COLORADO

Department of Health Care Policy & Financing

Fiscal Year 2020–2021 Site Review Report

for

Denver Health Medical Plan

Region 5 Managed Care Organization

April 2021

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

In accordance with its authority under Colorado Revised Statute 25.5-1-101 et seq., the Department of Healthcare Policy and 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 MCOs to comply with specified provisions of 42 CFR §438—managed care regulations—and requires that states conduct a periodic evaluation of their MCOs to determine compliance with federal Medicaid managed care regulations published May 6, 2016. The Department has elected to complete this requirement by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This report documents results of the fiscal year (FY) 2020–2021 compliance site 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 2020–2021 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2019–2020 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the credentialing and recredentialing record reviews. Appendix C lists HSAG, MCO, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan (CAP) process that the MCO will be required to complete for FY 2020–2021 and the required template for doing so. Appendix E contains a detailed description of HSAG's site review activities consistent with the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[1-1]

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

Summary of 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)
VII. Provider Participation and Program Integrity	16	15	15	0	0	1	100%
VIII. Credentialing and Recredentialing	32	32	32	0	0	0	100%
IX. Subcontractual Relationships and Delegation	4	4	3	1	0	0	75%
X. Quality Assessment and Performance Improvement	17	17	16	1	0	0	94%
Totals	**69**	**68**	**66**	**2**	**0**	**1**	**97%**

*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 PH provider credentialing and recredentialing record reviews. Details of the findings for the record reviews are in Appendix B—Record Review Tools.

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Credentialing	100	96	96	0	4	100%
Recredentialing	90	86	86	0	4	100%
Totals	**190**	**182**	**182**	**0**	**8**	**100%**

*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 VII—Provider Participation and Program Integrity

Summary of Strengths and Findings as Evidence of Compliance

Policies, procedures, and other submitted evidence demonstrated comprehensive provider participation and compliance programs. The provider relations and contracting department was a small team comprised of various roles such as credentialing specialists, liaison representatives, and a manager. The network management team contracted with Perspecta to ensure a regularly updated provider directory, which was populated with data from the QNXT system. The compliance department delegated its Special Investigation Unit functions to Lexis-Nexis, which performed data mining for claims and pharmacy data to identify any fraud, waste, and abuse. **DHMP** also delegated credentialing functions to the Denver Health and Hospital Authority (DHHA) medical staff office.

The network management team analyzed both qualitative and quantitative data such as network adequacy reports, providers who experienced referral barriers, and grievance and appeal trends to determine if gaps in the network existed. If gaps were identified, recruiting efforts were deployed. Staff members reported the addition of the Metro Community Provider Network (also known as STRIDE) as a major enhancement to the network in calendar year (CY) 2020. Provider education and training were conducted by this team through various means such as newsletters (biweekly), direct interactions, letters, and postings to the centralized provider Web portal. Efforts to retain providers included an annual *Provider and Practitioner Experience Survey*, which assessed satisfaction. CY 2020's provider survey focused on providers' satisfaction regarding interactions with utilization management.

Credentialing and recredentialing policies aligned with the National Committee for Quality Assurance (NCQA) and included procedures to ensure **DHMP** did not discriminate against providers. Staff members reported that no providers were declined during the review period. Verification sources such as the National Practitioner Database, List of Excluded Individuals/Entities, System for Award Management, and State websites were used to verify work history, education, licensure, and ensure **DHMP** did not employ or contract with providers or other individuals or entities excluded from participation with federal healthcare programs.

The Enterprise Compliance Services (ECS) program presented well-developed arrangements and procedures that articulated **DHMP**'s commitment to comply with federal, State, and contract requirements related to detecting and preventing fraud, waste, and abuse. This included clear responsibilities of the chief executive officer; board of directors; compliance committee; and chief compliance and audit officer. Onboarding and annual trainings were required for general staff members, and in-person, individualized trainings were conducted for board members. ECS staff member training requirements were noted in policy and described by staff members as ranging in expectations from maintenance of medical degrees, certifications in healthcare compliance, research compliance, internal audit, and more.

DHMP contracted with the vendor ValuesLine, which was described by ECS staff members as having positively impacted the staff's feelings of safety in being able to anonymously report issues to a third

party. The compliance officer noted that this approach has worked as intended, with increased reporting year over year, while remaining within range of national reporting trends. The vendor platform included capabilities to categorize the reported concern and automatically filter to the appropriate **DHMP** department and staff member responsible for an investigation.

Procedures outlined how **DHMP** monitored and updated databases based on member date of death, change of address, disenrollment and eligibility updates, and how staff members would research claims and provide notification to the Department in a timely manner. Overpayment notification timelines, auditing timelines, and provider termination timelines were all thoroughly documented. Staff members described both an automated and manual process for researching overpayments. MCO services were randomly selected monthly, and members received sample surveys to verify if the services were received.

Summary of Findings Resulting in Opportunities for Improvement

Although **DHMP** did not object to providing services on moral or religious grounds, the member handbook contained information that may be confusing to the member. Page 15 noted that members would be notified if there were significant changes due to moral or religious objections, and page 16 noted that the member could request disenrollment if **DHMP** was not able to provide a service based on such objections. HSAG recommends that these sections be updated to further clarify that, while an individual provider may have such objections, **DHMP** as an organization does not, and that the member has the right to change providers if an individual provider has objections to performing a service.

Regarding the sampling of MCO services and surveys to members to ensure such services were received, HSAG encourages **DHMP** to expand the sampling methodology to all members, not only adults 18 and over.

Summary of Required Actions

HSAG identified no required actions for this standard.

Standard VIII—Credentialing and Recredentialing

All **DHMP** MCO members received BH services through the Colorado Access (COA) Regional Accountable Entity (RAE) BH provider network. All BH network providers are credentialed by COA; therefore, credentialing and recredentialing requirements apply only to **DHMP**'s capitated PH providers.

Summary of Strengths and Findings as Evidence of Compliance

DHMP's credentialing department operated with detailed policies and procedures, based on NCQA and Council for Affordable Quality Healthcare (CAQH) protocols, and maintained oversight through a bimonthly credentialing committee. Notably, initial credentialing checks were completed through a manual process, then ongoing monitoring occurred through a software system that provided notifications regarding recredentialing timelines. **DHMP** maintained necessary criteria for credentialing and recredentialing, including verification sources, decision-making procedures, and file management systems.

Record reviews for both credentialing and recredentialing demonstrated consistent application of verification for education, work history, board certification, licensure, malpractice history and sanctions, proof of malpractice insurance, national provider identifier verification, and checks for any reports on the United States Department of Health and Human Services Office of Inspector General (HHS-OIG) and System for Award Management websites. Recredentialing procedures also included cross-referencing with **DHMP**'s grievance, appeal, and quality of care logs to further ascertain whether the provider was in good standing. Timely attestation, verification, recredentialing, and site surveys (as applicable) were completed with 100 percent compliance for the records review samples.

Nondiscrimination during the credentialing and recredentialing procedures was ensured by the credentialing manager not including details regarding gender, age, or ethnicity as part of the committee approval packet. **DHMP** reported that no providers were turned away in CY 2020.

The credentialing committee was comprised of a variety of medical and administrative professionals to ensure peer review procedures. Specialists were available through either the **DHMP** network or through external consultation if needed for specialized peer reviews. The medical director maintained primary oversight for the credentialing program and approving clean credentialing files. Files were stored in a shared drive consistent with **DHMP**'s information technology policies and security protocols and reviewed through a virtual committee for the second half of CY 2020.

