COLORADO

Department of Health Care Policy & Financing

Fiscal Year 2022–2023 Compliance Review Report

for

Denver Health Medical Plan

Region 5 Managed Care Organization

April 2023

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

In accordance with its authority under Colorado Revised Statute 25.5-1-101 et seq., the Department of Healthcare Policy & Financing (the Department) executed a contract with **Denver Health Medical Plan** (**DHMP**), effective January 1, 2020, to serve as a managed care capitation initiative within the Accountable Care Collaborative (ACC) program. **DHMP** provides the managed care capitation initiative physical health (PH) benefits and the capitated behavioral health (BH) benefits for the Region 5 Medicaid population enrolled with **DHMP**. Per the Code of Federal Regulations, Title 42 (42 CFR)—federal Medicaid managed care regulations published May 6, 2016—**DHMP** qualifies as a managed care organization (MCO). 42 CFR requires Primary Care Case Management (PCCM) entities, Prepaid Inpatient Health Plans (PIHPs), and MCOs to comply with specified provisions of 42 CFR §438—managed care regulations—and requires that states conduct a periodic evaluation of their managed care entities (MCEs), including PCCM entities, PIHPs, and MCOs, to determine compliance with Medicaid managed care regulations published May 6, 2016. Additional revisions were released in November 2020, with an effective date of December 2020. The Department has elected to complete this requirement for the MCOs by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This report documents results of the fiscal year (FY) 2022–2023 compliance review activities for **DHMP**. For each of the four standard areas reviewed this year, this section contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 2 describes the background and methodology used for the FY 2022–2023 compliance monitoring review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2021–2022 compliance review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the denials of authorization of services (denials), grievances, and appeals record review tools. Appendix C lists HSAG, MCO, and Department personnel who participated in some way in the compliance review process. Appendix D describes the corrective action plan (CAP) process that the MCO will be required to complete for FY 2022–2023 and the required template for doing so. Appendix E 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*, October 2019.[1-1]

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Feb 24. 2023 At the start of FY 2022–2023 compliance review, CMS had not finalized the 2022 CMS EQR Protocol 4; therefore, the 2019 CMS EQR Protocol 3 was used for the period under review.

Summary of Compliance Results

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

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

Table 1-1—Summary of Scores for Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
I. Coverage and Authorization of Services	33	33	32	1	0	0	97%
II. Adequate Capacity and Availability of Services	13	13	12	1	0	0	92%
VI. Grievance and Appeal Systems	35	35	28	7	0	0	80%
XII. Enrollment and Disenrollment	6	6	6	0	0	0	100%
Totals	**87**	**87**	**78**	**9**	**0**	**0**	**90%**

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

Table 1-2 presents the scores for **DHMP** for the denials, grievances, and appeals record reviews. Details of the findings for the record reviews are in Appendix B—Record Review Tools.

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Denials	100	68	58	10	32	85%
Grievances	60	51	51	0	9	100%
Appeals	60	54	53	1	6	98%
Totals	**220**	**173**	**162**	**11**	**47**	**94%**

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

Standard I—Coverage and Authorization of Services

Evidence of Compliance and Strengths

Documentation submitted by **DHMP** addressed procedures to ensure sufficient covered services, furnished to members in alignment with requirements for processing requests for authorization of services. Criteria used for service authorization decisions included the Department's definition of "medical necessity" which included Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), and the use of Milliman Care Guidelines, American Society of Addiction Medicine (ASAM) level of care criteria, and Hayes, Inc. Knowledge Center Guidelines. In addition to the **DHMP** medical director's review, the subcontractor All-Med Healthcare Management physician specialists performed clinical reviews that were outside the scope of a family physician.

Interrater reliability (IRR) testing most recently occurred in August 2022, and staff members reported that the passing rate was 97 percent. **DHMP** leadership decided to raise the passing rate from 80 percent to 90 percent to align with Colorado Access (COA). Additionally, **DHMP** intends to reduce passing attempts from three attempts to two. Monthly peer-to-peer reviews of randomly selected charts provide an additional opportunity for utilization management (UM) staff members to receive feedback throughout the year. **DHMP** monitored COA IRR results via a semiannual process; the most recent reported results from December 2022 met the 90 percent passing rate. All-Med's most recent IRR results met the current requirement of 85 percent, with the lowest score reported at 86 percent and an average score of 91 percent.

DHMP's notice of adverse benefit determination (NABD) letters reviewed demonstrated the following strengths:

- All denial record reviews were processed within timeliness standards.
- The letters contained most of the required information.
- The letters were easy for the member to understand, scoring at or around the sixth-grade reading level.
- Requests that were due to out-of-network providers included member-specific information and confirmation that timely appointments were available within the **DHMP** network. One letter noted that the member would be referred to case management, and another noted that a **DHMP** staff member would outreach the member to set an appointment. HSAG recognizes this communication and follow-up as a best practice.

Finally, **DHMP**'s submitted documents, including the Adjudication of Urgent Care, Emergency Care, Emergency Observation, and Emergency Admission and Post Stabilization Claims policies, accurately defined "emergency services," "emergency conditions," and "poststabilization" and outlined procedures in accordance with federal and State requirements. Staff members described how the claims processing system ensured that emergency claims with specific place of service codes were set up to pay without the need for UM review. UM department staff members described additional monitoring if a pended

claim resulted from a provider coding issue, and staff members confirmed that the review still followed the prudent layperson's definition of "emergency" and that they only reviewed to ensure the accuracy of the service and location.

Opportunities for Improvement and Recommendations

HSAG recommends the following policy updates:

- Include one cohesive definition of "medical necessity" that incorporates ASAM and EPSDT definitions in one location rather than across multiple documents.
- Regarding service authorization extensions, clarify that **DHMP** will justify *to the Department, upon request*, a need for additional information.
- Clarify that the NABD is mailed for denial of payment, *at the time of any denial affecting the claim* and for service authorization decisions not reached within the required time frames, on the date the time frames expire.
- The Utilization Review policy stated that **DHMP** does not reduce, suspend, or terminate previously authorized services. However, HSAG recommends clarifying the exceptions to the 10-day prior notification in the Job Aid: Duplicates and Authorization Change Requests. **DHMP** included many but not all exceptions.
  - The Contractor receives a clear written statement signed by the member that the member no longer wishes services or gives information that requires termination or reduction of services and indicates that the member understands that this must be the result of supplying that information.
  - The member's whereabouts are unknown.
  - A change in the level of medical care is prescribed by the member's physician.
  - For cases of fraud, notice is given *five days before* the intended effective date.

HSAG recommends updating NABD template language to remove language that may be confusing to the member such as "not a covered benefit" when the denial is solely regarding out-of-network requests.

The NABD letter included language to the member, "You may want to talk about this decision with your doctor to make sure that all of the information needed to support the request was given to us. Your doctor can discuss this decision with our Medical Doctor by calling us." This language conflicts with the intent of the requirement which is to complete the peer-to-peer consultation *prior* to making the denial decision and notifying the member. Any peer-to-peer conversations after the issuance of a NABD must occur through the appeal process. **DHMP** should clarify that, when appropriate, staff members outreach the requesting provider to attempt to obtain additional clinical information prior to making an authorization decision and prior to notifying the member regarding the denial.

Required Actions

DHMP must update its NABD templates to ensure accurate information and must develop a process to ensure that the updated NABD is used consistently. The updated NABD template must:

- Include the date the appeal is due.
- Remove references indicating that members must submit a signed copy of an appeal.
- Inform members that they may receive a complete copy of their file, *at no cost*, upon request.
- Include that a State fair hearing may be requested within 120 days from the *adverse appeal resolution*.
- Clarify that peer-to-peer reviews after issuance of the NABD will occur as part of the appeal process.
- Clarify the denial decision date in headings rather than using the terminology "Effective Date of Denial." The preamble of the original Balanced Budget Act included references to the effective date of the action, but that reference applied to notices which were terminating or reducing services (which is not allowed under the Department of Insurance). Regarding the Department's intended use of the NABD template, HSAG received the following instruction:
  - New requests should include the date the determination was made.
  - Concurrent reviews should include the date the current authorization expires or the first nonauthorized day.
  - In the rare instance of a termination, suspension, etc. (pursuant to §438.420—prior to the end of an authorization period), it would be a date 10 days in the future as a 10-day advance notice is required (again, **DHMP** would want to change the word "on" to "effective" for ease of reading). For example, "We made the decision to deny services on 1/1/23, for all service dates requested." Using "effective" would apply when there may be a future date involved, such as the concurrent review and subsequent denial of a request for additional services.

Standard II—Adequate Capacity and Availability of Services

Evidence of Compliance and Strengths

The Network Adequacy Plan, quarterly network reports, GeoAccess reports, and other submitted documents described a provider network through the Denver Health and Hospital Authority (DHHA) employed providers, contracted network (ADD LIST), and specialists.

Staff members described oversight and monitoring of access to care through the Provider Relations Committee, the higher-level Quality Management Committee, and the Problem Solvers workgroup that takes a hands-on approach to reviewing access trends and opportunities.

The *DHHA Annual Training* included topics related to cultural competency such as embracing diversity, ensuring inclusion, maximizing positive interactions with members and their caregivers/family, and other methods to ensure members feel "comfortable, cared for, and valued." Staff members described ongoing targeted efforts for lesbian, gay, bisexual, transgender, and queer (LGBTQ), criminal justice, foster care, and refuge members, and the training addressed ways to support members with body type diversity to ensure correctly sized medical equipment. Submitted documents such *as Cultural and Linguistic Appropriate Services* and *Evaluating Members Non-English Language Needs* policies further detailed **DHMP**'s methods to ensure care for members needing physical and medical accommodations and linguistic supports. During the review period, **DHMP** also hired a health equity director to ensure that health equity components are woven throughout the **DHMP** system. The provider contract outlined detailed expectations related to accessibility and cultural competence and the Provider Directory tips document as well as the online provider directory website included the ability to query and filter for providers with different types of accessibility.

Opportunities for Improvement and Recommendations

Quarterly network reports indicated an opportunity to continue working with COA and the Department to identify ways to improve compliance with time and distance standards for substance use disorder (SUD) treatment practitioners (i.e., ASAM levels 3.3, 3.7 and 3.7WM). ASAM level of care 3.3 had particularly low compliance, whereas levels of care 3.7 and 3.7 WM were reported having 93 percent to 94 percent compliance in quarter 1 of FY 2022–2023.

Additionally, staff members and network reports detailed ongoing data issues with member addresses that resulted in a portion (roughly 1,000 members, less than 1 percent) of the network reporting as not met or not reported due to records placing the member outside of the contracted region after geocoding. In 85 percent of these cases, data suggest that the address is accurate but the county is incorrect. HSAG recommends ongoing conversations with the Department to improve data accuracy to monitor the **DHMP** network more clearly against eligible members in the applicable counties.

The Provider Access Survey presentation from quarter 3 2022 indicated that contracted providers had low compliance with timely appointments. HSAG recommends reintroducing CAPs when the focus of

larger efforts begins to move away from the coronavirus disease 2019 (COVID-19) public health emergency.

Required Actions

The **DHMP** Medicaid (MCD) member handbook included physical health appointment timeliness content but did not include behavioral health appointment timeliness standards. Additionally, the Network Plan stated that urgently needed services are available within 48 hours of being requested by the member or the member's provider(s). **DHMP** must update its MCD member handbook to include behavioral health appointment timeliness standards and its Network Plan to include the 24-hour urgent care timeliness requirement.

Standard VI—Grievance and Appeal Systems

Evidence of Compliance and Strengths

DHMP submitted a thorough policy and procedure that indicates a sufficient process to accept, document, and respond to grievances and appeals. Evidence of these policies and procedures included an Appeal Process, Grievance Process, Provider Manual, Grievance and Appeals quarterly reports, grievance acknowledgement letter templates, appeal acknowledgement letter templates, and expedited downgrade letter template. In all policies and other submitted documents, **DHMP** identified who can file and how to file a grievance, an appeal, and State fair hearing. **DHMP** has a standardized system, Altruista Health's Guiding Care, that accurately tracks all information and data related to grievances and appeals.

