledgement or resolution letter was sent to the member. A resolution letter was sent to the provider dated 04/03/20. This case was an administrative denial.											
2	****	02/28/20	M ☐ N ☒ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	Not sent	M ☐ N ☒	M ☐ N ☒	M ☐ N ☒
Comments: No acknowledgement or resolution letter was sent to the member. A resolution letter was sent to the provider dated 04/01/20.											
3	****	02/28/20	M ☐ N ☒ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	Not sent	M ☐ N ☒	M ☐ N ☒	M ☐ N ☒
Comments: No acknowledgement letter was sent to the member or provider. A resolution letter was sent to the provider dated 04/01/20.											
4	****	02/28/20	M ☐ N ☒ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	Not sent	M ☐ N ☒	M ☐ N ☒	M ☐ N ☒
Comments: No acknowledgement letter was sent to the member or provider. A resolution letter was sent to the provider dated 04/02/20.											
5	****	07/14/20	M ☐ N ☒ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	Not sent	M ☐ N ☒	M ☐ N ☒	M ☐ N ☒
Comments: No acknowledgement letter was sent to the member or provider. A resolution letter was sent to the provider dated 08/18/20, and an explanation of benefits (EOB) was sent to the member dated 06/22/20. A notification of overturned denial dated 10/01/20 was sent to the provider.											
6	****	07/22/20	M ☐ N ☒ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	Not sent	M ☐ N ☒	M ☐ N ☒	M ☐ N ☒
Comments: No acknowledgement letter was sent to the member or provider. A resolution letter was sent to the provider dated 09/10/20.											
7	****	07/31/20	M ☐ N ☒ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	10/01/20	M ☐ N ☒	M ☐ N ☒	M ☐ N ☒
Comments: No acknowledgement letter was sent to the member or provider. A resolution letter was sent to the provider dated 08/26/20 upholding the denial. An EOB was sent to the member dated 07/14/20. A letter overturning the denial was sent to the member and provider on 10/01/20.											
Do not score shaded columns below.											
Column Subtotal of Applicable Elements			**7**	**7**	**7**				**7**	**7**	**7**
Column Subtotal of Compliant (Met) Elements			**0**	**7**	**7**				**0**	**0**	**0**
Percent Compliant (Divide Met by Applicable)			**0%**	**100%**	**100%**				**0%**	**0%**	**0%**

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Appeals Record Review Tool
for Friday Health Plans

Key: M = Met; N = Not Met
N/A = Not Applicable
Yes; No = Not scored—information only

Total Applicable Elements	**42**
Total Compliant (Met) Elements	**14**
Total Percent Compliant	**33%**

***Appeal resolution letter time frame** does not exceed 10 working days from the day the health plan receives the appeal (unless expedited—three calendar days; or unless extended—+14 calendar days).

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

**** = Redacted Member ID

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2020–2021 site review of **FHP**.

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

HSAG Review Team	Title
Barbara McConnell	Executive Director
Sarah Lambie	Project Manager II
Erica Arnold-Miller	Project Manager II
FHP Participants	**Title**
Ashley Booth	Government Programs Specialist
Jennifer Mueller	Chief Operating Officer
Manuela Heredia	Senior Director of Compliance and Quality Assurance
Shoshanna Montoya	Operations Specialist
Department Observers	**Title**
Amy Ryan	CHP+ Contract and Program
Elizabeth Mattes	Project Coordinator
Jeffrey Jaskuna	CHP+ Program Manager
Russell Kennedy	Quality and Compliance Specialist

Appendix D. Corrective Action Plan Template for FY 2020–2021

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 SAFE 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 2020–2021 Corrective Action Plan for FHP