The vendor, Perspecta, was responsible for the provider directory, and **DHMP** staff members performed quarterly audits to ensure data consistency between the listings and credentialing information available. One hundred percent of the provider directory was reportedly audited every 18 months, and results of such audits were presented at the network management committee at least annually.

Information was made available to practitioners on the **DHMP** website, in the provider manual, and through externally accessible policy and procedures regarding rights during the application process and also appeal rights for those who did not meet quality standards.

DHMP maintained detailed policies regarding monitoring delegate credentialing practices, which were guided by NCQA standards for monitoring. Credentialing staff members reported only minor findings during such delegate credentialing audits, which often included feedback on policies and small errors in record reviews. No findings in CY 2020 were reported to reach the level of needing a CAP. Delegation agreements included an assessment of capacity to meet NCQA requirements before delegation began and for annual reviews of delegate's policies and procedures, including audits of files, and regular evaluation of reports.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Required Actions

HSAG identified no required actions for this standard.

Standard IX—Subcontractual Relationships and Delegation

Summary of Strengths and Findings as Evidence of Compliance

DHMP's *Delegation of Credentialing Activities* policy described a list of eight predelegation evaluation and initial delegation activities, along with **DHMP**'s process for managing delegated credentialing activities. The policy included a statement that it is company policy to comply with all federal, State, and local laws and regulations. Audits were annual, and expectations of delegates were listed, including reporting requirements.

DHMP provided a contract template for Medicaid and CHP+, which **DHMP** was in the process of transitioning into use for all delegated credentialing activities and anticipated completing over the next several months. Many of the delegated activities were related to credentialing and recredentialing. Delegated functions also included printing and mailing member materials, pharmacy services, BH services, and hospital/clinic services. Subcontracts contained the majority of information necessary to meet the requirements. HSAG reviewed a sample of five **DHMP** subcontracts for audit.

DHMP presented evidence of monitoring activities for several of the delegated entities. Delegate oversight included annual audits, monitoring reports, and regular meetings with agendas and minutes for the BH services contract delegate. **DHMP** also supplied audit results for review.

Summary of Findings Resulting in Opportunities for Improvement

While **DHMP** submitted a delegation policy, it only addressed delegated credentialing. HSAG recommends that **DHMP** expand the *Delegation of Credentialing Activities* policy or develop a second

policy to address delegation expectations for the other types of activities that **DHMP** subcontracts to outside organizations.

DHMP's monitoring of the BH delegate, COA, occurred through biweekly operational meetings, learning collaboratives, and review of annual audit reports performed by external entities, such as HSAG. HSAG noted that external compliance audits are retrospective in nature and recommends that **DHMP** develop an assessment and audit result procedure to allow more timely identification and remedy of any potential issues and align with the monitoring practices **DHMP** engages in with other delegates.

Summary of Required Actions

The language used in the subcontracts reviewed varied significantly across contracts. While the new contract template submitted for Medicaid met requirements, three of the subcontracts did not contain all required language. The University Physicians Incorporated (UPI) contract included the correct language; however, the right to audit statement included a six-year rather than a 10-year right to audit time frame. HSAG noted that the Clarity and DHHA agreements were missing the right of CMS or the HHS-OIG to audit. The contracts were also missing the right to audit for 10 years from the final date of the contract periods, the types of documents or records to be made available, or other specifics outlined in the language of 42 CFR 438.230(c)(3). **DHMP** must revise the subcontracts to include all required language.

Standard X—Quality Assessment and Performance Improvement

Summary of Strengths and Findings as Evidence of Compliance

The *Quality Program Description* clearly outlined a mission statement, data sources, sub-committees, and ultimate responsibility, which resided with the board of directors. The quality management, credentialing, pharmacy and therapeutics, compliance, ambulatory, network management, medical management, operations management, patient safety, and physician executive committees worked together to support monitoring functions. For each committee and leadership role, goals and responsibilities were clearly described. The quality assurance and performance improvement (QAPI) program was evaluated annually, and the evaluation report contained extensive qualitative and quantitative documentation of successes and follow-up action plans. QAPI information was published in the provider section of the **DHMP** website and also summarized in provider newsletters.

Performance improvement projects (PIPs) included submissions for **DHMP**'s PH topic as well as COA's PIP, which focused on BH. **DHMP**'s PIP focused on well-care access for adolescents and the BH PIP focused on referral from primary care physicians (PCPs) to BH following a positive depression screen for members 10 to 14 years of age. Although the PIPs were halted due to coronavirus disease 2019 (COVID-19), **DHMP** reported that initial results were positive and there were plans to pursue text message notifications when schools and school-based health centers re-open.

DHMP noted efforts over CY 2020 to align risk stratification with the Department's approach and also efforts to produce baseline data for various performance measures. Data collection, analysis, and action plans were woven throughout QAPI documents. Both under- and overutilization were monitored through regular reporting and reviewed at the QMC. Over utilization was assessed through metrics such as emergency department visits, inpatient length of stay, inpatient per 1,000 members, readmissions, and other related Healthcare Effectiveness Data and Information Set (HEDIS®)[1-2] measures. The aforementioned reports were reviewed at the QMC and the medical management committee.

Special health care needs (SHCN) assessment and monitoring included approaches such as development and maintenance of treatment plans, reviewing access to care, and ensuring transition of care. Additionally, **DHMP** set stretch goals for SHCN members to monitor that this population received services at a higher rate than general Medicaid members. Members with SHCN were also evaluated against benchmarks to ensure member trends were maintained within normal ranges and any data trends outside of normal ranges were further evaluated. Perceptions of member satisfaction were monitored through grievance trends, pharmacy surveys, open shopper surveys, and two Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-3] surveys: one for clinical groups and one for adult Medicaid members.

DHMP's health information system was able to effectively collect, analyze, integrate, and report key data. Staff members described how data were imported from 834 and 837 files into QNXT, which served as the source of truth for enrollment and claims data. MedImpact housed pharmacy benefit data, and Altruista's Guiding Care program was the platform for care management and authorizations. Data related to HEDIS measures were extracted monthly for the vendor Cotiviti and later merged back into **DHMP**'s system to enable additional internal reports.

Provider submitted data were screened upon being loaded into QNXT to ensure providers who submitted claims matched in the Prospectus provider directory. Unmatched data (i.e., not aligned with a validated provider) were filtered out for further review. **DHMP** maintained a claims denial dashboard to further investigate claims denials and report any trends to providers.

Summary of Findings Resulting in Opportunities for Improvement

Quality of care concerns (QOCC) procedures were documented in detail and reports noted a decrease with falls, injuries, and average monthly events over the last five years while working toward the "target zero" initiative. However, the timeline for responding to a Department request for QOCC information was incorrectly stated as 14 business days for the Medicaid line of business. HSAG recommends updating this to be in alignment with the contract's 10-business-day requirement.

DHMP reviewed and adopted PH clinical practice guidelines and circulated such guidelines to providers via newsletters and to members through the member handbook and targeted member education materials

[1-2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[1-3] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

(i.e., Early and Periodic Screening, Diagnostic and Treatment [EPSDT] fliers, which were based on Bright Futures protocols) but did not have BH guidelines available on the provider webpage or elsewhere (with the exception of depression and attention-deficit/hyperactivity disorder). Although **DHMP** stated that there are plans to post or link to COA's BH guidelines in the near future, provider access to these documents was not in place at the time of the virtual review. As the contract holder, **DHMP** is responsible for BH guidelines and oversight. HSAG recommends including relevant BH guideline details in the **DHMP** QAPI program, including alignment with utilization management practices and member education.

