COLORADO

Department of Health Care Policy & Financing

Fiscal Year 2024–2025 Compliance Review Report

for

Denver Health Medical Plan

Managed Care Organization

March 2025

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

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

Summary of Results

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

Denver Health Medical Plan (DHMP) showed a strong understanding of federal regulations related to all standards reviewed during the fiscal year (FY) 2024–2025 compliance monitoring review.

Table 1-1 presents the scores for DHMP for each of the standards. Findings for all requirements are summarized in Section 2—Assessment and Findings. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* are included 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%~
VIII. Credentialing and Recredentialing	32	32	32	0	0	0	100%~
XI. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	7	7	7	0	0	0	100%~
Totals	**55**	**55**	**55**	**0**	**0**	**0**	**100%**

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

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

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

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

Table 1-2 presents the scores for DHMP for the credentialing and recredentialing record reviews. Details of the findings for the record reviews are included in Appendix B—Record Review Tools.

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Credentialing	90	76	76	0	14	100%~
Recredentialing	70	65	65	0	5	100%~
Totals	**160**	**141**	**141**	**0**	**19**	**100%~**

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

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

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

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

Standard III—Coordination and Continuity of Care

Evidence of Compliance and Strengths

DHMP presented comprehensive evidence of its care coordination program structure through policies, procedures, detailed tracking mechanisms, and interview discussions. The program leveraged a multidisciplinary team of 33 employees comprised of care coordinators and clinical care managers to address the unique needs of each member. Member identification for care coordination occurred through various channels, including the Health First Colorado administered Health Needs Survey (HNS); risk stratification assessments; condition management; utilization management; and referrals from providers, family members, and self-referrals. DHMP described additional efforts to engage members in completing the HNS, where DHMP contracted with an HNS vendor, Symphony Performance Health, to outreach members to promote completion of the screening. Further, DHMP gave members other options to complete the HNS through mail, online, or by phone with a vendor representative. During the interview, DHMP shared that these efforts were successful in increasing the number of HNSs completed.

If the HNS indicated a healthcare or support need, or if the member was identified through some other method, a care coordination team member would outreach the member to assist, gather more information, have the member complete additional specialized assessments, or refer the member to the Complex Case Management (CCM) program, if necessary. Members with special healthcare needs were clearly defined in the policy and procedure and could be identified through data. DHMP described that members were informed about how to contact their primary healthcare providers through welcome materials, and if enrolled in the CCM program, the member would receive a welcome letter with care manager contact information.

When enrolled in the CCM program, initial assessments were completed by clinical staff members of the CCM team. DHMP's policy described that assessments include in-depth information about the member, including health status, documentation of clinical history, activities of daily living, behavioral health status, social determinants of health, and evaluation of cultural and linguistic needs. CCM staff members used information gathered by these assessments to develop treatment plans that identify goals and interventions. DHMP submitted various dashboards and care coordination process screenshots, which provided evidence of how CCM care managers monitor member needs and address open care gaps.

DHMP submitted policies that described its relationship with Colorado Access (COA) for providing behavioral health services. During the interview, DHMP detailed daily communication methods, including dashboards, which staff members reported using to facilitate real-time updates. In addition, DHMP described regular meetings to review strengths and opportunities regarding care management activities.

DHMP used GuidingCare as its electronic care coordination tool. DHMP provided the GuidingCare User Guide, which described how the tool worked on mobile devices and met Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy requirements. GuidingCare maintained member demographics and care coordination information and activities, as well as supported communication and care coordination efforts between members and DHMP staff. Care coordination staff documented all contact with members in GuidingCare and tracked and monitored progress on care plans, goals, and interventions through various audits and cross-functional activities.

Opportunities for Improvement and Recommendations

HSAG identified no opportunities for improvement.

Required Actions

HSAG identified no required actions.

Standard IV—Member Rights, Protections, and Confidentiality

Evidence of Compliance and Strengths

DHMP's Member Rights and Responsibilities Policy outlined member rights and responsibilities and how the MCO complies with applicable federal and State laws. DHMP MCP's policies and staff members described that member rights are communicated through various channels such as the member handbook, quick reference guide (QRG), member newsletters, the MCO's website, and the grievance system. The member handbook educated members of their right to participate in decisions concerning their healthcare, receive information about treatment options and alternatives, obtain a second opinion, and file a grievance if the member feels their rights were violated. During the interview, DHMP CHP+ described that staff members are trained to be aware of any issues that relate to member rights and how to escalate the issues through the grievance process. The provider manual, code of conduct, policies, new provider orientation, and annual trainings informed employees and providers of member rights and applicable laws.

DHMP provided robust HIPAA policies that discussed measures for securing and transmitting protected health information (PHI), including how DHMP maintains adequate safeguards and firewalls. During the interview, staff members described the annual trainings regarding HIPAA's general, practical, and position-specific requirements.

DHMP's policies and procedures, the member handbook, QRG, the MCO's website, and the provider manual educated members, providers, and staff on advance directives. DHMP's website provided members and the community with information on advance directives and provided the following forms: medical power of attorney, living will, and the cardiopulmonary resuscitation (CPR) directive. The Advance Directives Policy referenced compliance with applicable State laws 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."

Recommendations and Opportunities for Improvement

HSAG identified no opportunities for improvement.

Required Actions

HSAG identified no required actions.

Standard VIII—Credentialing and Recredentialing

Evidence of Compliance and Strengths

DHMP demonstrated a comprehensive credentialing and recredentialing process that complies with National Committee for Quality Assurance (NCQA) standards. DHMP provided detailed descriptions of its credentialing department, associated software systems, credentialing committee structure, and the application review process. Throughout the interview, DHMP demonstrated that practitioners and organizations were consistently reviewed for credentialing and recredentialing in accordance with established policies and procedures. DHMP reported that recently it contracted with a Credentials Verification Organization (CVO) to conduct initial credentialing. All recredentialing reviews are conducted internally.

DHMP's credentialing process included a thorough file verification. Clean files were approved by the medical director, while more complex files required in-depth review and discussion by the credentialing committee, which met bimonthly. Additionally, practitioners were notified within 60 calendar days of the decision.

