CHP+

Child Health Plan *Plus*

Fiscal Year 2021–2022 Site Review Report

for

Friday Health Plans

January 2022

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

Public Law 111-3, Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, requires that each state's Children's Health Insurance Program (CHIP) apply several provisions of Section 1932 of the Social Security Act (the Act) in the same manner as the provisions apply under Title XIX of the Act. This requires managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to comply with provisions of the Code of Federal Regulations, Title 42 (42 CFR)—federal Medicaid managed care regulations published May 6, 2016. The updated Medicaid and Child Health Plan *Plus* (CHP+) managed care regulations published May 6, 2016, became applicable to CHIP effective July 1, 2018. Additional revisions were released in November 2020, with an effective date of December 2020. The CFR requires that states conduct a periodic evaluation of their MCOs and PIHPs to determine compliance with federal healthcare regulations and managed care contract requirements. The Department of Health Care Policy and Financing (the Department) has elected to complete this requirement for Colorado's CHP+ managed care health plans by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

In order to evaluate the CHP+ health plans' compliance with federal managed care regulations and State contract requirements, the Department determined that the review period for fiscal year (FY) 2021–2022 was January 1, 2021, through December 31, 2021. This report documents results of the FY 2021–2022 site review activities for **Friday Health Plans** (**FHP**). For each of the standard areas reviewed this year, this section contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 2 describes the background and methodology used for the FY 2021–2022 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2020–2021 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for both the credentialing and recredentialing record reviews. Appendix C lists HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan (CAP) process the health plan will be required to complete for FY 2021–2022 and the required template for doing so. Appendix E contains a detailed description of HSAG's site review activities consistent with the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[1-1]

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Sep 27, 2021.

Summary of Results

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

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

Table 1-1—Summary of Scores for the 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	5	5	0	0	50%
IV. Member Rights, Protections, and Confidentiality	5	5	4	1	0	0	80%
VIII. Credentialing and Recredentialing	32	31	24	7	0	1	77%
X. Quality Assessment and Performance Improvement	18	18	12	6	0	0	67%
Totals	**65**	**64**	**45**	**19**	**0**	**1**	**70%**

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

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

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Credentialing	100	85	84	1	15	99%
Recredentialing	54	53	51	2	1	96%
Totals	**154**	**138**	**135**	**3**	**16**	**98%**

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

Standard III—Coordination and Continuity of Care

Summary of Strengths and Findings as Evidence of Compliance

FHP described a case management department supported by medical directors, registered nurses, and medical specialists all based in the Alamosa, Colorado, headquarters. Member levels of care were split into entry, intermediate, and upper classifications, and staff members explained various outreach expectations associated with each level. Members classified as "low needs" were targeted to receive occasional outreach, members classified as "intermediate needs" typically received monthly outreach, and members classified with "upper needs" were supported exclusively by registered nurses and required constant monitoring.

The regulatory operations department conducted the initial health risk assessment (HRA) outreach by phone, additional follow-ups were attempted by mail, and the utilization review team described monitoring authorization requests for additional member needs and referral to case management. Staff members described a regular process of reviewing inpatient and emergency room data for additional member needs.

Member privacy and professional documentation and health record maintenance expectations were outlined in detail through the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Confidentiality, Uses & Disclosures of Protected Health Information policy manual, Authorization for Release of Protected Health Information Policy and Procedure, provider manual, and notice of privacy practices. Staff members described internal information technology (IT) mechanisms to ensure appropriate access to member's medical records and regular checks by IT to review system access levels.

Community resources frequently used by **FHP** staff members were documented in a CO Resource Utilization Review (UR) Template that included a variety of facilities and notes regarding whether the provider was in or out of network, any age restrictions for the facility, and current contract status. Although **FHP**'s Standing Referral Policy was described to be retired, **FHP** communicated its standing referral process to providers through their contract and provider manual which provided for uninterrupted, continuous medical care and alleviated the burden of paperwork.

Summary of Findings Resulting in Opportunities for Improvement

Members who were not identified to need case management were provided information regarding their primary care physician (PCP) through welcome packet information and their member ID card. Members assigned to case management were provided with verbal information regarding their case manager's direct phone line, and customer support was also able to access a member's case manager and assist in coordinating any communications. While this is adequate information for the majority of the population, HSAG recommends expanding case management procedures to include a structured welcome script and welcome letter (or similar approach) to ensure members are informed of how to contact their case manager.

Summary of Required Actions

The overall documentation and description of **FHP**'s case management program did not meet State minimum expectations to adequately identify and deliver care coordination services. Out of a population of approximately 1,900 members, only two members were engaged in case management services at the time of the review. Furthermore, procedures and mechanisms to ensure timely and collaborative coordination were not adequately outlined in documentation. Throughout the review, staff members described an individualized approach to case management for the CHP+ population; however, process documentation as evidence of these practices on a day-to-day basis was lacking. **FHP** must further develop operational procedures to ensure:

- Timely coordination with the member, the member's family or guardians, and the treatment team.
- Identification and support of members requiring services from multiple providers with complex coordination needs.
- Involvement of family or guardians and treatment teams in medical treatment.
- Continuity of care for newly enrolled members.

During the interview, staff members described ways to coordinate care between other managed care plans, levels of care such as short-term and long-term hospital and institutional stays, and general resource documents used to identify community and social supports; however, **FHP** did not submit evidence of implementing procedures to ensure coordination of care in these situations. **FHP** must develop and implement general procedures to outline key steps in coordinating care between settings of care, managed care plans, and with community and social support providers.