Staff reported that they very rarely miss a deadline when sending grievance and appeal acknowledgment letters and resolution letters to members. Specifically, the grievance and appeal manager stated that if a coordinator ever missed a deadline, an intervention and prevention task would be implemented during staff biweekly one-on-one meetings to avoid any future delays in sending these letters.

When a provider files an appeal on behalf of a member, in addition to sending a written acknowledgement letter to the member, **DHMP** will verbally contact the provider to request additional documents and inform the provider that documents can be submitted via Epic Systems Corporation's online system. Additionally, when an appeal was denied due to the provider or a facility incorrectly billing the wrong code, staff reported that they would outreach that provider or facility to ensure the member was not responsible due to an error on behalf of the provider or facility.

Grievance and appeal notices were written at approximately a sixth-grade reading level. **DHMP** consistently met the timeliness requirements for grievance acknowledgement and resolution notices as well as for appeal resolution letters. **DHMP**'s MCO grievance record reviews showed 100 percent

compliance. **DHMP** demonstrated strong monitoring over grievances and appeals and conducted regular committee meetings to discuss issues.

Opportunities for Improvement and Recommendations

All opportunities for improvement HSAG identified resulted in a required action.

Required Actions

On page 3, **DHMP**'s Appeal Process stated the accurate time frame for a member to file an appeal, set by the State. However, on page 5 the Appeal Process stated that a specialist at **DHMP** would write the member's appeal and send it with the acknowledgement letter, and that the member is required to sign and return the written appeal within 10 working days. **DHMP** must remove any language from the Appeal Process that requires the member to sign and return a written appeal it to **DHMP**.

DHMP's MCO appeal record reviews demonstrated compliance with 98 percent of elements reviewed. Although **DHMP**'s appeal process stated that a written acknowledgement letter for an appeal would be sent out within two working days of receipt, the MCO's appeal sample case file 8 did not include a written acknowledgement letter. During the review, **DHMP** reported that communications were completed orally with the member and that the member then requested a standard appeal. The resolution was mailed to the member within three days, overturning the denial decision. However, the written acknowledgement letter was not issued. **DHMP** must ensure that timely written acknowledgement letters for appeals are sent even when a member withdraws an expedited appeal and the appeal is downgraded to a standard appeal.

DHMP included accurate information in the Appeal Process and member appeal acknowledgement letters that informed members that they have reasonable opportunity to present evidence, testimony, and make legal and factual arguments and that they had limited time available for this sufficiently in advance of the resolution time frame in the case of an expedited resolution. However, **DHMP**'s Medicaid Choice Grievance and Appeals "After you file an appeal" section of its website and the MCO's NABD letters do not include that this information would be provided free of charge and sufficiently in advance of the appeal resolution time frame, upon request. **DHMP** must update its NABDs and the Medicaid website to inform the member or member's representative that this information must be provided free of charge and sufficiently in advance of the appeal resolution time frame, upon request.

The **DHMP** Medicaid website stated that expedited appeal decisions are to be made no later than three working days after receiving the appeal. However, federal regulation set forth the time frame for expedited resolution to not exceed 72 hours. The website sections "Filing an expedited (quick) appeal" and "After you file an appeal" must be updated to reflect the accurate time frame of 72 hours set forth by federal and State regulation.

The appeal acknowledgement and resolution templates did not include accurate information about continuation of benefits during a State fair hearing. **DHMP** must update its appeal acknowledgement

and resolution templates to state that *both* the State fair hearing and continuation of benefits must be requested within 10 days of the appeal resolution letter not in the member's favor. HSAG recommends removing language related to continuation of benefits if the denial that is being appealed is not regarding a previously authorized service that has been terminated, suspended, or reduced.

In addition, **DHMP**'s Provider Manual and Medicaid website (under "Continuation of Benefits") do not accurately include that **DHMP** must provide the disputed services as promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination if the services were not furnished while the appeal was pending. **DHMP** must update the "Continuation of Benefits" section of its Medicaid website and the "Effectuation of Appeal Resolutions" section of the Provider Manual to state that **DHMP** will provide the disputed services as promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination if the services were not furnished while the appeal was pending.

The Provider Manual included the following inaccurate information, and **DHMP** must update its Provider Manual to accurately state the following information:

- Time frame of a decision on an expedited appeal.
- Time frame to file a State fair hearing is 120 days from the adverse *appeal* resolution.
- Time frames of an appeal request and continuation of benefits request.
- Clarification that the end of the service authorization does not impact continuation of benefits during a State fair hearing.

Standard XII—Enrollment and Disenrollment

Evidence of Compliance and Strengths

DHMP submitted its Enrollment and Disenrollment Practice policies, which described a process and procedure to electronically receive daily 834 files from the Department and to add members into the system in the order in which they are received. Staff members described that on receipt of the 834 files from the Department, validation checks for errors were performed daily.

DHMP described a process to ensure that it does not discriminate against members. **DHMP** staff members reported that if a member had a complaint related to discrimination, **DHMP** would assist the member to file a grievance with the grievance team and work with the member to resolve the situation to the member's satisfaction. Staff members also reported that when they "ingest" members from the Department files, they immediately begin supporting and providing healthcare services to those members.

Additionally, staff members reported that they only disenroll a member strictly by contractual requirements if the member is behaving in an aggressive or violent manner that becomes a threat to the

staff, other patients, or provider. For instances involving a disruptive member, **DHMP** would work with the member and with the Department extensively during biweekly operational meetings to discuss unique cases.

Opportunities for Improvement and Recommendations

HSAG identified no opportunities for improvement or recommendations for this standard.

Required Actions

HSAG identified no required actions for this standard.

2. Overview and Background

Overview of FY 2022–2023 Compliance Monitoring Activities

For the FY 2022–2023 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 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. 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 MCO's contract requirements and regulations specified by the federal Medicaid managed care regulations published May 6, 2016. Additional revisions were released in November 2020, with an effective date of December 2020. 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 January 1, 2022, through December 31, 2022. HSAG conducted a desk review of materials submitted prior to the compliance review activities; a review of records, documents, and materials requested during the compliance review; and interviews of key MCO personnel to determine compliance with applicable federal managed care regulations and contract requirements. Documents submitted for the desk review and compliance review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to denials of authorization, grievances, and appeals.

HSAG reviewed a sample of the MCO's administrative records related to denials, grievances, and appeals to evaluate implementation of federal and State healthcare regulations. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records (to the extent that a sufficient number existed) for each of the denials, grievances, and appeals. Using a random sampling technique, HSAG selected the samples from all MCO denial, grievance, and appeal records that occurred between January 1, 2022, and December 31, 2022. For the record review, the MCO received a score of *Met (M)*, *Not Met (NM)*, or *Not Applicable (NA)* for each required element. Results of record reviews were considered in the review of applicable requirements in Standard I—Coverage and Authorization of Services and Standard VI—Grievance and Appeal Systems. HSAG separately calculated a record review score for each record review requirement and an overall record review score.

The 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*, October 2019. Appendix E 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 2022–2023 compliance reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights, Protections, and Confidentiality, Standard V—Member Information Requirements, Standard VII—Provider Selection and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontractual Relationships and Delegation, Standard X—Quality Assessment and Performance Improvement, and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT).

Objective of the Compliance Review

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

- The 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 MCO into compliance with federal healthcare regulations and contract requirements in the standard areas reviewed.
- The quality and timeliness of, and access to, services furnished by the MCO, as assessed by the specific areas reviewed.
- Possible interventions recommended to improve the quality of the MCO's services related to the standard areas reviewed.

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

FY 2021–2022 Corrective Action Methodology

As a follow-up to the FY 2021–2022 compliance review, each 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 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 MCO and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **DHMP** until it completed each of the required actions from the FY 2021–2022 compliance monitoring review.

Summary of FY 2021–2022 Required Actions

For FY 2021–2022, HSAG reviewed Standard III—Coordination and Continuity of Care; Standard IV—Member Rights, Protections, and Confidentiality; Standard V—Member Information Requirements; and Standard XI—EPSDT.

Related to Standard V—Member Information Requirements, **DHMP** was required to complete four corrective actions:

- Develop mechanisms to ensure all required member informational materials may be easily understood to the extent possible.
- Update the definition of "grievance" in the Medicaid Choice member handbook to be consistent with the State and federal definition.
- Revise the Medicaid Choice member handbook website, welcome letter, quick reference guide, Provider Directory Tip Sheet, and Formulary List to include all required components of a tagline.
- Develop a mechanism to ensure that upon request, members are provided with informational material within five business days, at no cost.

Summary of Corrective Action/Document Review

DHMP submitted a proposed CAP in May 2022. HSAG and the Department reviewed and approved the proposed plan and responded to **DHMP**. **DHMP** submitted final evidence that included a Readability Policy, updated Medicaid Member Handbook, Medicaid Formulary Intro, Marketing Ticket Form, Desktop Operating Procedure Marketing Ticket, and Marketing Monitoring Report Example to HSAG as evidence and completed the CAP in October 2022.

Summary of Continued Required Actions

DHMP successfully completed the FY 2021–2022 CAP, resulting in no continued corrective actions.

Appendix A. Colorado Department of Health Care Policy & Financing FY 2022–2023 Compliance Monitoring Tool for Denver Health Medical Plan