DHMP's credentialing policies detailed the process for conducting credentialing and recredentialing in a nondiscriminatory manner. Further, all credentialing committee members complete nondiscrimination attestations on an annual basis.

HSAG reviewed a sample of initial credentialing files and found that DHMP processed all records in a timely manner. Each initial credentialing file included evidence of license and education verification through the Colorado Department of Regulatory Agencies (DORA), verification of work history in the most recent five years, professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner in the most recent five years, and the Drug Enforcement Administration (DEA) verification and board certification verification, if applicable. HSAG also reviewed a sample of recredentialing files and found that DHMP appropriately recredentialed providers and organizations

within the 36-month time frame. Further, DHMP provided evidence that it conducted ongoing monitoring of practitioners and organizations through National Practitioner Data Bank (NPDB) continuous query monitoring and DORA.

DHMP delegated credentialing and recredentialing activities to numerous contracted organizations. Annual monitoring of delegates was conducted by DHMP through a delegation audit, ensuring compliance with activities, responsibilities, and reporting.

Recommendations and Opportunities for Improvement

HSAG identified no opportunities for improvement.

Required Actions

HSAG identified no required actions.

Standard XI—EPSDT Services

Evidence of Compliance and Strengths

During the interview, staff members described DHMP's approach to onboard and inform members of EPSDT services within the first 60 days after eligibility determination. Staff members described multiple methods to outreach members at least one time annually if a member had not utilized EPSDT services. DHMP used a vendor to gather initial assessment information from each new member and followed up with telephone calls. EPSDT materials used a combination of approaches 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 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 (CY) 2024, DHMP distributed two provider newsletters 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 provided anecdotal information describing situations where provider relations and/or case management staff members attempted to find rare openings for services or secure one-time contract agreements with providers to fill in any network gaps.

Recommendations and Opportunities for Improvement

HSAG identified no opportunities for improvement.

Required Actions

HSAG identified no required actions.

3. Background and Overview

Background

In accordance with its authority under Colorado Revised Statute 25.5-1-101 et seq., the Department of Health Care Policy & Financing (the Department) executed a contract with 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. In accordance with Title 42 of the Code of Federal Regulations (42 CFR) federal Medicaid managed care regulations published May 6, 2016, DHMP qualifies as a managed care organization (MCO). The CFR requires Primary Care Case Management (PCCM) entities, Prepaid Inpatient Health Plans (PIHPs), and MCOs to comply with specified provisions of 42 CFR §438—managed care regulations—and requires that states conduct a periodic evaluation of their managed care entities (MCEs), including PCCM entities, PIHPs, and MCOs, to determine compliance with Medicaid managed care regulations published May 6, 2016. Additional revisions were released in December 2020, February 2023, and May 2024. The Department has elected to complete this requirement for the MCOs by contracting with an external quality review organization (EQRO), HSAG.

To evaluate the DHMP's compliance with federal managed care regulations and State contract requirements, the Department determined that the review period for FY 2024–2025 was CY 2024. This report documents results of the FY 2024–2025 compliance review activities for DHMP. Section 1 includes the summary of scores for each of the standards reviewed this year. Section 2 contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 3 describes the background and methodology used for the FY 2024–2025 compliance monitoring review. Section 4 describes follow-up on the corrective actions required as a result of the FY 2023–2024 compliance review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the credentialing and recredentialing record reviews. Appendix C lists the HSAG, MCO, and Department personnel who participated in the compliance review process. Appendix D describes the corrective action plan (CAP) process that the MCO will be required to complete for FY 2024–2025 and the required template for doing so. Appendix E contains a detailed description of HSAG's compliance review activities consistent with the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023.[3-1]

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Aug 20, 2024.

Overview of FY 2024–2025 Compliance Monitoring Activities

For the FY 2024–2025 compliance review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools for the four chosen standards:

- Standard III—Coordination and Continuity of Care
- Standard IV—Member Rights, Protections, and Confidentiality
- Standard VIII—Credentialing and Recredentialing
- Standard XI—EPSDT Services

Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the MCO's contract requirements and regulations specified by the federal Medicaid managed care regulations published May 6, 2016. Additional revisions were released in December 2020, February 2023, and May 2024. HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable.* The Department determined that the review period was CY 2024. HSAG reviewed materials submitted prior to the compliance review activities, materials requested during the compliance review, and considered interviews with key MCO personnel to determine compliance with applicable federal managed care regulations and contract requirements. Documents consisted of policies and procedures, staff training materials, reports, committee meeting minutes, and member and provider informational materials.

The compliance review processes were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Appendix E contains a detailed description of HSAG's compliance review activities consistent with those outlined in the CMS EQR protocol. The four standards chosen for the FY 2024–2025 compliance reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services; Standard II—Adequate Capacity and Availability of Services; Standard V—Member Information Requirements; Standard VI—Grievance and Appeal Systems; Standard VII—Provider Selection and Program Integrity; Standard IX—Subcontractual Relationships and Delegation; Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems; and Standard XII—Enrollment and Disenrollment.

Objective of the Compliance Review

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

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

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

FY 2023–2024 Corrective Action Methodology

As a follow-up to the FY 2023–2024 compliance review, each MCO that received one or more *Partially Met* or *Not Met* scores was required to submit a CAP to the Department addressing those requirements found not to be fully compliant. If applicable, the MCO was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the MCO and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with DHMP until it completed each of the required actions from the FY 2023–2024 compliance monitoring review.

Summary of FY 2023–2024 Required Actions

For FY 2023–2024, HSAG reviewed Standard V—Member Information Requirements, Standard VII—Provider Selection and Program Integrity, Standard IX—Subcontractual Relationships and Delegation, and Standard X—QAPI, Clinical Practice Guidelines, and Health Information Systems.

Related to Standard V—Member Information Requirements, DHMP was required to complete three required actions:

- Review and revise the provider termination notices to ensure that the manner and format of the letters are easily understood and meet the sixth-grade reading level requirement.
- Modify the tagline in the formulary list to be in a conspicuously visible font size.
- Correct the provider directory to include the following: a direct URL to the provider website; whether the provider completed cultural competency training; and whether the provider has accommodations for people with disabilities.

Related to Standard VII—Provider Selection and Program Integrity, DHMP was required to complete one required action:

- Add the word "suspended" in its policy and provider manual regarding the reason for not working with an entity.

