CHP+

Child Health Plan *Plus*

Fiscal Year 2023–2024 Compliance Review Report

for

Colorado Access

March 2024

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

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Summary of Results

Based on conclusions drawn from the review activities, Health Services Advisory Group, Inc. (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 im7provement with associated recommendations for some elements, regardless of the score.

Colorado Access (COA) showed a moderate understanding of federal regulations. COA demonstrated a comprehensive quality assessment and performance improvement program; however, for two standards reviewed, COA's scoring decreased when compared with the prior review.

Table 1-1 presents the scores for COA for each of the standards. Findings for all requirements are summarized in the Assessment and Findings 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	20	1	0	0	95%~
VII. Provider Selection and Program Integrity	16	16	15	1	0	0	94%v
IX. Subcontractual Relationships and Delegation	4	4	1	3	0	0	25%v
X. Quality Assessment and Performance Improvement (QAPI)**	17	17	17	0	0	0	100%^
Totals	**58**	**58**	**53**	**5**	**0**	**0**	**91%**

*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.

v Indicates that the score decreased compared to the previous review year.

^ Indicates that the score increased compared to the previous review year.

~ Indicates that the score remained unchanged compared to the previous review year.

**The full name of Standard X is Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems.

Standard V—Member Information Requirements

Evidence of Compliance and Strengths

HSAG reviewed a variety of COA's policies pertaining to effective communication, accessibility, and cultural sensitivity that outlined the steps COA takes to ensure effective communication with members. These steps include, but are not limited to, testing readability, keeping the message simple, and understanding the audience. COA had a Member Advisory Council (MAC) in place to provide user experience insights. The MAC is a group of members, family members, and caregivers facilitated by COA that reviews (i.e., member tests) and provides input on all member-facing materials prior to dissemination. COA provided MAC meeting minutes from May 2023 that detailed an ongoing review process for such materials.

COA submitted a Member Materials policy that outlined the procedures and standards for ensuring that the information in the member materials is effectively communicated. HSAG found that the member materials provided for review were easily understood and compliant with Section 508 guidelines. Staff members discussed the accessibility widget tool that enabled COA to internally ensure accessibility and readability of member information on its website. The Culturally Sensitive Services for Diverse Populations policy described health literacy techniques that staff members must follow.

COA submitted an *Effective Communication with Limited English Proficiency (LEP) and Sensory Impaired/Speech Impaired (SI-SI) Persons* policy that stated the availability of language interpretation/translation, including American Sign Language (ASL), and/or auxiliary aids and services provided at no cost to members.

HSAG noted that COA had processes to ensure that specific documents available electronically on the COA website are machine readable and comply with Section 508 guidelines, Section 504 of the Rehabilitation Act, and the World Wide Web Consortium (W3C) Web Content Accessibility Guidelines. During the interview, staff members responsible for these processes stated that COA had contracted with an outside resource to ensure that its website remained compliant as information was added and updated. HSAG reviewed several webpages for compliance with Section 508 guidelines using the WAVE evaluation tool and assessed compliance.

COA's maintained an electronic provider directory that enabled members to search and select providers using different criteria such as the provider's name and group affiliation, street address(es), telephone number(s), specialty, and whether the provider will accept new members. The provider directory also included the cultural and linguistic capabilities offered by the provider or provider's office as well as the Americans with Disabilities Act (ADA) accessibility options at the provider's office.

Opportunities for Improvement and Recommendations

HSAG reviewed COA's provider directory on its website and identified the following statement at the top of the page: *If you need this document in another language, large print or on tape, please call Customer Service at 1-800-511-5010 (toll free). TTY/TDD users call 1-888-803-4494*. During the interview, HSAG asked if the statement referred to a cassette tape and if COA offers translation, interpretation, or records member information on cassette tapes as an auxiliary aid to members. COA stated that it does not offer information on cassette tape. HSAG recommends that COA update this statement on the website and in any other member materials where applicable to indicate available media.

Required Actions

COA's electronic provider directory did not include the provider website URLs as required. COA must update its provider directory to include the provider URLs.

Standard VII—Provider Selection and Program Integrity

Evidence of Compliance and Strengths

Regarding provider retention, COA described a claims report that provided information for the practice facilitators and practice support staff members how to identify providers who had not submitted claims in a year or had submitted a lower volume of claims in the past year. COA staff members described that providers are targeted for outreach, with a focus on specialty providers. Additionally, staff members described heat map reports to identify where providers are located in relation to members. COA also hosted quarterly forums and professional networking opportunities as part of its efforts to maintain its provider network. Staff members described the Language First Effort initiative which pays providers who speak languages other than English an additional 10 percent.

COA submitted detailed documentation regarding credentialing and recredentialing procedures in alignment with the National Committee for Quality Assurance. The Contracting department staff members stated that COA rarely declines a provider's application to join the network and that there are three systems used to track contract execution: DocuSign, Salesforce, and Formstack.

The Sanction and Exclusion Screening policy and Ongoing Monitoring of Providers policy described in detail the processes for monitoring exclusion lists. Staff members shared that any providers with hits in Department of Regulatory Agencies, List of Excluded Individuals/Entities, System for Award Management, or the Streamline Verify exclusion software system are typically retrospective hits for providers who have already been terminated, and if an active provider was identified, the provider would be subject to immediate termination for cause.

COA communicated methods of reporting fraud, waste, or abuse to providers through the provider agreement and provider manual, and to staff members through onboarding and annual trainings. COA monitored the efficacy of communication mechanisms by surveying staff members' comfort levels regarding self-reporting, which was found to have improved 3 percent since the previous year.

COA maintained a clear reporting structure from the Core Policy team and Provider Performance Committee up through the Executive Compliance Committee to the Finance, Audit, and Compliance Committee (FACC), and ultimately to the Board of Directors. To gather meaningful data about trends and risks, COA used the EthicsPoint system to track any incidents as well as track and trend issues and questions that it received from members, staff members, and providers. Staff members also described the employee newsletter, which features a "Compliance Corner" article regarding identified trends and risks as well as regular reminders related to program integrity.

COA staff members described the process for regularly monitoring service verification feedback from members, and detailed common findings. HSAG recognized that the timeliness of available data regarding member service verification and summary of trends is a best practice.

Opportunities for Improvement and Recommendations

HSAG recommends that COA expand its Selection and Retention of Providers policy to include the additional details regarding provider retention monitoring efforts that were described during the interview, as well as any provider training and professional networking opportunities.