Summary of Required Actions

Although **DHMP**'s health information system provided information on utilization, encounters, claims, grievances, and appeals, there was no procedure for monitoring disenrollment for reasons other than the loss of Medicaid eligibility. Staff members reported that the data sources have not been particularly reliable and, to date, these disenrollment trends had not been reported through quality, member services, or elsewhere. **DHMP** must develop a mechanism to collect information regarding disenrollment for reasons other than the loss of Medicaid eligibility.

2. Overview and Background

Overview of FY 2020–2021 Compliance Monitoring Activities

For the FY 2020–2021 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontractual Relationships and Delegation, and Standard X—Quality Assessment and Performance Improvement. Compliance with applicable federal managed care regulations and managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the MCO's contract requirements and regulations specified by the federal Medicaid managed care regulations published May 6, 2016. 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, 2020, through December 31, 2020. HSAG conducted a desk review of materials submitted prior to the site review activities; a review of records, documents, and materials requested during the site review; and interviews of key MCO personnel to determine compliance with applicable federal managed care regulations and contract requirements. Documents submitted for the desk review and site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials.

HSAG also reviewed a sample of the MCO's administrative records related to both MCO credentialing and MCO recredentialing of PH providers to evaluate implementation of applicable 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 credentialing and recredentialing. Using a random sampling technique, HSAG selected the samples from all MCO PH provider credentialing records, and all MCO PH provider recredentialing records that occurred between January 1, 2020, and December 31, 2020. For the record review, the MCO received a score of *Met (M)*, *Not Met (NM)*, or *Not Applicable (NA)* for each required element. HSAG separately calculated a record review score for each record review requirement and an overall record review score. Results of record reviews were considered in the review of applicable requirements in Standard VIII—Credentialing and Recredentialing.

The site review processes were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS EQR protocol. The four standards chosen for the FY 2020–2021 site reviews

represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information Requirements, Standard VI—Grievance and Appeal Systems, and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services.

Objective of the Site Review

The objective of the site 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 2019–2020 Corrective Action Methodology

During FY 2019–2020, **DHMP** provided capitated PH services as the managed care initiative within the COA Region 5 RAE. As a follow-up to the FY 2019–2020 RAE site 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 2019–2020 compliance monitoring site review.

Summary of FY 2019–2020 Required Actions

For FY 2019–2020, HSAG reviewed Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, and Standard VI—Grievances and Appeals. Regarding Standard I—Coverage and Authorization of Services, **DHMP** had one required action to correct inaccuracies within the medical necessity denial letter (regarding dates, continuation of services, appeal, and State fair hearing [SFH] information). Within Standard II—Access and Availability, **DHMP** had two required actions: 1) develop a mechanism to track compliance with timely appointments (non-urgent symptomatic and post-hospitalization follow-up care) and 2) develop a mechanism to monitor contracted providers to ensure compliance with timely access standards and implement CAPs if they fail to comply.

Regarding Standard VI—Grievances and Appeals, **DHMP** had six required actions:

- Communicate that **DHMP** will assist the member with any procedural steps related to the appeal.
- Ensure that if writing to deny a request for an expedited resolution, the written notice includes the reason for denying the expedited request.
- Ensure that appeal resolution letters are written in language that is easy for the member to understand.
- Clarify the appeal resolution letter to omit references to the appeal process (as it has been exhausted at this stage).
- Update details regarding the continued benefits process and time frames.
- Update the provider manual to include accurate details regarding grievances, appeals, and SFHs, including how to request continuation of benefits.

Summary of Corrective Action/Document Review

DHMP submitted a proposed CAP in May 2020. HSAG and the Department reviewed and approved the proposed interventions. **DHMP** submitted evidence of completion in August 2020 and final documents in September 2020.

