COLORADO

Department of Health Care Policy & Financing

Fiscal Year 2021–2022 Site Review Report

for

Denver Health Medical Plan
Region 5 Managed Care Organization

April 2022

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 Health Care 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 Primary Care Case Management (PCCM) entities and Prepaid Inpatient Health Plans (PIHPs) to comply with specified provisions of 42 CFR §438—managed care regulations—and requires that states conduct a periodic evaluation of their PCCM entities and PIHPs to determine compliance with federal Medicaid managed care regulations published May 6, 2016. Additional revisions were released in November 2020, with an effective date of December 2020. The Department has elected to complete this requirement for the MCOs by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This report documents results of the fiscal year (FY) 2021–2022 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 2021–2022 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2020–2021 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B lists HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix C describes the corrective action plan (CAP) process that the health plan will be required to complete for FY 2021–2022 and the required template for doing so. Appendix D 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: Sep 27, 2021.

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)
III. Coordination and Continuity of Care	10	10	10	0	0	0	100%
IV. Member Rights, Protections, and Confidentiality	6	6	6	0	0	0	100%
V. Member Information Requirements	18	18	14	4	0	0	78%
XI. Early and Periodic Screening, Diagnostic, and Treatment Services	7	7	7	0	0	0	100%
Totals	**41**	**41**	**37**	**4**	**0**	**0**	**90%**

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

Standard III—Coordination and Continuity of Care

Summary of Strengths and Findings as Evidence of Compliance

DHMP described a team of 26 employees comprised of care managers providing healthcare provider coordination across 17 care management programs, ranging from transition of care, disease management, complex case management, high utilizers, emotional well-being, medication management, and other lower-level supports. Members are informed about how to contact their primary healthcare providers through welcome materials, and members enrolled in a specific care management program receive a welcome letter with additional contact information.

Submitted documentation provided a wide variety of details regarding how **DHMP** makes its best effort to assess member healthcare needs within the first 90 days after enrollment. If the Department's initial attempt to collect health needs survey data was unsuccessful, the contracted vendor, Symphony Performance Health, Inc. (SPH), works to collect the health needs survey in paper format and follows up with a telephone survey if the mailed survey is unsuccessful. If the health needs survey indicates a healthcare or support need, **DHMP** care management staff members follow up on any identified needs with additional specialized assessments in a timely manner. Members with special healthcare needs were clearly defined in the policy and procedure and could be identified through data. The case management referral form was also available online for ease of submitting outside referrals.

Members could access the **DHMP** portal which included programs to assist with healthcare self-management skills and goals. **DHMP** documented all other care planning in the Altruista GuidingCare system. **DHMP** stated that its staff members monitored notes, care plans, and documentation through various audits and cross-functional activities.

DHMP submitted a workflow of operations for coordinating behavioral health services and care management needs with Colorado Access (COA) through email on a daily basis and regular team meetings. Policies described that care coordination team members have a Care Coordination Department contact list which provided contact information for internal team members as well as COA contact information for BH services. Submitted workflows detailed daily communication methods which staff members reported using to facilitate real-time updates between **DHMP** and COA. Although there was no current data inter-operability between the entities, both health plans used similar software systems and held regular meetings to review strengths and opportunities regarding care management activities.

Care management leadership described frequent, internal coordination and planning meetings that are attended by staff members such as social workers, transition-of-care nurses, and other specialty providers, as needed, in an effort to communicate the member's status to the treatment team and reduce duplication of activities. **DHMP**'s ability to coordinate efficiently and effectively is further supported by the EPIC system's ability to send out a system-wide message to the treatment team, which **DHMP** staff members described as particularly useful if there were to be a roadblock in seeking care/next steps. When communication outside **DHMP**'s EPIC system was required, staff members reported providers

and administrative staff utilized encrypted email to ensure compliance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) and privacy standards.

To aid with additional referrals, call center and care management staff members maintained access to a master list of community resources, services, and supports. Additionally, care management staff members described that these entities frequently joined the care management team meetings to provide details about the way to effectively refer members.

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 IV—Member Rights, Protections, and Confidentiality

Summary of Strengths and Findings as Evidence of Compliance

The *Member Rights and Responsibilities* policy outlined member rights and responsibilities and how **DHMP** complies with applicable federal and State laws. The provider manual, code of conduct, policies, and annual trainings such as the *Basics of LGBTQ Affirming Care* and *Denver Health Experience* informed its workforce about these laws. **DHMP**'s policies and staff members described that **DHMP** communicates member rights through various channels such as the member handbook, provider manual, new provider orientation, provider and member newsletters, website, the grievance system, the *Notice of Privacy Practices*, and evidence of coverage information.

DHMP provided a robust *HIPAA Hybrid Entity Health Care Components* policy that discussed measures for securing and transmitting personal health information (PHI), including how **DHMP** maintains adequate safeguards and firewalls. During the review, staff members described the annual trainings regarding HIPAA's general, practical, and position-specific requirements.

DHMP's policies and procedures, Medicaid Choice member handbook, member newsletter, website, and provider manual educates members, providers, and staff on advance directives. The **DHMP** website provides members and the community with information on advance directives (including accepting medical treatment, refusing medical treatment, living wills, resuscitation directives, substitute decision makers, and medical guardians) and provides the following forms: medical power of attorney, living will, and the cardiopulmonary resuscitation (CPR) directive. The *Advance Directives* policy referenced applicable State law concerning advance directives and stated that "members are not required to have an

advance directive and the existence or lack of an advance directive does not determine a member's access to care, treatment, and services; members are not discriminated against based on whether or not they have executed an advance directive." Staff members reported that **DHMP** did not have any limitations regarding the implementation of an advance directive as a matter of conscience and was not aware of any providers having limitations.

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 V—Member Information Requirements

Summary of Strengths and Findings as Evidence of Compliance

Staff members discussed the process for members to review and provide recommendations for communications and informational materials through the "Connect with Us" website. The *Creation, Review and Readability of Member Materials* policy stated that **DHMP**'s member materials contain culturally and gender sensitive images and content understandable at a sixth-grade reading level, and that materials are available in English and other languages. The Medicaid Choice member website and provider directory provided accessibility widgets to accommodate members with special needs. The provider directory included the option to export search results to PDF. During the review, staff members demonstrated how **DHMP** ensures Americans with Disabilities Act of 1990 (ADA) and other accommodations can be found on the **DHMP** website in the same area as the provider directory search feature.

DHMP utilizes the Medicaid Choice welcome letter and member handbook, quick reference guide (QRG), and new member orientation videos to assist members in understanding its requirements and benefits. **DHMP** maintains contracts with vendors that have delegated responsibilities to support the member information requirements. Vendors are delegated responsibilities for translation services (translations of member materials and communications), interpreter services (utilized during calls with members that speak alternate languages), as well as printing services for all member materials. Staff members reported that **DHMP** sends welcome packet information to members within approximately 10 days of enrollment, and **DHMP** provided the *New Member 834 Enrollment Example* and the *New Member Enrollment Packet Example* documents to show the turnaround time from when **DHMP** receives notification about a member's enrollment from the Department to when the member is provided

with the new member enrollment packet. The contract outlined the vendor's responsibility to mail new member materials within two days of the vendor's receipt of the 834-member enrollment file.