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor ensures that the services are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished. *42 CFR 438.210(a)(3)(i)* DHMP MCO Contract: Exhibit B-7—13.1.1.1, 13.4.1	Note: Federal requirements only apply to MCOs and PIHPs (behavioral health services of RAEs) unless otherwise noted. • Policy: Utilization Review Determinations, Page 5	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42 CFR 438.210(a)(3)(ii)* DHMP MCO Contract: Exhibit B-7—13.1.1.3, 13.4.4, 14.6.4	• Policy: Utilization Review Determinations, page 5	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor may place appropriate limits on services— • On the basis of criteria applied under the Medicaid State plan (such as medical necessity). • For the purpose of utilization control, provided that the services furnished can reasonably achieve their purpose. – For Utilization Management, provided family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used. *Note: The Contractor shall not deny or reduce the amount, duration, and scope of services provided under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) as long as the service is supporting a member to maintain stability or level of functioning or making treatment progress.*	• Policy: Utilization Review Determinations, page 5 • Member handbook Family Planning pages 14, 31	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.210(a)(4) DHMP MCO Contract: Exhibit B-7—13.4.5, 14.6.2.1 14.6.5, 14.6.5.2, 14.6.5.2.3		
4. The Contractor may place appropriate limits on services for utilization control, provided that any financial requirement or treatment limitation applied to mental health or substance use disorder (SUD) benefits in any classification is no more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to members (whether or not the benefits are furnished by the same Contractor). • The Contractor shall only apply a Non-Quantitative Treatment Limitation (NQTL) for mental health or substance use disorder benefits, in any classification, in a manner comparable to and no more stringently than, the processes, strategies, evidentiary standards, or other factors applied to the same NQTL in the same benefit classification of the members' medical/surgical benefits. *42 CFR 438.905* *HB19-1269: Section 3–10-16-104(3)(B)* DHMP MCO Contract: Exhibit B-7—14.15.1.1, 14.6.5.2.2	• Utilization Management Program_ 2023 pg. 19 • UM102 Utilization Review Determinations pg. 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor covers all medically necessary covered treatments for covered behavioral health (BH diagnoses), regardless of any co-occurring conditions. The Contractor must ensure that the diagnosis of an intellectual or developmental disability, a neurological or neurocognitive disorder, or a traumatic brain injury does not preclude an individual from receiving a covered BH service. *HB19-1269: Section 12—25.5-5-402(3)(h-i)*	• Job Aid - Wrap Benefits pg. 3, 4 • DHMP Behavioral Health Tip Sheet	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The Contractor definition of "medically necessary": • Is no more restrictive than that used in Colorado's Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in Colorado statutes and regulations, the Health First Colorado plan, and other Colorado policies and procedures; and • Addresses the extent to which the MCO is responsible for covering services that address: – The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability. – The ability for a member to achieve age-appropriate growth and development. – The ability for a member to attain, maintain, or regain function capacity. *Note: For the purposes of EPSDT, medical necessity includes a good or service that will, or is reasonably expected to, assist the client to achieve or maintain maximum functional capacity in performing one*	• Policy: Utilization Review Determinations, page 3, 7 • ASAM Criteria within MCG for IP Substance-Related Disorders Adult	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
or more Activities of Daily Living; and meets the criteria set forth at Section 8.076.1.8.b–g. *The Contractor shall determine medical necessity under EPSDT for members ages 20 and under based on an individualized clinical review of a member's medical status and in consideration that the requested treatment can correct or ameliorate a diagnosed health condition.* *Note: The Contractor shall utilize the American Society of Addiction Medicine (ASAM) criteria to determine medical necessity for residential and inpatient substance use disorder treatment services.* *42 CFR 438.210(a)(5)* DHMP MCO Contract: Exhibit B-7—14.6.5.1.1, 14.8.3 10 CCR 2505-10 8.280.4.E.2 10 CCR 2505-10 8.205.10.B.4.a		
7. The Contractor and its subcontractors have in place and follow written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42 CFR 438.210(b)(1)* DHMP MCO Contract: Exhibit B-7—13.6.2, 14.8.2	• Policy: Utilization Review Determinations, Pg 6	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor and its subcontractors have mechanisms in place to ensure consistent application of review criteria for authorization decisions. *42 CFR 438.210(b)(2)(i)* DHMP MCO Contract: Exhibit B-7—13.6.2.6, 14.8.2.6	• Policy: Consistency in Applying UM Criteria - Inter Rater Reliability	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor and its subcontractors have in place mechanisms to consult with the requesting provider for medical services when appropriate. *42 CFR 438.210(b)(2)(ii)* DHMP MCO Contract: Exhibit B-7—13.6.2.5, 14.8.2.5	Note: DHMP does not reduce, suspend, or terminate previously authorized services. • Policy: Access to MCD section H • Utilization Management Program_2023 pg. 17	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the member's medical or BH needs. The Contractor's utilization management program includes identification of the type of personnel responsible for each level of utilization management decision-making. *42 CFR 438.210(b)(3)* DHMP MCO Contract: Exhibit B-7—13.4.6, 13.6.2.4, 14.6.6	• Policy: Utilization Review Determinations, pg. 7, 8 • Policy: Appropriate Professionals – Use of Qual pg. 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor notifies the requesting provider and gives the member written notice of any decision by the Contractor to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. *Note: Notice to the provider may be oral or in writing.* *42 CFR 438.210(c)* DHMP MCO Contract: Exhibit B-7—8.8.11.6 10 CCR 2505-10 8.209.4.A.1	• Policy: Utilization Review Determinations, pg. 8	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor adheres to the following time frames for making standard and expedited authorization decisions: • For standard authorization decisions—as expeditiously as the member's condition requires and not to exceed 10 calendar days following the receipt of the request for service. • If the provider indicates, or the Contractor determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service. *42 CFR 438.210(d)(1–2)* *Memo: HCPF FFS UM Policy Requirements for SUD Benefit—August 4, 2020* DHMP MCO Contract: Exhibit B-7—8.7.3.5, 8.7.4 10 CCR 2505-10 8.209.4.A.3(c)	• Policy: Utilization Review Determinations, pg 6	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
13. The Contractor may extend the time frame for making standard or expedited authorization decisions by up to 14 additional calendar days if: • The member or the provider requests an extension, or • The Contractor justifies (to the Department, upon request) a need for additional information and how the extension is in the member's interest. *42 CFR 438.210(d)(1)(i–ii) and (d)(2)(ii)* DHMP MCO Contract: Exhibit B-7—8.7.3.5.1, 8.7.5	• Policy: Utilization Review Determinations, pg. 7, 8	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor provides telephonic or telecommunications response within 24 hours of a request for prior authorization of covered outpatient drugs. *42 CFR 438.210(d)(3)* *42 US Code 1396r-8(d)(5)(a)* DHMP MCO Contract: Exhibit B-7—13.2.1.6.3.2.1	• Added by HSAG after review.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. The notice of adverse benefit determination must be written in language easy to understand, available in State-established prevalent non-English languages in the region, and available in alternative formats for persons with special needs. *42 CFR 438.404(a)* DHMP MCO Contract: Exhibit B-7—8.7.1-8.7.1.4 10 CCR 2505-10 8.209.4.A.1	• Policy: Utilization Review Determinations, pg. 9	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor or its subcontractor has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to and copies of all documents and records relevant to the adverse benefit determination (includes medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits). • The member's right (or member's designated representative) to request one level of appeal with the Contractor and the procedures for doing so.	• Policy: Utilization Review Determination, page 9, 10 • ASAM Criteria within MCG IP Substance-Related Disorders Adult • Policy: Appeal Process pg. 11 Section 4a	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The date the appeal is due. • The member's right to request a State fair hearing after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State fair hearing. • The circumstances under which an appeal process can be expedited and how to make this request. • The member's rights to have benefits/services continue (if applicable) pending the resolution of the appeal, how to request that benefits continue, and the circumstances (consistent with State policy) under which the member may be required to pay the cost of these services. • How each dimension of the most recent edition of ASAM criteria was considered when determining medical necessity for any adverse determination concerning residential or inpatient substance use disorder services. *42 CFR 438.404(b)* *SB21-137: Section 10-25.5-5-424(3)* DHMP MCO Contract: Exhibit B-7—8.7.1.5-8.7.1.13 10 CCR 2505-10 8.209.4.A.2		
Findings: Two NABD templates appeared to be in use by the MCO line of business during the review period. Denial files 1, 4, 7, 8, and 10 did not include the date the appeal was due. These denial files contained a heading "Effective Date of Denial" that indicated the date the service was requested by the provider, and could be misunderstood and should be clarified for new requests to indicate the date the determination was made, or for a concurrent review, the date the concurrent authorization expires or first nonauthorized day.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Files 1, 4, 7, 8, and 10 incorrectly stated that the State fair hearing may be requested within 120 days after the NABD, which should be 120 days after the adverse appeal resolution. The NABD did not include details regarding the timeline to file for continuation of benefits during the State fair hearing or inform members that they may have to pay for continued services received during the State fair hearing. Members were informed that they "have a chance to look at" their appeal file, but DHMP has an opportunity to clarify that they may receive a full copy of their record at no cost, upon request. And files 2, 3, 5, 6, and 9 incorrectly stated that if the member submitted an appeal over the phone, the member would need to sign a copy and submit it to DHMP. This version of the NABD did not include the filing time frame for continuation of benefits during the State fair hearing. Members were informed that they may receive a complete copy of their file upon request; however, DHMP has an opportunity to clarify that these records are provided at no cost. Files 1, 4, 7, 8, and 10 included the wording "you may want to talk about this decision with your doctor to make sure that all of the information needed to support the request was given to us" and "the requesting provider/physician is carbon copied on this denial notification and has the right to discuss this decision with Denver Health Medical Plan Inc.'s Physician Reviewer and/or Medical Director (peer to peer conversation). If your provider wishes to discuss this decision, they should call the Utilization Management Department" … "to arrange for the conversation to take place within 10 days of the receipt of the oral and written request," which may be misleading. DHMP should clarify that any additional peer-to-peer efforts after the NABD need to occur as part of the appeal process.		
Required Actions: DHMP must update its NABD template to revise or clarify all language noted in the finding and must develop a process to ensure that the updated NABD is used consistently. HSAG recommends removing information about continuation of benefits from NABDs that do not involve suspending, reducing, or terminating a previously authorized service.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The Contractor mails the notice of adverse benefit determination within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, as defined in 42 CFR 431.211, 431.213 and 431.214 (see below). • For denial of payment, at the time of any denial affecting the claim. • For standard service authorization decisions that deny or limit services, within 10 calendar days following the receipt of the request for service. • For expedited service authorization decisions, within 72 hours after receipt of the request for service. • For extended service authorization decisions, no later than the date the extension expires. • For service authorization decisions not reached within the required time frames, on the date the time frames expire. *42 CFR 438.404(c)* *42 CFR 438.210(d)* DHMP MCO Contract: Exhibit B-7—8.7.3.1, 8.7.3.4-8.7.4 10 CCR 2505-10 8.209.4.A.3	• Policy: Utilization Review Determinations, pg. 6-8	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. For reduction, suspension, or termination of a previously authorized Medicaid-covered service, the Contractor gives notice at least 10 days before the intended effective date of the proposed adverse benefit determination except: • The Contractor gives notice on or before the intended effective date of the proposed adverse benefit determination if: – The Contractor has factual information confirming the death of a member. – The Contractor receives a clear written statement signed by the member that the member no longer wishes services or gives information that requires termination or reduction of services and indicates that the member understands that this must be the result of supplying that information. – The member has been admitted to an institution where the member is ineligible under the plan for further services. – The member's whereabouts are unknown, and the post office returns Contractor mail directed to the member indicating no forwarding address. – The Agency establishes that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth. – A change in the level of medical care is prescribed by the member's physician. – The notice involves an adverse benefit determination made with regard to the preadmission screening requirements.	• Job Aid _Duplicates and Auth Change Requests • Policy: Utilization Review Determination pg. 5 Section E	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• If probable member fraud has been verified, the Contractor gives notice five calendar days before the intended effective date of the proposed adverse benefit determination. *42 CFR 438.404(c)* *42 CFR 431.211* *42 CFR 431.213* *42 CFR 431.214* DHMP MCO Contract: Exhibit B-7—8.7.3.1-8.7.3.2, 8.7.3.3.1-8.7.3.3.8 10 CCR 2505-10 8.209.4.A.3(a)		
19. If the Contractor extends the time frame for standard authorization decisions, it must give the member written notice of the reason for the extension and inform the member of the right to file a grievance if the member disagrees with that decision. *42 CFR 438.404(c)(4)* DHMP MCO Contract: Exhibit B-7—8.7.3.5.2 10 CCR 2505-10 8.209.4.A.3 (c)(1*)*	• Policy: Utilization Review Determinations, pg. 7	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
20. The Contractor provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42 CFR 438.210(e)* DHMP MCO Contract: Exhibit B-7—13.6.6, 14.8.7	• Policy: Utilization Review Determinations, pg. 5	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
21. The Contractor defines emergency medical condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part. *42 CFR 438.114(a)* DHMP MCO Contract: Exhibit B-7—2.1.43, 7.3.8.1.6.1	• Member Handbook, pg. 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
22. The Contractor defines emergency services as covered inpatient or outpatient services furnished by a provider that is qualified to deliver these services and are needed to evaluate or stabilize an emergency medical condition. *42 CFR 438.114(a)* DHMP MCO Contract: Exhibit B-7—2.1.44	• Policy: Utilization Review Determinations, pg. 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
23. The Contractor defines poststabilization care services as covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or provided to improve or resolve the member's condition. *42 CFR 438.114(a)* DHMP MCO Contract: Exhibit B-7—2.1.93	• Policy: Utilization Review Determinations, pg. 4 • Member handbook pg. 24	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
24. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. *42 CFR 438.114(c)(1)(i)* DHMP MCO Contract: Exhibit B-7—13.2.1.2.1, 14.5.6.2.2	• Policy: Utilization Review Determinations, pg. 2 • Member Handbook pg. 24 • Adjudication of Urgent Care, Emergency Care, Emergency Observation and Emergency Admission and Post Stabilization Claims pg. 2, section A	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
25. The Contractor may not deny payment for treatment obtained under either of the following circumstances: • A member had an emergency medical condition, including cases in which the absence of immediate medical attention would *not* have had the following outcomes: – Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; – Serious impairment to bodily functions; or – Serious dysfunction of any bodily organ or part. *(Note: The Contractor bases its coverage decisions for emergency services on the severity of the symptoms at the time of presentation and*	• Member Handbook pg. 24 • Policy: Adjudication of Urgent Care, Emergency Care, Emergency Observation and Emergency Admission and Post Stabilization Claims pg. 2 & pg. 3 section A	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. 42 CFR 438.114—Preamble) • A representative of the Contractor's organization instructed the member to seek emergency services. *42 CFR 438.114(c)(1)(ii)* DHMP MCO Contract: Exhibit B-7—13.2.1.2.1.2		
26. The Contractor does not: • Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms. • Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent failing to notify the member's primary care provider or the Contractor of the member's screening and treatment within 10 calendar days of presentation for emergency services. *42 CFR 438.114(d)(1)* DHMP MCO Contract: Exhibit B-7—13.2.1.2.1.3, 13.2.1.4.1, 14.5.6.2.8,	• Member Handbook pg. 24 • Policy: Adjudication of Urgent Care, Emergency Care, Emergency Observation and Emergency Admission and Post Stabilization Claims pg. 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
27. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42 CFR 438.114(d)(2)* DHMP MCO Contract: Exhibit B-7—13.2.1.2.1.4, 14.5.6.2.9	• Member Handbook pg. 24 • Policy: Adjudication of Urgent Care, Emergency Care, Emergency Observation and Emergency Admission and Post Stabilization Claims pg. 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
28. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment. *42 CFR 438.114(d)(3)* DHMP MCO Contract: Exhibit B-7—13.2.1.2.1.5, 14.5.6.2.10	• Member Handbook, Pg. 25 • Policy: Adjudication of Urgent Care, Emergency Care, Emergency Observation and Emergency Admission and Post Stabilization Claims pg. 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
29. The Contractor is financially responsible for poststabilization care services that are prior authorized by an in-network provider or Contractor's representative, regardless of whether they are provided within or outside the Contractor's network of providers. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(i)* DHMP MCO Contract: Exhibit B-7—13.2.1.2.1.6, 14.5.6.2.11	• Member Handbook, Pg. 25 • Policy: Adjudication of Urgent Care, Emergency Care, Emergency Observation and Emergency Admission and Post Stabilization Claims pg. 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
30. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition within one hour of a request to the organization for pre-approval of further poststabilization care services. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(ii)* DHMP MCO Contract: Exhibit B-7—13.2.1.2.1.7, 14.5.6.2.12	• Member Handbook, Pg. 25 • Policy: Adjudication of Urgent Care, Emergency Care, Emergency Observation and Emergency Admission and Post Stabilization Claims pg. 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
31. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the member's stabilized condition if: • The organization does not respond to a request for pre-approval within one hour. • The organization cannot be contacted. • The organization's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the organization must give the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with care of the patient until a plan provider is reached or one of the criteria in 422.113(c)(2)(iii) is met. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(iii)*	• Member Handbook, Pg. 25 • Policy: Adjudication of Urgent Care, Emergency Care, Emergency Observation and Emergency Admission and Post Stabilization Claims pg. 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
DHMP MCO Contract: Exhibit B-7—13.2.1.2.1.7.1-3, 14.5.6.2.12		
32. The Contractor's financial responsibility for poststabilization care services it has not pre-approved ends when: • A plan physician with privileges at the treating hospital assumes responsibility for the member's care, • A plan physician assumes responsibility for the member's care through transfer, • A plan representative and the treating physician reach an agreement concerning the member's care, or • The member is discharged. *42 CFR 438.114(e)* *42 CFR 422.113(c)(3)* DHMP MCO Contract: Exhibit B-7—13.2.1.2.1.8, 14.5.6.2.14	• Member Handbook, Pg. 25 • Policy: Adjudication of Urgent Care, Emergency Care, Emergency Observation and Emergency Admission and Post Stabilization Claims pg. 3, section D & E	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
33. If the member receives poststabilization care services from a provider outside the Contractor's network, the Contractor does not charge the member more than they would be charged if they had obtained the services through an in-network provider. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(iv)* DHMP MCO Contract: Exhibit B-7—13.2.1.2.1.7.4, 14.5.6.2.13	• Member Handbook, Pg. 25 • Policy: Adjudication of Urgent Care, Emergency Care, Emergency Observation and Emergency Admission and Post Stabilization Claims pg. 3, section F	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	32	X	1.00	=	32
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	33	**Total Score**		=	32
				Total Score ÷ Total Applicable		=	97%