Summary of Continued Required Actions

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

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements written policies and procedures for selection and retention of providers. *42 CFR 438.214(a)* DHMP Contract Amendment #1: Exhibit B-1—9.1.8	• P&P- Provider Selection and Retention	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor follows a documented process for credentialing and recredentialing that complies with the standards of the National Committee for Quality Assurance (NCQA). The Contractor ensures that all laboratory testing sites providing services under this contract have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration. *42 CFR 438.214(b) and (e)* DHMP Contract Amendment #1: Exhibit B-1—9.2.1, 9.2.2, 9.3.4.3, 9.3.4.3.1	• P&P- Credentialing and Recredentialing of Practitioners • P&P- Assessment of Organizational Providers • DHMP CLIA • COA Credentialing-Related Policies • COA Credentialing Desktop Procedures • COA Credentialing	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor's provider selection policies and procedures include provisions that the Contractor does not: • Discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. • Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42 CFR 438.12(a)(1) and (2)*	• P&P- Credentialing and Recredentialing of Practitioners- Pg. 5, Section A: Non-Discrimination • P&P- Provider Selection and Retention- Pg. 2, E	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.214(c) DHMP Contract Amendment #1: Exhibit B-1—9.1.8.1, 9.1.8.2		
4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This is not construed to: • Require the Contractor to contract with providers beyond the number necessary to meet the needs of its members. • Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. • Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members. *42 CFR 438.12(a-b)* DHMP Contract Amendment #1: Exhibit B-1—9.1.8.4	• P&P- Credentialing and Recredentialing of Practitioners- Pg. 14, J Notification of Credentialing and Recredentialing Decision • Attachment C - Sample Notification of Credentialing and Recredentialing Decision	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Contractor has a signed contract or participation agreement with each provider. *42 CFR 438.206(b)(1)* DHMP Contract Amendment #1: Exhibit B-1—9.1.16	• Contract Template	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor does not employ or contract with providers or other individuals or entities excluded for participation in federal health care programs under either Section 1128 or 1128 A of the Social Security Act. • The Contractor performs monthly monitoring against HHS_OIG's List of Excluded Individuals. *(This requirement also requires a policy.)* *42 CFR 438.214(d)* *42 CFR 438.610* DHMP Contract Amendment #1: Exhibit B-1—9.1.18, 17.9.4.2.5	• Contract template- Section 3.2 • P&P- Credentialing and Recredentialing of Practitioners- Pg. 15, Ongoing Monitoring • P&P- Sanction Screening of Individuals-Providers and Entities- Pg. 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549. *42 CFR 438.610* DHMP Contract Amendment #1: Exhibit B-1—17.9.4.2.1-4	• P&P- Provider Selection and Retention- Pg.2, H • P&P- Credentialing and Recredentialing- Pg. 7 • P&P- Sanction Screening of Individuals-Providers and Entities- Pg. 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: • The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered.	• P&P- Provider Selection and Retention- Pg.2, F	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Any information the member needs in order to decide among all relevant treatment options. • The risks, benefits, and consequences of treatment or non-treatment. • The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. *42 CFR 438.102(a)(1)* DHMP Contract Amendment #1: Exhibit B-1—14.7.3		
9. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: • To the State upon contracting or when adopting the policy during the term of the contract. • To members before and during enrollment. • To members 30 days prior to adopting the policy with respect to any particular service. *42 CFR 438.102(b)* DHMP Contract Amendment #1: Exhibit B-1—7.3.6.1.12-13, 14.4.7	• Provider Manual 2020_Final- Pg. 7 • 2020 Medicaid Member Handbook- Document Pg. 15 • P&P- Religious Accommodations and Conscience Objections Relative to Provision of Care	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor has administrative and management arrangements or procedures, including a compliance program to detect and prevent fraud, waste, and abuse and includes: • Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal, State, and contract requirements. • The designation of a compliance officer who is responsible for developing and implementing policies, procedures and practices to ensure compliance with requirements of the contract and reports directly to the CEO and Board of Directors. • The establishment of a Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program. • Training and education of the compliance officer, management, and organization's staff members for the federal and State standards and requirements under the contract. • Effective lines of communication between the compliance officer and the Contractor's employees. • Enforcement of standards through well-publicized disciplinary guidelines. • Implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks. • Procedures for prompt response to compliance issues as they are raised, investigation of potential compliance problems identified in the course of self-evaluation and audits, corection of such problems quickly and thoroughly to reduce the	• Compliance Program 2020- Pgs. 5, 7, 8, 9, 10, 11, 12, 14 • 2020 Code Of Conduct	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
potential for reoccurence, and ongoing compliance with the requirements under the contract. *42 CFR 438.608(a)(1)* DHMP Contract Amendment #1: Exhibit B-1—17.1.3, 17.1.5.1-7		
11. The Contractor's administrative and management procedures to detect and prevent fraud, waste, and abuse include: • Written policies for all employees, contractors or agents that provide detailed information about the False Claims Act, including the right of employees to be protected as whistleblowers. • Provisions for prompt referral of any potential fraud, waste, or abuse to the Department and any potential fraud to the State Medicaid Fraud Control Unit. • Provisions for suspension of payments to a network provider for which the State determines there is credible allegation of fraud (in accordance with 455.12). *42 CFR 438.608(a)(6-8)* DHMP Contract Amendment #1: Exhibit B-1—17.1.6, 17.1.5.9, 17.7.1, 17.5.1	• Compliance Program 2020- Pg. 13 • P&P- Fraud- Waste- and Abuse- Pg. 5 • P&P- False Claims- Fraud- Waste and Abuse- Pg.1, Pg. 5	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor's Compliance Program includes: • Provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potenial fraud. • Provision for prompt notification to the State about member circumstances that may affect the member's eligibility, including change in residence and member death. • Provision for notification to the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including termination of the provider agreement with the Contractor. • Provision for a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. *42 CFR 438.608 (a)(2-5)* DHMP Contract Amendment #1: Exhibit B-1--17.1.5.7.2-5, 17.1.5.7.1, 17.1.5.7.6, 17.3.1.3.2.1, 17.3.1.1.2.3-4, 17.3.1.3.1.1	• P&P- Provider-Vendor-Subcontractor Overpayments- Pgs. 4-5 • DOD Workflow • Change of Address Workflow • Medicaid Verification of Services_Combined Letter Sample • DOP-Verification of Services • P&P- Provider Terminations	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor ensures that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure screening, and enrollment requirements of the State. • The Contractor may execute network provider agreements pending the outcome of the State's screening and enrollment process of up to one-hundred and twenty days (120) days, but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one one-hundred and twenty days (120)-day period without enrollment of the provider, and notify affected enrollees. *42 CFR 438.608(b)* DHMP Contract Amendment #1: Exhibit B-1—9.2.1.1, 9.3.2, 17.9.2	• DLP- Medicaid and Child Health Plan Plus Provider Revalidation Process	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor has procedures to provide to the State: • Written disclosure of any prohibited affiliation (as defined in 438.610). • Written disclosure of ownership and control (as defined in 455.104) • Identification within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract. *42 CFR 438.608(c)* DHMP Contract Amendment #1: Exhibit B-1—17.3.1.5.1.1, 17.9.4.3, 17.10.2.1	• P&P- Credentialing and Recredentialing of Practitioners- Pg. 7 • DOP- Recon Process	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The Contractor has a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days of identifying the overpayment, and to notify the Contractor in writing of the reason for the overpayment. • The Contractor reports semi-annually to the State on recoveries of overpayments. *42 CFR 438.608 (d)(2) and (3)* DHMP Contract Amendment #1: Exhibit B-1—17.1.5.8, 17.3.1.2.4.4	• Claims Guide 2020- Pg. 34-36 • DH_FWARpt_Q3Q4FY19-20- most recent report sent for overpayments/audits • P&P- Provider-Vendor-Subcontractor Overpayments- Pgs. 2-5	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. The Contractor provides that members are not held liable for: • The Contractor's debts in the event of the Contractor's insolvency. • Covered services provided to the member for which the State does not pay the Contractor. • Covered services provided to the member for which the State or the Contractor does not pay the health care provider that furnishes the services under a contractual, referral, or other arrangement. • Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. *42 CFR 438.106* DHMP Contract Amendment #1: Exhibit B-1—13.12.1-2; 14.14.1-2, 17.14.2-4	• Provider Manual 2020_Final- Pg. 65	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard VII—Provider Participation and Program Integrity							
Total	Met	=	15	X	1.00	=	15
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	15	**Total Score**		=	15
Total Score ÷ Total Applicable						=	100%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. • The Contractor shall use National Committee on Quality Assurance (NCQA) credentialing and re-credentialing standards and guidelines as the uniform and required standards for all applicable providers. *42 CFR 438.214(b)* NCQA CR1 DHMP Contract Amendment #1: Exhibit B-1—9.3.4.3.1	Note: These are NCQA MBHO and NCQA HP requirements available at the time of drafting this tool (6/2020). • Credentialing and Re-credentialing of Practitioners Page 1 Under Purpose	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners it credentials and recredentials. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. *Examples of BH practitioners include psychiatrists, physicians, addiction medicine specialists, doctoral or master's-level psychologists, master's-level clinical social workers, master's-level clinical nurse specialists or psychiatric nurse practitioners, and other behavioral health care specialists.* *Examples of HP practitioners include medical doctors, chiropractors, osteopaths, podiatrists, NPs, etc.* *42 CFR 438.214(a)* NCQA CR1—Element A1	• Provider Selection and Retention Policy Credentialing and Re-credentialing of Practitioners Pg 1 & 2 Under Scope and Policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.B. The verification sources it uses. NCQA CR1—Element A2	• Credentialing and Re-credentialing of Practitioners pg 10 H	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	• Credentialing and Re-credentialing of Practitioners Under pg 8 table F	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	• Credentialing and Re-credentialing of Practitioners pg 14 I & J	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.E. The process for managing credentialing/recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	• Credentialing and Re-credentialing of Practitioners Pgs 4 & 5 A.5, Pg 8 F	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.F. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. *Examples include: non-discrimination of applicant, process for preventing and monitoring discriminatory practices, and monitoring the credentialing/recredentialing process for discriminatory practices at least annually.