HSAG encourages COA to further detail expectations regarding prompt reporting timelines in its employee training and related policies. Additionally, HSAG recommends that COA document compliance training expectations for its management level staff members and its compliance officer.

While COA's provider agreement clearly stated that members are not held liable for the provider's debts, services, or payments, as outlined in 42 CFR 438.106, COA has an opportunity to further clarify in the Compliance Operations Manual that the member is not held liable for:

- COA's debts in the event of the contractor's insolvency.
- Covered services provided to the member for which the State does not pay COA.
- Covered services provided to the member for which the State or COA 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 COA provided the services directly.

Required Actions

COA's policies and procedures stated that COA would not knowingly employ any staff members who are excluded from participation in federal health care programs. However, the policies and procedures

did not state that COA would not knowingly employ any staff members who are *debarred* or *suspended*. COA must update its policies and procedures to align in full detail with the federal and State requirements.

Standard IX—Subcontractual Relationships and Delegation

Evidence of Compliance and Strengths

COA has written delegation agreements for the following services: credentialing, printing, and pharmacy benefit management. HSAG reviewed a sample of the delegation agreements to determine their compliance with federal requirements. The written agreements included language that required the subcontractor to comply with all applicable laws, regulations, and applicable subregulatory guidance and contract provisions.

COA's Delegation policy included a process that required the compliance officer or applicable business representative to conduct an evaluation of a potential subcontractor's ability to perform the functions of the agreement and comply with regulatory requirements. During the interview, a COA staff member discussed the process as it related to a credentialing agreement and submitted evidence of a completed pre-delegation audit.

Opportunities for Improvement and Recommendations

HSAG identified no opportunities for improvement for this standard.

Required Actions

HSAG reviewed a sample of the delegation agreements submitted by COA and found that the MCO did not maintain ultimate responsibility for subcontractor agreements. Staff members were unaware of contract status and were unable to communicate a current process that addresses corrective action plans (CAPs) in relation to subcontractor performance. COA must maintain ultimate responsibility of subcontractor agreements by ensuring centralized oversight (i.e., by the legal department) of all agreements and ensure that a process is outlined (e.g., a desktop procedure or policy) that addresses CAPs in relation to subcontractor performance.

COA's contract with OneTouchPoint Mountain States, LLC, did not include the delegated activities or obligations and related reporting responsibilities. During the interview, a COA staff member confirmed that the language was missing. COA must ensure that all contracts, including the one with OneTouchPoint Mountain States, LLC, specify the delegated activities or obligations and related reporting responsibilities.

HSAG reviewed a sample of contracts across the delegated activities and found the written agreements did not include all of the required language. COA must ensure, via revisions or amendments, that subcontractor agreements include the following language:

- 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 members.
  - The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
  - If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems

Evidence of Compliance and Strengths

HSAG reviewed COA's annual Quality Assessment and Performance Improvement (QAPI) documents, including its QAPI Program Description, the Annual Quality Report, and the Annual Quality Improvement Plan. Within its QAPI Program Description and Annual Quality Report, COA described a comprehensive program that included processes to address appropriateness of care, quality of care, and member experience. Quality and appropriateness of care for members with special healthcare needs was addressed through various care management initiatives and included the identification of treatment barriers and the supports needed to improve member health.

During the compliance interview, the quality director further described a thorough and comprehensive QAPI program that has evolved and grown over time to meet the changing needs of COA members and the health quality landscape of COA's service region in Colorado. The director described mechanisms used to address member over- and underutilization of services, which were delineated within COA's policies. Within its policies, COA described processes to monitor, assess, and intervene to reduce over- and underutilization of medically necessary services and ensure appropriate levels of care. Among the methods, COA monitored utilization through implementation of the Colorado Client Overutilization Program (COUP) to address members with high utilization of emergency department visits or prescription drug benefits. Other strategies included ongoing review of utilization criteria, identifying impatient utilization trends, assuring timely utilization management decisions, and a process that assessed the interrater reliability of decision-makers.

Grievance data, member survey results, secret shopper calls, and population-based data analyses were used by COA to evaluate access to care and identify areas of need.

COA adopted and disseminated clinical practice guidelines which were reviewed annually and included a process for soliciting feedback from contracted providers. The guidelines were posted to the COA website and were accessible to providers as well as members. COA established processes to communicate changes to the guidelines with internal teams to ensure consistency among various operational departments.

COA submitted a COA System Architecture diagram and a summary of the systems utilized by COA to manage health information data that included the following:

- HealthEdge HealthRules Payer: Payer transaction system to manage member enrollment and eligibility data as well as claims reimbursement and payments.
- HealthEdge GuidingCare: System that includes utilization and care management, claims appeals, and grievances.
- HealthProof ePlus: System for customer service call documentation.

COA staff members reported that health information data were collected and managed through multiple systems and configured through COA's enterprise data warehouse, which allowed COA to integrate and submit the necessary data to the Department in the required standardized 837 file format. COA described how claims, encounter, utilization, grievance, appeal, and other data were available for extraction from the data warehouse to complete analyses and reporting, calculate performance, and identify cost and care trends for use across the organization.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Required Actions

HSAG identified no required actions for this standard.

3. Background and Overview

Background

Public Law 111-3, Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, requires that each state's Children's Health Insurance Program (CHIP) apply several provisions of Section 1932 of the Social Security Act (the Act) in the same manner as the provisions apply under Title XIX of the Act. This requires managed care organizations (MCOs) to comply with provisions of the Code of Federal Regulations, Title 42 (42 CFR)—Medicaid and CHIP managed care regulations published May 6, 2016, which became applicable to CHIP MCOs effective July 1, 2018. Additional revisions were released in December 2020 and February 2023. The Department administers and oversees the Child Health Plan *Plus* (CHP+) program (Colorado's implementation of CHIP).

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

In order to evaluate the CHP+ MCOs' compliance with federal managed care regulations and State contract requirements, the Department determined that the review period for fiscal year (FY) 2023–2024 was calendar year (CY) January 1, 2023, through December 31, 2023. This report documents results of the FY 2023–2024 compliance review activities for COA. Section 1 includes the summary of scores for each of the standards reviewed this year. Section 2 contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 3 describes the background and methodology used for the FY 2023–2024 compliance monitoring review. Section 4 describes follow-up on the corrective actions required as a result of the FY 2022–2023 compliance review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B lists HSAG, CHP+ MCO, and Department personnel who participated in some way in the compliance review process. Appendix C describes the CAP process the CHP+ MCO will be required to complete for FY 2023–2024 and the required template for doing so. Appendix D contains a detailed description of HSAG's compliance review activities consistent with the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023.[3-1]

[3-1] 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*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Aug 8, 2023.