Related to Standard IX—Subcontractual Relationships and Delegation, DHMP was required to complete three required actions:

- Ensure, via revisions or amendments, that the subcontractor agreements include the required language that specified a provision for revocation of the delegation of activities or obligations or

specify other remedies in instances where DHMP determines that the subcontractor has not performed satisfactorily.

- Ensure, via revisions or amendments, that the subcontractor agreements include the required language that the subcontractor's agreement must comply with all applicable CHP+ laws and regulations, including applicable subregulatory guidance and contract provisions.
- Revise or amend the subcontractor agreements to include:
  - The State, CMS, the U.S. Department of Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State.
    - The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems related to members.
    - The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
    - If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

Related to Standard X—QAPI, Clinical Practice Guidelines, and Health Information Systems, HSAG found no required actions for this standard.

Summary of Corrective Action/Document Review

DHMP submitted a proposed CAP in May 2024. HSAG and the Department reviewed and approved the proposed CAP and responded to DHMP. DHMP submitted the most recent CAP documentation in November 2024.

Summary of Continued Required Actions

DHMP has not successfully completed the FY 2023–2024 CAP, resulting in one continued corrective action.

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 members and ensure active management of high-cost and high-need members. 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.	•Policy - Care Management for Medicaid Choice and Child Health Plans Plus Members •Policy - Complex Case Management Process •Policy - Complex Case Management Member Identification Process •Policy - Cultural and Linguistic Appropriate Services -CLAS •Policy - Member Rights & Responsibilities •CM Activity BH Coordination •CM Activity Healthcare Provider Coordination •Screenshots Epic SDOH Wheel Gaps in Care •Care Coordination via EPIC Hyperdrive EMR •Sample CM SDOH Assessment •Sample CM Functional Assessment •Sample CM Complex Health Assessment •DHMP EPIC Guide •EPIC Tip Sheet - Documentation Encounters •EPIC Tip Sheet - Scanning Documents •EPIC Tip Sheet - DHMP Patients List"	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.208(b) RMHP Prime Contract Amendment 19: Exhibit M-18—11.3.3, 11.3.7 DHMP Contract Amendment 15: Exhibit B-14—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)* RMHP Prime Contract Amendment 19: Exhibit M-18—None DHMP Contract Amendment 15: Exhibit B-14—None	• Policy - Care Management for Medicaid Choice and Child Health Plans Plus Members-Page 5 MCD • Care Management Referral Form • Medicaid Member Handbook- Pg. 37-38 •DHMP Member Newsletter Fall 2024 (Pg. 8) •Standard III 2 Screenshots MCD Website	☒ 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). RMHP Prime Contract Amendment 19: Exhibit M-18—6.7 DHMP Contract Amendment 15: Exhibit B-14—6.7	"- Medicaid Member Handbook- Pg. 12-14 - Medicaid QRG- Pg. 2 - Change in Circumstance Report"	☒ 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 extensive assistance and include appropriate interventions. RMHP Prime Contract Amendment 19: Exhibit M-18—11.3.3 DHMP Contract Amendment 15: Exhibit B-14—11.3.3	"•Policy - Care 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"	☒ 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.	"•Policy - Care Management for Medicaid Choice and Child Health Plan Plus Members (Pages 4 and 6) •Policy - Coordination and Continuity of Care for Members with Special Health Care Needs •DHMP Care Management and Care Coordination Care Transitions Procedures •CM Activity Community and Social Support and Services - Example of a report that can be pulled to monitor all CM outreaches for community and social supports •CM Activity Transitions of Care - 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**
• Including Medicaid-eligible individuals being released from incarceration to ensure they transition successfully to the community. *Note: Contractor shall ensure that care coordination is provided to members who are transitioning between health care settings and to populations who are served by multiple systems, including, but not limited to, children involved with child welfare; Medicaid-eligible individuals transitioning out of the criminal justice system; members receiving long-term services and supports (LTSS); members transitioning out of inpatient, residential, and institutional settings; and members residing in the community who are identified as at-risk for institutionalization.* *42 CFR 438.208(b)(2)* RMHP Prime Contract Amendment 19: Exhibit M-18—10.3.2, 10.3.4, 11.3.5, 11.3.7.7, 11.3.10, 11.3.10.4.2.3 DHMP Contract Amendment 15: Exhibit B-14—10.3.2, 10.3.4, 11.3.5, 11.3.10, 11.3.10.4.2.3	•Sample CM TOC Assessment •UM OTA Job Aid •Member Transition of Care Coordination (RAE to RAE) Form"	
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.	"•Policy- Medicaid and CHP+ Health Needs Survey •Policy- Care Management for Medicaid Choice and Child Health Plan Plus Members • CM Activity HNS Care Coordination - Example of a report showing care coordination activities based on HNS responses	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.208(b)(3) RMHP Prime Contract Amendment 19: Exhibit M-18—7.5.2–3 DHMP Contract Amendment 15: Exhibit B-14—7.5.2–3	•Medicaid Sample Survey_HNA_English- Survey sent by DHMP/vendor to all new members •Letter_DHMPh_HNA_Medicaid- letter that is sent with the health needs survey •DH_HN_Screening_Medicaid_Adult_ SPH Phone Script- Phone script for the DHMP/vendor health needs survey •HNS Response Job Aid •sow DenverHealth SPH HRAMedicaidCHP FINAL 082622 •CM HNS Metrics 2024"	
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)* RMHP Prime Contract Amendment 19: Exhibit M-18—14.5.1 DHMP Contract Amendment 15: Exhibit B-14—13.5.1	"•Policy - Care Management for Medicaid Choice and Child Health Plan Plus Members (Pages 5 and 7) •Policy- Medicaid and CHP+ Health Needs Survey •Policy - Complex Case Management Process (Page 5) •Policy - Coordination and Continuity of Care for Members with Special Health Care Needs •CM Activity Care Plan Update Review - Example of a report showing members who were outreached to update or review their 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**
	•Sample Assessments Folder- Samples of different types of assessments used for care plans •Essential Care Management Elements of a Care Plan •CM Screenshots plan of care following assessment"	
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)* RMHP Prime Contract Amendment 19: Exhibit M-18—None DHMP Contract Amendment 15: Exhibit B-14—None	"•Policy - Care Management for Medicaid Choice and Child Health Plan Plus Members (Page 8 MCD) •Policy - Complex Case Management Process (Pages 5 and 10 MCD) •CM Activity Epic Hyperdrive Look Up- Example of a report showing referrals and care coordination out of EPIC •Screenshots Epic SDOH Wheel Gaps in Care •Care Coordination via EPIC Hyperdrive EMR •DHMC EPIC Guide •EPIC Tip Sheet - Documentation Encounters •EPIC Tip Sheet - Scanning Documents •EPIC Tip Sheet - DHMP Patients List"	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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)* RMHP Prime Contract Amendment 19: Exhibit M-18—11.3.7.13, 15.1.1.5 DHMP Contract Amendment 15: Exhibit B-14—11.3.7.12, 15.1.1.5	"- Policy- HIPAA Hybrid Entity – Health Care Components •Policy - Care Management for Medicaid Choice and Child Health Plan Plus Members"	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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.	"•Guiding Care - Care Management User Guide •Medicaid Choice Guiding Care Screenshots"	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• 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. The care coordination tool, at a minimum: • Works on mobile devices. • Supports HIPAA and 42 CFR Part 2 compliant data sharing. • Provides role-based access to providers and care coordinators. *Note: The Contractor shall collect and be able to report the information identified in Section 15.2.1.3 for its entire network. Although network providers and subcontracted care coordinators may use their own data collection tools, the Contractor shall require them to collect and report on the same data.* RMHP Prime Contract Amendment 19: Exhibit M-18—15.2.1.1, 15.2.1.3–4 DHMP Contract Amendment 15: Exhibit B-14—15.2.1.1, 15.2.1.2, 15.2.1.3–4		