* NCQA CR1—Element A6	• Credentialing and Re-credentialing of Practitioners pg 5 A	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.G. The process for notifying practitioners if information obtained during the Contractor's credentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A7	• Credentialing and Re-credentialing of Practitioners pg 5-6 B	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.H. The process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the Credentialing Committee's decision. NCQA CR1—Element A8	• Credentialing and Re-credentialing of Practitioners pg 14 J	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.I. The medical director or other designated physician's direct responsibility and participation in the credentialing program. NCQA CR1—Element A9	• Credentialing and Re-credentialing of Practitioners pg 2 (A)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.J. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law. NCQA CR1—Element A10	• Credentialing and Re-credentialing of Practitioners pg 5 #4 this is not tagged/flagged in policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.K. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification (including board certification, if applicable) and specialty. NCQA CR1—Element A11	• Credentialing and Re-credentialing of Practitioners pg 15 (L) • Web Based Provider Directory page 4-6	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor notifies practitioners about their rights: 3.A. To review information submitted to support their credentialing or recredentialing application. *The Contractor is not required to make references, recommendations, and peer-review protected information available.* NCQA CR1—Element B1	• Credentialing and Re-credentialing of Practitioners pg 5 (B)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3.B. To correct erroneous information. NCQA CR1—Element B2	• Credentialing and Re-credentialing of Practitioners pg 5 (B)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3.C. To receive the status of their credentialing or recredentialing application, upon request. NCQA CR1—Element B3	• Credentialing and Re-credentialing of Practitioners pg 5 (B)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing and recredentialing decisions. NCQA CR2—Element A1	• Credentialing and Re-credentialing of Practitioners pg 3 (D) and pg 6 (D)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Credentialing Committee: • Uses participating practitioners to provide advice and expertise for credentialing decisions. • Reviews credentials for practitioners who do not meet established thresholds. • Ensures that clean files are reviewed and approved by a medical director or designated physician. NCQA CR2—Element A	• Credentialing and Re-credentialing of Practitioners pg 6 (D) not tagged in policy I added	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. For credentialing and recredentialing, the Contractor verifies the following within the prescribed time limits: • A current, valid license to practice (verification time limit = 180 calendar days). • A valid, current Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (verification time limit = prior to the credentialing decision). • Education and training—the highest of the following: graduation from medical/professional school graduate; completion of residency; or board certification (verification time limit = prior to the credentialing decision; if board certification, time limit = 180 calendar days.) • Work history—most recent five years—if less, from time of initial licensure—from practitioner's application or CV (verification time limit = 365 calendar days). – If a gap in employment exceeds six months, the practitioner clarifies the gap verbally or in writing and notes clarification in the credentialing file. If the gap in employment exceeds	• Credentialing and Re-credentialing of Practitioners pg 7 E	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
one year, the practitioner clarifies the gap in writing. • History of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner—most recent five years (verification time limit = 180 calendar days). – The organization is not required to obtain this information for practitioners who had a hospital insurance policy during a residency or fellowship. *Note: Education/training and work history are NA for recredentialing. Verification of board certification does not apply to nurse practitioners or other health care professionals unless the organization communicates board certification of those types of providers to member.* NCQA CR3—Element A		
7. The Contractor verifies the following sanction information for credentialing and recredentialing (verification time limit = 180 days): • State sanctions, restrictions on licensure or limitations on scope of practice. • Medicare and Medicaid sanctions. NCQA CR3—Element B	• Credentialing and Re-credentialing of Practitioners pg 7 E	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. Applications for credentialing include the following (attestation verification time limit = 365 days): • Reasons for inability to perform the essential functions of the position, with or without accommodation. • Lack of present illegal drug use. • History of loss of license and felony convictions.	• Credentialing and Re-credentialing of Practitioners pg 8 F	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• History of loss or limitation of privileges or disciplinary actions. • Current malpractice insurance coverage (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate) • Current and signed attestation confirming the correctness and completeness of the application. NCQA CR3—Element C		
9. The Contractor formally recredentials its practitioners within the 36-month time frame. NCQA CR4	• Credentialing and Re-credentialing of Practitioners pg 10 (G)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor implements policies and procedures for ongoing monitoring and takes appropriate action, including: • Collecting and reviewing Medicare and Medicaid sanctions. • Collecting and reviewing sanctions or limitations on licensure. • Collecting and reviewing complaints. • Collecting and reviewing information from identified adverse events. • Implementing appropriate interventions when it identifies instances of poor quality related to the above. NCQA CR5—Element A	• Credentialing and Re-credentialing of Practitioners Pg 15-16 A-G	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor has policies and procedures for taking action against a practitioner who does not meet quality standards: • The range of actions available to the Contractor • Making the appeal process known to practitioners. *Examples of range of actions: how the organization reviews practitioners whose conduct could adversely affect members' health or welfare; the range of actions that may be taken to improve practitioner performance before termination; reporting actions taken to the appropriate authorities.* NCQA CR6—Element A	• Credentialing and Re-credentialing of Practitioners pg 14 (K) • Practitioner Appeal Rights and Notification to Authorities based on Issues of Quality of Care	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of *organizational* health care delivery providers and specifies that before it contracts with a provider, and for at least every 36 months thereafter: 12.A. The Contractor confirms that the organizational provider is in good standing with State and federal regulatory bodies. *Policies specify the sources used to confirm—which may only include applicable state or federal agency, agent of the applicable state or federal agency, or copies of credentials (e.g., state licensure) from the provider. Attestations are not acceptable.* NCQA CR7—Element A1	• Assessment of Organizational Providers pg 4 (5) A-H	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12.B. The Contractor confirms that the organizational provider has been reviewed and approved by an accrediting body. *Policies specify the sources used to confirm—which may only include applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, copies of credentials—e.g., licensure, accreditation report, or letter—from the provider. Attestations are not acceptable.* NCQA CR7—Element A2	• Assessment of Organizational Providers pg 4 (5) A-H	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12.C. The Contractor conducts an on-site quality assessment if the organizational provider is not accredited. *Policies include: on-site quality assessment criteria for each type of unaccredited organizational provider; a process for ensuring that the provider credentials its practitioners.* *The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: The CMS or State review is no more than three years old; the organization obtains a survey report or letter from CMS or the State, from either the provider or from the agency, stating that the facility was reviewed and passed inspection; the report meets the organization's quality assessment criteria or standards. (Exception: Rural areas.)* NCQA CR7—Element A3	• Assessment of Organizational Providers pg 5 First full paragraph	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor's organizational provider assessment policies and process includes: • For behavioral health, facilities providing mental health or substance abuse services in the following settings: – Inpatient – Residential – Ambulatory • For physical health, at least the following providers: – Hospitals – Home health agencies – Skilled nursing facilities – Free-standing surgical centers NCQA MBHO CR7—Element B NCQA HP CR7-Elements B&C	• Assessment of Organizational Providers pg 1,2 & 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor has documentation that it assesses behavioral health and or physical health providers every 36 months. NCQA MBHO CR7—Element C NCQA HP CR7-Elements D&E	• Credentialing and Re-credentialing of Practitioners pg 10 (G)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. If the Contractor delegates credentialing/re-credentialing activities, the Contractor has a written delegation document with the delegate that: • Is mutually agreed upon. • Describes the delegated activities and responsibilities of the Contractor and the delegated entity. • Requires at least semiannual reporting by the delegated entity to the Contractor (includes details of what is reported, how, and to whom). • Describes the process by which the Contractor evaluates the delegated entity's performance. • Specifies that the organization retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making. • Describes the remedies available to the Contractor (including circumstances that result in revocation of the contract) if the delegate does not fulfill its obligations, including revocation of the delegation agreement. NCQA CR8—Element A	• Delegation Template Bullet one: pg 1 paragraphs 1 & 3 Bullet two: pg 3 (B) Bullet three: pg 5 (F) Bullet Four: pg 3 #6 Bullet Five: pg 2 #3 Bullet Six: pg 3 #6 & 8	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. For new delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity to meet NCQA requirements before delegation began. *NA if the contractor does not delegate or if delegation arrangements have been in effect for longer than the look-back period.* NCQA CR8—Element B	• Delegation of Credentialing Activities pg 2 A	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. For delegation agreements in effect 12 months or longer, the Contractor: • Annually reviews its delegate's credentialing policies and procedures. • Annually audits credentialing and recredentialing files against its standards for each year that delegation has been in effect. • Annually evaluates delegate performance against its standards for delegated activities. • Semiannually evaluates regular reports specified in the written delegation agreement. NCQA CR8—Element C	• Delegation of Credentialing Activities pg 2 B 1-10	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
18. For delegation agreements that have been in effect for more than 12 months, at least once in each of the past two years, the Contractor identified and followed up on opportunities for improvement, if applicable. NCQA CR8—Element D	• Delegation of Credentialing Activities pg 3 #8	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	32	X	1.00	=	32
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	32	**Total Score**		=	32
				Total Score ÷ Total Applicable		=	100%