Through policies, procedures, and processes, **DHMP** described its objectives and goals for the organization to foster a cultural and language sensitive workplace. The *Cultural and Linguistic Appropriate Service (CLAS)* policy discussed an assessment given to bilingual staff to test for fluency levels in a target language. The *CLAS* policy stated that **DHMP** maintains a library of culturally sensitive educational materials, and staff members are required to complete trainings related to cultural diversity and the use of interpreter services. **DHMP**'s member website contained all the required information. HSAG observed that **DHMP**'s provider directories are made available on the website in a machine-readable file and format. **DHMP** submitted the *Provider Terminations* policy and sample termination letters for review. The *Provider Terminations* policy detailed the process to notify members affected by the termination of a provider within 15 days after receipt of notification or 30 days prior to effective termination date. **DHMP** described its involvement in ensuring that members are assisted with selecting a new provider. The Medicaid member handbook stated that "DHMC does not use a Physician Incentive Plan. This means that DHMC does not pay providers more money to give you less health care services or pay providers less money when they give you more health care services."

Summary of Findings Resulting in Opportunities for Improvement

While taglines were present in the summer and winter 2021 member newsletters, the taglines were on the last page of these letters. HSAG recommends that the taglines be present on the first page, or at the beginning, of any critical member informational materials per the intent of the tagline to direct members to other resources if needed.

Summary of Required Actions

DHMP described its use of a Health Literacy software to test and review the sixth-grade readability of member materials. Staff members explained that when assessing member materials, **DHMP** aimed to maintain some clinical terminology that would not have the same meaning if replaced. Additionally, staff members described that **DHMP**'s approach focused on the "critical health related" details of documents (e.g., member rights) and did not always include readability checks for non-health-related information (e.g., nutritional recipes in the member newsletter). HSAG observed during readability testing that even when excluding complex content such as phone numbers, websites, and benefit information that might be more clinical in nature, some critical member materials were above the sixth-grade reading level. **DHMP** must develop mechanisms to ensure that all required member informational materials may be easily understood (i.e., sixth-grade reading level) to the extent possible. HSAG recommends using simplified language next to any clinical terminology that **DHMP** does not wish to alter.

In **DHMP**'s Medicaid Choice member handbook, the "grievance" definition was inconsistent with the State and the federal definition. **DHMP** defined a grievance as a "formal complaint" instead of "any

expression of dissatisfaction." **DHMP** must update the definition of "grievance" in the Medicaid Choice member handbook to be consistent with the State and federal definition.

The *Creation, Review, and Readability of Member Materials* policy stated that all written materials for members must use a font size no smaller than 12 points, be available in alternative formats and provide access to auxiliary aids and services while taking into consideration members with disabilities and limited English proficiency, include toll-free customer service and TTY/TDD numbers, and available at no cost to members. The *Translation-508 Compliance-Alternative Format Requests* document described the procedures to ensure compliance with member information requirements. However, the **DHMP** Medicaid member handbook, welcome letter, QRG, provider directory tip sheet, and formulary list did not include all the required components of a tagline. **DHMP** must revise the Medicaid Choice member handbook website, welcome letter, QRG, provider directory tip sheet, and formulary list to include all required components of a tagline.

Although **DHMP** provided a section of the printing vendor contract to demonstrate a two business day turnaround time for when new member enrollment packets are mailed, the submitted section did not provide any supporting documentation regarding ad-hoc requests for printed materials. **DHMP** must develop a mechanism to ensure that upon request, members are provided with printed materials within five business days and at no cost.

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services

Summary of Strengths and Findings as Evidence of Compliance

During the virtual interview, staff members described **DHMP**'s approach to compiling and disseminating Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services informational materials. **DHMP** used the vendor SPH to gather initial assessment information from each new member using mailed assessment forms and following up with phone calls. **DHMP**'s reported outreach completion rates showed improvement from 5 percent to 10 percent over the review period, and staff members described the growth of maternal care caseloads from July 1, 2021, through December 31, 2021.

EPSDT materials used a combination of approaches to onboard and inform members within the first 60 days after eligibility determination, and staff members described multiple methods to outreach members at least one time annually if a member had not utilized EPSDT services. These reminders occurred through the form of annual birthday fliers, the member portal, care management outreach, and direct provider outreach.

Providers were informed about EPSDT services at the time of contracting through the provider manual and on an ongoing basis through the provider newsletter. During calendar year 2021, **DHMP** distributed a provider newsletter with EPSDT information once every six months that linked to the Department's

EPSDT training and additional Department-approved resources. Provider materials noted that EPSDT services are at no cost to the member and linked the provider to additional billing resources.

DHMP ensured screenings and exams were recorded through various claims audits and care management review. Staff members noted that some EPSDT services were difficult to provide in a timely manner and described other means of attempting to meet the member's needs until the member could receive the service (e.g., residential care). **DHMP** stated that in these situations, provider relations attempted to secure one-time contract agreements with providers to fill in any network gaps. Staff members also described outreach to other available resources to attempt to fill care gaps while the member waited for previously authorized services. Submitted documentation included a *Community Resource* attachment with over 200 resources for care managers to assist with EPSDT referrals and other healthcare needs.

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.

2. Overview and Background

Overview of FY 2021–2022 Compliance Monitoring Activities

For the FY 2021–2022 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 III—Coordination and Continuity of Care, Standard IV—Member Rights, Protections, and Confidentiality, Standard V—Member Information Requirements, and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services. 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 health plan'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, 2021, through December 31, 2021. HSAG conducted a desk review of materials submitted prior to the site review activities; a review of documents and materials requested during the site review; and interviews of key health plan 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.

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 D 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 2021–2022 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 VI—Grievance and Appeal Systems, 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.

Objective of the Site Review

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

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

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

FY 2020–2021 Corrective Action Methodology

As a follow-up to the FY 2020–2021 site review, each health plan that received one or more *Partially Met* or *Not Met* scores was required to submit a CAP to the Department addressing those requirements found not to be fully compliant. If applicable, the health plan was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the health plan and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **DHMP** until it completed each of the required actions from the FY 2020–2021 compliance monitoring site review.

Summary of FY 2020–2021 Required Actions

For FY 2020–2021, HSAG reviewed Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontractual Relationships and Delegations, and Standard X—Quality Assessment and Performance Improvement.

There were no required actions for Standard VII—Provider Participation and Program Integrity or Standard VIII—Credentialing and Recredentialing.

Related to Standard IX—Subcontractual Relationships and Delegations, **DHMP** was required to revise subcontracts to include all required language as outlined in 42 CFR 438.230(c)(3).

Related to Standard X—Quality Assessment and Performance Improvement, **DHMP** was required to develop mechanisms to collect information regarding disenrollment for reasons other than the loss of Medicaid eligibility.