Overview of FY 2023–2024 Compliance Monitoring Activities

For the FY 2023–2024 compliance review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard V—Member Information Requirements, Standard VII—Provider Selection and Program Integrity, Standard IX—Subcontractual Relationships and Delegation, and Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems. Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the CHP+ MCO's contract requirements and regulations specified by the federal Medicaid and CHIP managed care regulations published May 6, 2016. Additional revisions were released in December 2020 and February 2023. HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable.* The Department determined that the review period was CY January 1, 2023, through December 31, 2023. HSAG reviewed materials submitted prior to the compliance review activities, materials requested during the compliance review, and considered interviews with key CHP+ MCO personnel to determine compliance with federal managed care regulations and contract requirements. Documents consisted of policies and procedures, staff training materials, reports, committee meeting minutes, and member and provider informational materials.

The compliance review processes were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Appendix D contains a detailed description of HSAG's compliance review activities consistent with those outlined in the CMS EQR protocol. The four standards chosen for the FY 2023–2024 compliance 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—Adequate Capacity and Availability of Services; Standard III—Coordination and Continuity of Care; Standard IV—Member Rights, Protections, and Confidentiality; Standard VI—Grievance and Appeal Systems; Standard VIII—Credentialing and Recredentialing; and Standard XII—Enrollment and Disenrollment.

Objective of the Compliance Review

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

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

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

FY 2022–2023 Corrective Action Methodology

As a follow-up to the FY 2022–2023 compliance review, each CHP+ MCO that received one or more *Partially Met* or *Not Met* scores was required to submit a CAP to the Department addressing those requirements found not to be fully compliant. If applicable, the CHP+ MCO was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the CHP+ MCO and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with COA until it completed each of the required actions from the FY 2022–2023 compliance monitoring review.

Summary of FY 2022–2023 Required Actions

For FY 2022–2023, HSAG reviewed Standard I—Coverage and Authorization of Services, Standard II—Adequate Capacity and Availability of Services, Standard VI—Grievance and Appeal Systems, and Standard XII—Enrollment and Disenrollment.

Related to Standard I—Coverage and Authorization of Services, COA was required to complete four the following required actions:

- Update its procedures to further delineate provider claims issues which are separate from member-related issues in which a service is denied or partially denied. Policies, procedures, and monitoring must be enhanced to ensure that the member is notified in writing of the denial or partial denial of a service.
- Enhance its monitoring procedures to ensure that all authorization decisions are made within required time frames.
- Make necessary system and procedural updates to ensure that templates being used for CHP+ denials do not include references to continuation of benefits or Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), but do include information about the member's right to appeal under the State's Children and Youth Mental Health Treatment Act (CYMHTA), when applicable.

Related to Standard II—Adequate Capacity and Availability of Services, HSAG identified no required actions.

Related to Standard VI—Grievance and Appeal Systems, COA was required to complete three required actions:

- Enhance its monitoring system to ensure that the appeal acknowledgement letters are sent within two working days.
- Eliminate any language that refers to continuation of benefits from its appeals resolution letters. COA must also clarify the language on its website (i.e., that continuation of benefits only applies to Medicaid lines of business and does not apply to CHP+ members) to be consistent with its policies.
- Remove the inaccurate statement in its Member Appeal Process policy that states that a member must follow an oral request for an appeal in writing.

Related to Standard XII—Enrollment and Disenrollment, HSAG identified no required actions.

Summary of Corrective Action/Document Review

COA submitted a proposed CAP in July 2023. HSAG and the Department reviewed and approved the proposed CAP and responded to COA. COA submitted final documentation and completed the CAP in October 2023.