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. Notwithstanding any relationship(s) with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. *42 CFR 438.230(b)(1)* DHMP Contract Amendment #1: Exhibit B-1--4.2.12.2	• Contract for Medicaid and CHP Template Section 3.2 • Delegated Credentialing Agreement, Section A, 1	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. All contracts or written arrangements between the Contractor and any subcontractor specify: • The delegated activities or obligations and related reporting responsibilities. • That the subcontractor agrees to perform the delegated activities and reporting responsibilities. • Provision for revocation of the delegation of activities or obligations or specify other remedies in instances where the Contractor determines that the subcontractor has not performed satisfactorily. *Note: Subcontractor requirements do not apply to network provider agreements.* *42 CFR 438.230(b)(2) and (c)(1)* DHMP Contract Amendment #1: Exhibit B-1—4.2.12.6	• Contract for Medicaid and CHP Template Section 3.17 • Contract for Medicaid and CHP Template Section 3.28 • Delegated Credentialing Agreement, bullet 1Delegated Credentialing Agreement, Bullet 1 = section B Bullet 2 = cover and final page Bullet 3 = section A, 6	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's written agreement with any subcontractor includes: • The subcontractor's agreement to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions. *42 CFR 438.230(c)(2)* DHMP Contract Amendment #1: 21.B, Exhibit B-1—4.2.12.6	• Contract for Medicaid and CHP Template Section 3.2 • Delegated Credentialing Agreement, Section B, 2. • Delegation of Credentialing Activities Policy Pg, Policy Section	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. The written agreement with the subcontractor includes: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State. – The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems related to Medicaid enrollees. – The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. – If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of	• Contract for Medicaid and CHP Template Section 3.12 • Delegated Credentialing Agreement, Section B, 5-8 • Delegation of Credentialing Activities Policy Pg 2, Section B, 1	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. *42 CFR 438.230(c)(3)* DHMP Contract Amendment #1: Exhibit B-1—4.2.12.6		
Findings: The language used in the subcontracts varied significantly across contracts. While the new contract template submitted for Medicaid met requirements, three of the subcontracts did not contain all required language. The UPI contract included the correct language; however, the right to audit statement included a six-year rather than a 10-year right to audit time frame. HSAG noted that the Clarity and DHHA agreements were missing the right of CMS or the HHS-OIG to audit. The contracts were also missing the right to audit for 10 years from the final date of the contract periods, the types of documents or records to be made available, or other specifics outlined in the language of 42 CFR 438.230(c)(3).		
Required Actions: DHMP must revise the subcontracts to include all required language.		