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)* RMHP Prime Contract Amendment 19: Exhibit M-18—7.3.7.1 DHMP Contract Amendment 15: Exhibit B-14—7.3.7.1	Policy- Member Rights and Responsibilities	☒ 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)* RMHP Prime Contract Amendment 19: Exhibit M-18—5.2.4 DHMP Contract Amendment 15: Exhibit B-14—5.10	•Policy- Member Rights and Responsibilities - Pg.2 procedure A. •2024 Denver Health Code of Conduct. – PDF Pg. 7 •Provider Manual 2024– Pg. 7, Pg. 54 and 55	☒ 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.	• Policy- Member Rights and Responsibilities - Pg. 2 - 3 (a,b,c,d,e,j and p.)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• 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. • 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)* RMHP Prime Contract Amendment 19: Exhibit M-18—7.3.7.2 DHMP Contract Amendment 15: Exhibit B-14—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 treat(s) the member. *42 CFR 438.100(c)* RMHP Prime Contract Amendment 19: Exhibit M-18—7.3.7.2.7 DHMP Contract Amendment 15: Exhibit B-14—7.3.7.2.7	•Policy- Member Rights and Responsibilities Policy Pg.- 3 • Medicaid Member Handbook- Pg. 24	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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* RMHP Prime Contract Amendment 19: Exhibit M-18—11.3.7.13, 15.1.1.5 DHMP Contract Amendment 15: Exhibit B-14—11.3.7.12, 15.1.1.5	• Policy- Protected Health Information Uses and Disclosures without Authorization • MCD HIPA Privacy web link • Policy- Electronic Messaging – Email, Texting, Mobile Photography	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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.	• Policy- Advance Medical Directives • Medicaid Member Handbook- Pg.. 19 & 20 • Policy- Member rights and responsibilities	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– 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. – 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.		