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The MCO maintains and monitors a network of providers that are supported by written agreements and is sufficient to provide access to all covered services to all members, including those with limited English proficiency or physical or mental disabilities. The provider network includes the following provider types and areas of expertise: • Adult primary care providers • Pediatric primary care providers • OB/GYNs • Family planning providers • Gerontologists • Internal medicine providers • Physician specialists • Adult mental health providers • Pediatric mental health providers • Psychiatrists • Child psychiatrists • Psychiatric prescribers *42 CFR 438.206(b)(1)* DHMP MCO Contract: Exhibit B-7—9.13.1.1, 9.13.1.3.7.1	• Provider Directory Screenshot • DH_NetworkRpt_Q3FY21-22 - example of report used to monitor the network • DH_NetworkRpt_Q3FY21-22 Narrative - example of report used to monitor the network • DH_NetworkPln_FY22-23 • MCD Provider Directory Tips- Pg.8	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor ensures that its provider network complies with time and distance standards as follows: • Adult primary care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Pediatric primary care providers: – Urban counties—30 miles or 30 minutes	• DH_NetworkRpt_Q3FY21-22 - example of report used to monitor the network • DH_NetworkRpt_Q3FY21-22 Narrative - example of report used to monitor the network • Policy- Access to Care and Service Standards	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Obstetrics or gynecology: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Specialists—adult and pediatric: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—100 miles or 100 minutes • Pharmacy: – Urban counties—10 miles or 10 minutes – Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes • Acute care hospitals: – Urban counties—20 miles or 20 minutes – Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes • Psychiatrists and psychiatric prescribers for both adults and children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes		

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Mental health providers for both adults and children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes • SUD providers for both adults and children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes *Note: If there are no BH providers that meet the BH provider standards within the defined area for a specific member, then the Contractor shall not be bound by the time and distance requirements. (Exhibit B2—9.4.10.1)* *42 CFR 438.206(a)* DHMP MCO Contract: Exhibit B-7—9.4.8.1.1, 9.5		
3. The Contractor provides female members with direct access to a women's health care specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health care specialist. *42 CFR 438.206(b)(2)* DHMP MCO Contract: Exhibit B-7—9.2.8.3.2	• Medicaid Member Handbook- Pg. 16 • Policy- Access to Care and Service Standards	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor provides for a second opinion from a network provider or arranges for the member to obtain one outside the network (if there is no qualified provider within the network), at no cost to the member. *42 CFR 438.206(b)(3)* DHMP MCO Contract: Exhibit B-7—9.11.8	• Policy- Access to Care and Service Standards • Medicaid Member Handbook- Pg. 23 • Provider Manual 2022	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. If the provider network is unable to provide necessary covered services to a particular member in network, the Contractor must adequately and in a timely manner cover the services out of network for as long as the Contractor is unable to provide them. *42 CFR 438.206(b)(4)* DHMP MCO Contract: Exhibit B-7—14.6.11	• Policy- Access to Care and Service Standards • Policy- Utilization Review Determinations • Medicaid Member Handbook- Pg.22	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The Contractor requires out-of-network providers to coordinate with the Contractor for payment and ensures that the cost to the member is no greater that it would be if the services were furnished within the network. *42 CFR 438.206(b)(5)* DHMP MCO Contract: Exhibit B-7—14.6.11.1	• Policy- Access to Care and Service Standards • OTA Template 2022- Pg. 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The Contractor must meet, and require its providers to meet, the State standards for timely access to care and services, taking into account the urgency of the need for services. The Contractor ensures that services are available as follows: • Emergency BH care:	• Policy- Access to Care and Service Standards • Medicaid Member Handbook- Pg. 27 & 46	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– By phone within 15 minutes of the initial contact. – In-person within 1 hour of contact in urban and suburban areas. – In-person within 2 hours of contact in rural and frontier areas. • Urgent care within 24 hours from the initial identification of need. • Non-urgent symptomatic care visit within 7 days after member request. • Well-care visit within 1 month after member request. • Outpatient follow-up appointments within 7 days after discharge from hospitalization. • Members may not be placed on waiting lists for initial routine BH services. *42 CFR 438.206(c)(1)(i)* DHMP MCO Contract: Exhibit B-7—9.10.1-4, 9.10.4.2, 9.11.1		
Findings: The DHMP MCD handbook included physical health appointment timeliness content but did not include behavioral health appointment timeliness standards. Additionally, the Network Plan stated that urgently needed services are available within 48 hours of being requested by the member or the member's provider(s).		
Required Actions: DHMP must update its MCD member handbook to include behavioral health appointment timeliness standards and its Network Plan to include the 24-hour urgent care timeliness requirement.		

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor and its providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service. The Contractors network provides: • Minimum hours of provider operation from 8:00 a.m. to 5:00 p.m. Mountain Time, Monday through Friday. • Extended hours on evenings and weekends, including access to clinical staff, not just an answering service or referral service. • Alternatives for emergency department visits for after-hours urgent care. *42 CFR 438.206(c)(1)(ii)* DHMP MCO Contract: Exhibit B-7—9.4.3-5	• Policy- Access to Care and Service Standards- shows the Nurseline as available to members for extended hours and after hours urgent care • Medicaid Member Handbook- Pg. 47 • Contract Template 2022- Pg. 11	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor makes services included in the contract available 24 hours a day, 7 days a week, when medically necessary. *42 CFR 438.206(c)(1)(iii)* DHMP MCO Contract: Exhibit B-7—9.4.7	• Policy- Access to Care and Service Standards • Medicaid Member Handbook- Pg. 25, 26	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor ensures timely access by: • Establishing mechanisms to ensure compliance with access (e.g., appointment) standards by network providers. • Monitoring network providers regularly to determine compliance. • Taking corrective action if there is failure to comply. *42 CFR 438.206(c)(1)(iv)–(vi)* DHMP MCO Contract: Exhibit B-7—13.4.11.3	• Policy- Access to Care and Service Standards • DH_NetworkPln_FY22-23	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. and sex. This includes: • Making written materials that are critical to obtaining services available in prevalent non-English languages. • Providing cultural and disability competency training programs, as needed, to network providers and health plan staff regarding: – Health care attitudes, values, customs and beliefs that affect access to and benefit from health care services. – Medical risks associated with the member population's racial, ethnic, and socioeconomic conditions. • Identifying members whose cultural norms and practices may affect their access to health care. These efforts shall include, but are not limited to, inquiries conducted by the Contractor of the language proficiency of individual members.	• Policy- Cultural and Linguistic Appropriate Services -CLAS • Policy- Access to Care and Service Standards • Policy-Evaluating Members Non-English Language Needs for Language Translation Services • Contract Template 2022- Pg. 7 • DH Annual Training	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Providing language assistance services for all Contractor interactions with members. *42 CFR 438.206(c)(2)* DHMP MCO Contract: Exhibit B-7—7.2.1-5		
12. The Contractor must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities. *42 CFR 438.206(c)(3)* DHMP MCO Contract: Exhibit B-7—9.13.1.2	• MCD Provider Directory Tips • Contract Template 2022- Pg. 9 • Policy- Access to Care and Service Standards	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
13. The Contractor submits to the State (in a format specified by the State) documentation to demonstrate that the Contractor offers an appropriate range of preventive, primary care, and specialty services that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. • A Network Adequacy Plan is submitted to the State annually. • A Network Adequacy Report is submitted to the State quarterly. *42 CFR 438.207(b)* DHMP MCO Contract: Exhibit B-7—9.13.2-3	• DH_NetworkRpt_Q1FY22-23 • DH_NetworkRpt_Q1FY22-23 Narrative • DH_NetworkRpt_Q4FY21-22 • DH_NetworkRpt_Q4FY21-22 Narrative • DH_NetworkRpt_Q3FY21-22 • DH_NetworkRpt_Q3FY21-22 Narrative • DH_NetworkPln_FY22-23	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard II—Adequate Capacity and Availability of Services							
Total	Met	=	12	X	1.00	=	12
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	13	**Total Score**		=	12
				Total Score ÷ Total Applicable		=	92%