Summary of Continued Required Actions

COA successfully completed the FY 2022–2023 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 members. *Note: Readily accessible means electronic information which complies with 508 guidelines, Section 504 of the Rehabilitation Act, and World Wide Web Consortium Web Content Accessibility Guidelines 2.0 Level AA and successor versions.* *42 CFR 438.10(c)(1)* CHP+ Contract Amendment 2: Exhibit B2—7.2.5 and 7.2.7.5	• ADM206 Culturally Sensitive Services for Diverse Populations • ADM207 Effective Communication with LEP and SI-SI Persons • ADM208 Member Materials • MKT DP03 Accessibility Standards - 508/ADA Compliance • MAC Minutes 5-16-23 ○ Pg 4 Member Materials	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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 Amendment 2: Exhibit B2—7.3.7.2.1.5	• CHP+ Welcome letter • CHP Member Handbook • COA Website ○ https://www.coaccess.com/members/chp/benefits/ ○ https://www.coaccess.com/members/chp/	☒ 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 Amendment 2: Exhibit B2—3.2 and 7.2.7.5	• CHP Member Handbook ○ Glossary pg106 in the document • PD Ops DP03 Monitoring Terminology in Contracts	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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. • Written materials that are critical to obtaining services include, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices. • 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 conspicuously visible font size 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)(2-3) and (d)(6)* CHP+ Contract Amendment 2: Exhibit B2—7.2.7.3.1 and 7.2.7.5-7	• ADM206 Culturally Sensitive Services for Diverse Populations o Procedure 2 A-B • ADM207 Effective Communication with LEP and SI-SI o Policy Section • ADM208 Member Materials o Definitions-Tagline o Policy 1-3 o Procedure 3 • MKT201 Printed Marketing/Informational and Corporate Branding Material o Procedure 2 A-D	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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 Amendment 2: Exhibit B2—7.3.12.1.1-5	• MKT203 Website Design Maintenance and Oversight • MKT DP03 Accessibility Standards 508/ADA Compliance • COA Website: https://www.coaccess.com/ ○ Accessibility Widget in lower left corner of screen • COA Website: ○ https://www.coaccess.com/members/services/	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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(h)(4)(i)* CHP+ Contract Amendment 2: Exhibit B2—7.3.7.1.2-3	• CHP Member Handbook ○ Member Benefits Covered Services Outpatient Pharmacy and Prescription Medication pg. 71-75 in the document • COA Website: ○ https://www.coaccess.com/providers/resources/pharmacy/	☒ 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 Amendment 2: Exhibit B2—7.2.6.2, 7.2.6.4, and 7.2.6.5	• ADM207 Effective Communication with LEP and SI-SI Persons ○ Policy Section • ADM208 Member Materials • CS DP28 Nextalk for TTY_TTD • CS DP29 Interpreting Services • COA Website: https://www.coaccess.com/members/services/	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor notifies members that oral interpretation is available for any language, written translation is available in prevalent languages, and auxiliary aids and services are available upon request at no cost for members with disabilities, and how to access them. *42 CFR 438.10(d)(5)* CHP+ Contract Amendment 2: Exhibit B2—7.2.6.4.1-3	• ADM207 Effective Communication with LEP and SI-SI Persons • CS DP29 Interpreting Services • Provider Manual ○ Section 2, page 2-1 Effective Communication and Language Assistance • See COA website and language options at top of page: www.coaccess.com	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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 2: Exhibit B2—7.3.7.1	• PD Ops DP02 CHP HMO New Member Mailing • COA Website: ○ https://www.coaccess.com/wp-content/uploads/2023/09/50-11-101-0823U_CHP-Member-Handbook_Full_Covers.pdf	☒ 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 Amendment 2: Exhibit B2—7.2.7.5	• ADM328 Significant Changes in Members Rights, Benefits or Processes	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor makes a good faith effort to give written notice of termination of a contracted provider by the later of 30 calendar days prior to the effective date of the termination, or 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 Amendment 2: Exhibit B2—7.3.9.1	• ADM300 Provider Terminations	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor shall develop and maintain a customized and comprehensive website that includes: • The CHP+ MCO's contact information. • Member rights and responsibilities. • Member handbook. • Grievance and appeal procedures and rights. • General functions of the CHP+ MCO. • Provider directory. • Access to care standards. • Colorado Crisis Services information. • A link to the Department's website for standardized information such as member rights and handbooks. CHP+ Contract Amendment 2: Exhibit B2—7.3.8	• COA Website: ○ https://www.coaccess.com/contact/ ○ https://www.coaccess.com/members/services/rights/ ○ https://www.coaccess.com/wp-content/uploads/2023/09/50-11-101-0823U_CHP-Member-Handbook_Full_Covers.pdf ○ https://www.coaccess.com/members/services/grievances/ ○ https://www.coaccess.com/members/chp/ ○ https://www.coaccess.com/ ▪ Find a Provider ○ https://www.coaccess.com/members/services/quality/ ○ https://www.coaccess.com/members/mentalhealth/	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	○ https://www.coaccess.com/members/services/resources/	
13. The Contractor makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, pharmacies, and behavioral health providers, and 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 members. • The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training. • Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment. *Note: Information included in a paper provider directory must be updated at least monthly and quarterly for a mobile enabled or electronic directory.* *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 Amendment 2: Exhibit B2—7.3.8.1.7-8	• Provider Directory Link: https://secure.healthx.com/s/COA_Provider_DIrectory (members may also access the directory by going to the Colorado Access website, and use the Find a Provider link)	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: COA's electronic provider directory did not include the provider website URLs as required.		
Required Actions: COA must update its provider directory to include the provider URLs.		
14. 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 Amendment 2: Exhibit B2—7.3.8.1.9	• Provider Directory Link: https://secure.healthx.com/s/COA_Provider_DIrectory (members may also access the directory by going to the Colorado Access website, and use the Find a Provider link)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. The member handbook provided to members following enrollment includes: • The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled. • Procedures for obtaining benefits, including authorization requirements and/or referrals for specialty care and for other benefits not furnished by the member's primary care provider. • 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.	• CHP+ HMO Member Handbook- ○ Summary of Covered Benefits pg. 14-17 in document ○ About your Health Care Coverage ▪ Primary Care Providers pg. 20 in document ▪ Choosing or Changing Your PCP pg. 21 in document ▪ Referrals p.23 in document ○ Member Benefits-Covered Services ▪ Family Planning pg. 31 in document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Any restrictions on the member's freedom of choice among network providers. • In the case of a counseling or referral service or CHP+ covered 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 Amendment 2: Exhibit B2—7.3.7.2.1.5-7, 7.2.7.2.1.9-10, and 10.3.2	▪ Provider Office Services pg.34 in document ○ Managing Care ▪ Preauthorization for Health Care Services pg.86 in document ▪ Utilization Management pg.91in document	
16. 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.	• CHP+ HMO Member Handbook- ○ Member Rights & Responsibilities pg.17-19 in document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Request and receive a copy of his or her medical records, and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for 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 Amendment 2: Exhibit B2—7.3.6.3 and 7.3.7.2.1.16.		
17. 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. *42 CFR 438.10(g)(2)(xi)* CHP+ Contract Amendment 2: Exhibit B2—7.3.7.2.1.23	• CHP+ HMO Member Handbook- ○ Complaints (Grievances) pg.97-98 in document ○ Appeals, pg. 99-101in document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. 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 Amendment 2: Exhibit B2—7.3.7.2.1.8.1-2, 7.3.7.2.1.8.4, and 7.3.7.2.1.8.7	• CHP+ HMO Member Handbook- ○ Member Benefits-Covered Services ▪ Urgent/After-Hours Care, Emergency Care and Travel Outside the Country, pg. 41-45 in document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
19. 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 CHP+ 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.	• CHP+ HMO Member Handbook- ○ Welcome pg.1-3 in document ▪ Do You Need Special Help with this Booklet? pg.1in document ○ Summary of Covered Benefits pg.16 in document ○ Changing your Information pg. 12 in document ○ Summary of Covered Benefits pg.14-17 in document ○ What You Pay (Cost Sharing)-For Enrollment & Services	☒ 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 Amendment 2: Exhibit B2—7.3.7.2, 7.3.7.2.1.2, 7.3.7.2.1.19.1, and 7.3.7.2.1.21	▪ Copayments (Cost Sharing) pg.24-26 in document ○ Other Legal information ▪ Preventing Fraud pg.103 in document ○ Member Benefits-Covered Services ▪ Ambulance Transportation Services pg.45-46 in document ○ Utilization Management pg. 91in document ○ Care Management and Disease Management pg. 91-92 in document ○ Footer on the bottom of every page: ▪ *Have questions? Need help? We are here to help you in the language you speak! Free interpretation services are available* Call us at 303-751-9021 or 888-214-1101 (toll free) TTY users should call or Email us	

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 Amendment 2: Exhibit B2—7.3.12	• CHP+ New Member Mailing • ADM207 Effective Communication with LEP and SI-SI Persons • ADM230 Member Disability Rights Request • See language on web, "For Our Members": ○ www.coaccess.com	☒ 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 Amendment 2: Exhibit B2—7.3.5.1.13	• PNS218 Physician Incentive Plans	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard V—Member Information Requirements							
Total	Met	=	20	X	1.00	=	20
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	21	**Total Score**		=	20
			Total Score ÷ Total Applicable			=	95%