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
1. The Contractor provides all required member information to members in a manner and format that may be easily understood and is readily accessible by enrollees. *Note: Readily accessible means electronic information which complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines.* *42 CFR 438.10(b)(1)* CHP Contract: Section 21.A.	FHP's member handbook and welcome kit were written at a reading level much higher than sixth grade. Using the Flesch-Kincaid tool, testing selected pages revealed reading levels from 7.3 to 14.2. There were several instances in which FHP had copied either the federal regulation language or contract language verbatim into the member handbook, causing the document to be potentially not easily understood by an average CHP+ parent or guardian. Using the Adobe Acrobat accessibility tools, HSAG found that the member handbook, provider directory, and formulary showed multiple document reader, table, and contrast errors.	FHP must develop a mechanism to use tools or mechanisms of FHP's choice to ensure that member informational materials are in a format that may be easily understood—i.e., sixth grade reading level to the extent possible—and readily accessible based on Section 508 guidelines. HSAG recommends that FHP use tool kits for writing member materials developed by CMS.
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 V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
3. For consistency in the information provided to members, the Contractor uses the following as developed by the State: • Definitions for managed care terminology, including appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. • Model member handbooks and member notices. *42 CFR 438.10(c)(4)* CHP+ Contract: Exhibit B1—2.8.4	In FHP's CHP+ member handbook, there were a few definitions that were inconsistent with definitions outlined in FHP's CHP+ contract with the Department. In addition, the care management discussion in the member handbook included a sentence that had not been completed.	FHP must review how it is defining or using terms that are defined in the CHP+ contract and revise the handbook accordingly to ensure consistency. FHP should pay particular attention to the following terms: care management, care coordination, experimental/investigational, medical necessity, and utilization management.

Standard V—Member Information Requirements		
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 V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
4. The Contractor makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • All written materials for members must: – Use easily understood language and format. – Use a font size no smaller than 12 point. – Be available in alternative formats and through provision of auxiliary aids and service that takes into consideration the special needs of members with disabilities or limited English proficiency. – Include taglines in large print (18 point) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service number, and availability of materials in alternative formats. *42 CFR 438.10(d)(3) and (d)(6)* CHP+ Contract: Exhibit B1—6.3.1.14, 14.1.3.1, 14.1.3.2, 14.1.3.4, 14.1.3.5	FHP informed members that materials were available in Spanish and FHP staff members stated during the web-based interview that Spanish materials were sent upon request by the member. Although the member handbook and welcome kit were primarily written in 12-point font, the benefits table was provided in 10-point font. FHP included a tagline in the welcome letter in English and Spanish; however, the tagline did not include information about how to request auxiliary aids other than TTY/TDD, written translation, or oral interpretation. HSAG found no taglines in large print in the member handbook. Due to revisions to the Medicaid and CHIP managed care regulations posted November 13, 2020, there will be no required corrective actions related to the previous requirement for 18-point font. The definition of "large print" has been revised to be considered "conspicuously visible."	FHP must ensure that member informational materials are written in, at a minimum, 12-point font and contain taglines written in a large font that include how to request auxiliary aids and services in addition to TTY/TDD, written translation, and oral interpretation.

Standard V—Member Information Requirements		
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 V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
5. If the Contractor makes information available electronically— Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of readily accessible above). • The information is placed in a website location that is prominent and readily accessible. • The information can be electronically retained and printed. • The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge upon request and is provided within five (5) business days. *42 CFR 438.10(c)(6)* CHP+ Contract: Exhibit B1—14.1.3.13.2	FHP provided member informational materials through its website and the welcome kit (mailed to members) informed members that the information is available in written form upon request within five business days. HSAG found that the provider directory, member handbook, and the formulary were on the website in PDF format which could be retained and printed. HSAG, however, found that the placement of these documents was not prominent as the website was difficult to navigate. The website was not compliant with Section 508 guidelines. Using the online tool at http://wave.webaim.org/, HSAG found numerous document content and contrast errors on FHP's website.	FHP must ensure that information available for members electronically is placed in a website location that is prominent and that the information is readily accessible (complies with Section 508 guidelines).
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
12. The Contractor makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, pharmacies, and behavioral health providers, and LTSS providers (as applicable): • The provider's name and group affiliation, street address(es), telephone number(s), website URL, specialty (as appropriate), whether the providers will accept new enrollees. • The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training. • Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment. *Note: Information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after the Contractor receives updated provider information.*	Neither FHP's PDF version of the provider directory, nor the provider search feature on FHP's website included information about whether the providers have completed cultural competency training or whether the providers' offices have accommodations for members with physical disabilities. Due to revisions to the Medicaid and CHIP managed care regulations posted November 13, 2020, there will be no required corrective action related to findings regarding the provider directory not including information regarding whether or not the provider has completed cultural competency training.	FHP must ensure that its provider directory includes information about whether the providers' offices have accommodations for members with physical disabilities.