Summary of Corrective Action/Document Review

DHMP submitted a proposed CAP in May 2021. HSAG and the Department reviewed and approved the proposed plan. Initial documents as evidence of completion were submitted in September 2021. **DHMP** resubmitted final CAP documents in October 2021.

Summary of Continued Required Actions

DHMP successfully completed the FY 2020–2021 CAP, resulting in no continued corrective actions.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. A. The MCO implements procedures to deliver care to and coordinate services for all members. B. *For all MCO members*, the MCO's care coordination activities place emphasis on acute, complex, and high-risk patients and ensure active management of high-cost and high-need patients. The MCO ensures that care coordination: • Is accessible to members. • Is provided at the point of care whenever possible. • Addresses both short- and long-term health needs. • Is culturally responsive. • Respects member preferences. • Supports regular communication between care coordinators and the practitioners delivering services to members. • Reduces duplication and promotes continuity by collaborating with the member and the member's care team to identify a lead care coordinator for members receiving care coordination from multiple systems. • Is documented, for both medical and non-medical activities. • Addresses potential gaps in meeting the member's interrelated medical, social, developmental, behavioral, educational, informal support system, financial, and spiritual needs. *42 CFR 438.208(b)*	• Policy "Case Management for Medicaid Choice and Child Health Plans Plus Members" • Policy "Complex Case Management Process" • Care Coordination via Epic Healthy Planet Link- Documentation system • CM Activity Health Care Provider Coordination • CM Activity BH Coordination • Epic Healthy Planet Link Screenshots • Policy "Complex Case Management Member Identification Process" • Policy "Cultural and Linguistic Appropriate Services -CLAS" • Policy "Member Rights & Responsibilities" • Sample CM Complex Health Assessment • Sample CM Functional Assessment • CM SDOH Assessment • Screenshots Epic SDOH Wheel_Gaps in Care	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
DHMP Contract Amendment 4: Exhibit B-4—11.3.1, 11.3.7		
2. The MCO ensures that each member has an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member. • The member must be provided information on how to contact their designated person or entity. *42 CFR 438.208(b)(1)* DHMP Contract Amendment 4: Exhibit B-4—None	• Policy "Case Management for Medicaid Choice and Child Health Plans Plus Members"- pg. 5 • Standard III_2_Screenshots_MCD: Website, CM Referral Form, COA Behavioral Health • Medicaid Member Handbook- Pg. 36-37 • DHMP Member Newsletter_Fall 2021- Pg. 10 • Care Management Self-Referral Form	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The MCO receives and processes the Department's attribution and assignment list to ensure accurate member attribution and assignment. Members enrolled in the MCO have 90 days in which to opt out. Any member who does not opt out remains enrolled until the member's next open enrollment period, at which time the member shall receive an open enrollment notice. Subsequent enrollment will be for 12 months, and a member may not disenroll from the limited managed care capitation initiative (except as provided in the disenrollment terms). DHMP Contract Amendment 4: Exhibit B-4—6.7	• Change in Circumstance Report Job Aid: used to ensure accurate assignment and to catch members who are incorrectly assigned • Medicaid Member Handbook- Pg. 15-16 shows 90 day opt out period, disenrollment reasons and open enrollment • 2022 Medicaid Quick Reference Guide- Pg. 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The MCO's care coordination activities will comprise: • A range of deliberate activities to organize and facilitate the appropriate delivery of health and social services that support member health and well-being. • Activities targeted to specific members who require more intense and extended assistance and include appropriate interventions. DHMP Contract Amendment 4: Exhibit B-4—11.3.3	• Policy "Case Management for Medicaid Choice and Child Health Plan Plus Members" • Policy "Complex Case Management Process" • Care Management Programs Overview_How_to_Refer • CM Activity Care Coordination activities	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The MCO is fully integrated with the entirety of work outlined in the contract, thereby creating a seamless experience for members and providers. The MCO implements procedures to coordinate services furnished to the member: • Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. • With the services the member receives from any other managed care plan. • With the services the member receives in fee-for-service (FFS) Medicaid. • With the services the member receives from community and social support providers. *42 CFR 438.208(b)(2)*	• Policy "Case Management for Medicaid Choice and Child Health Plan Plus Members"- Pg. 3 C, Pg.4 E, Pg. 6 K • Policy "Coordination and Continuity of Care for Members with Special Health Care Needs"- Pg. 3 • Job Aid- UM OTA Job Aid- Pg. 3 • DHMP Care Management and Care Coordination Care Transitions Procedures • CM Activity Community and Social Support and Services_MCD_2021- Example of a report that can be pulled to monitor all CM outreaches for community and social supports • CM Activity Transitions of Care_MCD_2021- Example of a report that can be pulled to monitor all CM outreaches for members transitioning levels of care	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
DHMP Contract Amendment 4: Exhibit B-4—10.3.2, 10.3.4, 11.3.5, 11.3.10	• Member Transition of Care Coordination (RAE to RAE) Form • Sample CM Transition of Care Assessment	
6. The MCO uses the results of the health needs survey, provided by the Department, to inform member outreach and care coordination activities. The MCO: • Processes a daily data transfer from the Department containing responses to member health needs surveys. • Reviews the member responses to the health needs survey on a regular basis to identify members who may benefit from timely contact and support from the member's PCMP and/or MCO. *42 CFR 438.208(b)(3)* DHMP Contract Amendment 4: Exhibit B-4—7.5.2–3	• Policy "Case Management for Medicaid Choice and Child Health Plan Plus Members"- Pg. 4 (E) • Policy "Medicaid and CHP- Health Needs Survey" • CM Medicaid HNS Metrics 2021 • Health Needs Survey Response Job Aid • CM Activity_HNS Care Coordination_MCD_2021- Example of a report showing care coordination activities based on HNS responses • Medicaid Sample Survey_HNA_English- Survey sent by DHMP/vendor to all new members • DH_HN_Screening_Medicaid_Adult_ SPH Phone Script- Phone script for the DHMP/vendor health needs survey • Letter_DHMPh_HNA_Medicaid- letter that is sent with the health needs survey • SOW DHMP_SPH 2020 HNA for Medicaid & CHP 02_20_20 FE- SOW for vendor who completes the health needs surveys	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The MCO ensures that it has procedures to ensure: • Each member receives an individual intake and assessment appropriate for the level of care needed. • It uses the information gathered in the member's intake and assessment to build a service plan in a timely manner. • It provides continuity of care for members who are involved in multiple systems and experience service transitions from other Medicaid programs and delivery systems. *42 CFR 438.208(c)(2-3)* DHMP Contract Amendment 4: Exhibit B-4—13.5.1	• Policy "Case Management for Medicaid Choice and Child Health Plan Plus Members"- Pg. 4-5 G & H, pg. 7 • Policy "Medicaid and CHP- Health Needs Survey"- One method used for initial intake • Policy "Complex Case Management Process"- Pg. 4 D, E • Policy "Coordination and Continuity of Care for Members with Special Health Care Needs"- Pg. 4 B • CM Activity Care Plan Update-Review_MCD_2021- Example of a report showing members who were outreached to update or review their care plan • CM Screenshots plan of care following assessment • Sample Assessments Folder- Samples of different types of assessments used for care plans • Essential Care Management Elements of a Care Plan	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The MCO shares with other entities serving the member the results of its identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR 438.208(b)(4)* DHMP Contract Amendment 4: Exhibit B-4—None	• Policy "Case Management for Medicaid Choice and Child Health Plan Plus Members"- Pg. 7 details interactions with Colorado Access to prevent duplication • Policy "Complex Case Management"- Pg. 4, pg. 8 I • Epic Health Planet Link (HPL) Screenshots • Care Coordination via Epic Healthy Planet Link • CM Activity Epic Healthy Planet Link MCD- Example of a report showing referrals and care coordination out of EPIC • Screenshots Epic SDOH Wheel_Gaps in Care	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The MCO ensures that each provider furnishing services to members maintains and shares, as appropriate, member health records, in accordance with professional standards and in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that they are applicable. *42 CFR 438.208(b)(5) and (6)* DHMP Contract Amendment 4: Exhibit B-4—15.1.1.5, 11.3.7.11	• HIPAA Hybrid Entity Health Care Components	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The MCO possesses and maintains an electronic care coordination tool to support communication and coordination among members of the provider network and health neighborhood. The care coordination tool collects and aggregates, at a minimum: • Name and Medicaid ID of member for whom care coordination interventions were provided. • Age. • Gender identity. • Race/ethnicity. • Name of entity or entities providing care coordination, including the member's choice of lead care coordinator if there are multiple coordinators. • Care coordination notes, activities, and member needs. • Stratification level. • Information that can aid in the creation and monitoring of a care plan for the member—such as clinical history, medications, social supports, community resources, and member goals. DHMP Contract Amendment 4: Exhibit B-4—15.2.1.1, 15.2.1.3-4	• CM Guiding Care User-Guide-Part-I • CM Guiding Care User-Guide-Part-II • Medicaid Choice Guiding Care Screenshots	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	10	X	1.00	=	10
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	10	**Total Score**		=	10
				Total Score ÷ Total Applicable		=	100%