Standard VII—Provider Selection 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 Amendment 2: Exhibit B2—9.1.7 and 9.1.10	• PNS202 Selection and Retention of Providers	☒ 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)* CHP+ Contract Amendment 2: Exhibit B2—9.2.3 and 9.2.3.3	• CR301 Provider Credentialing and Recredentialing • CR305 Assessment of Organizational Providers	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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.	• PNS202 Selection and Retention of Providers • CR301 Provider Credentialing and Recredentialing o Procedure #2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.12(a)(1) and (2) *42 CFR 438.214(c)* CHP+ Contract Amendment 2: Exhibit B2—9.1.8-9		
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 Amendment 2: Exhibit B2—9.1.11	• PNS202 Selection and Retention of Providers ○ Procedure #1.F • CR301 Provider Credentialing and Recredentialing • CR305 Assessment of Organizational Providers	☒ 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 Amendment 2: Exhibit B2—9.5.1.1	• PNS202 Selection and Retention of Providers ○ Procedure #1.G-H • PNS217 Single Case Agreements Policy • Provider Participation Agreement	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection 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. • The Contractor performs monthly monitoring against HHS_OIG's List of Excluded Individuals. *(This requirement also requires a policy.)* *42 CFR 438.214(d)* *42 CFR 438.610* CHP+ Contract Amendment 2: Exhibit B2—9.1.20	• CMP206 Sanction and Exclusion Screening • CR DP04 Ongoing Monitoring of Providers	☒ 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 Amendment 2: Exhibit B2—15.9.4.2	• CMP206 Sanction and Exclusion Screening • CMP DP08 Compliance Program Operations Manual ○ Conducting Exclusion Screens • CR DP04 Ongoing Monitoring of Providers	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: COA's policies and procedures stated that COA would not knowingly employ any staff members who are excluded from participation in federal health care programs. However, the policies and procedures did not state that COA would not knowingly employ any staff members who are *debarred* or *suspended*.		
Required Actions: COA must update its policies and procedures to align in full detail with the federal and State requirements.		

Standard VII—Provider Selection 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 Amendment 2: Exhibit B2—11.11.10	• CS212 Member Rights & Responsibilities • Provider Participation Agreement • Provider Manual Section 2 ○ Alternative Treatment Options	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection 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(a)(2)-(b)* CHP+ Contract Amendment 2: Exhibit B2—11.7	• Colorado Access does not object to providing any services under the contract • Provider Manual Section 2 ○ Moral or Religious Objections	☒ 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 Chief Executive Officer 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.	• SFY 23-24 Compliance Plan and Program Overview • CMP204 Compliance Education and Training • CMP211 Fraud Waste and Abuse • CMP212 False Claims Acts • CMP213 Internal Compliance Reviews • CM DP08 Compliance Operations Manual • Board of Directors FACC Charter • Code of Conduct • 2023 New Hire Training_Compliance FWA	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Training and education of the compliance officer, management, and organization's staff members for the federal and State standards and requirements under the contract. • Effective lines of communication between the compliance officer and the Contractor's employees. • Enforcement of standards through well-publicized disciplinary guidelines. • Implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks. • 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 Amendment 2: Exhibit B2—15.1.1 and 15.1.5.1-7		
11. The Contractor's administrative and management procedures to detect and prevent fraud, waste, and abuse include: • Written policies for all employees, subcontractors or agents that provide detailed information about the False Claims Act, including the right of employees to be protected as whistleblowers.	• SFY 23-24 Compliance Plan and Program Overview • CM DP08 Compliance Operations Manual ○ Overpayments	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• 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 455.23.) *42 CFR 438.608 (a)(6-8)* CHP+ Contract Amendment 2: Exhibit B2—1.14.1, 15.1.5.9, 15.1.6, and 15.7.1 10 CCR 2505-10, Section 8.076	○ Reporting Suspected Provider or Member Fraud-Suspending Payments • CMP211 Fraud Waste and Abuse • CMP212 False Claims Acts	
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	**Suggested Document:** Most recent Monthly Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report **Submitted Documents:** • CM DP08 Compliance Operations Manual ○ Overpayments ○ Member Services Verification • CS DP25 Change in Member Status • CHP+ Monthly FWA RPT_ 11-23	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
to have been delivered by network providers were received by members. *42 CFR 438.608 (a)(2-5)* CHP+ Contract Amendment 2: Exhibit B2—15.1.5.7.6, 15.3.1.1, and 15.3.1.3.2.1		
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 members. *42 CFR 438.608 (b)* CHP+ Contract Amendment 2: Exhibit B2—15.9.2	• CR301 Provider Credentialing and Recredentialing ○ Procedure #7 • CR305 Assessment of Organizational Providers ○ Procedure #2 • PNS 202 Selection and Retention of Providers ○ Procedure 1.B • Provider Participation Agreement	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor has procedures to provide to the State: • Written disclosure of any prohibited affiliation (as defined in 438.610). • Written disclosure of ownership and control (as defined in 455.104) • Identification within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract. *42 CFR 438.608(c)* CHP+ Contract Amendment 2: Exhibit B2—15.3.1.5.1.1, 15.9.4.3, and 15.10.4.2	• CMP 206 Sanction Screening • LGL DP02 Disclosure of Change in Ownership and Control • The State automatically adjusts capitation payments	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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 semi-annually to the State on recoveries of overpayments. *42 CFR 438.608(d)(2) and (3)* CHP+ Contract Amendment 2: Exhibit B2—15.1.5.8 and 15.3.1.2.4.4	• CM DP08 Compliance Operations Manual o Overpayments • CLM DP10 Provider Identified Claim Overpayments • Provider Manual Sections 2 & 6 o Overpayments	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection 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 2: Exhibit B2—15.12.2-4	• Provider Participation Agreement o Section C.7 • CM DP08 Compliance Operations Manual o Investigating and Reporting Member Balance Billing Issues	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard VII—Provider Selection and Program Integrity							
Total	Met	=	15	X	1.00	=	15
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	16	**Total Score**		=	15
Total Score ÷ Total Applicable						=	94%