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
42 CFR 438.10(h)(1-3) CHP+ Contract: Exhibit B1—14.1.3.6-7		
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 V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
13. Provider directories are made available on the Contractor's website in a machine readable file and format. *42 CFR 438.10(h)(4)* CHP+ Contract: Exhibit B1—14 1.3.8	FHP's provider directory was available on the FHP website in a PDF format; however, the PDF document was not compliant with Section 508 guidelines.	FHP must develop a mechanism to ensure that the provider directory is available in a machine readable format (compliant with Section 508 guidelines).
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
16. The member handbook provided to members following enrollment includes the following information regarding the grievance, appeal, and fair hearing procedures and time frames: • The right to file grievances and appeals. • The requirements and time frames for filing a grievance or appeal. • The right to a request a State fair hearing after the Contractor has made a determination on a member's appeal which is adverse to the member. • The availability of assistance in the filing process. • The fact that, when requested by the member: – Benefits that the Contractor seeks to reduce or terminate will continue if the member files an appeal or a request for State fair hearing is filed within the time frames specified for filing. – If benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal or State fair hearing is pending if the final	FHP's member handbook contained information about grievances and appeals that included how to file, authority to file, and time frames and requirements. However, the time frames and requirements related to the continuation of services during an appeal and SFH were inaccurate and did not reflect the changes depicted in the 2016 revisions of the Medicaid managed care regulations. In addition, the examples provided for when to file an appeal were not entirely clear and could be interpreted inaccurately.	FHP must revise the member handbook information about the grievances and appeals to ensure that members understand that: • The right to file an appeal continues 60 days following the adverse benefit determination whether or not the member is requesting continuation of services during the appeal. • If a member requests continuation of services during the appeal, the request for the continued services (not the appeal filing) must be submitted before the effective date of the advance notice to terminate, suspend, or reduce the previously authorized services. • If the member has continued services during the appeal and requests continued services during the SFH, the member has 10 calendar days following the notice of appeal resolution to request the SFH and request the continued services (otherwise the member has 120 days following appeal resolution to request the SFH if continued services during the SFH is not being requested). • If the member continued services during the appeal but does not request continued services during the SFH within 10 calendar days following the appeal resolution, the continued services will then end. FHP must also clarify in its examples of appealable situations that appeals may only be filed in response to NABDs.

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
decision is adverse to the member. *42 CFR 438.10(g)(2)(xi)* CHP+ Contract: Exhibit B1—14.1.3.10 Exhibit K—1.1.18, 1.1.18.1, 1.1.18.1.1, 1.1.18.1.3, 1.1.18.2.1		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
1. The Contractor has an internal grievance and appeal system in place for members. A grievance and appeal system means the processes the Contractor implements to handle grievances and appeals of an adverse benefit determination, as well as processes to collect and track information about grievances and appeals. *42 CFR 438.400(b)* *42 CFR 438.402(a)* CHP+ Contract: Exhibit B1—7.9.1 10 CCR 2505-10—8.209.1	HSAG found that FHP did not meet many requirements regarding grievance and appeal systems. FHP submitted one procedural document related to grievance and appeal systems; however, this document appeared to be a duplication of the member handbook section for grievances and appeals and did not include details for how FHP staff members should process, monitor, or resolve cases. Additionally, overall appeal record scores demonstrated compliance with only around one-third of the requirements.	FHP must update and expand its grievance and appeal policies, procedures, and letter templates to more clearly define both grievance and appeal and delineate processes. Additionally, FHP must develop detailed procedures to better train and monitor staff members to ensure that grievances and appeals are being collected, processed, and resolved in compliance with federal and State requirements.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
3. The Contractor defines "appeal" as a review by the Contractor of an adverse benefit determination. *42 CFR 438.400(b)* CHP+ Contract: Exhibit B1—1.1.4 10 CCR 2505-10—8.209.2.A.7	The definitions for "appeal" provided within the member handbook, provider manual, and desktop procedure were all aligned with the federal definition. However, when staff members described the differences between member and provider appeals, staff members reported that any appeal submitted by a provider was considered a provider appeal. The record review contained multiple instances of durable medical equipment (DME) denials, in which the member was denied insulin pumps and the provider was informed the member had reached the maximum benefit limit. HSAG clarified that any issue not related to provider procedural issues should be processed as a CHP+ member appeal, regardless of whether the member filed the appeal, or the provider on behalf of the member. On November 13, 2020, CMS revisions to the definition of an adverse benefit determination further clarified that an appeal is anything other than "a denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a clean claim." Additionally, examples provided within the member handbook did not accurately describe an appeal. The appeal example stated, "You are told you are being discharged from the hospital and don't feel ready to go." However, this example is not entirely clear. If the	FHP must update and expand its internal appeal documentation to more clearly define appeals. FHP must develop detailed procedures to better train and monitor staff members and ensure that appeals are being collected, processed, and resolved in compliance with federal and State requirements. FHP must update the member handbook to clarify that members may appeal the denial of services once an NABD has been received.