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– To educate 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. *Note: The MCO must be able to document its community education efforts.* *42 CFR 422.128 and 438.3(j)* RMHP Prime Contract Amendment 19: Exhibit M-18—7.3.11.3–6 DHMP Contract Amendment 15: Exhibit B-14—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 VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. • The Contractor shall use National Committee on Quality Assurance (NCQA) credentialing and recredentialing standards and guidelines as the uniform and required standards for all applicable providers. *42 CFR 438.214(b)* NCQA CR1 RMHP Prime Contract Amendment 19: Exhibit M-18—9.2.4 DHMP Contract Amendment 15: Exhibit B-14—9.2.2	Policy- Credentialing and Re-credentialing of Practitioners- pg 1 under Purpose	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners it credentials and recredentials. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. The Contractor shall document and post on its public website policies and procedures for the selection and retention of providers. *Examples of behavioral health practitioners include psychiatrists, physicians, addiction medicine specialists, doctoral or master's-level psychologists, master's-level clinical*	• Provider Selection and Retention Policy pg 1 • Screenshot Provider Selection and Retention	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
social workers, master's-level clinical nurse specialists or psychiatric nurse practitioners, and other behavioral health care specialists. *Examples of health plan (HP) practitioners include medical doctors, chiropractors, osteopaths, podiatrists, nurse practitioners (NPs), etc.* *42 CFR 438.214(a)–(b)(1)* NCQA CR1—Element A1 RMHP Prime Contract Amendment 19: Exhibit M-18—9.1.7 DHMP Contract Amendment 15: Exhibit B-14—9.1.8		
2.B. The verification sources it uses. NCQA CR1—Element A2	Attachment B_Acceptable Verification Sources for Practitioner Credentialing	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	Policy- Credentialing and Recredentialing of Practitioners pg 8 table F	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	Policy- Credentialing and Recredentialing of Practitioners pg 7&8 section E3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.E. The process for managing credentialing/recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	Policy- Credentialing and Recredentialing of Practitioners pg 10 section G	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.F. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. *Examples include nondiscrimination of applicant, a process for preventing and monitoring discriminatory practices, and monitoring the credentialing/recredentialing process for discriminatory practices at least annually.* *42 CFR 438.214(c)* NCQA CR1—Element A6	Policy- Credentialing and Recredentialing of Practitioners pg 6 section B	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.G. The process for notifying practitioners if information obtained during the Contractor's credentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A7	Policy- Credentialing and Recredentialing of Practitioners pg 6&7 section C	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.H. The process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the Credentialing Committee's decision. NCQA CR1—Element A8	Policy- Credentialing and Recredentialing of Practitioners pg 17 section K	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.I. The medical director or other designated physician's direct responsibility and participation in the credentialing program. NCQA CR1—Element A9	Policy- Credentialing and Recredentialing of Practitioners pg 5 under procedures & pg10 section G	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.J. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law. NCQA CR1—Element A10	Policy- Credentialing and Recredentialing of Practitioners pgs 5&6 section A	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.K. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification (including board certification, if applicable) and specialty. NCQA CR1—Element A11	Policy- Credentialing and Recredentialing of Practitioners pg 17 section M Policy- Web Based Provider and Hospital Directory pgs 4-8	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor notifies practitioners about their rights: 3.A. To review information submitted to support their credentialing or recredentialing application. *The Contractor is not required to make references, recommendations, or peer-review protected information available.* NCQA CR1—Element B1	Policy- Credentialing and Recredentialing of Practitioners pgs 6&7 section C and pg 17 section L Policy- Credentialing and Recredentialing of Practitioners pg 6&7section C #1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3.B. To correct erroneous information. NCQA CR1—Element B2	Policy- Credentialing and Recredentialing of Practitioners pg 7 section C #2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3.C. To receive the status of their credentialing or recredentialing application, upon request. NCQA CR1—Element B3	Policy- Credentialing and Recredentialing of Practitioners pg 7 section C #3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing and recredentialing decisions. NCQA CR2	Policy- Credentialing and Recredentialing of Practitioners pg 7&8 section E	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Credentialing Committee: • Uses participating practitioners to provide advice and expertise for credentialing decisions. • Reviews credentials for practitioners who do not meet established thresholds. • Ensures that clean files are reviewed and approved by a medical director or designated physician. NCQA CR2—Element A1–3	Policy- Credentialing and Recredentialing of Practitioners pg 7&8 section E Policy- Credentialing Committee Charter	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. For credentialing and recredentialing, the Contractor verifies the following within the prescribed time limits.: • A current, valid license to practice (verification time limit is 180 calendar days). • A current, valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (verification time limit is prior to the credentialing decision). • Education and training—the highest of the following: graduation from medical/professional school; completion of residency; or board certification (verification time limit is prior to the credentialing decision; if board certification, time limit is 180 calendar days). • Work history—most recent five years; if less, from time of initial licensure—from practitioner's application or CV (verification time limit is 365 calendar days). – If a gap in employment exceeds six months, the practitioner clarifies the gap verbally or in writing and notes clarification in the credentialing file. If the gap in employment exceeds one year, the practitioner clarifies the gap in writing. • History of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner—most recent five years (verification time limit is 180 calendar days).	Policy- Credentialing and Recredentialing of Practitioners pgs 8-10 section F	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– The organization is not required to obtain this information for practitioners who had a hospital insurance policy during a residency or fellowship. *Note: Education/training and work history are NA for recredentialing. Verification of board certification does not apply to nurse practitioners or other health care professionals unless the organization communicates board certification of those types of providers to members.* NCQA CR3—Element A		
7. The Contractor verifies the following sanction information for credentialing and recredentialing (verification time limit is 180 days): • State sanctions, restrictions on licensure, or limitations on scope of practice. • Medicare and Medicaid sanctions. *42 CFR 438.214(d)(1)* NCQA CR3—Element B	Policy- Credentialing and Recredentialing of Practitioners pgs 8-10 section F	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. Applications for credentialing include the following (attestation verification time limit is 365 days): • Reasons for inability to perform the essential functions of the position, with or without accommodation. • Lack of present illegal drug use. • History of loss of license and felony convictions.	Policy- Credentialing and Recredentialing of Practitioners pgs 8-10 section F	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• History of loss or limitation of privileges or disciplinary actions. • Current malpractice insurance coverage (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate). • Current and signed attestation confirming the correctness and completeness of the application. NCQA CR3—Element C		
9. The Contractor formally recredentials its practitioners within the 36-month time frame. NCQA CR4	Policy- Credentialing and Recredentialing of Practitioners pg 12 section H	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor implements policies and procedures for ongoing monitoring and takes appropriate action, including: • Collecting and reviewing Medicare and Medicaid sanctions. • Collecting and reviewing sanctions or limitations on licensure. • Collecting and reviewing complaints. • Collecting and reviewing information from identified adverse events. • Implementing appropriate interventions when it identifies instances of poor quality related to the above.	Policy- Credentialing and Recredentialing of Practitioners pgs 15-17 #6 A-I	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.214(d)(1) NCQA CR5—Element A		
11. The Contractor has policies and procedures for taking action against a practitioner who does not meet quality standards that include: • The range of actions available to the Contractor. • Making the appeal process known to practitioners. *Examples of range of actions: how the organization reviews practitioners whose conduct could adversely affect members' health or welfare; the range of actions that may be taken to improve practitioner performance before termination; reporting actions taken to the appropriate authorities.* NCQA CR6—Element A	• Policy- Credentialing and Recredentialing of Practitioners pg 17 section L • Policy- Practitioner Appeal Rights Notification to Authorities Based on Issues of QOC	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of *organizational* health care delivery providers and specifies that before it contracts with a provider, and for at least every 36 months thereafter: 12.A. The Contractor confirms that the organizational provider is in good standing with State and federal regulatory bodies. *Policies specify the sources used to confirm good standing—which may only include the applicable State or federal agency, agent of the applicable State or federal agency, or copies of*	Policy- Assessment of Organizational Providers under purpose Policy- Assessment of Organizational Providers under procedures section A	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
credentials (e.g., State licensure) from the provider. Attestations are not acceptable. *42 CFR 438.214(d)(1)* NCQA CR7—Element A1		
12.B. The Contractor confirms that the organizational provider has been reviewed and approved by an accrediting body. *Policies specify the sources used to confirm accreditation—which may only include the applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, or copies of credentials (e.g., licensure, accreditation report, or letter) from the provider. Attestations are not acceptable.* NCQA CR7—Element A2	Policy- Assessment of Organizational Providers pg 4&5 section A #5	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12.C. The Contractor conducts an on-site quality assessment if the organizational provider is not accredited. *Policies include on-site quality assessment criteria for each type of unaccredited organizational provider, and a process for ensuring that the provider credentials its practitioners.* *The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: The CMS or State review is no more than three years old; the organization obtains a survey report or letter from CMS or the State, from either the provider or from the agency, stating that the facility was reviewed and passed inspection; the report meets the organization's quality assessment criteria or*	Policy- Assessment of Organizational Providers pg 5 section A #6	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
standards. (Exception: Rural areas.) NCQA CR7—Element A3		
13. The Contractor's organizational provider assessment policies and processes includes: • For behavioral health, facilities providing mental health or substance abuse services in the following settings: – Inpatient – Residential – Ambulatory • For physical health, at least the following providers: – Hospitals – Home health agencies – Skilled nursing facilities – Free-standing surgical centers NCQA MBHO CR7—Element B NCQA HP CR7—Elements B and C	Policy- Assessment of Organizational Providers pg 2 Behavioral Health	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor has documentation that it assesses providers every 36 months. NCQA MBHO CR7—Element C NCQA HP CR7—Elements D and E	Policy- Assessment of Organizational Providers under purpose	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The Contractor shall submit a monthly Credentialing and Contracting Report to the Department with information about Provider contracting timelines, using a format determined by the Department. RMHP Prime Contract Amendment 19: Exhibit M-18—9.1.7.5.5 Contract Amendment 15: Exhibit B-14—9.1.8.5.5	This was removed from the most recent contract amendment	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. If the Contractor delegates credentialing/recredentialing activities, the Contractor has a written delegation document with the delegate that: • Is mutually agreed upon. • Describes the delegated activities and responsibilities of the Contractor and the delegated entity. • Requires at least semiannual reporting by the delegated entity to the Contractor (and includes details of what is reported, how, and to whom). • Describes the process by which the Contractor evaluates the delegated entity's performance. • Specifies that the organization retains the right to approve, suspend, and terminate individual practitioners, providers, and sites, even if the organization delegates decision making. • Describes the remedies available to the Contractor (including circumstances that result in revocation of the contract) if the delegate does not fulfill its obligations, including revocation of the delegation agreement. NCQA CR8—Element A	Delegation Template Bullet #1 pg 1 paragraphs 1 & 3 Bullet #2 section A&B Bullet #3 pg 5 (F) Bullet #4 pg 3 #6 Bullet #5: pg 2 #3 Bullet #6 pg 3 section A #6 & section B #8	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. For new delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity to meet NCQA requirements before delegation began. *The requirement is NA if the Contractor does not delegate or if delegation arrangements have been in effect for longer than the look-back period.* NCQA CR8—Element B	Policy- Delegation of Credentialing Activities pg 2 section A	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
18. For delegation agreements in effect 12 months or longer, the Contractor: • Annually reviews its delegate's credentialing policies and procedures. • Annually audits credentialing and recredentialing files against its standards for each year that delegation has been in effect. • Annually evaluates delegate performance against its standards for delegated activities. • Semiannually evaluates regular reports specified in the written delegation agreement. • At least annually, monitors the delegate's credentialing system security controls to ensure the delegate monitors its compliance with the delegation agreement or with the delegates policies and procedures. • At least annually, acts on all findings from above monitoring for each delegate and implements a quarterly monitoring process until each delegate demonstrates	Policy- Delegation of Credentialing Activities pgs 3&4 section B #1-14	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
improvement for one finding over three consecutive quarters. NCQA CR8—Element C		
19. For delegation agreements that have been in effect for more than 12 months, at least once in each of the past two years, the Contractor identified and followed up on opportunities for improvement, if applicable. NCQA CR8—Element D	Policy-Delegation of Credentialing Activities pg 4 section B #9	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