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 Amendment 2: Exhibit B2—2.5.4.4	• ADM223 Delegation	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: During the interview, HSAG found that the MCO did not maintain ultimate responsibility for subcontractor agreements. First, the MCO submitted a delegated agreement for peer review services; however, the MCO staff members were unaware of the status of the contract. After consulting with other staff members, the MCO determined that the contract had been inactive for several years. Second, the MCO staff members were unable to communicate a current process that addresses CAPs in relation to subcontractor performance.		
Required Actions: The MCO must maintain ultimate responsibility for subcontractor agreements by ensuring centralized oversight (i.e., by the legal department) of all agreements. The MCO must also ensure that a process is outlined (e.g., a desktop procedure or policy) that addresses CAPs in relation to subcontractor performance.		
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*	• ADM223 Delegation	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
plan are not considered subcontractors. *42 CFR 438.230(b)(2) and (c)(1)* CHP+ Contract Amendment 2: Exhibit B2—2.5.4.4		
Findings: The MCO contract with OneTouchPoint Mountain States, LLC, did not include the delegated activities or obligations and related reporting responsibilities. During the interview, MCO staff members confirmed that the language was missing.		
Required Actions: The MCO must ensure that all contracts, including the contract with OneTouchPoint Mountain States, LLC, specify the delegated 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 CHP+ laws, regulations, including applicable subregulatory guidance and contract provisions. *42 CFR 438.230(c)(2)* CHP+ Contract Amendment 2: Exhibit B2—2.5.4.6	• ADM223 Delegation	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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.	• ADM223 Delegation	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– 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 members. – The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. – If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. *42 CFR 438.230(c)(3)* CHP+ Contract Amendment 2: Exhibit B2—15.10.11		
Findings: HSAG reviewed a sample of contracts across the delegated activities and found the written agreements did not include all of the required information.		
Required Actions: The MCO must ensure, via revisions or amendments, that subcontractor agreements include: • 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 members. – The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.		

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– 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. **Recommendation**: HSAG recommends that the MCO consider implementing a regular (e.g., annual) review of subcontractor agreements to verify their active status and ensure they are compliant.		

Results for Standard IX—Subcontractual Relationships and Delegation							
Total	Met	=	1	X	1.00	=	1
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	4	**Total Score**		=	1
				Total Score ÷ Total Applicable		=	25%

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. *42 CFR 438.330(a)(1)* CHP+ Contract Amendment 2: Exhibit B-2—14.1.1	• Quality Assessment and Performance Improvement Program ○ Quality Assessment and Performance Improvement Summary and Program Description pages 4-7 (as identified in the document) • Annual Quality Report CHP+ MCO ○ Quality Assessment and Performance Improvement page 1 (as identified in the document) • Annual Quality Improvement Plan CHP+ MCO ○ Quality Assessment and Performance Improvement pages 1-2 (as defined in the document)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor's QAPI Program includes conducting and submitting (to the State) annually and when requested by the Department performance improvement projects (PIPs) that focus on both clinical and nonclinical areas. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. Each PIP includes the following: • Measurement of performance using objective quality indicators. • Implementation of interventions to achieve improvement in the access to and quality of care. • Evaluation of the effectiveness of the interventions based on the objective quality indicators.	• Quality Assessment and Performance Improvement Program ○ Performance Improvement Projects page 17 (as identified in the document) • Annual Quality Report CHP+ MCO ○ Performance Improvement Projects pages 7-9 (as identified in the document) • Annual Quality Improvement Plan CHP+ MCO	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Planning and initiation of activities for increasing or sustaining improvement. *42 CFR 438.330(b)(1) and (d)(2) and (3)* CHP+ Contract Amendment 2: Exhibit B-2—14.2.1.1 and 14.3	○ Performance Improvement Projects page 10 (as identified in the document)	
3. The Contractor's QAPI Program includes collecting and submitting (to the State) annually: • Performance measure data using standard measures identified by the State. • Data, specified by the State, which enable the State to calculate the Contractor's performance using the standard measures identified by the State. • A combination of the above activities. *42 CFR 438.330(b)(2) and (c)* CHP+ Contract Amendment 2: Exhibit B2—14.4	• Quality Assessment and Performance Improvement Program ○ Performance Measurement pages 15-16 (as identified in the document) • Annual Quality Report CHP+ MCO ○ Collection and Submission of Performance Measurement Data pages 10-24 (as identified in the document) • Annual Quality Improvement Plan CHP+ MCO ○ Collection and Submission of Performance Measurement Data pages 11-13 (as identified in the document)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42 CFR 438.330(b)(3)* CHP+ Contract Amendment 2: Exhibit B-2—14.6	• UM101 Criteria for Utilization Review • UM102 Utilization Review Determinations • Quality Assessment and Performance Improvement Program ○ Under-utilization and Over-utilization of Services pages 11-12 (as identified in the document) • Annual Quality Report CHP+ MCO	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	○ Under and Over-Utilization of Services pages 32-41 (as identified in the document) • Annual Quality Improvement Plan CHP+ MCO ○ Under and Over-Utilization of Services pages 14-17 (as identified in the document)	
5. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. *Note: Persons with special health care needs shall mean persons having ongoing health conditions that have a biological, psychological, or cognitive basis; have lasted or are estimated to last for at least one year; and produce one or more of the following: (1) a significant limitation in areas of physical, cognitive, or emotional function; (2) dependency on medical or assistive devices to minimize limitation of function or activities; (3) for children: significant limitation in social growth or developmental function; need for psychological, educational, medical, or related services over and above the usual for the child's age; or special ongoing treatments such as medications, special diets, interventions or accommodations at home or at school.* *42 CFR 438.330(b)(4)* CHP+ Contract Amendment 2: Exhibit B2—14.6.1	• Quality Assessment and Performance Improvement Plan ○ Quality, Safety, and Appropriateness of Clinical Care and Members with Special Health Care Needs page 15 (as identified in the document) • Annual Quality Report CHP+ MCO ○ Quality and Appropriateness of Care Furnished to Members pages 42-43 (as identified in the document) • Annual Quality Improvement Plan CHP+ MCO ○ Quality and Appropriateness of Care Furnished to Members page 17 (as identified in the document) • QM302 Quality Review of Provider Medical Records	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor monitors members' perceptions of accessibility and adequacy of services provided, including: • Member surveys. • Anecdotal information. • Grievance and appeals data. • Call center data. • Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[A-1] surveys. CHP+ Contract Amendment 2: Exhibit B-2—14.5.2-3	• Quality Assessment and Performance Improvement Plan ○ Access and Availability of Services page 11 (as identified in the document) • Annual Quality Report CHP+ MCO ○ Member Experience of Care pages 25-31 (as identified in the document) • Annual Quality Improvement Plan CHP+ MCO ○ Member Experience of Care pages 13-14 (as identified in the document)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program at least annually. *42 CFR 438.330(e)(2)* CHP+ Contract Amendment 2: Exhibit B-2—14.2.5	• Quality Assessment and Performance Improvement Program ○ QAPI Program Impact and Effectiveness Analysis pages 19-20 (as identified in the document) ○ Appendix A: QAPI Self-Assessment Tool pages 22-27 (as identified in the document)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor adopts or develops practice guidelines that meet the following requirements: • Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. • Consider the needs of the Contractor's members.	• QM311 Clinical Practice Guidelines • Clinical Practice Guideline Annual Review • Colorado Access Provider Manual Section 3 ○ Clinical Practice Guidelines page 8 (as identified in the document) • Colorado Access Website	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