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
	authorized stay has expired, and no new request submitted, the member may not appeal. If a provider submitted a request for authorizing additional hospital days that was denied, then an NABD would be sent, which the member could appeal. The end of an authorization period does not trigger an NABD or appeal rights.	
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
4. The Contractor defines "grievance" as an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. A grievance includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision. *42 CFR 438.400(b)* CHP+ Contract: Exhibit B1—1.1.44 10 CCR 2505-10—8.209.2.D, 8.209.4.A.3.c.i	Definitions throughout the member handbook, provider manual, and desktop procedure included separate definitions for "complaints" and "grievances," which could be misleading to members and staff. For example, the provider manual stated that "The terms 'complaint' and 'grievance' are sometimes used interchangeably. A complaint may be resolved without further action." It goes on to say, "A grievance usually invokes the organization determination process through documented action and is generally considered more formal than a complaint." Within the desktop procedure *Tracking Suggestions/Inquiries/Complaints/Grievances/Appeals/Provider Disputes*, the terms were also used incorrectly: "In the event that the complaint is actually a grievance the grievance policy is followed. In the event that the issue is still categorized as a complaint and it is unable to be resolved during the first call, FHP will ensure that all complaints are resolved within 7 days from receipt. Verbal notice is given to the member within 24 hours from resolution." This direction is out of compliance with federal grievance and appeal regulations. Additional training evidence submitted post-audit included a training manual that outlined how customer service should handle a "complaint call" and did not include any reference to a complaint being a grievance, nor the need to alert the grievance and appeal department, log the grievance, or follow-up with an acknowledgement or resolution letter.	FHP must update and clarify this information in all related documents (included procedures and training materials) to align the definition of "grievance" with the federal definition. These updates must clarify that "complaints" are the same as "grievances" and must be treated the same way. FHP must remove references that there are differences between formal and informal grievances or complaints.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
6. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. *42 CFR 438.406(a)(1)* CHP+ Contract: Exhibit B1—None 10 CCR 2505-10—8.209.4.C	While the supporting documents did outline that FHP staff members would assist in filing efforts, the language in the grievance section did not include specifics about auxiliary aids and interpreter services.	FHP must update related grievance and appeal documents to clarify that auxiliary aids and interpreter services are available at no cost to the member in order to help members with completing any forms or other procedural steps related to grievances and appeals.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
14. The Contractor may have only one level of appeal for members. *42 CFR 438.402(b)* CHP+ Contract: None	FHP's *Quick Reference Guide* detailed second-level appeal rights and did not clarify that CHP+ members only have one level of appeal.	FHP must update documents to clarify that for the CHP+ line of business there is only one level of appeal for CHP+ members.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
17. The Contractor sends written acknowledgement of each appeal within two (2) working days of receipt, unless the member or designated representative requests an expedited resolution. *42 CFR 438.406(b)(1)* CHP+ Contract: Exhibit B1—14.1.4.1.3 10 CCR 2505-10 8.209. 4.D	The member handbook, provider manual, and desktop procedure all included accurate language describing the time frame for mailing members appeal acknowledgement letters. However, record review findings indicated that none of the seven appeals included acknowledgement letters for members or providers.	FHP must develop a mechanism to ensure that member acknowledgement letters for each appeal are sent in a timely manner.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
21. If the Contractor denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the time frame for standard resolution. • Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and within two (2) calendar days provide the member written notice of the reason for the decision and inform the member of the right to file a grievance if he or she disagrees with that decision. *42 CFR 438.410(c)* CHP+ Contract: Exhibit B1—14.1.4.1.8.4.1 10 CCR 2505-10 8.209.4.S	Despite having the time frames accurately outlined in the desktop policy, FHP's documents did not include language regarding a member's right to file a grievance in response to the denial of an expedited appeal.	FHP must update grievance and appeal documents to include the member's right to file a grievance in response to a denial of an expedited appeal request.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
22. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)* *42 CFR 438.408(d)(2)* *42 CFR 438.10* CHP+ Contract: Exhibit B1—14.1.4.1.4, 14.1.3.1 10 CCR 2505-10 8.209.4.J.1	Appeal resolution timelines were accurately described in the member handbook, provider manual, desktop procedure, but not within the *Quick Reference Guide*. The *Quick Reference Guide* depicted "10 days" instead of the "10 working day" requirement. And although the 10 calendar days would be a greater benefit to the CHP+ member, the policy was not consistently applied in practice. Record review findings showed that appeal resolution letters were not sent to members in six of the seven samples. In the one case in which a letter was sent to the member, it was mailed over 60 days after the appeal was submitted.	FHP must update documents to reflect the 10-working day timeline and develop a mechanism to ensure appeals are resolved and members are notified within timeliness standards.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
23. For expedited appeal, the Contractor must resolve the appeal and provide written notice of disposition to affected parties within 72 hours after the Contractor receives the appeal. • For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. *42 CFR 438.408(b)(3) and (d)(2)(ii)* CHP+ Contract: Exhibit B1—14.1.4.1.8.4.2, 14.1.4.1.8.4.5 10 CCR 2505-10 8.209.4.J.2, 8.209.4.L	While FHP's documents did include language regarding the 72-hour expedited appeal timeline, the desktop procedure *Expedited Determinations* also referred to a three-business day timeline.	FHP must remove references to three business days and update all time frames to reflect that both verbal and written notice must take place within the 72-hour time frame.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
25. If the Contractor extends the time frames, it must—for any extension not requested by the member: • Make reasonable efforts to give the member prompt oral notice of the delay. • Within two (2) calendar days, give the member written notice of the reason for the delay and inform the member of the right to file a grievance if he or she disagrees with that decision. • Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. *42 CFR 438.408(c)(2)* CHP+ Contract: Exhibit B1—14.1.4.1.4.2, 14.1.4.1.8.4.4–5	Although FHP's extension process and samples included the correct time frames and described efforts to provide prompt oral notice, the documents did not include the member's right to file a grievance if the member disagrees with the extension.	FHP must update documents to include the member's right to file a grievance in response to an extension if the member disagrees with the extension.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
27. The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of resolution. • If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. *42 CFR 438.408(f)(1–2)* CHP+ Contract: Exhibit B1—14.1.4.1.10.1-2 10 CCR 2505-10 8.209.4.N and O	Sections of FHP's member handbook, desktop procedure, and provider manual included inaccurate timelines regarding SFHs (60 days from the notice of action instead of 120 days from the notice of appeal resolution). Also, although the request for continued services was accurately outlined as 10 days from the adverse appeal determination, the language regarding "or before the effective date of the termination or changes in services" does not apply during a SFH, only appeals.	FHP must update the SFH timelines to reflect that the member has 120 days from the appeal resolution to request a SFH unless the member is also requesting continuation of the disputed services, in which case both the continued services and the SFH must be requested within 10 days following the appeal resolution. FHP must also remove the reference to the original effective date of the termination of the services from the SFH section of its documents.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
29. The Contractor provides for continuation of benefits/services (when requested by the member) while the Contractor-level appeal is pending if: • The member files in a timely manner* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the Contractor mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal within 60 days of the notice of adverse benefit determination. **This definition of timely filing only applies for this scenario—i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced. (Note:*	In regard to SFH, FHP's documents did not clearly indicate that the member must request both the continuation of benefits and SFH within 10 days of the adverse appeal determination. FHP must also clarify that the provider may not request continued benefits on behalf of the member due to the potential financial liability for the member.	FHP must update all related grievance and appeal systems documents to clearly indicate the timelines for requesting continuation of benefits during appeals and SFH and who may request such benefits.