Results for 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 and scheduling assistance. RMHP Prime Contract Amendment 19: Exhibit M-18—7.3.12.1, 7.6.2 DHMP Contract Amendment 15: Exhibit B-14—7.3.12.1, 7.6.2	- Medicaid Member handbook- Bullet 1 & 3. pages 33-35 - Policy EPSDT- Bullet 1. page 3 & 4, Bullet 3. page 3 & 4 - DHMP Newsletter Regulatory 2024- Annual newsletter for members - Member Webpages on EPSDT - EPSDT Flyer- Flyer included in the mailings for new members along with the Health Needs Survey -SPH HN Phone Screen- Phone script used for health needs survey outreach attempts (EPSDT is addressed) for all new members -SPH Health Needs Assessment - Birthday Card_DHMP Kids_English 2024- mailer sent out to members who have not received a well child visit - Birthday Card_DHMP Teens_English 2024- mailer sent out to members who have not received a well child visit	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for 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 • Automated calls • Email, text/SMS messages RMHP Prime Contract Amendment 19: Exhibit M-18—7.6.6 DHMP Contract Amendment 15: Exhibit B-14—7.6.6	-Policy-EPSDT - Bullet 1. page 3 & 4, Bullet 3. page 4 - Medicaid Member Handbook- page 33-35 - Medicaid QRG- sent to all new members with directions on how to make appointments - Birthday Card_DHMP Kids_English 2024 - Birthday Card_DHMP Teen_English 2024 - WCVRobocallScript- call script used for robo dialer for kids that still need a well visit	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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. RMHP Prime Contract Amendment 19: Exhibit M-18—12.8.3.4, 12.9.2.5 DHMP Contract Amendment 15: Exhibit B-14—12.9.3.4, 12.10.3.4	- Policy- ESPDT- Bullet 1. page 5 & 6, Bullet 2. page 5 -EPSDT Provider Newsletter 10-02-24 -EPSDT Provider Newsletter 02-28-24 -Provider Webpages on EPSDT -Provider Manual- Bullet 1. page 65 - 67	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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. • 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)* RMHP Prime Contract Amendment 19: Exhibit M-18—7.7.5	- Policy- EPSDT * Bullet 1. page 1 * Bullet 2. page 6 * Bullets 3 & 4. page 7 * Bullet 5: page 7 * Bullet 6: pages 7 & 8 -Provider Manual * Bullet 1. page 65 * Bullet 2. page 65 * Bullet 3. page 67 * Bullet 4. page 34 * Bullet 5. page 67 * Bullet 6. page 65 - Provider Webpages on EPSDT - Medicaid Behavioral Health Practice Guidelines- Bullets 2, 3 & 4 - Pediatric and Adolescent Preventive Healthcare Guidelines * Bullet 1. page 1, 6 & 7 * Bullet 2. page 3, 5 & 6	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
DHMP Contract Amendment 15: Exhibit B-14—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)	* Bullet 3. page 9 * Bullet 5. page 3 * Bullet 6. page 7 - Pediatrics Early Intervention, Child Find or Developmental Delay Clinical Referral Guideline * Bullet 1. page 1 * Bullet 2. page 2	
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* RMHP Prime Contract Amendment 19: Exhibit M-18—7.7.5 DHMP Contract Amendment 15: Exhibit B-14—7.7.5 10 CCR 2505-10 8.280.4.C	-Policy- EPSDT * Bullet 1. page 11 * Bullet 2. page 3, 4 & 5 * Bullet 3. page 11 -Member Webpage on EPSDT -MCD Handbook- Bullet 1. page 35 • CM Activity Community Resources EPSDT - Example of a report showing referrals to State and community programs	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for 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 nor 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. RMHP Prime Contract Amendment 19: Exhibit M-18—7.7.5 DHMP Contract Amendment 15: Exhibit B-14—7.7.5 10 CCR 2505-10 8.076.8; 8.076.8.1; 8.280.4.E	-Policy- EPSDT- Pg. 2, 9 -Provider Manual- Pg. 66 -UM Job Aid- EPSDT	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for 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: intensive case management, prevention/early intervention activities, clubhouse and drop-in centers, residential care, assertive community treatment (ACT), and recovery services. *Note: All EPSDT services are included in the State Plan or in the Non-State Plan 1915(b)(3) Waiver Services (except for respite and vocational rehabilitation).* RMHP Prime Contract Amendment 19: Exhibit M-18—14.5.7.1, 2.1.1 DHMP Contract Amendment 15: Exhibit B-14—14.5.7.1, 2.1.1	-Policy - Complex Case Management Member Identification Process - Shows the intensive case management identification including referral process - Member Webpages on EPSDT - EPSDT Policy- pages 4, 6, 9, 10	☒ 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. Colorado Department of Health Care Policy & Financing
FY 2024–2025 External Quality Review
Initial Credentialing Record Review
for Denver Health Medical Plan MCO