[A-1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Are adopted in consultation with participating providers. • Are reviewed and updated periodically, as appropriate. *42 CFR 438.236(b)* CHP+ Contract Amendment 2: Exhibit B-2—10.5.8.2-4	○ https://www.coaccess.com/providers/resources/quality/	
9. The Contractor adopts or develops practice guidelines for the following: • Perinatal, prenatal, and postpartum care. • Conditions related to persons with a disability or special health care needs. • Well-child care. CHP+ Contract Amendment 2: Exhibit B-2—10.5.8.1	• QM311 Clinical Practice Guidelines • Colorado Access Provider Manual Section 3 ○ Clinical Practice Guidelines page 8 (as identified in the document) • Colorado Access Website ○ https://www.coaccess.com/providers/resources/quality/	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor disseminates the guidelines to all affected providers and, upon request, members, and potential members. *42 CFR 438.236(c)* CHP+ Contract Amendment 2: Exhibit B-2—10.5.8	• QM311 Clinical Practice Guidelines • Colorado Access Provider Manual Section 3 ○ Clinical Practice Guidelines page 8 (as identified in the document) • Colorado Access Website ○ https://www.coaccess.com/providers/resources/quality/ • Provider Update from Colorado Access	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42 CFR 438.236(d)* CHP+ Contract Amendment 2: Exhibit B-2—10.5.8.5	• QM311 Clinical Practice Guidelines • UM101 Medical Criteria for Utilization Review	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42 CFR 438.242(a)* CHP+ Contract Amendment 2: Exhibit B-2—13.1.1 and 15.10.2	• Systems to Manage Health Information Data • COA System Architecture	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
13. The Contractor's health information system provides information about areas including but not limited to utilization, claims, grievances and appeals, and disenrollment for other than loss of CHP+ eligibility. *42 CFR 438.242(a)* CHP+ Contract Amendment 2: Exhibit B-2—8.1 and 13.1.1	• CHP DP04 Monitoring Plan Terminations • Systems to Manage Health Information Data • COA System Architecture	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor's claims processing and retrieval systems collect data elements necessary to enable the mechanized claims processing and information retrieval systems operated by the State. • Contractor electronically submits encounter claims data in the interChange ANSI X12N 837 format directly to the Department's fiscal agent using the Department's data transfer protocol. The 837-format encounter claims	• COA System Architecture • 2.0 Claims and Encounters	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
(reflecting claims paid, adjusted, and/or denied by the Contractor) shall be submitted via a regular batch process. *42 CFR 438.242(b)(1)* CHP+ Contract Amendment 2: Exhibit B-2—13.1.6.3		
15. The Contractor collects data on member and provider characteristics and on services furnished to members through an encounter data system (or other methods specified by the State). *42 CFR 438.242(b)(2)* CHP+ Contract Amendment 2: Exhibit B-2—13.1.5.1 and 13.1.6.2	• COA System Architecture • 2.0 Claims and Encounters • Systems to Manage Health Information Data	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. The Contractor ensures that data received from providers are accurate and complete by: • Verifying the accuracy and timeliness of reported data, including data from network providers compensated through capitation payments. • Screening the data for completeness, logic, and consistency. • Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies used for CHP+ quality improvement and care coordination efforts. *42 CFR 438.242(b)(3) and (4)* CHP+ Contract Amendment 2: Exhibit B-2—13.1.6 and 13.1.7.1.2.1	• Mechanisms to Ensure Accurate and Complete Data • Systems to Manage Health Information Data	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The Contractor: • Collects and maintains sufficient member encounter data to identify the provider who delivers any items or services to members. • Submits member encounter data to the State in Accredited Standards Committee (ASC) X12N 837, National Council for Prescription Drug Programs (NCPDP), and ASC X12N 835 formats as appropriate. • Submits member encounter data to the State at the level of detail and frequency specified by the State. *42 CFR 438.242(c)* CHP+ Contract Amendment 2: Exhibit B-2—13.1.6.2-3 and 13.1.6.4-5	• 2.0 Claims and Encounters	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems							
Total	Met	=	17	X	1.00	=	17
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	17	**Total Score**		=	17
				Total Score ÷ Total Applicable		=	100%

Appendix B. Compliance Review Participants

Table B-1 lists the participants in the FY 2023–2024 compliance review of COA.

Table B-1—HSAG Reviewers and COA and Department Participants

HSAG Review Team	Title
Gina Stepuncik	Associate Director
Sarah Lambie	Associate Director
Cynthia Moreno	Project Manager III
Crystal Brown	Project Manager I
COA Participants	**Title**
Amanda Fitzsimons	Manager of Compliance and Privacy
Marcy Mullan	Director of Compliance
Richard Akoto	Policy and Privacy Specialist
Lisa Hug	Director of Program Operations
John Priddy	Vice President of Health Plan Operations
Ward Peterson	Director of Enrollment and Child Health Plan Plus
Taylor Mitchell	Child Health Plan Plus Program Manager
Reyna Garcia	Senior Director of Customer Service
Michelle Tomsche	Director of Claims, Operations, and Research
Jeni Sargent	Director of Member and Provider Data Integrity
Beth Coleman	Director of Provider Contracting
Anne Taylor	Provider Recruitment Program Manager
Travis Roth	Manager of Credentialing and Provider Data
Mika Gans	Director of Quality Improvement
Sarah Thomas	Quality Improvement Program Manager
Lauren Ratliff	Quality Improvement Program Manager
Jason Beard	Senior Web Manager
Kellen Roth	Director of Member Affairs
Thomas Mayo	Director of Utilization Management
Kris Cooper	Supervisor of Behavioral Health
Josette Hizon	Supervisor of Behavioral Health
Kathy Nyberg	Manager of Legal Services
Dana Pepper	Vice President of Provider Performance and Network Services

Department Observers	Title
Russell Kennedy	Quality Program Manager
Blue Parish	Program Specialist
Matthew Pfeifer	Unit Supervisor
Sandra Wetenkamp	Network Accountability Specialist
Hilary Erickson	Child Health Plan Plus Integrity Specialist
Jerry Ware	Quality Contract Manager
Helen Desta-Fraser	Quality Section Manager

Appendix C. Corrective Action Plan Template for FY 2023–2024

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

Table C-1—Corrective Action Plan Process

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

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

The CAP template follows on the next page.