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
The provider may not request continuation of benefits on behalf of the member.) The Contractor provides for continuation of benefits/services (when requested by the member) while the State fair hearing is pending if: • The member requests a State fair hearing with a request for continuation of benefits in a timely manner—defined as on or before the following: – Within 10 days of the Contractor mailing the notice of appeal resolution not in favor of the member. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment (and the member requested and received continued benefits during the Contractor appeal). • The services were ordered by an authorized provider. *42 CFR 438.420(a) and (b)* CHP+ Contract: Exhibit B1—14.1.4.1.9.1 10 CCR 2505-10 8.209.4.T		

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

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
30. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal is pending, the benefits must be continued until one of the following occurs: • The member withdraws the appeal. • The member does not request continued benefits during a State fair hearing within 10 calendar days after the Contractor sends the notice of an appeal resolution not in the member's favor. If, at the member's request, the Contractor continues or reinstates the benefits while the State fair hearing is pending, the benefits must be continued until one of the following occurs: • The member withdraws the request for a State fair hearing. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR 438.420(c)* CHP+ Contract: Exhibit B1—14.1.4.1.9.2 10 CCR 2505-10 8.209.4.U	While parts of FHP's desktop procedure, member handbook, and provider manual included partially accurate information, this language should be under the appeals section, not SFH: "A total of ten (10) calendar days pass after we mail the original notice to you that we are denying your appeal. If you request a State fair hearing within those ten (10) calendar days, your benefits will continue until the hearing is finished." Lastly, the authorization period for services does not trigger the end of services once the services have been continued during the SFH as the authorization may have since expired during the appeal or SFH.	FHP must update all related documentation to clarify the duration of continued benefits during an appeal and SFH.

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

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
31. Member responsibility for continued services: • If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's adverse benefit determination, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. *42 CFR 438.420(d)* CHP+ Contract: Exhibit B1—14.1.4.1.9.3 10 CCR 2505-10 8.209.4.V	Although the FHP member handbook, provider manual, and desktop procedure accurately described the member's responsibility for continued services during the appeal, the SFH section did not include that the member may also be financially liable for services continued during the SFH.	FHP must clarify within the SFH section related to continued benefits that the member may be held liable for services continued during the appeal and SFH.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
33. The Contractor maintains records of all grievances and appeals. The records must be accurately maintained in a manner accessible to the State and available on request to CMS. • The record of each grievance and appeal must contain, at a minimum, all of the following information: – A general description of the reason for the grievance or appeal. – The date received. – The date of each review or, if applicable, review meeting. – Resolution at each level of the appeal or grievance. – Date of resolution at each level, if applicable. – Name of the person for whom the appeal or grievance was filed. • The Contractor quarterly submits to the Department a Grievance and Appeals report including this information. *42 CFR 438.416* CHP+ Contract: Exhibit B1—14.1.4.1.12, 15.5.1 10 CCR 2505-10 8.209.3.C	Documentation stated that "Friday maintains procedures to collect, track and report suggestions, inquiries, complaints, grievances and appeals received,". While the appeals records did include key documentation, the 2020 Complaint Log did not include the minimum required elements (i.e. name of the person for whom the grievance was filed and a general description of the reason for the grievance). HSAG also noted there was not a section in the complaint log to include additional dates or information regarding resolution letters (when applicable).	FHP must enhance policies, procedures, and monitoring practices to ensure that all required grievance information is maintained.

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

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
34. The Contractor provides the information about the grievance, appeal, and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing.* – The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member.	Within the provider manual, the terms "complaint" and "grievance" were defined separately, which did not clearly convey that the terms mean the same thing based on federal regulations. Additionally, the manual included other inaccuracies regarding appeal and SFH timelines and continuation of benefits.	FHP must ensure that updates to other requirements are accurately implemented in the provider manual and associated materials so that providers and subcontractors receive accurate information about grievances, appeals, and SFHs at the time they enter into a contract.

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
* *Time frames specified for filing:* *During an appeal: Request continued benefits within 10 days of the notice of adverse benefit determination.* *During a State fair hearing: Request continued benefits within 10 days of the notice of adverse appeal resolution.* *42 CFR 438.414* *42 CFR 438.10(g)(xi)* CHP+ Contract Amendment 3: Exhibit B1—14.1.4.1.1.1, 14.1.5.1.1 10 CCR 2505-10 8.209.3.B		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VII—Provider Participation and Program Integrity		
Requirement	**Findings**	**Required Action**
10. The Contractor has administrative and management arrangements or procedures, including a compliance program to detect and prevent fraud, waste, and abuse and includes: • Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal, State, and contract requirements. • The designation of a compliance officer who is responsible for developing and implementing policies, procedures and practices to ensure compliance with requirements of the contract and reports directly to the CEO and Board of Directors. • The establishment of a Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program. • Training and education of the compliance officer, management, and organization's staff members for the federal and State standards and requirements under the contract. • Effective lines of communication between the compliance officer and the Contractor's employees.	The *Compliance Program* description conveyed FHP's commitment to comply with all applicable federal and State requirements; designated a chief compliance officer; and described the Compliance Committee structure, participants, and duties in alignment with regulations. However, the plan lacked details regarding the specific training for the compliance officer and health plan managers. Staff interviews confirmed that no specific training plans were in place for compliance leadership beyond the general internal staff-level training.	FHP must further develop training and education requirements for the compliance officer and compliance management staff members.