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The MCO has written policies regarding the member rights specified in this standard. *42 CFR 438.100(a)(1)* DHMP Contract Amendment 4: Exhibit B-4—7.3.7.1	• Member Rights and Responsibilities Policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The MCO complies with any applicable federal and State laws that pertain to member rights (e.g., non-discrimination, Americans with Disabilities Act) and ensures that its employees and contracted providers observe and protect those rights. *42 CFR 438.100(a)(2) and (d)* DHMP Contract Amendment 4: Exhibit B-4—5.10	• Member Rights and Responsibilities Policy pg. 2 • 2020 Code of Conduct- pg. 11. • Provider Manual 2021 pg. 51.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The MCO's policies and procedures ensure that each member is guaranteed the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for their dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding their health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.	• Member Rights and Responsibilities - pg. 2 & 3 (a. -e., j. and p.) • Medicaid Member Handbook pdf pg. 23.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Request and receive a copy of their medical records and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210). *42 CFR 438.100(b)(2) and (3)* DHMP Contract Amendment 4: Exhibit B-4—7.3.7.2		
4. The MCO ensures that each member is free to exercise their rights and that the exercise of those rights does not adversely affect the way the MCO, its network providers, or the State Medicaid agency treats the member. *42 CFR 438.100(c)* DHMP Contract Amendment 4: Exhibit B-4—7.3.7.2.7	• Member Rights and Responsibilities Policy- Pg. 3 • Medicaid Member Handbook- Pg. 24	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. For medical records and any other health and enrollment information that identifies a particular member, the MCO uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42 CFR 438.224* DHMP Contract Amendment 4: Exhibit B-4—11.3.7.11, 15.1.1.5	• Medicaid HIPAA Privacy Web • Protected Health Information Uses and Disclosures without Authorization	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The MCO maintains written policies and procedures and provides written information to individuals concerning advance directives with respect to all adult individuals receiving care by or through the MCO. Advance directives policies and procedures include: • Notice that members have the right to request and obtain information about advance directives at least once per year. • A clear statement of limitation if the MCO cannot implement an advance directive as a matter of conscience. – The difference between institution-wide conscientious objections and those raised by individual physicians. – Identification of the State legal authority permitting such objection. – Description of the range of medical conditions or procedures affected by the conscientious objection. • Provisions: – For providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and is unable to receive information. – For providing advance directive information to the incapacitated member once he or she is no longer incapacitated. – To document in a prominent part of the member's medical record whether the member has executed an advance directive.	• Advance Medical Directives Policy • Medicaid Member Handbook- Pg. 19-20 • DHMP Member Newsletter_Summer 2021_Eng- Member Rights section reviews right to advanced directive. Newsletters are sent once a quarter and this topic is reviewed annually. • Advance Directives: MDPOA, CPR Directives, Living Wills, MOST • DHHA Religious Accommodations and Conscience Objections Relative to Provision of Care • DHHA Proxy Decision-Maker	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– That care to a member is not conditioned on whether the member has executed an advance directive, and provision that members are not discriminated against based on whether they have executed an advance directive. – To ensure compliance with State laws regarding advance directives. – To inform individuals that complaints concerning noncompliance with advance directive requirements may be filed with the Colorado Department of Public Health and Environment. – To inform members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. – To educate of staff concerning its policies and procedures on advance directives. – The components for community education regarding advance directives that include: ▪ What constitutes an advance directive. ▪ Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. ▪ Description of applicable State law concerning advance directives. *The MCO must be able to document its community education efforts.*		

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.3(j) *42 CFR 422.128* DHMP Contract Amendment 4: Exhibit B-4—7.3.11.3-6		

Results for Standard IV—Member Rights, Protections, and Confidentiality							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	6	**Total Score**		=	6
				Total Score ÷ Total Applicable		=	100%

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The MCO provides all required member information to members in a manner and format that may be easily understood and is readily accessible by enrollees. • The MCO ensures that all member materials (for large-scale member communications) have been member tested. *Note: Readily accessible means electronic information which complies with Section 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines.* *42 CFR 438.10(c)(1)* DHMP Contract Amendment 4: Exhibit B-4—7.2.5, 7.2.7.9	• Member Testing on Member Materials • Creation, Review and Readability of Member Materials policies PDF page 2 and 3/4. • Medicaid Welcome Letter 2021. • Medicaid Quick reference guide page 9.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DHMP described its use of a Health Literacy software to test and review the sixth-grade readability of member materials. Staff members explained that when assessing member materials, DHMP aimed to maintain some clinical terminology that would not have the same meaning if replaced. Additionally, staff members described that DHMP's approach focused on the "critical health related" details (e.g., member rights) and did not always include readability checks for non-health-related information (e.g., nutritional recipes in the member newsletter). HSAG observed during readability testing that even when excluding complex content such as phone numbers, websites, and benefit information that might be more clinical in nature, some critical member materials were above the sixth-grade reading level. The DHMP Medicaid Choice member handbook, member newsletter, and the member quick reference guide (QRG) scored well above the sixth-grade reading level. HSAG noted that there were instances where DHMP copied either the federal regulation language or contract language verbatim into the member handbook, causing the document to be potentially not easily understood		
Required Actions: DHMP must develop mechanisms to ensure that all required member informational materials may be easily understood (i.e., sixth-grade reading level) to the extent possible. HSAG recommends using simplified language next to any clinical terminology that DHMP does not wish to alter.		