Table C-2—FY 2023–2024 Corrective Action Plan for COA CHP+

Standard V—Member Information Requirements
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
13. The Contractor makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, pharmacies, and behavioral health providers, and 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 members. • The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training. • Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment. *Note: Information included in a paper provider directory must be updated at least monthly and quarterly for a mobile enabled or electronic directory. 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 Amendment 2: Exhibit B2—7.3.8.1.7-8
Findings
COA's electronic provider directory did not include the provider website URLs as required.
Required Actions
COA must update its provider directory to include the provider URLs.
Planned Interventions

Standard V—Member Information Requirements
Person(s)/Committee(s) Responsible
Training Required
Monitoring and Follow-Up Activities Planned
Documents to Be Submitted as Evidence of Completion
HSAG Initial Review:
Documents Included in Final Submission: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***
Date of Final Evidence:

Standard VII—Provider Selection and Program Integrity
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
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 Amendment 2: Exhibit B2—15.9.4.2
Findings
COA's policies and procedures stated that COA would not knowingly employ any staff members who are excluded from participation in federal health care programs. However, the policies and procedures did not state that COA would not knowingly employ any staff members who are *debarred* or *suspended*.
Required Actions
COA must update its policies and procedures to align in full detail with the federal and State requirements.
Planned Interventions
Person(s)/Committee(s) Responsible
Training Required

Standard VII—Provider Selection and Program Integrity
Monitoring and Follow-Up Activities Planned
Documents to Be Submitted as Evidence of Completion
HSAG Initial Review:
Documents Included in Final Submission: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***
Date of Final Evidence:

Standard IX—Subcontractual Relationships and Delegation
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
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 Amendment 2: Exhibit B2—2.5.4.4
Findings
During the interview, HSAG found that the MCO did not maintain ultimate responsibility for subcontractor agreements. First, the MCO submitted a delegated agreement for peer review services; however, the MCO staff members were unaware of the status of the contract. After consulting with other staff members, the MCO determined that the contract had been inactive for several years. Second, the MCO staff members were unable to communicate a current process that addresses CAPs in relation to subcontractor performance.
Required Actions
The MCO must maintain ultimate responsibility for subcontractor agreements by ensuring centralized oversight (i.e., by the legal department) of all agreements. The MCO must also ensure that a process is outlined (e.g., a desktop procedure or policy) that addresses CAPs in relation to subcontractor performance.
Planned Interventions
Person(s)/Committee(s) Responsible

Standard IX—Subcontractual Relationships and Delegation
Training Required
Monitoring and Follow-Up Activities Planned
Documents to Be Submitted as Evidence of Completion
HSAG Initial Review:
Documents Included in Final Submission: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***
Date of Final Evidence:

Standard IX—Subcontractual Relationships and Delegation
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
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 Amendment 2: Exhibit B2—2.5.4.4
Findings
The MCO contract with OneTouchPoint Mountain States, LLC, did not include the delegated activities or obligations and related reporting responsibilities. During the interview, MCO staff members confirmed that the language was missing.
Required Actions
The MCO must ensure that all contracts, including the contract with OneTouchPoint Mountain States, LLC, specify the delegated activities or obligations and related reporting responsibilities.
Planned Interventions

Standard IX—Subcontractual Relationships and Delegation
Person(s)/Committee(s) Responsible
Training Required
Monitoring and Follow-Up Activities Planned
Documents to Be Submitted as Evidence of Completion
HSAG Initial Review:
Documents Included in Final Submission: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***
Date of Final Evidence:

Standard IX—Subcontractual Relationships and Delegation
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
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 members. – The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. – If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. *42 CFR 438.230(c)(3)* CHP+ Contract Amendment 2: Exhibit B2—15.10.11
Findings
HSAG reviewed a sample of contracts across the delegated activities and found the written agreements did not include all of the required information.
Required Actions
The MCO must ensure, via revisions or amendments, that subcontractor agreements include: • 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 members.

Standard IX—Subcontractual Relationships and Delegation
– 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. HSAG recommends that the MCO consider implementing a regular (e.g., annual) review of subcontractor agreements to verify their active status and ensure they are compliant.
Planned Interventions
Person(s)/Committee(s) Responsible
Training Required
Monitoring and Follow-Up Activities Planned
Documents to Be Submitted as Evidence of Completion
HSAG Initial Review:

Standard IX—Subcontractual Relationships and Delegation
Documents Included in Final Submission: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***
Date of Final Evidence:

Appendix D. 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*, February 2023.

Table D-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the review to assess compliance with federal managed care regulations and Department contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop desk request forms, compliance monitoring tools, report templates, agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all reviewers to ensure consistency in scoring across MCEs.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided MCEs with proposed review dates, group technical assistance, and training, as needed. • HSAG confirmed a primary MCE contact person for the review and assigned HSAG reviewers to participate in the review. • Sixty days prior to the scheduled date of the review, HSAG notified the MCE in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and review agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and the review activities. Thirty days prior to the review, the MCE provided documentation for the desk review, as requested. • Documents submitted for the review consisted of the completed desk review form, the compliance monitoring tool with the MCE's section completed, policies and procedures, staff training materials, reports, minutes of key committee meetings, and member and provider informational materials. • The HSAG review team reviewed all documentation submitted prior to the review and prepared a request for further documentation and an interview guide to use during the review.

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct the Review**
	• During the review, HSAG met with groups of the MCE's key staff members to obtain a complete picture of the MCE's compliance with federal healthcare regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the MCE's performance. • HSAG requested, collected, and reviewed additional documents as needed. • At the close of the review, HSAG provided MCE staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2023–2024 Department-approved Compliance Review Report template to compile the findings and incorporate information from the pre-review and review activities. • HSAG analyzed the findings and calculated final scores based on Department-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the Department**
	• HSAG populated the Department-approved report template. • HSAG submitted the draft Compliance Review Report to the MCE and the Department for review and comment. • HSAG incorporated the MCE and Department comments, as applicable, and finalized the report. • HSAG included a pre-populated CAP template in the final report for all elements determined to be out of compliance with managed care regulations. • HSAG distributed the final report to the MCE and the Department.