Review Period:	January 1, 2024 – December 31, 2024
Completed By:	Deb Harris
Date of Review:	January 8, 2025 – January 9, 2025
Reviewer:	Crystal Brown
Participating MCE Staff Member During Review:	Deb Harris and Dr. Christine Seals-Messersmith

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10
Provider ID #	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****
Provider Type (e.g., MD, PA, NP, LCSW, PsyD, DDS, DMD)	LPC	BA	PA	CM	SLP	OD	OT	NP	BA	LPC
Provider Specialty (e.g., PCP, surgeon, therapist, periodontist)	Professional Counselor	Applied Behavior Analyst	Physician Assistant	Nurse Midwife	Speech Language Pathologist	Optometrist	Occupational Therapist	Psychiatric/ Mental Health Nurse Practitioner	Applied Behavior Analyst	Professional Counselor
Date of Completed Application [MM/DD/YYYY]	1/3/2024	3/6/2024	3/11/2024	10/26/2023	10/5/2023	6/28/2024	7/10/2024	9/4/2024	10/17/2024	4/26/2024
Date of Initial Credentialing [MM/DD/YYYY]	2/9/2024	3/19/2024	4/16/2024	4/17/2024	2/15/2024	6/28/2024	7/26/2024	9/20/2024	10/29/2024	9/25/2024
Completed Application for Appointment Met? [VIII.8]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Verification of Current and Valid License Yes, No, Not Applicable (NA)	Yes	NA	Yes	Yes	Yes	Yes	Yes	Yes	NA	Yes
Evidence of Verification of Current and Valid License Met? [VIII.6]	Met	NA	Met	Met	Met	Met	Met	Met	NA	Met
Evidence of Board Certification Yes, No, NA	NA	Yes	Yes	Yes	Yes	NA	NA	Yes	Yes	NA
Evidence of Board Certification Met? [VIII.6]	NA	Met	Met	Met	Met	NA	NA	Met	Met	NA
Evidence of Valid DEA or CDS Certificate (for prescribing providers only) Yes, No, NA	NA	NA	Yes	Yes	NA	NA	NA	NA	NA	NA
Evidence of Valid DEA or CDS Certificate Met? [VIII.6]	NA	NA	Met	Met	NA	NA	NA	NA	NA	NA
Evidence of Education/Training Verification Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Education/Training Verification Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Work History (most recent five years or, if less, from the time of initial licensure) Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Work History Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Malpractice History Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice History Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence Malpractice Insurance/Required Amount (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate) Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice Insurance/Required Amount Met? [VIII.8]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Verification That Provider Is Not Excluded From Federal Participation Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Verification That Provider Is Not Excluded From Federal Participation Met? [VIII.7]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2024–2025 External Quality Review
Initial Credentialing Record Review
for Denver Health Medical Plan MCO

Scoring	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10
Applicable Elements	7	7	9	9	8	7	7	8	7	7
Compliant (Met) Elements	7	7	9	9	8	7	7	8	7	7
Percent Compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Total Applicable Elements	76									
Total Compliant Elements	76									
Total Percent Compliant	100%									

Notes:

1. Current, valid license with verification that no State sanctions exist
2. Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate (applicable to practitioners qualified to write prescriptions—e.g., psychiatrists, MD, DO)
3. Education/training—the highest of board certification, residency, graduation from medical/professional school
4. Applicable if the practitioner states on the application that he or she is board certified
5. Most recent five years or from time of initial licensure (if less than five years)
6. Malpractice settlements in most recent five years
7. Current malpractice insurance (physicians: $500,000/$1.5 million) verified through certificate of insurance
8. Verified that provider is not excluded from participation in federal programs
9. Application must be complete (see the compliance monitoring tool for elements of complete application)
10. Verification time limits:

Prior to Credentialing Decision
- DEA or CDS certificate
- Education and training

180 Calendar Days
- Current, valid license
- Board certification status
- Malpractice history
- Exclusion from federal programs

365 Calendar Days
- Signed application/attestation
- Work history

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2024–2025 External Quality Review
Recredentialing Record Review
for Denver Health Medical Plan MCO