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an established internal grievance and appeal system in place for members, providers acting on their behalf, or designated member representatives. A grievance and appeals system means the processes the Contractor implements to handle grievances and appeals of an adverse benefit determination, as well as processes to collect and track information about grievances and appeals. *42 CFR 438.400(b)* *42 CFR 438.402(a)* DHMP MCO Contract: Exhibit B-7—8.1 10 CCR 2505-10 8.209.1	• Appeals Process • Grievance Process	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor defines adverse benefit determination as: • The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. • The reduction, suspension, or termination of a previously authorized service. • The denial, in whole, or in part, of payment for a service. • The failure to provide services in a timely manner, as defined by the State. • The failure to act within the time frames defined by the State for standard resolution of grievances and appeals. • The denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other member financial liabilities).	• Appeals Process– Page 1, ABD definition.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.400(b) DHMP MCO Contract: Exhibit B-7—2.1.3 10 CCR 2505-10 8.209.2.A		
3. The Contractor defines an appeal as a review by the Contractor of an adverse benefit determination. *42 CFR 438.400(b)* DHMP MCO Contract: Exhibit B-7—2.1.6 10 CCR 2505-10 8.209.2.B	• Appeals Process – Page 1, appeal definition	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor defines a grievance as an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. A grievance includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision. *42 CFR 438.400(b)* DHMP MCO Contract: Exhibit B-7—2.1.53, 8.7.3.5.2 10 CCR 2505-10 8.209.2.D, 8.209.4.A.3.c.(i)	• Grievances Process, Page 2 Grievance definition.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor has provisions for who may file: • A member may file a grievance or a Contractor-level appeal and may request a State fair hearing. • With the member's written consent, a provider or authorized representative may file a grievance or a Contractor-level appeal and may request a State fair hearing on behalf of a member. *Note: Throughout this standard, when the term "member" is used it includes providers and authorized representatives acting on behalf of the member (with the exception that providers cannot exercise the member's right to request continuation of benefits under 42 CFR 438.420).* *42 CFR 438.402(c)* DHMP MCO Contract: Exhibit B-7—8.6.1, 8.8.5, 8.8.1, 8.8.13.1, 8.8.5	• Appeals Process, page 3 (B) and Page 7 (M). • Grievance Process page 3 (C).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, as well as providing interpreter services and toll-free numbers that have adequate TeleTYpe/Telecommunications Device for the Deaf (TTY/TDD) and interpreter capabilities. *42 CFR 438.406(a)* DHMP MCO Contract: Exhibit B-7—8.4 10 CCR 2505-10 8.209.4.C	• Appeals Process– Page. 3 (C, 3, a) • Grievance Process– Page. 1 (B)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who: • Were not involved in any previous level of review or decision-making nor a subordinate of any such individual. • Have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding any of the following: – An appeal of a denial that is based on lack of medical necessity. – A grievance regarding the denial of expedited resolution of an appeal. – A grievance or appeal that involves clinical issues. *42 CFR 438.406(b)(2)* DHMP MCO Contract: Exhibit B-7—8.6.4, 8.8.4 10 CCR 2505-10 8.209.5.C, 8.209.4.E	• Appeals Process – Page. 6 (J). • Grievance Process– Page. 2 (E)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor ensures that the individuals who make decisions on grievances and appeals: • Take into account all comments, documents, records, and other information submitted by the member or the member's representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. *42 CFR 438.406(b)(2)* DHMP MCO Contract: Exhibit B-7—8.7.2 10 CCR 2505-10 8.209.5.C, 8.209.4.E	• Appeals Process– Page. 6 (J). • Grievance Process– Page. 4 (H,1)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor accepts grievances orally or in writing. *42 CFR 438.402(c)(3)(i)* DHMP MCO Contract: Exhibit B-7—8.6.3 10 CCR 2505-10 8.209.5.D	• Grievance Process– Page. 3 (D)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. Members may file a grievance at any time. *42 CFR 438.402(c)(2)(i)* DHMP MCO Contract: Exhibit B-7—8.6.3 10 CCR 2505-10 8.209.5.A	• Grievance Process– Page. 3 (D)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor sends the member written acknowledgement of each grievance within two working days of receipt. *42 CFR 438.406(b)(1)* DHMP MCO Contract: Exhibit B-7—8.1 10 CCR 2505-10 8.209.5.B	• Grievance Process– Page 4 (G).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor must resolve each grievance and provide notice as expeditiously as the member's health condition requires, and within 15 working days of when the member files the grievance. • Notice to the member must be in a format and language that may be easily understood by the member. *42 CFR 438.408(a);(b)(1); and (d)(1)* DHMP MCO Contract: Exhibit B-7—8.6.5, 7.2.7.3, 7. 2.7.4, 7.2.7.5. 10 CCR 2505-10 8.209.5.D	• Grievance Process - Page 3 (E). and page 1, C	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The written notice of grievance resolution includes: • Results of the disposition/resolution process and the date it was completed. *42 CFR 438.408(a)* DHMP MCO Contract: Exhibit B-7—8.1 10 CCR 2505-10 8.209.5.G	• Grievance Process– Page 4 (H,1) • Attachment F (grievance disposition letter)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor may have only one level of appeal for members. *42 CFR 438.402(b)* DHMP MCO Contract: Exhibit B-7—8.2	• Appeals Process -Page 2, Policy.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. A member may file an appeal with the Contractor within 60 calendar days from the date on the adverse benefit determination notice. *42 CFR 438.402 (c)(2)(ii)* DHMP MCO Contract: Exhibit B-7—8.8.5.1 10 CCR 2505 10 8.209.4.B	• Appeals Process– Page 3 (D)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The member may file an appeal either orally or in writing, and the Contractor must treat oral appeals in the same manner as appeals received in writing. The Contractor may not require that oral requests for an appeal be followed with a written request. *42 CFR 438.402(c)(3)(ii)* *42 CFR 438.406(b)(3)* DHMP MCO Contract: Exhibit B-7—8.8.6–8.8.6.1 10 CCR 2505-10 8.209.4.F	Inform health plan on-site that proposed federal rule changes include: Eliminate the requirement that an oral appeal must be followed by a written, signed appeal (must continue to treat oral appeals the same as written appeals). • Appeals Process– Page 3	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: On page 3, DHMP's Appeal Process stated the accurate time frame for a member to file an appeal set by the State. However, on page 5, the Appeal Process stated that a DHMP specialist would write the member's appeal and send it with the acknowledgement letter, and that the member is required to sign and return the written appeal within 10 working days.		
Required Actions: DHMP must remove any language from the Appeal Process that requires the member to sign and return a written appeal to DHMP.		
17. The Contractor sends written acknowledgement of each appeal within two working days of receipt, unless the member or designated client representative requests an expedited resolution. *42 CFR 438.406(b)(1)* DHMP MCO Contract: Exhibit B-7—8.1, 8.8.3 10 CCR 2505-10 8.209. 4.D	• Appeals Process– Page 5 (I, 8)	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Although DHMP's appeal process stated that a written acknowledgement letter for an appeal would be sent out within two working days of receipt, the MCO's appeal sample case file 8 did not include a written acknowledgement letter. During the review, DHMP reported that communications were completed orally with the member and that the member then requested a standard appeal. The resolution was mailed to the member within three days, overturning the denial decision. However, the written acknowledgement letter was not issued.		