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The MCO has in place a mechanism to help members understand the requirements and benefits of the plan. *42 CFR 438.10(c)(7)* DHMP Contract Amendment 4: Exhibit B-4—7.3.8.1	• Medicaid Welcome Letter 2021. • Requirement 2_website videos_screen prints. • Medicaid Quick Reference Guide pages 1 and 2 • Medicaid Member handbook page 6, 9 ,10 and 14.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. For consistency in the information provided to members, the MCO uses the following as developed by the State, when applicable and when available: • Definitions for managed care terminology, including: appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, participating provider, physician services, plan, preauthorization, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. • Model member handbooks and member notices. *42 CFR 438.10(c)(4)* DHMP Contract Amendment 4: Exhibit B-4—3.6	• Member Handbook Content Requirements page 6 C.1. • Medicaid Member handbook pages 3 and 4 (TERMINOLOGY)	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: In DHMP's Medicaid Choice member handbook, the "grievance" definition was inconsistent with the State and the federal definition. DHMP defined a grievance as a "formal complaint" instead of "any expression of dissatisfaction."		
Required Actions: DHMP must update the definition of "grievance" in the Medicaid Choice member handbook to be consistent with the State and federal definition.		
4. The MCO makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • Written materials that are critical to obtaining services include, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices. • All written materials for members must: – Use easily understood language and format. – Use a font size no smaller than 12-point. – Be available in alternative formats and through provision of auxiliary aids and service that take into consideration the special needs of members with disabilities or limited English proficiency. – Include taglines in large print (conspicuously-visible font size) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDD customer service numbers and availability of materials in alternative formats. – Be member tested.	• Member Testing on Member Materials Policy. • Creation- Review and Readability of Member Materials Policy page 2. • Requirement 4 Language Assistance page screen print and link. • Medicaid Member handbook page 2 and 6 • Standard Tagline Government Product • Translation-508 Compliance-Alternative Format Requests	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.10(d)(3) and (d)(6) DHMP Contract Amendment 4: Exhibit B-4—7.2.7.3–9; 7.3.13.3		

Findings:

The *Creation, Review, and Readability of Member Materials* policy stated that all written materials for members must use a font size no smaller than 12 points, be available in alternative formats and provide access to auxiliary aids and services while taking into consideration members with disabilities and limited English proficiency, include toll-free customer service and TTY/TDD numbers, and available at no cost to members. The *Translation-508 Compliance-Alternative Format Requests* document described the procedures to ensure compliance with member information requirements. However, the DHMP Medicaid member handbook, welcome letter, QRG, provider directory tip sheet, and formulary list did not include all the required components of a tagline.

- The Medicaid Choice member handbook tagline only indicated that the phone call is "at no cost."
- The welcome letter tagline had a different font style; however, it was not in large print (conspicuously visible font size) and did not include "available in alternative formats" or "at no cost."
- The QRG tagline did not include "available in alternative formats" or "at no cost."
- The provider directory tip sheet tagline did not include "available in alternative formats" or "at no cost."
- The formulary list did not include a tagline in the document.

Required Actions:

DHMP must revise the Medicaid Choice member handbook website, welcome letter, QRG, provider directory tip sheet, and formulary list to include all required components of a tagline.

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. *If the MCO makes information available electronically:* Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of "readily accessible" above). • The information is placed in a website location that is prominent and readily accessible. • The information can be electronically retained and printed. • The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge upon request and is provided within five business days. Provide a link to the Department's website on the MCO's website for standardized information such as member rights and handbooks. *42 CFR 438.10(c)(6)* DHMP Contract Amendment 4: Exhibit B-4—7.3.14.1, 7.3.9.2	• Requirement 5 accessibility and 508 compliance screenshots	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Although DHMP provided a section of the printing vendor contract to demonstrate a two business day turnaround time for when new member enrollment packets are mailed, the submitted section did not provide any supporting documentation regarding ad-hoc requests for printed materials.		
Required Actions: DHMP must develop a mechanism to ensure that upon request, members are provided with informational materials within five business days and at no cost.		