Standard VII—Provider Participation and Program Integrity		
Requirement	**Findings**	**Required Action**
• Enforcement of standards through well-publicized disciplinary guidelines. • Implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks. • Procedures for prompt response to compliance issues as they are raised, investigation of potential compliance problems identified in the course of self-evaluation and audits, corection of such problems quickly and thoroughly to reduce the potential for reoccurence, and ongoing compliance with the requirements under the contract. *42 CFR 438.608(a)(1)* CHP+ Contract: Exhibit B1—14.2.5.2–3, 14.2.5.4.1–2, 14.2.5.4.9, 14.2.7.2–5		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		

Standard VII—Provider Participation and Program Integrity		
Requirement	**Findings**	**Required Action**
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VII—Provider Participation and Program Integrity		
Requirement	**Findings**	**Required Action**
11. The Contractor's administrative and management procedures to detect and prevent fraud, waste, and abuse include: • Written policies for all employees, contractors or agents that provide detailed information about the False Claims Act, including the right of employees to be protected as whistleblowers. • Provisions for prompt referral of any potential fraud, waste, or abuse to the Department and any potential fraud to the State Medicaid Fraud Control Unit. • Provisions for suspension of payments to a network provider for which the State determines there is credible allegation of fraud (in accordance with 455.12.) *42 CFR 438.608 (a)(6-8)* CHP+ Contract: Exhibit B1—14.2.6.1, 14.2.7.1, 14.2.7.6	The False Claims Act was accurately described within the *Compliance Program* description; however, it did not include specific details regarding staff members' rights to be protected. Furthermore, the description did not consistently outline details about how staff members should make a prompt referral (i.e., reporting timelines, appropriate method for reporting). In addition, page 20 of the plan stated, "The Companies and Applicable Persons may be required to comply with the following federal and state laws." The training manual submitted did not contain additional information regarding compliance, fraud, waste, abuse, or reporting hotlines. While FHP did describe that suspension of payments would be processed through the PAC, FHP did not submit written procedures regarding provisions for suspension of payments to a network provider for which the State determines there is a credible allegation of fraud.	FHP must update its *Compliance Program* description and supporting documents to further detail staff members' rights to be protected under the False Claims Act and include additional details (i.e., reporting methods, contact methods, timelines, etc.) for prompt referral of fraud, waste, and abuse both internally and also to the State as applicable.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		

Standard VII—Provider Participation and Program Integrity		
Requirement	**Findings**	**Required Action**
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VII—Provider Participation and Program Integrity		
Requirement	**Findings**	**Required Action**
12. The Contractor's *Compliance Program* includes: • Provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potenial fraud. • Provision for prompt notification to the State about member circumstances that may affect the member's eligibility, including change in residence and member death. • Provision for notification to the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including termination of the provider agreement with the Contractor. • Provision for a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. *42 CFR 438.608 (a)(2-5)* CHP+ Contract: Exhibit B1—14.2.5.4.3–7	While the *Compliance Program* description spoke in general terms about FHP's "formal, systematic, and structured approach" which "involves planning, sampling, testing, and validating," there were no specific procedures to verify regularly, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. Methodology discussed by staff members included financial and claims review and general reconciliation processes but did not include a proactive way of validating services with members directly.	FHP must develop a method, such as member sampling, to assess regularly whether billed member services have been supplied by a provider.