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: DHMP must ensure that timely written acknowledgement letters for appeals are sent.		
18. The Contractor's appeal process must provide that included, as parties to the appeal, are: • The member and the member's representative, or • The legal representative of a deceased member's estate. *42 CFR 438.406(b)(3) and (6)* DHMP MCO Contract: Exhibit B-7—8.8.9 10 CCR 2505-10 8.209.4.I	• Appeals Process, Page 7 (J, 4)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
19. The Contractor's appeal process must provide: • The member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. (The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution time frame in the case of expedited resolution.) • The case file to the member and their representative, including medical records, other documents and records, and any new or additional documents considered, relied upon, or generated by the Contractor in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame. *42 CFR 438.406(b)(4-5)* DHMP MCO Contract: Exhibit B-7—8.8.7–8.8.8 10 CCR 2505-10 8.209. 4.G, 8.209.4.H	• Appeals Process– Page. 6 (J, 2-3)	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: DHMP included accurate information in the Appeal Process and Member appeal acknowledgement letters which informed members that they have reasonable opportunity to present evidence, testimony, and make legal and factual arguments and that they have limited time available for this sufficiently in advance of the resolution time frame in the case of an expedited resolution. However, DHMP's Medicaid Choice Grievance and Appeals "After you file an appeal" section of its website and the MCO's NABD letters do not include that this information would be provided free of charge and sufficiently in advance of the appeal resolution time frame.		
Required Actions: DHMP must update its NABDs and the Medicaid Choice Grievance and Appeals "After you file an appeal" section of website to inform the member and member's representative that this information must be provided free of charge and sufficiently in advance of the appeal resolution time frame, upon request.		
20. The Contractor maintains an expedited review process for appeals when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life; physical or mental health; or ability to attain, maintain, or regain maximum function. The Contractor's expedited review process includes that: • The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. *42 CFR 438.410(a–b)* DHMP MCO Contract: Exhibit B-7—8.8.10, 8.8.12.2.1 10 CCR 2505-10 8.209.4.Q-R	• Appeals Process – Page 4 (H, 1).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
21. If the Contractor denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the time frame for standard resolution. • Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and within two calendar days provide the member written notice of the reason for the decision and inform the member of the right to file a grievance if the member disagrees with that decision. *42 CFR 438.410(c)* DHMP MCO Contract: Exhibit B-7—8.8.12.2.2 10 CCR 2505-10 8.209.4.S	• Appeals Process – Page 4, H (2, a, b, c)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
22. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)* *42 CFR 438.408(d)(2)(i)* *42 CFR 438.10* DHMP MCO Contract: Exhibit B-7—8.8.12.1, 7.2.2, 7.2.5 10 CCR 2505-10 8.209.4.J.1	• Appeals Process -Page 4, (F, 1) • Page. 2, Policy section	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
23. For expedited appeal, the Contractor must resolve the appeal and provide written notice of disposition to affected parties within 72 hours after the Contractor receives the appeal. • For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. *42 CFR 438.408(b)(3) and (d)(2)(ii)* DHMP MCO Contract: Exhibit B-7—8.8.12.2.3, 8.8.12.2.6 10 CCR 2505-10 8.209.4.J.2, 8.209.4.L	• Appeals Process -Page 4, (F, 2)	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DHMP's website for Medicaid stated that expedited appeal decisions are to be made within three working days after receiving the appeal. However, federal and State regulation set forth the time frame for expedited resolution to not exceed 72 hours.		
Required Actions: DHMP must update the Medicaid website sections "Filing an expedited (quick) appeal" and "After you file an appeal" to reflect the accurate time frame of 72 hours.		
24. The Contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: • The member requests the extension; or • The Contractor shows (to the satisfaction of the Department, upon request) that there is need for additional information and how the delay is in the member's interest. *42 CFR 438.408(c)(1)* DHMP MCO Contract: Exhibit B-7—8.6.6, 8.8.12.2.2, 8.8.12.2.4 10 CCR 2505-10 8.209.4.K, 8.209.5.E	• Appeals Process– Page 4 (G,1-2) • Grievance Process– Page 3 (F, 1-2)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
25. If the Contractor extends the time frames for a grievance or appeal, it must—for any extension not requested by the member: • Make reasonable efforts to give the member prompt oral notice of the delay. • Within two calendar days, give the member written notice of the reason for the delay and inform the member of the right to file a grievance if the member disagrees with that decision. • Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires (14 days following the expiration of the original grievance or appeal resolution time frame). *42 CFR 438.408(c)(2)* DHMP MCO Contract: Exhibit B-7—8.6.7, 8.8.12.1, 8.8.12.2.1, 8.8.12.2.5-6 10 CCR 2505-10 8.209.4.L, 8.209.4.K, 8.209.4.A. 3.C(ii), 8.209.5.E	• Grievance Process– Page 3 (F, a-b-c) • Appeals Process– Page 4 (G)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
26. The written notice of appeal resolution must include: • The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. – The right to request that benefits/services continue* while the hearing is pending, and how to make the request. – That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's adverse benefit determination.	• Appeals Process– Page 7, K,1 (a, b, c)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
**Continuation of benefits applies only to previously authorized services for which the Contractor provides 10-day advance notice to terminate, suspend, or reduce.* *42 CFR 438.408(e)* DHMP MCO Contract: Exhibit B-7—8.8.12.3, 8.8.12.4 10 CCR 2505-10 8.209.4.M		
27. The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of appeal resolution. • If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. *42 CFR 438.408(f)(1–2)* DHMP MCO Contract: Exhibit B-7—8.8.13.1-2 10 CCR 2505-10 8.209.4.N and O	• Appeals Process– Page 8 (M, 1)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
28. The parties to the State fair hearing include the Contractor as well as the member and their representative or the representative of a deceased member's estate. *42 CFR 438.408(f)(3)* DHMP MCO Contract: Exhibit B-7—8.8.13.3	• Appeals Process– Page 8 (M, 5).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
29. The Contractor provides for continuation of benefits/services (when requested by the member) while the Contractor-level appeal and the State fair hearing are pending if: • The member files in a timely manner* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the Contractor mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal in accordance with required time frames. * *This definition of timely filing only applies for this scenario—i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced. (Note: The provider may not request continuation of benefits on behalf of the member.)* *42 CFR 438.420(a) and (b)* DHMP MCO Contract: Exhibit B-7—8.8.11.1 10 CCR 2505-10 8.209.4.T	• Appeals Process– Page 8 and 9, N (Continuation of Benefits Pending Appeal or State Fair Hearing Decision), section 1 (a, b, c, d and e)	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The appeal acknowledgement and resolution templates did not include accurate information about continuation of benefits during a State fair hearing.		
Required Actions: DHMP must update its appeal acknowledgement and resolution templates to state that *both* the State fair hearing and continuation of benefits must be requested within 10 days of the appeal resolution letter not in the member's favor. HSAG recommends removing language related to continuation of benefits if the denial that is being appealed is not regarding a previously authorized service that has been terminated, suspended, or reduced.		
30. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of the following occurs: • The member withdraws the appeal or request for a State fair hearing. • The member fails to request a State fair hearing and continuation of benefits within 10 calendar days after the Contractor sends the notice of an adverse resolution to the member's appeal. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR 438.420(c)* DHMP MCO Contract: Exhibit B-7—8.8.11.2 10 CCR 2505-10 8.209.4.U	• Appeals Process– Page 9 (Continuation of Benefits Pending Appeal or State Fair Hearing Decision), section 3 (a, b, c)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
31. Member responsibility for continued services: • If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's adverse benefit determination, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. *42 CFR 438.420(d)* DHMP MCO Contract: Exhibit B-7—8.8.11.3 10 CCR 2505-10 8.209.4.V	• Appeals Process– Page 9 (Continuation of Benefits Pending Appeal or State Fair Hearing Decision), section 4. a	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
32. If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services as promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. *42 CFR 438.424(a)* DHMP MCO Contract: Exhibit B-7—8.8.11.4 10 CCR 2505-10 8.209.4.W	• Appeals Process– Page 9, section 5, a -i	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: In addition, DHMP's Provider Manual and Medicaid website (under "Continuation of Benefits") do not accurately include that DHMP must provide the disputed services as promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination if the services were not furnished while the appeal was pending.		

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: DHMP must update the "Continuation of Benefits" section of its Medicaid website and the "Effectuation of Appeal Resolutions" section of the Provider Manual to state that DHMP will provide the disputed services as promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination if the services were not furnished while the appeal was pending.		
33. If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the Contractor must pay for those services. *42 CFR 438.424(b)* DHMP MCO Contract: Exhibit B-7—8.8.11.5 10 CCR 2505-10 8.209.4.X	• Appeals Process– Page 10, i	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
34. The Contractor maintains records of all grievances and appeals. The records must be accurately maintained in a manner accessible to the State and available on request to CMS. • The record of each grievance and appeal must contain, at a minimum, all of the following information: – A general description of the reason for the grievance or appeal. – The date received. – The date of each review or, if applicable, review meeting. – Resolution at each level of the appeal or grievance. – Date of resolution at each level, if applicable. – Name of the person for whom the appeal or grievance was filed. • The Contractor quarterly submits to the Department a *Grievance and Appeals* report including this information.	• Appeals Process– Page 10, section O	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.416 DHMP MCO Contract: Exhibit B-7—8.10.1-8.10.1.6, 8.10.2 10 CCR 2505-10 8.209.3.C		
35. The Contractor provides the information about the grievance, appeal, and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. – The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member. *42 CFR 438.414* DHMP MCO Contract: Exhibit B-7—8.5 10 CCR 2505-10 8.209.3.B	• Provider Manual 2022- Section XIV page 37 - 43	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: DHMP's Provider Manual stated inaccurate time frames for expedited appeals. DHMP also stated that the member has 120 days from the date of notice of adverse action to request a hearing. However, it should state that the member has 120 days from the date of the appeal resolution letter to request a hearing. Additionally, the Provider Manual inaccurately mentioned that the appeal and continuation of benefits during an appeal must be requested on or before 10 days after the NABD date, when in fact a member can file an appeal within 60 days from the NABD date and file for continuation of benefits on or before 10 days after the NABD date. Lastly, DHMP included a bullet point under "Continuation of Benefits" that stated continuation of benefits will end if the service authorization expires. While this is true when filing for continuation of benefits during an appeal, it does not apply to or end continuation of benefits during a State fair hearing.		
Required Actions: DHMP must update its Provider Manual to accurately state the following information: • On page 40 update the language to correctly reflect the accurate time frame of a decision on an expedited appeal. • On page 42 update the language to say time frame to file a State fair hearing is 120 days from date of the adverse *appeal* resolution not the *notice of adverse determination* letter. • Reword the first bullet on page 43 to accurately state the time frames of an appeal request and continuation of benefits request. • Clarification that the end of the service authorization expiration only impacts the continuation of benefits when requesting an appeal but not a State fair hearing.		

Results for Standard VI—Grievance and Appeal Systems							
Total	Met	=	28	X	1.00	=	28
	Partially Met	=	7	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	35	**Total Score**		=	28
				Total Score ÷ Total Applicable		=	80%

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor agrees to accept individuals eligible for enrollment into its MCO in the order in which they are assigned without restriction and according to the enrollment policies and procedures. Members will be enrolled with the appropriate aid eligibility category and in the service area until the enrollment cap has been met. *42 CFR 438.3(d)(1)* DHMP MCO Contract: Exhibit B-7—6.6, 6.6.1	• Enrollment and Disenrollment Practices, page 4, 2-a. • Enrollment and Disenrollment Practices, page 2, 3 and 4, A - i through xxvi.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor does not discriminate against individuals eligible to enroll or use any policy or practice that has the effect of discriminating against individuals, based upon health status or need for health care services, race, color, national origin, ancestry, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs, or disability. *42 CFR 438.3(d)(3-4)* DHMP MCO Contract: Exhibit B-7—6.5	• Enrollment and Disenrollment Practices, page 4 section 2. Discrimination prohibited and other requirements of the Company, subsection C	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor may not request disenrollment of a member because of an adverse change in the member's health status or because the member's: • Utilization of medical services. • Diminished mental capacity. • Uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the Contractor's ability to furnish services to the member or to other members).	• Enrollment and Disenrollment Practices, page 10, section 5. Disenrollment for cause, a, b, c, and d	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.56(b)(2) DHMP MCO Contract: Exhibit B-7—6.13.2		
4. The Contractor may initiate disenrollment of any member's participation in the MCO upon one or more of the following grounds: • Uncooperative or disruptive behavior such that continued enrollment would seriously impair the Contractor's ability to furnish services to the member or poses physical threat to the provider, to other providers, contractor staff, or other members. • For cause, at any time under the following circumstances: – Admission of the member to any federal, state, or county governmental institution for treatment of mental illness, narcoticism or alcoholism, or a correctional institute. – Receipt of comprehensive health cover, other than Medicaid. – Enrollment in a Medicare MCO or capitated health plan other than such plan offered by the Contractor. – Ongoing pattern of failure on the part the member to keep scheduled appointments or meet any other member responsibilities. – The member has moved out of the Contractor's service area. – The Contractor does not (due to moral or religious objections) cover the service the member needs. – The member needs related services to be performed at the same time, not all related services are available from the	• Enrollment and Disenrollment Practices, page 11, 8, i and iii. • Enrollment and Disenrollment Practices, page 9, b, i through xi	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contractor's network, and the member's primary care provider (or another provider) determines that receiving the services separately would subject the member to unnecessary risk. – Administrative error on the part of the Department or its designee or the Contractor including, but not limited to, system error. – Poor quality of care. – Lack of access to covered services, or lack of access to providers experienced with dealing with the member's specific needs. – The member commits fraud or furnishes incorrect or incomplete information on applications, questionnaires, forms, or statements submitted as part of the member's enrollment. – Any other reason determined by the Department. *42 CFR 438.56(b)(1)* *42 CFR 436.56(d)(2)(i)-(v)* DHMP MCO Contract: Exhibit B-7—6.13.1.1-7		

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. To initiate disenrollment of a member's participation with the MCO, the Contractor must provide the Department with documentation justifying the proposed disenrollment. *42 CFR 438.56(b)(3)* DHMP MCO Contract: Exhibit B-7—6.13.1.7.4	• Enrollment and Disenrollment Practices, Page 7, section B, 2 • Enrollment and Disenrollment trackers_resaons_contarct language • DHMC Enrollment Request Tracker Template	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The member may request disenrollment as follows: • For cause at any time, including: – The member has moved out of the Contractor's service area. – The Contractor does not (due to moral or religious objections) cover the service the member needs. – The member needs related services to be performed at the same time, not all related services are available from the Contractor's network, and the member's primary care provider (or another provider) determines that receiving the services separately would subject the member to unnecessary risk. – Administrative error on the part of the Department or its designee or the Contractor including, but not limited to, system error. – Poor quality of care. – Lack of access to covered services, or lack of access to providers experienced with dealing with the member's specific needs.	• Enrollment and Disenrollment Practices, page 8 and 9, section 4, subsection b, i, ii, iii, iv, v, vi, and vii. • Enrollment and Disenrollment Practices, page 8, section 3 disenrollment without cause, subsection a, ii, iii, iv and c • Enrollment and Disenrollment Practices, page 10, xii through xviii – a	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– The member enrolled with their provider and the provider leaves the Contractor. – The member is a resident of a long-term institutional care facility. – The member is enrolled into a Medicare managed care plan or Medicare capitated health plan other than the limited managed care capitation imitative offered by the Contractor and the Contractor cannot provide the member with reasonable access to a Medicare-approved provider or, if the member is enrolled in a Medicare managed care plan, and the Contractor cannot provide the member with providers participating in both plans. – The member is in long-term community-based care. – The member is an Indian member and there is not timely access to an Indian Health Care Provider. – The member is a foster child. – A newborn member's mother, or designated representative, may request disenrollment with cause of the newborn within 90 days following: ○ Enrollment of the newborn or 90 days following notice of enrollment, whichever is later. ○ The mother to a newborn, who is not a member of the managed care capitation initiative, has a newborn that is enrolled as a member into the managed care capitation initiative: the mother of the newborn, or the Contractor, may request disenrollment of the newborn from the managed care capitation initiative.		