Results for Standard IX—Subcontractual Relationships and Delegation							
Total	Met	=	3	X	1.00	=	3
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	4	**Total Score**		=	3
				Total Score ÷ Total Applicable		=	75%

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. *42 CFR 438.330(a)* DHMP Contract Amendment #1: Exhibit B-1—16.1.1	• MCD_CHP+_QI_Program_Description_2020-2021 • 2020-2021 MCD_CHP+ Work Plan • 2019-2020 MCD_CHP+ Evaluation • SEPTEMBER 2020 QMC MINUTES-signed • Draft Jan 2021 QMC Minutes	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor's QAPI Program includes conducting and submitting (to the State) annually performance improvement projects (PIPs) that focus on both clinical and nonclinical areas. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. Each PIP includes the following: • Measurement of performance using objective quality indicators. • Implementation of interventions to achieve improvement in the access to and quality of care. • Evaluation of the effectiveness of the interventions based on the objective quality indicators. • Planning and initiation of activities for increasing or sustaining improvement. *For DHMP two PIPs are required, one for physical health and one for behavioral health.* *42 CFR 438.330(b)(1) and (d)(2) and (3)* DHMP Contract Amendment #1: Exhibit B-1—16.2.1.1, 16.3.5, 16.3.8	• PIP Documents folder	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's QAPI Program includes collecting and submitting (to the State): • Quarterly performance measure data using standard measures identified by the State. • Data, specified by the State, which enables the State to calculate the Contractor's performance using the standard measures identified by the State. • A combination of the above activities. *42 CFR 438.330(b)(2) and (c)* DHMP Contract Amendment #1: Exhibit B-1—16.4.1, 16.4.4	• CAHPS 2020 IDSS SCREENSHOT • HEDIS 2020 IDSS SCREENSHOT • 2019-2020 MCD_CHP+ Evaluation	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42 CFR 438.330(b)(3)* DHMP Contract Amendment #1: Exhibit B-1—16.6.1	• 2019-2020 MCD_CHP+ Evaluation- Pg. 6 • SEPTEMBER 2020 QMC MINUTES-signed • Draft Jan 2021 QMC Minutes • Over-Under Utilization presentation September 2020 • Over Under Utilization for HEDIS measures MY 2019	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Contractor's QAPI program includes mechanisms for identifying, investigating, analyzing, tracking, trending and resolving any alleged quality of care concerns. DHMP Contract Amendment #1: Exhibit B-1—16.7.1.1, 16.7.2	• P&P- Notification and Investigation of Quality of Care Complaints • SEPTEMBER 2020 QMC MINUTES-signed- Pg. 7 & 8. QOCC are addressed at every QMC meeting. • QOCC Case Report Q1 2020- example of reviewing QOCC in a standard format	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. *Note: Persons with special health care needs shall mean persons having ongoing health conditions that have a biological, psychological, or cognitive basis; have lasted or are estimated to last for at least one year; and produce one or more of the following: 1) a significant limitation in areas of physical, cognitive, or emotional function; 2) dependency on medical or assistive devices to minimize limitation of function or activities; 3) for children: significant limitation in social growth or developmental function; need for psychological, educational, medical, or related services over and above the usual for the child's age; or special ongoing treatments such as medications, special diets, interventions, or accommodations at home or at school.* *42 CFR 438.330(b)(4)* DHMP Contract Amendment #1: Exhibit B-1—16.2.1.4, 16.5.5 10 C.C.R. 2505-10, 8.205.9	• P&P-Coordination and Continuity of Care for Members with Special Health Care Needs • 2019-2020 MCD_CHP+ Evaluation- Pgs. 11, 27 • Job Aid – Time Frames with Special Needs • Quality Performance for Members with Special Health Care Needs report Dec 2019 - May 2020 • Population Mgmt Strategic Plan_DHMP SFY20-21 07212020 • 2019 Pop Health Strategy Evaluation	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The Contractor monitors member perceptions of accessibility and adequacy of services provided. Tools shall include, at a minimum: • Member surveys • Anecdotal information • Grievance and appeals data • Call center data • CAHPS survey • ECHO survey DHMP Contract Amendment #1: Exhibit B-1—16.5.1-3, 16.5.6, 16.5.8	• DH_GrieveAppealRpt_Q4FY19-20 (Excel) • DH_GrieveAppealRpt_Q4FY19-20 (PDF) • 2020 Pharmacy Member Satisfaction Survey Results- Slide 7 shows Medicaid specific results, Slides 10-15 shows additional open ended feedback from Medicaid members • Member Satisfaction Survey_GC Script • 2019-2020 MCD_CHP+ Evaluation- various pages	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis. *42 CFR 438.330(e)(2)* DHMP Contract Amendment #1: Exhibit B-1—16.2.5	• 2019-2020 MCD_CHP+ Evaluation	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor adopts practice guidelines that meet the following requirements: • Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. • Consider the needs of the Contractor's members. • Are adopted in consultation with contracted health care professionals. • Are reviewed and updated periodically as appropriate. *42 CFR 438.236(b)* DHMP Contract Amendment #1: Exhibit B-1—13.6.9.1-3, 14.8.8.1-3	DHMP contract—practice guidelines apply to both BH and PH services. • Guidelines 2020 Folder • COA Clinical Practice Guidelines	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor disseminates the guidelines to all affected providers, and upon request, to members and potential members. *42 CFR 438.236(c)* DHMP Contract Amendment #1: Exhibit B-1—13.6.9; 14.8.8	• DHMP Member Newsletter_Summer 2020- Pg. 10 • QI Website for Providers • Screenshot of Provider Newsletter Topics • DHMP Provider Newsletter_QI Programs and Goals_3-11-20 • Provider Manual 2020- Pg. 29 • 2020 Medicaid Member Handbook - Pg. 36	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42 CFR 438.236(d)* DHMP Contract Amendment #1: Exhibit B-1—13.6.10	• IRR Completion Report 10-13-20- Report scores for reader reliability for staff to make sure they are meeting guidelines • P&P- Inter-Rater Reliability of Utilization Management • 2020 Medicaid Member Handbook- Pg. 31	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42 CFR 438.242(a)* DHMP Contract Amendment #1: Exhibit B-1—15.1.1	• Information System-Summary.asd • AltruistaHealth-DHHA-ETL-Process-1510	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
13. The Contractor's health information system provides information on areas including, but not limited to, utilization, encounters, claims, grievances and appeals, and disenrollment (for reasons other than loss of Medicaid eligibility). *42 CFR 438.242(a)* DHMP Contract Amendment #1: Exhibit B-1—15.1.1, 8.1.3	Note: For DHMP, these elements apply to both BH and PH services. • Information System-Summary.asd • COA Architecture Diagram V1.6 • COA_R3_R5_CO2020-21_HSAG_Standard X 13-14 • COA CLM SWP01 37&837 Encounter File Process 10.06.20 • COA Systems_to_Manage_Health_ Information_Data	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Although DHMP's health information system provided information on utilization, encounters, claims, grievances, and appeals, there was no procedure for monitoring disenrollment for reasons other than the loss of Medicaid eligibility. Staff members reported that the data sources have not been particularly reliable and, to date, these disenrollment trends had not been reported through quality, member services, or elsewhere.		
Required Actions: DHMP must develop a mechanism to collect information regarding disenrollment for reasons other than the loss of Medicaid eligibility.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor's claims processing and retrieval systems collect data elements necessary to enable the mechanized claims processing and information retrieval systems operated by the State. • Contractor electronically submits encounter claims data in the interchange ANSI X12N 837 format directly to the Department's fiscal agent using the Department's data transfer protocol. The 837-format encounter claims (reflecting claims paid, adjusted, and/or denied by the Contractor) shall be submitted via a regular batch process. *42 CFR 438.242(b)(1)* DHMP Contract Amendment #1: Exhibit B-1—15.2.3.1, 15.2.3.2	Note: for DHMP, claims/encounter systems relate to both BH and PH capitated services. • Information System-Summary.asd • COA Architecture Diagram V1.6 • COA_R3_R5_CO2020-21_HSAG_Standard X 13-14 • COA CLM SWP01 37&837 Encounter File Process 10.06.20 • COA Systems_to_Manage_Health_ Information_Data	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. The Contractor collects data on member and provider characteristics and on services furnished to members through an encounter data system (or other methods specified by the State). *42 CFR 438.242(b)(2)* DHMP Contract Amendment #1: Exhibit B-1—15.2.2, 15.2.3	• Information System-Summary.asd • Encounter Submission Example with Member Provider Data • Encounter Submission Example	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. The Contractor ensures that data received from providers are accurate and complete by: • Verifying the accuracy and timeliness of reported data, including data from network providers compensated through capitation payments. • Screening the data for completeness, logic, and consistency.	• DHHA Directory Audit • DHHA Roster 9.2020 • Care Coordination via Epic Healthy Planet Link • Web-Based Provider and Hospital Directory • Data Warehouse Explanation	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for Medicaid quality improvement and care coordination efforts. • Making all collected data available to the State and upon request to CMS. *42 CFR 438.242(b)(3) and (4)* DHMP Contract Amendment #1: Exhibit B-1—15.2.3.1, 15.2.3.6.1		
17. The Contractor: • Collects and maintains sufficient member encounter data to identify the provider who delivers any items or services to members. • Submits member encounter data to the State in standardized ASC X12N 837 formats as appropriate. • Submits member encounter data to the State at the level of detail and frequency specified by the State (within 120 days of an adjudicated provider claim). *42 CFR 438.242(c)* DHMP Contract Amendment #1: Exhibit B-1—15.2.2.1-2, 15.2.3.2, 15.2.3.4, 15.2.3.6	• Information System-Summary.asd • Encounter Submission Example with Member Provider Data • Encounter Submission Example	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard X—Quality Assessment and Performance Improvement							
Total	Met	=	16	X	1.00	=	16
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	17	**Total Score**		=	16
			Total Score ÷ Total Applicable			=	94%

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Credentialing Record Review Tool
for Denver Health Medical Plan MCO

Review Period:	January 1, 2020–December 31, 2020
Date of Review:	February 3, 2021
Reviewer:	Sarah Lambie
Health Plan Participant:	Shanique Horne & Kerilyn Matsunaga Gottlieb

Sample #	1	2	3	4	5	6	7	8	9	10
	Valid License/No Sanctions	DEA/CDS Certificate	Education/ Training	Board Certified	Work History	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits
File #1 Provider ID: **** Credentialing Date: 03/30/2020	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #2 Provider ID: **** Credentialing Date: 05/19/2020	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #3 Provider ID: **** Credentialing Date: 09/25/2020	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #4 Provider ID: **** Credentialing Date: 05/31/2020	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Credentialing Record Review Tool
for Denver Health Medical Plan MCO

Sample #	1	2	3	4	5	6	7	8	9	10
	Valid License/No Sanctions	DEA/CDS Certificate	Education/ Training	Board Certified	Work History	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits
File #5 Provider ID: **** Credentialing Date: 02/26/2020	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #6 Provider ID: **** Credentialing Date: 02/26/2020	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #7 Provider ID: **** Credentialing Date: 09/25/2020	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #8 Provider ID: **** Credentialing Date: 06/29/2020	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #9 Provider ID: **** Credentialing Date: 10/27/2020	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Credentialing Record Review Tool
for Denver Health Medical Plan MCO

Sample #	1	2	3	4	5	6	7	8	9	10
	Valid License/No Sanctions	DEA/CDS Certificate	Education/ Training	Board Certified	Work History	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits
File #10 Provider ID: **** Credentialing Date: 02/26/2020	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
Number of Applicable Elements	**10**	**6**	**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**
Number of Compliant Elements	**10**	**6**	**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**
Percentage Compliant	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Total Number of Applicable Elements	**96**
Total Number of Compliant Elements	**96**
Overall Percentage Compliant	**100%**

Key: Y = Yes; N = No; NA = Not Applicable

Instructions:

1. Current, valid license with verification that no State sanctions exist
2. Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate (applicable to practitioners qualified to write prescriptions—e.g., psychiatrists, MD, DO)
3. Education/training—the highest of board certification, residency, graduation from medical/professional school
4. Applicable if the practitioner states on the application that he or she is board certified
5. Most recent five years or from time of initial licensure (if less than five years)
6. Malpractice settlements in most recent five years
7. Current malpractice insurance (physicians: $500,000/$1.5 million) verified through certificate of insurance