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The MCO makes available to members in electronic or paper form information about its formulary: • Which medications are covered (both generic and name brand). • What tier each medication is on. • Formulary drug list must be available on the MCO's website in a machine-readable file and format. *42 CFR 438.10(i)* DHMP Contract Amendment 4: Exhibit B-4—13.2.1.6.2.1.2	• Medicaid Choice.CHP Formulary_4Q2021_ENG FULL VERSION • https://www.denverhealthmedicalplan.org/sites/default/files/2021-12/Medicaid%20Choice.CHP%20Formulary_1Q2022.pdf • Provider Directory UAT URL passes accessibility	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The MCO makes interpretation services (for all non-English languages) and use of auxiliary aids such as TTY/TDD and American Sign Language available free of charge, notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and informs about how to access those services. *42 CFR 438.10 (d)(4) and (d)(5)* DHMP Contract Amendment 4: Exhibit B-4—7.2.6.2–4	• Medicaid Member handbook page 9 • Creation, Review and Readability of Member Materials policy page 2 and 3. • Cultural and Linguistic Appropriate Services (CLAS) policy page 4 and 5.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The MCO ensures that: • Language assistance is provided at all points of contact, in a timely manner and during all hours of operation. • Customer service telephone functions easily access interpreter or bilingual services. DHMP Contract Amendment 4: Exhibit B-4—7.2.6.1, 7.2.6.4	• Cultural and Linguistic Appropriate Services (CLAS) policy PDF page 4 and 5.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The MCO provides each member with a member handbook within a reasonable time after receiving notification of the member's enrollment. *42 CFR 438.10(g)(1)* DHMP Contract Amendment 4: Exhibit B-4—7.3.8.1	*Instructions: Unless the MCO has its own handbook or supplement, score this Not Applicable.* • Medicaid Quick Reference Guide • Medicaid Welcome Letter 2021 • New Member 834 enrollment example. • New enrollment packet example • Description: When the 834 file comes in with an enrollment this prompts a code to issue out the Welcome letter, ID and a Quick Reference Guide (QRG)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The MCO gives members written notice of any significant change (as defined by the State) in the information required at 438.10(g) at least 30 days before the intended effective date of the change. *42 CFR 438.10(g)(4)* DHMP Contract Amendment 4: Exhibit B-4—7.3.8.3	*Instructions: If the MCO does not produce a handbook or supplement, score Not Applicable.* • Member Handbook Content Requirement page 6, B.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. For any MCO member handbook or supplement to the member handbook provided to members, the MCO ensures that information is consistent with federal requirements in 42 CFR 438.10(g). • The MCO ensures that its member handbook or supplement includes a link to the online Health First Colorado member handbook. *42 CFR 438.10*	*Instructions: If the MCO does not produce a handbook or supplement, score Not Applicable. If the MCO produces its own handbook or supplemental handbook—(a) review for accuracy of any applicable elements and (b) must reference the Department's handbook.* • Medicaid Member Handbook Pg. 47.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
DHMP Contract Amendment 4: Exhibit B-4—7.3.8.1	• https://www.healthfirstcolorado.com/wp-content/uploads/2020/05/Health-First-Colorado-Member-Handbook.pdf • Creation- Review and Readability of Member Materials Policy pgs. 2 and 3 • Requirement 11 DHMP website with link to Health First Colorado website	
12. The MCO makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice or 30 days prior to the effective date of the termination, whichever is later, to each member who received their primary care from, or was seen on a regular basis by, the terminated provider. *42 CFR 438.10(f)(1)* DHMP Contract Amendment 4: Exhibit B-4—7.3.10.1	• Provider Terminations Policy 2021 • Sample Termination Letters 2021 o Term Letter [name redacted] o Term Letter [name redacted]	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
13. The MCO shall develop and maintain a customized and comprehensive website that includes: • The MCO's contact information. • Member rights and handbooks. • Grievance and appeal procedures and rights. • General functions of the MCO. • Trainings. • Provider directory. • Access to care standards. • Health First Colorado Nurse Advice Line.	• DHMP Website	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Colorado Crisis Services information. • A link to the Department's website for standardized information such as member rights and handbooks. DHMP Contract Amendment 4: Exhibit B-4—7.3.9		
14. The MCO makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, pharmacies, (and for DHMP, behavioral health providers): • The provider's name and group affiliation, street address(es), telephone number(s), website URL, specialty (as appropriate), and whether the provider will accept new enrollees. • The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office. • Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment. *Note: Information included in a paper provider directory must be updated at least monthly if the MCO does not have a mobile-enabled, electronic directory; or quarterly if the MCO has a mobile-enabled, electronic provider directory; and electronic provider directories must be updated no later than 30 calendar days after the contractor receives updated provider information.* *42 CFR 438.10(h)(1-3)* DHMP Contract Amendment 4: Exhibit B-4—7.3.9.2	• Provider Directory Tips • Provider Directory Example • Provider Directory Screenshot	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. Provider directories are made available on the MCO's website in a machine-readable file and format. *42 CFR 438.10(h)(4)* DHMP Contract Amendment 4: Exhibit B-4—7.3.9.2.8	• Provider Directory UAT URL passes accessibility • Provider Directory Example- format is machine readable	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. The MCO shall develop electronic and written materials for distribution to newly enrolled and existing members that include all of the following: • The MCO's single toll-free customer service phone number. • The MCO's email address. • The MCO's website address. • State relay information. • The basic features of the MCO's managed care functions as a primary care case management (PCCM) entity and prepaid inpatient health plan (PIHP). • The service area covered by the MCO. • Medicaid benefits, including State Plan benefits and those in the limited managed care capitation initiative. – And for DHMP, those in the Capitated Behavioral Health Benefit. • Any restrictions on the member's freedom of choice among network providers. • The requirement for the MCO to provide adequate access to behavioral health services included in the Capitated Behavioral Health Benefit, including the network adequacy standards (*DHMP only*).	• RAE Member Booklet- see marked sections • Medicaid Member hand book- see marked sections	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The MCO's responsibilities for coordination of member care. • Information about where and how to obtain counseling and referral services that the MCO does not cover because of moral or religious objections. • To the extent possible, quality and performance indicators for the MCO, including member satisfaction. DHMP Contract Amendment 4: Exhibit B-4—7.3.6.1		
17. The MCO provides member information by either: • Mailing a printed copy of the information to the member's mailing address. • Providing the information by email after obtaining the member's agreement to receive the information by email. • Posting the information on the website of the MCO and advising the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost. • Providing the information by any other method that can reasonably be expected to result in the member receiving that information. *42 CFR 438.10(g)(3)* DHMP Contract Amendment 4: Exhibit B-4—None	• Medicaid Welcome letter 2021 page 1. • Medicaid Quick Reference Guide page 1.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. The MCO must make available to members, upon request, any physician incentive plans in place. *42 CFR 438.10(f)(3)* DHMP Contract Amendment 4: Exhibit B-4—None	• Member Handbook Content Requirements, Page 7. • 2021 Member handbook page 17.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard V—Member Information Requirements							
Total	Met	=	14	X	1.00	=	14
	Partially Met	=	4	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	18	**Total Score**		=	14
				Total Score ÷ Total Applicable		=	78%