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Without cause at the following times: – During the 90 days following the date of the member's initial passive enrollment. – At least once every 12 months thereafter. – Upon automatic re-enrollment if temporary loss of eligibility has caused the member to miss the annual disenrollment opportunity. – When the Department has imposed sanctions on the MCO (consistent with 42 CFR 438.702(a)(4). *42 CFR 438.56(2)(i)-(v)* DHMP MCO Contract: Exhibit B-7—6.13.4.1.1-13, 6.13.4.2, 6.13.4.3.1-4		

Results for Standard XII—Enrollment and Disenrollment							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	6	**Total Score**		=	6
				Total Score ÷ Total Applicable		=	100%

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2022–2023 External Quality Review
Denials Record Review
for Denver Health Medical Plan

Review Period:	January 1, 2022–December 31, 2022
Date of Review:	January 24, 2023
Reviewer:	Sarah Lambie, MA, CPHQ
Participating MCE Staff Member(s):	Dr. Seals and Darla Schmidt

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Member ID #	****	****	****	****	****	****	****	****	****	****					
Date of Initial Request [XX/XX/XXXX]	1/20/2022	2/7/2022	2/28/2022	4/4/2022	4/27/2022	5/10/2022	6/23/2022	7/19/2022	8/19/2022	10/25/2022					
Type of Denial: Termination (T), New Request (NR), Claim (CL)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR					
Type of Request: Standard (S), Expedited (E), Retrospective (R), SUD Inpatient/Residential (SUD), or SUD Inpatient/Residential Special Connections (SUD SC)	S	S	S	S	S	S	S	E	S	E					
Date of Decision for Adverse Benefit Determination [XX/XX/XXXX]	1/25/2022	2/9/2022	3/8/2022	4/4/2022	5/3/2022	5/19/2022	6/23/2022	7/21/2022	8/23/2022	10/25/2022					
Date Notice of Adverse Benefit Determination (NABD) Sent [XX/XX/XXXX]	1/25/2025	2/9/2022	3/8/2022	4/8/2022	5/3/2022	5/19/2022	6/30/2022	7/21/2022	8/23/2022	10/26/2022					
Notice Sent to Provider and Member? [I.11]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Number of Hours or Days for Decision (H/D)	5 D	2 D	8 D	0 D	6 D	9 D	0 D	2 D	4 D	0 D					
Number of Hours or Days for Notice (H/D)	5 D	2 D	8 D	4 D	6 D	9 D	7 D	2 D	4 D	1 D					
Adverse Benefit Determination Decision Made Within Required Time Frame? [I.12] Standard: 10 calendar days Expedited: 72 hours SUD: 72 hours (calendar) or 24 hours (calendar) for special connections	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Notice Sent Within Required Time Frame? [I.17] Standard: 10 calendar days Expedited: 72 hours SUD: 72 hours (calendar) or 24 hours (calendar) for special connections Termination: 10 calendar days before the date of action	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Was Authorization Decision Timeline Extended? Yes or No	No	No	No	No	No	No	No	No	No	No					
If Extended, Extension Notification Sent to Member? [I.19]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA					
If Extended, Extension Notification Includes Required Content? [I.19]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA					
NABD Includes Required Content [I.15-16]	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met					
Authorization Decision Made by Qualified Clinician? [I.10]	Met	NA	NA	Met	NA	NA	Met	NA	NA	Met					
If Denied for Lack of Information, Was the Requesting Provider Contacted for Additional Information or Consulted (if applicable)? [I.9]	Met	NA	NA	Met	NA	NA	NA	Met	NA	Met					
Was the Decision Based on Established Authorization Criteria (i.e., not arbitrary)? [I.2]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Was Correspondence With the Member Easy to Understand? [I.14]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					

Scoring	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Applicable Elements	8	6	6	8	6	6	7	7	6	8					
Compliant (Met) Elements	7	5	5	7	5	5	6	6	5	7					
Percent Compliant	88%	83%	83%	88%	83%	83%	86%	86%	83%	88%					
Overall Total Applicable Elements	**68**														
Overall Total Compliant Elements	**58**														
Overall Total Percent Compliant	**85%**														

Comments:
All files included inaccurate information regarding continuation of benefits, appeals, and State fair hearings to some extent. See Compliance Monitoring Tool for full details.

Yes and No = not scored—for informational purposes only
**** = Redacted Member ID

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2022–2023 External Quality Review
Grievances Record Review
for Denver Health Medical Plan

Review Period:	January 1, 2022–December 31, 2022
Date of Review:	February 7–8, 2023
Reviewer:	Crystal Brown, CCMA
Participating MCE Staff Member(s):	Dr. Seals and Rebecca Sundquist

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Member ID #	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****					
Date Grievance Received [XX/XX/XXXX]	1/20/2022	3/13/2022	4/8/2022	5/5/2022	5/24/2022	6/24/2022	7/25/2022	9/24/2022	9/27/2022	11/2/2022					
Date of Acknowledgement Letter [XX/XX/XXXX]	1/24/2022	3/15/2022	4/11/2022	5/6/2022	5/25/2022	6/28/2022	7/26/2022	9/28/2022	9/28/2022	11/3/2022					
Days From Grievance Received to Acknowledgement	2	1	1	1	1	2	1	2	1	1					
Acknowledgement Letter Sent in 2 Working Days [VI.11]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Date of Written Notice [XX/XX/XXXX]	1/24/2022	3/22/2022	4/26/2022	5/6/2022	5/25/2022	7/14/2022	7/27/2022	10/14/2022	10/17/2022	11/21/2022					
# of Days to Notice	2	6	12	1	1	13	2	13	13	12					
Resolved and Notice Sent in Time Frame* [VI.12,24] Standard: 15 working days Extension: 15 working days + 14 calendar days	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Decision-Maker Not Involved in Grievance [VI.7]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Appropriate Level of Expertise (If Clinical) [VI.7]	NA	NA	NA	NA	NA	NA	NA	Met	NA	NA					
Resolution Letter Includes Required Content [VI.13]**	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Resolution Letter Easy to Understand [VI.12]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Scoring	**File 1**	**File 2**	**File 3**	**File 4**	**File 5**	**File 6**	**File 7**	**File 8**	**File 9**	**File 10**	**File OS1**	**File OS2**	**File OS3**	**File OS4**	**File OS5**
Applicable Elements	5	5	5	5	5	5	5	6	5	5					
Compliant (Met) Elements	5	5	5	5	5	5	5	6	5	5					
Percent Compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%					
Overall Total Applicable Elements	**51**														
Overall Total Compliant Elements	**51**														
Overall Total Percent Compliant	**100%**														

Comments:

* Grievance timeline for resolution and notice sent is 15 working days (unless extended, then up to 14 calendar days).

**Grievance resolution letter required content includes (1) results of the disposition/resolution process and (2) the date the disposition/resolution process was completed.

**** = Redacted Member ID

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2022–2023 External Quality Review
Appeals Record Review
for Denver Health Medical Plan

Review Period:	January 1, 2022–December 31, 2022
Date of Review:	February 7–8, 2023
Reviewer:	Crystal Brown, CCMA
Participating MCE Staff Member(s):	Dr. Seals and Rebecca Sundquist

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Member ID #	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****					
Date Appeal Received [XX/XX/XXXX]	1/21/2022	3/9/2022	6/10/2022	7/22/2022	8/30/2022	9/1/2022	9/13/2022	9/23/2022	10/19/2022	11/30/2022					
Date of Acknowledgement [XX/XX/XXXX]	1/22/2022	3/11/2022	6/13/2022	7/26/2022	8/31/2022	9/6/2022	9/14/2022		10/19/2022	12/2/2022					
Days From Appeal Received to Acknowledgement	0	2	1	2	1	2	1		0	2					
Acknowledgement Sent Within 2 Working Days? [VI.17]	Met	Met	Met	Met	Met	Met	Met	Not Met	Met	Met					
Decision-Maker Not Previous Level [VI.7]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Decision-Maker—Clinical Expertise [VI.7]	NA	NA	Met	NA	NA	NA	Met	NA	Met	Met					
Expedited Appeal: Yes or No	No	No	No	No	No	No	No	No	No	No					
Time Frame Extended: Yes or No	No	No	No	No	No	No	No	No	No	No					
Date Resolution Notice Sent [XX/XX/XXXX]	1/26/2022	3/18/2022	6/17/2022	7/26/2022	9/1/2022	9/9/2022	9/23/2022	9/28/2022	10/20/2022	12/6/2022					
Hours or Days From Appeal Filed to Resolution Notice Sent	3 D	7 D	5 D	2 D	2 D	5 D	8 D	3 D	1 D	4 D					
Notice Sent Within Time Frame*? [VI.22-25] Standard Resolution: 10 working days Expedited Resolution: 72 hours Time Frame Extended: +14 calendar days	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Resolution Letter Includes Required Content [VI.26]**	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Resolution Letter Easy to Understand [VI.22]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Scoring	**File 1**	**File 2**	**File 3**	**File 4**	**File 5**	**File 6**	**File 7**	**File 8**	**File 9**	**File 10**	**File OS1**	**File OS2**	**File OS3**	**File OS4**	**File OS5**
Applicable Elements	5	5	6	5	5	5	6	5	6	6					
Compliant (Met) Elements	5	5	6	5	5	5	6	4	6	6					
Percent Compliant	100%	100%	100%	100%	100%	100%	100%	80%	100%	100%					
Overall Total Applicable Elements	**54**														
Overall Total Compliant Elements	**53**														
Overall Total Percent Compliant	**98%**														

Comments:
File 8: DHMP did not mail a written acknowledgement letter.

***Appeal resolution letter time frame** does not exceed 10 working days from the day the MCE receives the appeal (unless expedited—72 hours; or unless extended—+14 calendar days).

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

**** = Redacted Member ID

Appendix C. Compliance Review Participants

Table C-1 lists the participants in the FY 2022–2023 compliance review of **DHMP**.