8. Verified that provider is not excluded from participation in federal programs

9. Application must be complete (see compliance tool for elements of complete application)

10. Verification time limits:

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

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Recredentialing Record Review Tool
for Denver Health Medical Plan MCO

Review Period:	January 1, 2020–December 31, 2020
Date of Review:	February 3, 2021
Reviewer:	Sarah Lambie
Health Plan Participant:	Shanique Horne & Kerilyn Matsunaga Gottlieb

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
File #1 Provider ID: **** Current Recredentialing Date: 08/27/2020 Prior Credentialing or Recredentialing Date: 08/27/2017, 12/04/2015	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #2 Provider ID: **** Current Recredentialing Date: 02/26/2020 Prior Credentialing or Recredentialing Date: 03/01/2017	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #3 Provider ID: **** Current Recredentialing Date: 10/27/2020 Prior Credentialing or Recredentialing Date: 11/12/2017, 12/18/2015	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
File #4 Provider ID: **** Current Recredentialing Date: 06/29/2020 Prior Credentialing or Recredentialing Date: 07/26/2017, 11/23/2015	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #5 Provider ID: **** Current Recredentialing Date: Prior Credentialing or Recredentialing Date: Not Applicable	Y ☐ N ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Comments: After multiple attempts to recredential, DHMP terminated the process on May 12, 2020. An additional file from the oversample was used to replace this record.									
File #6 Provider ID: **** Current Recredentialing Date: 06/29/2020 Prior Credentialing or Recredentialing Date: 07/26/2017, 12/04/2015	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #7 Provider ID: **** Current Recredentialing Date: 07/28/2020 Prior Credentialing or Recredentialing Date: 07/13/2017	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
Comments:									
File #8 Provider ID: **** Current Recredentialing Date: 08/27/2020 Prior Credentialing or Recredentialing Date: 12/16/2017	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #9 Provider ID: **** Current Recredentialing Date: 03/30/2020 Prior Credentialing or Recredentialing Date: 04/01/2017, 11/13/2015	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #10 Provider ID: **** Current Recredentialing Date: 09/25/2020 Prior Credentialing or Recredentialing Date: 09/26/2017	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Recredentialing Record Review Tool
for Denver Health Medical Plan MCO

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
File #OS1 Provider ID: **** Current Recredentialing Date: 04/22/2020 Prior Credentialing or Recredentialing Date: 06/19/2017, 11/23/2015	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
Number of Applicable Elements	**10**	**8**	**8**	**10**	**10**	**10**	**10**	**10**	**10**
Number of Compliant Elements	**10**	**8**	**8**	**10**	**10**	**10**	**10**	**10**	**10**
Percentage Compliant	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Total Number of Applicable Elements	**86**
Total Number of Compliant Elements	**86**
Overall Percentage Compliant	**100%**

Key: Y = Yes; N = No; NA = Not Applicable

Instructions:

1. Current, valid license with verification that no State sanctions exist
2. Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate (applicable to practitioners qualified to write prescriptions—e.g., psychiatrists, MD, DO)
3. Applicable if the practitioner states on the application that he or she is board certified
4. Malpractice settlements in most recent five years
5. Current malpractice insurance (physicians: $500,000/$1.5 million) verified through certificate of insurance
6. Verified that provider is not excluded from participation in federal programs

7. Application must be complete (see compliance tool for elements of complete application)

8. Verification time limits:

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

9. Within 36 months of previous credentialing or recredentialing approval date

Appendix C. Site Review Participants

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

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

HSAG Review Team	Title
Barbara McConnell	Executive Director
Sarah Lambie	Project Manager III
Erica Arnold-Miller	Project Manager II
DHMP Participants	**Title**
Bridget Johnson	Director of Compliance and Internal Audit
Bridget Kalell	DHMP Marketing and Sales Manager
Catherine Fortney	Chief Compliance and Audit Officer
Christopher Garcia	MC Government Products Analyst
Cynthia Chachas	Director of Pharmacy
Dallen Waldenrath Gomez	Health Plan Compliance Analyst
Gregg Kamas	Quality Improvement and Accreditation Director
Greg McCarthy	Executive Director, Managed Care
Jeremy Sax	Government Products Manager
Kaitlin Gaffney	MC Government Products Analyst
Kerilyn Matsunaga Gottlieb	Contract Manager, Provider Relations
Lisa Artale Bross	Compliance Manager
Lucas Wilson	Director of Information Services
Marques Haley	Monitoring, Auditing and Training Manager
Michael Wagner	Chief Administrative Officer, Managed Care/DHMP
Murielle Romine	Project Manager
Natalie Score	Director of Insurance Products
Shanique Horne	Director of Provider Relations and Contracts
Department Observers	**Title**
Ben Harris	ACC Program Specialist
Curt Curnow	Quality Improvement Section Manager
Russ Kennedy	Quality Program Manager
Tyller Kerrigan-Nichols	Managed Care Contract Specialist

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

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

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

The CAP template follows.

Table D-2—FY 2020–2021 Corrective Action Plan for DHMP

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Findings**	**Required Action**
4. The written agreement with the subcontractor includes: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State. – The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems related to Medicaid enrollees. – The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. – If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or	The language used in the subcontracts varied significantly across contracts. While the new contract template submitted for Medicaid met requirements, three of the subcontracts did not contain all required language. The UPI contract included the correct language; however, the right to audit statement included a six-year rather than a 10-year right to audit time frame. HSAG noted that the Clarity and DHHA agreements were missing the right of CMS or the HHS-OIG to audit. The contracts were also missing the right to audit for 10 years from the final date of the contract periods, the types of documents or records to be made available, or other specifics outlined in the language of 42 CFR 438.230(c)(3).	DHMP must revise the subcontracts to include all required language.

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Findings**	**Required Action**
similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. *42 CFR 438.230(c)(3)* DHMP Contract Amendment #1: Exhibit B-1—4.2.12.6		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
13. The Contractor's health information system provides information on areas including, but not limited to, utilization, encounters, claims, grievances and appeals, and disenrollment (for reasons other than loss of Medicaid eligibility). *42 CFR 438.242(a)* DHMP Contract Amendment #1: Exhibit B-1—15.1.1, 8.1.3	Although DHMP's health information system provided information on utilization, encounters, claims, grievances, and appeals, there was no procedure for monitoring disenrollment for reasons other than the loss of Medicaid eligibility. Staff members reported that the data sources have not been particularly reliable and, to date, these disenrollment trends had not been reported through quality, member services, or elsewhere.	DHMP must develop a mechanism to collect information regarding disenrollment for reasons other than the loss of Medicaid eligibility.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review Protocol Activities

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

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal managed care regulations and Department contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all site reviewers to ensure consistency in scoring across MCOs.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided MCOs with proposed site review dates, group technical assistance and training, as needed. • HSAG confirmed a primary MCO contact person for the site review and assigned HSAG reviewers to participate in the site review. • Sixty days prior to the scheduled date of the site review, HSAG notified the MCO in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and an site review agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and the site review activities. Thirty days prior to the review, the MCO provided documentation for the desk review, as requested. • Documents submitted for the desk review and site review consisted of the completed desk review form, the compliance monitoring tool with the MCO's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. • The MCO also submitted a list of all provider credentialing records and all provider recredentialing records that occurred between January 1, 2020, and December 31, 2020 (to the extent available at the time of the site review). The MCO submitted the lists to HSAG 10 days following receipt of the desk review request. HSAG used a random sampling technique to select records for desk review and the site review.

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