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The MCO onboards and informs members and their families regarding the services provided by Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). This includes: • Informing the member about the EPSDT program generally within 60 days of the member's initial Medicaid eligibility determination, or after a member regains eligibility following a greater than 12-month period of ineligibility, or within 60 days of identification of the member being pregnant. • At least one time annually, the MCO outreaches members who have not utilized EPSDT services in the previous 12 months in accordance with the American Association of Pediatrics (AAP) "Bright Futures Guidelines" and "Recommendations for Preventive Pediatric Health Care." • Information about benefits of preventive health care, including the American Association of Pediatrics Bright Futures Guidelines, services available under EPSDT, where services are available, how to obtain services, that services are without cost to the member, and how to request transportation. DHMP Contract Amendment 4: Exhibit B-4—7.3.12.1, 7.6.2	• Birthday Mailer Proofs 2021- Mailings are sent out to adult, teen and child members during their birthday month to encourage a well visit • Policy "Early and Periodic Screening-Diagnostic- and Treatment Benefit (EPSDT) Program"- Please see bookmarked sections • EPSDT Flyer- Flyer included in the mailings for new members along with the Health Needs Survey • Member Webpage EPSDT Services • Member Newsletter Summer 2021- Pg. 8 • SPH HN Phone Screen- Phone script used for health needs survey outreach attempts (EPSDT is addressed). • SPH Health Needs Assessment • Medicaid Member Handbook- Pg. 45-46	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The EPSDT informational materials use a combination of oral and written approaches to outreach EPSDT eligible members to ensure members receive regularly scheduled examinations, including physical and mental health services: • Mailed letters, brochures, or pamphlets • Face-to-face interactions • Telephone or automated calls • Video conferencing • Email, text/SMS messages DHMP Contract Amendment 4: Exhibit B-4—7.6.6	• Policy "Early and Periodic Screening-Diagnostic- and Treatment Benefit (EPSDT) Program"- Please see bookmarked sections • Birthday Mailer Proofs 2021- Mailed reminders for well visits for teens and children • CM Activity EPSDT Outreach_2021- Example of a report pulled to show all EPSDT related outreaches • COA EPSDT FY21-22 Strategic Plan- C. Methods of Contact Used Page3 • COA Newly Enrolled EPSDT Letter • COA_Well Visit Minor IVR Script • COA EPSDT Dental Reminder Flyer • R5_EPSDT_Q1SFY21-22- example of COA quarterly report showing contact methods • R5_EPSDTRpt_Q1SFY22_HCPF Response_Accepted- HCPF response letter for the quarterly report • R5_EPSDT_Q4FY20-21- example of COA quarterly report showing contact methods • R5_EPSDTRpt_Q4FY20-21_HCPF Response_Accepted- HCPF response letter for the quarterly report	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The MCO makes network providers aware of the Colorado Medicaid EPSDT program information by: • Using Department materials to inform network providers about the benefits of well-child care and EPSDT. • Ensuring that trainings and updates on EPSDT are made available to network providers every six months. DHMP Contract Amendment 4: Exhibit B-4—12.9.3.4, 12.10.3.4	• Policy "Early and Periodic Screening-Diagnostic- and Treatment Benefit (EPSDT) Program"- Please see highlighted sections • EPSDT Completed Training Roster 2021 • EPSDT Provider Newsletter 1-27-21 • EPSDT Provider Newsletter 6-16-21 • Provider Webpage EPSDT • EPSDT Provider Website Training • Provider Manual 2021- Pg. 62 & 63	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. For children under the age of 21, the MCO provides or arranges for the provision of all medically necessary *Capitated Physical Health Benefit* covered services in accordance with 42 CFR Sections 441.50 to 441.62 and 10 CCR 2505-10 8.280 (EPSDT program). The MCO: • Has written policies and procedures for providing EPSDT services to members ages 20 and under. • Ensures provision of all appropriate mental/behavioral health developmental screenings to EPSDT beneficiaries who request it. • Ensures screenings are performed by a provider qualified to furnish mental health services. • Ensures screenings are age appropriate and performed in a culturally and linguistically sensitive manner.	• Policy "Early and Periodic Screening-Diagnostic- and Treatment Benefit (EPSDT) Program"- Please see highlighted sections • Provider Webpage EPSDT • Provider Manual 2021- Pg. 63 • Clinical Practice and Preventive Care Guidelines- Pg. 1 • Policy "Clinical Criteria for Utilization Management Decisions"- Pg. 4 • Policy "Utilization Review Determinations"- Pg. 7 • Policy "Cultural and Linguistic Appropriate Services (CLAS)"- Policy showing culturally and linguistically sensitive materials and trainings are provided	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Ensures results of screenings and examinations are recorded in the child's medical record and include, at a minimum, identified problems, negative findings, and further diagnostic studies and/or treatments needed and the date ordered. • Provides diagnostic services in addition to treatment of mental illnesses or conditions discovered by any screening or diagnostic procedure. *42 CFR 441.55; 441.56(c)* DHMP Contract Amendment 4: Exhibit B-4—7.7.5 10 CCR 2505-10 8.280.8.A, 8.280.4.A (3)(d), 8.280.4.A (4), 8.280.4.A (5), 8.280.4.C (1–3)	• Policy "Access to Care and Service Standards"- Pg. 8 • Attachment B - BH DHMP_COA work flow	
5. The MCO: • Provides referral assistance for treatment not covered by the plan but found to be needed as a result of conditions disclosed during screening and diagnosis. • Provides assistance with transportation and assistance scheduling appointments for services if requested by the member/family. • Makes use of appropriate State health agencies and programs including: vocational rehabilitation; maternal and child health; public health, mental health, and education programs; Head Start; social services programs; and Women, Infants and Children (WIC) supplemental food program. *42 CFR 441.61–62* DHMP Contract Amendment 4: Exhibit B-4—7.7.5 10 CCR 2505-10 8.280.4.C	• Policy "Early and Periodic Screening-Diagnostic- and Treatment Benefit (EPSDT) Program"- Please see bookmarked sections • Member Webpage EPSDT Services • CM Activity_Community Resources_EPSDT_2021- Example of a report showing referrals to State and community programs • Member Newsletter Summer 2021- Pg. 8 • Wrap Around Service Referral Examples	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The MCO defines medical necessity for EPSDT services as a program, good, or service that: • Will or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all. • Assists the member to achieve or maintain maximum functional capacity. • Is provided in accordance with generally accepted professional standards for health care in the United States. • Is clinically appropriate in terms of type, frequency, extent, site, and duration. • Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider. • Is delivered in the most appropriate setting(s) required by the client's condition. • Provides a safe environment or situation for the child. • Is not experimental or investigational. • Is not more costly than other equally effective treatment options. DHMP Contract Amendment 4: Exhibit B-4—7.7.5 10 CCR 2505-10 8.076.8; 8.076.8.1; 8.280.4.E	• Policy "Early and Periodic Screening-Diagnostic- and Treatment Benefit (EPSDT) Program"- Please see bookmarked sections • Policy "Utilization Review Determinations Including Approvals and Actions" • Provider Manual 2021- Pg. 63-64	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The MCO provides or arranges for the following for children/youth from ages 0 to 21: vocational services, intensive case management, prevention/early intervention activities, clubhouse and drop-in centers, residential care, assertive community treatment (ACT), recovery services, respite services. *Note: All EPSDT services are included in the State Plan or in Non-State Plan 1915(b)(3) Waiver Services (respite and vocational rehabilitation).* DHMP Contract Amendment 4: Exhibit B-4—14.5.7.1, 2.1.1	• Member Webpage EPSDT Services • Member Newsletter Summer 2021- Pg. 8 • Policy "Early and Periodic Screening-Diagnostic- and Treatment Benefit - EPSDT- Program"- Pg. 8 • Policy "Complex Case Management Member Identification Process"- Shows the intensive case management identification including referral process • Policy "Case Management for Medicaid Choice and Child Health Plan Plus Members" • COA UM104 Early and Periodic Screening Diagnostic and Treatment EPSDT	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard XI—EPSDT Services							
Total	Met	=	7	X	1.00	=	7
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	7	**Total Score**		=	7
				Total Score ÷ Total Applicable		=	100%

Appendix B. Site Review Participants

Table B-1 lists the participants in the FY 2021–2022 site review of **DHMP**.

Table B-1—HSAG Reviewers and DHMP MCO and Department Participants

HSAG Review Team	Title
Sarah Lambie	Project Manager III
Evarista Ogbon	Project Manager I
Crystal Brown	Project Coordinator III
DHMP Participants	**Title**
Alicia Persich	Marketing and Engagement Manager
Barbara Toney	Contractor for Denver Health Medical Plan
Catharine Fortney	Chief Compliance and Audit Officer
Christina Porter	HPMM Q&A Training Manager
Clesson Connelly	Pharmacy Compliance Analyst
Dallen Waldenrath Gomez	Health Plan Compliance Analyst
Darla Schmidt	Contractor for Denver Health Medical Plan
Dawn Robinson	Care Coordination Operations Manager
Dr. Christine Seals	Medical Director
Elaina Holland	Director, Health Plan Services
Elizabeth Flood	Intervention Manager
Greg McCarthy	Executive Director, Managed Care
Jacqueline De La Torre	Project Manager
Jason Casey	Health Plan Compliance Analyst
Jeremy Sax	Government Products Manager
Kaitlin Gaffney	Lead Health Plan Compliance Analyst
Lisa Artale Bross	Compliance Manager
Lucas Wilson	Associate Chief Operating Officer
Marissa Schillaci-Kayton	Population Health and Quality Improvement Project Manager
Melanie Haste	Grievance and Appeals Manager
Michael Grimpo	Privacy Officer
Mike Wagner	Chief Operating Officer
Murielle Romine	Provider Relations and Contracts Analyst
Natalie Score	Director of Insurance Products

DHMP Participants	Title
Paula Diaz	Marketing Public Relations Strategist III
Robert Lodge	Pharmacy Manager
Ruie Winters	Director of Pharmacy
Shanique Horne	Director of Provider Relations and Contracts
Shannon Godbout	Project Manager I
Department Observers	**Title**
Curt Curnow	Quality Improvement Section Manager
Gina Robinson	Program Administrator
Jeff Helm	Program Design and Policy
Russell Kennedy	Quality and Compliance Specialist

Appendix C. Corrective Action Plan Template for FY 2021–2022

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

Table C-1—Corrective Action Plan Process

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

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

The CAP template follows.