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

HSAG Review Team	Title
Sarah Lambie	Senior Project Manager
Crystal Brown	Project Manager I
Barbara McConnell	Executive Director
DHMP Participants	**Title**
Jeremy Sax	Government Products Manager
Arjanea Williams	Health Plan Compliance Analyst
Jason Casey	Health Plan Compliance Analyst
Kaitlin Gaffney	Lead Health Plan Compliance Analyst
Lisa Artale Bross	Director of Health Plan Compliance—DHHA/Enterprise Compliance Services (ECS)
Dr. Christine Seals	Medical Director
Christina Porter	Health Plan Medical Management Quality Assurance Training Manager
Darla Schmidt	Director of Utilization Management
Robert Lodge	Pharmacy Manager
Aya Desouki	Pharmacist Clinical Specialist
Murielle Romine	Provider Relations & Contracts Analyst
Lucas Wilson	Associate Chief Operating Officer
Natalie Score	Director of Insurance Products
Mike Wagner	Chief Operating Officer
Greg McCarthy	Executive Director, Managed Care
James Buckley	Clinical Systems Analyst
Corie Culter	Manager of Utilization Management Operations
Alicia Persich	Marketing & Engagement Manager
Rebecca Sundquist	Supervisor of Grievances & Appeals
Christopher White	Enrollment Services Manager
Bryant Wiltrout	Director of Information Systems
Stacy Grein	Compliance Specialist—DHHA/ECS
Lucas Wilson	Associate Chief Operations Officer

Department Observers	Title
Russell Kennedy	Quality Program Manager
Jeff Helm	Program Design and Policy
Helen Desta	Quality Section Manager
Amy Ryan	CHP+ Contract and Program
Lindsey Folkerth	Contract Specialist/Health Programs Office

Appendix D. Corrective Action Plan Template for FY 2022–2023

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 D-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 D-2—FY 2022–2023 Corrective Action Plan for DHMP

Standard I—Coverage and Authorization of Services
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
16. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor or its subcontractor has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to and copies of all documents and records relevant to the adverse benefit determination (includes medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits). • The member's right (or member's designated representative) to request one level of appeal with the Contractor and the procedures for doing so. • The date the appeal is due. • The member's right to request a State fair hearing after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State fair hearing. • The circumstances under which an appeal process can be expedited and how to make this request. • The member's rights to have benefits/services continue (if applicable) pending the resolution of the appeal, how to request that benefits continue, and the circumstances (consistent with State policy) under which the member may be required to pay the cost of these services. • How each dimension of the most recent edition of ASAM criteria was considered when determining medical necessity for any adverse determination concerning residential or inpatient substance use disorder services. *42 CFR 438.404(b)* *SB21-137: Section 10-25.5-5-424(3)* DHMP MCO Contract: Exhibit B-7—8.7.1.5-8.7.1.13 10 CCR 2505-10 8.209.4.A.2

Standard I—Coverage and Authorization of Services
Findings
Two NABD templates appeared to be in use by the MCO line of business during the review period. Denial files 1, 4, 7, 8, and 10 did not include the date the appeal was due. These denial files contained a heading "Effective Date of Denial" that indicated the date the service was requested by the provider, and could be misunderstood and should be clarified for new requests to indicate the date the determination was made, or for a concurrent review, the date the concurrent authorization expires or first nonauthorized day. Files 1, 4, 7, 8, and 10 incorrectly stated that the State fair hearing may be requested within 120 days after the NABD, which should be 120 days after the adverse appeal resolution. The NABD did not include details regarding the timeline to file for continuation of benefits during the State fair hearing or inform members that they may have to pay for continued services received during the State fair hearing. Members were informed that they "have a chance to look at" their appeal file, but DHMP has an opportunity to clarify that they may receive a full copy of their record at no cost, upon request. And files 2, 3, 5, 6, and 9 incorrectly stated that if the member submitted an appeal over the phone, the member would need to sign a copy and submit it to DHMP. This version of the NABD did not include the filing time frame for continuation of benefits during the State fair hearing. Members were informed that they may receive a complete copy of their file upon request; however, DHMP has an opportunity to clarify that these records are provided at no cost. Files 1, 4, 7, 8, and 10 included the wording "you may want to talk about this decision with your doctor to make sure that all of the information needed to support the request was given to us" and "the requesting provider/physician is carbon copied on this denial notification and has the right to discuss this decision with Denver Health Medical Plan Inc.'s Physician Reviewer and/or Medical Director (peer to peer conversation). If your provider wishes to discuss this decision, they should call the Utilization Management Department" … "to arrange for the conversation to take place within 10 days of the receipt of the oral and written request," which may be misleading. DHMP should clarify that any additional peer-to-peer efforts after the NABD need to occur as part of the appeal process.
Required Actions
DHMP must update its NABD template to revise or clarify all language noted in the finding and must develop a process to ensure that the updated NABD is used consistently. HSAG recommends removing information about continuation of benefits from NABDs that do not involve suspending, reducing, or terminating a previously authorized service.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:

Standard I—Coverage and Authorization of Services
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard II—Adequate Capacity and Availability of Services
☐ 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 must meet, and require its providers to meet, the State standards for timely access to care and services, taking into account the urgency of the need for services. The Contractor ensures that services are available as follows: • Emergency BH care: – By phone within 15 minutes of the initial contact. – In-person within 1 hour of contact in urban and suburban areas. – In-person within 2 hours of contact in rural and frontier areas. • Urgent care within 24 hours from the initial identification of need. • Non-urgent symptomatic care visit within 7 days after member request. • Well-care visit within 1 month after member request. • Outpatient follow-up appointments within 7 days after discharge from hospitalization. • Members may not be placed on waiting lists for initial routine BH services. *42 CFR 438.206(c)(1)(i)* DHMP MCO Contract: Exhibit B-7—9.10.1-4, 9.10.4.2, 9.11.1
Findings
The DHMP MCD handbook included physical health appointment timeliness content but did not include behavioral health appointment timeliness standards. Additionally, the Network Plan stated that urgently needed services are available within 48 hours of being requested by the member or the member's provider(s).
Required Actions
DHMP must update its MCD member handbook to include behavioral health appointment timeliness standards and its Network Plan to include the 24-hour urgent care timeliness requirement.

Standard II—Adequate Capacity and Availability of Services
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:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
16. The member may file an appeal either orally or in writing, and the Contractor must treat oral appeals in the same manner as appeals received in writing. The Contractor may not require that oral requests for an appeal be followed with a written request. *42 CFR 438.402(c)(3)(ii)* *42 CFR 438.406(b)(3)* DHMP MCO Contract: Exhibit B-7—8.8.6–8.8.6.1 10 CCR 2505-10 8.209.4.F
Findings
On page 3, DHMP's Appeal Process stated the accurate time frame for a member to file an appeal set by the State. However, on page 5, the Appeal Process stated that a DHMP specialist would write the member's appeal and send it with the acknowledgement letter, and that the member is required to sign and return the written appeal within 10 working days.
Required Actions
DHMP must remove any language from the Appeal Process that requires the member to sign and return a written appeal to DHMP.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:

Standard VI—Grievance and Appeal Systems
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
17. The Contractor sends written acknowledgement of each appeal within two working days of receipt, unless the member or designated client representative requests an expedited resolution. *42 CFR 438.406(b)(1)* DHMP MCO Contract: Exhibit B-7—8.1, 8.8.3 10 CCR 2505-10 8.209. 4.D
Findings
Although DHMP's appeal process stated that a written acknowledgement letter for an appeal would be sent out within two working days of receipt, the MCO's appeal sample case file 8 did not include a written acknowledgement letter. During the review, DHMP reported that communications were completed orally with the member and that the member then requested a standard appeal. The resolution was mailed to the member within three days, overturning the denial decision. However, the written acknowledgement letter was not issued.
Required Actions
DHMP must ensure that timely written acknowledgement letters for appeals are sent.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:

Standard VI—Grievance and Appeal Systems
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
19. The Contractor's appeal process must provide: • The member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. (The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution time frame in the case of expedited resolution.) • The case file to the member and their representative, including medical records, other documents and records, and any new or additional documents considered, relied upon, or generated by the Contractor in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame. *42 CFR 438.406(b)(4-5)* DHMP MCO Contract: Exhibit B-7—8.8.7–8.8.8 10 CCR 2505-10 8.209. 4.G, 8.209.4.H
Findings
DHMP included accurate information in the Appeal Process and Member appeal acknowledgement letters which informed members that they have reasonable opportunity to present evidence, testimony, and make legal and factual arguments and that they have limited time available for this sufficiently in advance of the resolution time frame in the case of an expedited resolution. However, DHMP's Medicaid Choice Grievance and Appeals "After you file an appeal" section of its website and the MCO's NABD letters do not include that this information would be provided free of charge and sufficiently in advance of the appeal resolution time frame.
Required Actions
DHMP must update its NABDs and the Medicaid Choice Grievance and Appeals "After you file an appeal" section of website to inform the member and member's representative that this information must be provided free of charge and sufficiently in advance of the appeal resolution time frame, upon request.
Planned Interventions:

Standard VI—Grievance and Appeal Systems
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:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
23. For expedited appeal, the Contractor must resolve the appeal and provide written notice of disposition to affected parties within 72 hours after the Contractor receives the appeal. • For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. *42 CFR 438.408(b)(3) and (d)(2)(ii)* DHMP MCO Contract: Exhibit B-7—8.8.12.2.3, 8.8.12.2.6 10 CCR 2505-10 8.209.4.J.2, 8.209.4.L
Findings
DHMP's website for Medicaid stated that expedited appeal decisions are to be made within three working days after receiving the appeal. However, federal and State regulation set forth the time frame for expedited resolution to not exceed 72 hours.
Required Actions
DHMP must update the Medicaid website sections "Filing an expedited (quick) appeal" and "After you file an appeal" to reflect the accurate time frame of 72 hours.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:

Standard VI—Grievance and Appeal Systems
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
29. The Contractor provides for continuation of benefits/services (when requested by the member) while the Contractor-level appeal and the State fair hearing are pending if: • The member files in a timely manner* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the Contractor mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal in accordance with required time frames. * *This definition of timely filing only applies for this scenario—i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced. (Note: The provider may not request continuation of benefits on behalf of the member.)* *42 CFR 438.420(a) and (b)* DHMP MCO Contract: Exhibit B-7—8.8.11.1 10 CCR 2505-10 8.209.4.T
Findings
The appeal acknowledgement and resolution templates did not include accurate information about continuation of benefits during a State fair hearing.
Required Actions
DHMP must update its appeal acknowledgement and resolution templates to state that *both* the State fair hearing and continuation of benefits must be requested within 10 days of the appeal resolution letter not in the member's favor. HSAG recommends removing language related to continuation of benefits if the denial that is being appealed is not regarding a previously authorized service that has been terminated, suspended, or reduced.

Standard VI—Grievance and Appeal Systems
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:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
32. If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services as promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. *42 CFR 438.424(a)* DHMP MCO Contract: Exhibit B-7—8.8.11.4 10 CCR 2505-10 8.209.4.W
Findings
In addition, DHMP's Provider Manual and Medicaid website (under "Continuation of Benefits") do not accurately include that DHMP must provide the disputed services as promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination if the services were not furnished while the appeal was pending.
Required Actions
DHMP must update the "Continuation of Benefits" section of its Medicaid website and the "Effectuation of Appeal Resolutions" section of the Provider Manual to state that DHMP will provide the disputed services as promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination if the services were not furnished while the appeal was pending.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:

Standard VI—Grievance and Appeal Systems
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
35. The Contractor provides the information about the grievance, appeal, and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. – The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member. *42 CFR 438.414* DHMP MCO Contract: Exhibit B-7—8.5 10 CCR 2505-10 8.209.3.B
Findings
DHMP's Provider Manual stated inaccurate time frames for expedited appeals. DHMP also stated that the member has 120 days from the date of notice of adverse action to request a hearing. However, it should state that the member has 120 days from the date of the appeal resolution letter to request a hearing. Additionally, the Provider Manual inaccurately mentioned that the appeal and continuation of benefits during an appeal must be requested on or before 10 days after the NABD date, when in fact a member can file an appeal within 60 days from the NABD date and file for continuation of benefits on or before 10 days after the NABD date. Lastly, DHMP included a bullet point under "Continuation of Benefits" that stated continuation of benefits will end if the service authorization expires. While this is true when filing for continuation of benefits during an appeal, it does not apply to or end continuation of benefits during a State fair hearing.

Standard VI—Grievance and Appeal Systems
Required Actions
DHMP must update its Provider Manual to accurately state the following information: • On page 40 update the language to correctly reflect the accurate time frame of a decision on an expedited appeal. • On page 42 update the language to say time frame to file a State fair hearing is 120 days from date of the adverse *appeal* resolution not the *notice of adverse determination* letter. • Reword the first bullet on page 43 to accurately state the time frames of an appeal request and continuation of benefits request. • Clarification that the end of the service authorization expiration only impacts the continuation of benefits when requesting an appeal but not a State fair hearing.
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:
Documents Included in Final Submission:
Date of Final Evidence:

Appendix E. Compliance Monitoring Review Protocol Activities

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

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the 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, record review tools, report templates, agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all 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, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. • The MCEs also submitted lists denials, grievances, and appeals that occurred between January 1, 2022, and December 31, 2022 (to the extent available at the time of the review). MCEs submitted the lists to HSAG 10 days following receipt of the desk review request. HSAG used a random sampling technique to select records for the review. HSAG notified the MCE five days following receipt of the lists of records regarding the sample records selected.

For this step,	HSAG completed the following activities:
	• 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.
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 2022–2023 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.