Standard VII—Provider Participation and Program Integrity		
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 VII—Provider Participation and Program Integrity		
Requirement	**Findings**	**Required Action**
14. The Contractor has procedures to provide to the State: • Written disclosure of any prohibited affiliation (as defined in 438.610). • Written disclosure of ownership and control (as defined in 455.104) • Identification within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract. *42 CFR 438.608(c)* CHP+ Contract: Exhibit B1—19.4.1, 19.4.4	While FHP did submit evidence regarding how excess payments were addressed, FHP did not submit evidence of internal procedures for providing written disclosures of ownership and control or prohibited affiliations.	FHP must create and implement procedures to outline how FHP provides disclosures of ownership and control as well as prohibited affiliations to the State.
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 IX—Subcontractual Relationships and Delegation		
Requirement	**Findings**	**Required Action**
2. All contracts or written arrangements between the Contractor and any subcontractor specify— • The delegated activities or obligations and related reporting responsibilities. • That the subcontractor agrees to perform the delegated activities and reporting responsibilities. • Provision for revocation of the delegation of activities or obligations or specify other remedies in instances where the Contractor determines that the subcontractor has not performed satisfactorily. *Note: Subcontractor requirements do not apply to network provider agreements. In addition, wholly-owned subsidiaries of the health plan are not considered subcontractors.* *42 CFR 438.230(b)(2) and (c)(1)* CHP+ Contract: Exhibit B1—2.3	Only the Magellan agreement specified reporting responsibilities. All agreements provided included the subcontractor's agreement to perform the duties under the contract, provisions for remedies for instances of subcontractor nonperformance of the subcontracted activities, and agreement to comply with all regulations and laws pertaining to work under the contract. The UST agreement provided did not have the statement of work attached and, therefore, the document provided did not include the delegated activities or the reporting responsibilities.	FHP must amend the UST and VSP contracts to ensure that the delegation agreements specify the delegate's activities or obligations and related reporting responsibilities.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Findings**	**Required Action**
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Findings**	**Required Action**
4. The written agreement with the subcontractor includes: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State. – The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems related to Medicaid enrollees. – The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. – If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State,	Both the VSP and Magellan contracts were missing the required provisions that the State, CMS, and HHS personnel have the right to audit, evaluate, and inspect books, records, or premises as deemed necessary by the applicable agency. The contracts also required retention of records for only six years, which would not be sufficient to allow for agency audits through 10 years following the final date of the contract or agreement. None of the agreements provided for review included specific provisions related to CMS rights to audit based on suspicion of fraud.	FHP must amend all delegation agreements to ensure inclusion of the required contract provisions related to State, CMS, and HHS rights to audit. Amendments must include all required provisions and timelines.

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Findings**	**Required Action**
CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. *42 CFR 438.230(c)(3)* CHP+ Contract: Exhibit B1—2.3		
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:		

Appendix E. Compliance Monitoring Review Protocol Activities

The following table describes the activities performed throughout the compliance monitoring process. The activities listed below are consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal managed care regulations and Department contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all site reviewers to ensure consistency in scoring across health plans.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided health plans with proposed site review dates, group technical assistance, and training, as needed. • HSAG confirmed a primary health plan contact person for the site review and assigned HSAG reviewers to participate in the site review. • Sixty days prior to the scheduled date of the site 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 site review agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and the site review 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 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 member grievance and all member appeal records that occurred between January 1, 2020, and December 31, 2020 (to the extent available at the time of the site review). Health plans submitted the lists to HSAG 10 days following receipt of the desk review request. HSAG used a random sampling technique to select records for desk review and the site review. HSAG notified the

For this step,	HSAG completed the following activities:
	health plan five days following receipt of the lists of records regarding the sample records selected. • The HSAG review team reviewed all documentation submitted prior to the site review and prepared a request for further documentation and an interview guide to use during the site review.
Activity 3:	**Conduct Health Plan Site Review**
	• During the site review, HSAG met with groups of the health plan's key staff members to obtain a complete picture of the health plan's compliance with federal healthcare regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan's performance. • HSAG requested, collected, and reviewed additional documents as needed. • At the close of the site review, HSAG provided health plan staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2020–2021 Department-approved Site Review Report Template to compile the findings and incorporate information from the pre-site review and site review activities. • HSAG analyzed the findings and calculated final scores based on Department-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the Department**
	• HSAG populated the Department-approved report template. • HSAG submitted the draft Site Review Report to the health plan and the Department for review and comment. • HSAG incorporated the health plan and Department comments, as applicable, and finalized the report. • HSAG included a pre-populated CAP template in the final report for all elements determined to be out of compliance with managed care regulations. • HSAG distributed the final report to the health plan and the Department.