Table C-2—FY 2021–2022 Corrective Action Plan for DHMP MCO

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
1. The MCO provides all required member information to members in a manner and format that may be easily understood and is readily accessible by enrollees. • The MCO ensures that all member materials (for large-scale member communications) have been member tested. *Note: Readily accessible means electronic information which complies with Section 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines.* *42 CFR 438.10(c)(1)* DHMP Contract Amendment 4: Exhibit B-4—7.2.5, 7.2.7.9	DHMP described its use of a Health Literacy software to test and review the sixth-grade readability of member materials. Staff members explained that when assessing member materials, DHMP aimed to maintain some clinical terminology that would not have the same meaning if replaced. Additionally, staff members described that DHMP's approach focused on the "critical health related" details (e.g., member rights) and did not always include readability checks for non-health-related information (e.g., nutritional recipes in the member newsletter). HSAG observed during readability testing that even when excluding complex content such as phone numbers, websites, and benefit information that might be more clinical in nature, some critical member materials were above the sixth-grade reading level. The DHMP Medicaid Choice member handbook, member newsletter, and the member quick reference guide (QRG) scored well above the sixth-grade reading level. HSAG noted that there were instances where DHMP copied either the federal regulation language or contract language verbatim into the member handbook, causing the document to be potentially not easily understood.	DHMP must develop mechanisms to ensure that all required member informational materials may be easily understood (i.e., sixth-grade reading level) to the extent possible. HSAG recommends using simplified language next to any clinical terminology that DHMP does not wish to alter.

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to Be Submitted as Evidence of Completion:		
HSAG Initial Review:		
Documents for Final Submission:		
Date of Final Evidence:		

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
3. For consistency in the information provided to members, the MCO uses the following as developed by the State, when applicable and when available: • Definitions for managed care terminology, including: appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, participating provider, physician services, plan, preauthorization, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. • Model member handbooks and member notices. *42 CFR 438.10(c)(4)* DHMP Contract Amendment 4: Exhibit B-4—3.6	In DHMP's Medicaid Choice member handbook, the "grievance" definition was inconsistent with the State and the federal definition. DHMP defined a grievance as a "formal complaint" instead of "any expression of dissatisfaction."	DHMP must update the definition of "grievance" in the Medicaid Choice member handbook to be consistent with the State and federal definition.

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to Be Submitted as Evidence of Completion:		
HSAG Initial Review:		
Documents for Final Submission:		
Date of Final Evidence:		

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
4. The MCO makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • Written materials that are critical to obtaining services include, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices. • All written materials for members must: – Use easily understood language and format. – Use a font size no smaller than 12-point. – Be available in alternative formats and through provision of auxiliary aids and service that take into consideration the special needs of members with disabilities or limited English proficiency. – Include taglines in large print (conspicuously-visible font size) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation	The *Creation, Review, and Readability of Member Materials* policy stated that all written materials for members must use a font size no smaller than 12 points, be available in alternative formats and provide access to auxiliary aids and services while taking into consideration members with disabilities and limited English proficiency, include toll-free customer service and TTY/TDD numbers, and available at no cost to members. The *Translation-508 Compliance-Alternative Format Requests* document described the procedures to ensure compliance with member information requirements. However, the DHMP Medicaid member handbook, welcome letter, QRG, provider directory tip sheet, and formulary list did not include all the required components of a tagline. • The Medicaid Choice member handbook tagline only indicated that the phone call is "at no cost." • The welcome letter tagline had a different font style; however, it was not in large print (conspicuously visible font size) and did not include "available in alternative formats" or "at no cost." • The QRG tagline did not include "available in alternative formats" or "at no cost."	DHMP must revise the Medicaid Choice member handbook website, welcome letter, QRG, provider directory tip sheet, and formulary list to include all required components of a tagline.

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
and the toll-free and TTY/TDD customer service numbers and availability of materials in alternative formats. – Be member tested. *42 CFR 438.10(d)(3) and (d)(6)* DHMP Contract Amendment 4: Exhibit B-4—7.2.7.3–9; 7.3.13.3	• The provider directory tip sheet tagline did not include "available in alternative formats" or "at no cost." • The formulary list did not include a tagline in the document.	
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:		
HSAG Initial Review:		
Documents for Final Submission:		
Date of Final Evidence:		

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
5. *If the MCO makes information available electronically:* Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of "readily accessible" above). • The information is placed in a website location that is prominent and readily accessible. • The information can be electronically retained and printed. • The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge upon request and is provided within five business days. Provide a link to the Department's website on the MCO's website for standardized information such as member rights and handbooks. *42 CFR 438.10(c)(6)* DHMP Contract Amendment 4: Exhibit B-4—7.3.14.1, 7.3.9.2	Although DHMP provided a section of the printing vendor contract to demonstrate a two business day turnaround time for when new member enrollment packets are mailed, the submitted section did not provide any supporting documentation regarding ad-hoc requests for printed materials.	DHMP must develop a mechanism to ensure that upon request, members are provided with informational materials within five business days and at no cost.

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to Be Submitted as Evidence of Completion:		
HSAG Initial Review:		
Documents for Final Submission:		
Date of Final Evidence:		

Appendix D. Compliance Monitoring Review Protocol Activities

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

Table D-1—Compliance Monitoring Review Activities Performed

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

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct the Review**
	• During the review, HSAG met with groups of the health plan's key staff members to obtain a complete picture of the health plan's compliance with federal healthcare regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan's performance. • HSAG requested, collected, and reviewed additional documents as needed. • At the close of the review, HSAG provided health plan staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2021–2022 Department-approved Site Review Report template to compile the findings and incorporate information from the pre-review and review activities. • HSAG analyzed the findings and calculated final scores based on Department-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the Department**
	• HSAG populated the Department-approved report template. • HSAG submitted the draft Site Review Report to the health plan and the Department for review and comment. • HSAG incorporated the health plan and Department comments, as applicable, and finalized the report. • HSAG included a pre-populated CAP template in the final report for all elements determined to be out of compliance with managed care regulations. • HSAG distributed the final report to the health plan and the Department.