Review Period:	January 1, 2024 – December 31, 2024
Completed By:	Deb Harris
Date of Review:	January 8, 2025 – January 9, 2025
Reviewer:	Crystal Brown
Participating MCE Staff Member During Review:	Deb Harris and Dr. Christine Seals-Messersmith

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10
Provider ID #	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****
Provider Type (e.g., MD, PA, NP, LCSW, PsyD, DDS, DMD)	OD	NP	LPC	NP	NP	NP	MD	OD	MD	NP
Provider Specialty (e.g., PCP, surgeon, therapist, periodontist)	Optometrist	Psychiatric Mental Health	Professional Counselor	Psychiatric Mental Health	Psychiatric Mental Health	Psychiatric Mental Health	Ophthalmology	Optometrist	Ophthalmology	Psychiatric Mental Health
Date of Last Credentialing [MM/DD/YYYY]	9/16/2021	4/19/2021	4/9/2021	6/30/2021	6/17/2021	7/27/2021	9/30/2021	8/31/2021	9/30/2021	10/31/2021
Date of Recredentialing [MM/DD/YYYY]	5/30/2024	4/30/2024	4/30/2024	6/30/2024	6/17/2024	7/27/2024	7/31/2024	8/31/2024	7/31/2024	10/31/2024
Months From Initial Credentialing to Recredentialing	32	36	36	36	36	36	34	36	34	36
Time Frame for Recredentialing Met? [VIII.9] Is completed at least every three years (36 months)	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Verification of Current and Valid License Yes, No, Not Applicable (NA)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Verification of Current and Valid License Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Board Certification Yes, No, NA	NA	Yes	NA	Yes	Yes	Yes	Yes	NA	Yes	Yes
Evidence of Board Certification Met? [VIII.6]	NA	Met	NA	Met	Met	Met	Met	NA	Met	Met
Evidence of Valid DEA or CDS Certificate (for prescribing providers only) Yes, No, NA	NA	Yes	NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Valid DEA or CDS Certificate Met? [VIII.6]	NA	Met	NA	Met	Met	Met	Met	Met	Met	Met
Evidence of Malpractice History Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice History Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Malpractice Insurance/Required Amount (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate) Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice Insurance/Required Amount Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Ongoing Verification That Provider Is Not Excluded From Federal Participation Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Ongoing Verification That Provider Is Not Excluded From Federal Participation Met? [VIII.10]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Comments:										

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2024–2025 External Quality Review
Recredentialing Record Review
for Denver Health Medical Plan MCO

Scoring	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10
Total Applicable Elements	5	7	5	7	7	7	7	6	7	7
Total Compliant (Met) Elements	5	7	5	7	7	7	7	6	7	7
Total Percent Compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Total Applicable Elements	**65**									
Total Compliant Elements	**65**									
Total Percent Compliant	**100%**									

Notes:

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

   Prior to Credentialing Decision
   - DEA or CDS certificate

   180 Calendar Days
   - Current, valid license
   - Board certification status
   - Malpractice history
   - Exclusion from federal programs

   365 Calendar Days
   - Signed application/attestation
9. Within 36 months of previous credentialing or recredentialing approval date

Appendix C. Compliance Review Participants

Table C-1 lists the participants in the FY 2024–2025 compliance review of DHMP.

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

HSAG Reviewers	Title
Gina Stepuncik	Associate Director
Sara Dixon	Project Manager III
Crystal Brown	Project Manager I
DHMP Participants	**Title**
Gregory McCarthy	Executive Director, Managed Care
Christine Seals-Messersmith	Medical Director, Managed Care
Mike Wagner	Chief Operating Officer, Managed Care
Natalie Score	Director, Insurance Products
Ruie Winters III	Director Senior, Health Plan Pharmacy and Health Outcomes
Darla Schmidt	Director, Health Plan Utilization Management
Dawn Robinson	Director, Health Plan Care Management
Adam Bean	Compliance Manager
Katie Egan	Manager, Health Plan Quality Improvement
Jeremy Sax	Government Products Manager
Christina Porter	Program Manager, Utilization Management and Grievance Appeals
Marissa Schillaci-Kayton	Manager, Business Operations
Katie Gaffney	Lead Analyst, Health Plan Compliance
Arjanea Williams	Analyst, Health Plan Compliance
Pamela Briscoe	Senior Paralegal
Deb Harris	Managed Care Credentialing Coordinator
Pamela Roth	Managed Care Credentialing Coordinator
Chad Frankfather	Clinical Manager, Health Plan Care Management
Jason Casey	Analyst, Health Plan Compliance
Landon Palmer	Chief Compliance and Audit Officer
Beth Flood	Population Health Senior Manager
Shannon Godbout	Project Manager
Shelly Siedelberg	Quality Informatics Program Manager
Susannah Santamaria	Clinical Care Coordinator
Alicia Persich	Marketing and Engagement Manager

Department Observers	Title
Russell Kennedy	Quality Program Manager
Lindsey Folkerth	Managed Care Contract Specialist

Appendix D. Corrective Action Plan Template for FY 2024–2025

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

Table D-1—CAP Process

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

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

HSAG identified no required actions; therefore, the CAP template is not included.

Appendix E. Compliance Monitoring Review Protocol Activities

The following table describes the activities performed throughout the compliance monitoring process. The activities listed below are consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023.

Table E-1—Compliance Monitoring Review Activities Performed

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

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct the Review**
	• During the review, HSAG met with groups of the MCE's key staff members to obtain a complete picture of the MCE's compliance with federal healthcare regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the MCE's performance. • HSAG requested, collected, and reviewed additional documents as needed. • At the close of the review, HSAG provided MCE staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the Department-approved FY 2024–2025 Compliance Review Report template to compile the findings and incorporate information from the pre-review and review activities. • HSAG analyzed the findings and calculated final scores based on Department-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the Department**
	• HSAG populated the Department-approved report template. • HSAG submitted the draft Compliance Review Report to the MCE and the Department for review and comment. • HSAG incorporated the MCE and Department comments, as applicable, and finalized the report. • HSAG included a pre-populated CAP template in the final report for all elements determined to be out of compliance with managed care regulations. • HSAG distributed the final report to the MCE and the Department.