Staff members were able to describe the steps for conducting the initial HRA and submitted details regarding how data are entered and a log as evidence; however, the policies and procedures did not detail the 90-day timeline. The HRA Count spreadsheet captured HRA calls; HRAs sent by mail; and completed HRAs, which often showed a large gap between the total number of newly enrolled members and total completed HRAs for the month. The HRA Nurse Spreadsheet log included dates from enrollment to initial HRA and further clinical follow-up. Comments within the Nurse Spreadsheet log included notes with members' self-reported health issues and referral needs; however, at the time of the review, only two members in the CHP+ population were enrolled in case management. **FHP** must further outline in policy its procedure to make its best effort to collect HRA information within 90 days. **FHP**'s procedures and tracking mechanisms must further detail using HRA information to inform additional member outreach and engagement in care coordination activities. HSAG also suggests using other available data in addition to the HRA to identify other issues such as chronic illness, recent emergency room/inpatient visits, etc.

Although **FHP** submitted various initial HRA assessments, staff members were not able to describe any additional follow-up assessments used for members who indicated special health care needs or other case management needs based on the initial HRA assessment. Policies and procedures submitted did not detail the 30-calendar-day follow-up timeline or associated monitoring to ensure additional assessment when indicated. The Nurse Spreadsheet log indicated that out of the 14 members documented in

September 2021, many issues were identified by **FHP** clinical staff members including hospitalization, risk of suicide, and requested resources for mental health support; however, there was no documentation regarding follow-up contacts, and staff reported only two members were enrolled in case management at the time of the review. **FHP** must develop procedures and mechanisms to utilize HRA data to consistently follow-up within 30 calendar days and outreach members for additional screenings as indicated. The procedures should detail common types of special health care needs and associated assessments and next steps. Documentation should further detail the entry, intermediate, and upper classifications and expectations regarding regular care monitoring.

Staff members described a mechanism within the case management software to track member reassessment time periods; however, staff members were not able to describe required timelines associated with treatment plan updates. Policies and procedures lacked details regarding treatment plan updates or other instances when a reassessment is clinically indicated. **FHP** must expand policies and procedures to ensure members with special health care needs receive a timely assessment, the course of treatment is monitored, and the member is reassessed at least every 12 months or as indicated based on significant changes.

Standard IV—Member Rights, Protections, and Confidentiality

Summary of Strengths and Findings as Evidence of Compliance

FHP submitted policies, procedures, a code of conduct, a non-discrimination statement, and staff member trainings at the time of onboarding and annually as evidence of upholding member rights. **FHP** informed members of their rights through the CHP+ member handbook at the time of enrollment and the rights are also located on the website under "Member Resources." **FHP** informed its providers about member rights through the provider manual as well as the physician contract. **FHP**'s evidence included a zero-tolerance policy pertaining to retaliation against members for exercising their rights.

Furthermore, the HIPAA policy included a robust collection of documents outlining expectations for protecting member privacy and approved methods of communicating while providing treatment or support services. The procedures discussed electronic and non-electronic media forms of protected health information (PHI). The documents outlined security definitions, the HIPAA security officer, the compliance hotline number, safeguards (administrative, physical, technical), employee training on security awareness, handling of breaches and security incidences, and practices for employees telecommuting. The policy also contained physical safeguards and technical safeguards such as facility access controls, workstation use and security, device and media controls, and transmission security. Adherence to the HIPAA procedures were further evidenced by the process of members signing release of information forms and a detailed process for entering and tracking this information within the electronic health record.

Summary of Findings Resulting in Opportunities for Improvement

While required language was present in a variety of documents, HSAG recommends that **FHP** develop a concise policy that either includes all required language or includes all other documents as resources/references to ensure all criteria are clear and connected. For example, the Member Rights and Responsibilities policy states that **FHP** is required to comply with State and federal laws, but does not go into detail, and staff training samples provided did not include specific examples of how **FHP** communicates applicable statutes (i.e., non-discrimination, Americans with Disabilities Act, etc.).

Additionally, staff members described monitoring for member rights issues through grievances; however, **FHP** has not recorded any grievances in the last few years. HSAG recommends additional training and additional forms of monitoring to ensure members' rights are upheld.

Summary of Required Actions

FHP's policies and procedures did not include the full list of member rights and responsibilities as required by federal regulations. **FHP** must update its policies to include the full list of rights as indicated in 42 CFR §438.100(b)(2).

Standard VIII—Credentialing and Recredentialing

Summary of Strengths and Findings as Evidence of Compliance

The Credentialing Plan submitted by **FHP** contained a well-defined credentialing, recredentialing, and organizational credentialing process for selecting and evaluating providers. The documents followed both the National Committee for Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC) standards and guidelines. **FHP** delegated nearly all initial and recredentialing responsibilities to the vendor Verified, which is associated with the Council for Affordable Quality Healthcare (CAQH). Only organizational facility credentialing and the occasional ad hoc provider credentialing were conducted by **FHP** staff members. However, **FHP** maintained all final review responsibilities and determined if files passed credentialing. "Clean" files were routed directly to a medical director for review, and files with any issues would be sent for additional review by the Physician Advisory Committee (PAC).

The PAC held responsibilities for reviewing and approving the files with ultimate sign off from a medical director. Procedures included timelines for notifying providers who did not pass initial credentialing or recredentialing. Efforts to maintain provider privacy related to personal information were outlined in detail within the Credentialing File Maintenance desktop procedure and other compliance policies and procedures, and **FHP** staff members described physical and technological safeguards for credentialing information.

Summary of Findings Resulting in Opportunities for Improvement

When updating associated required actions, HSAG recommends that **FHP** also consider NCQA credentialing standard eight (CR8), element D regarding a system to monitor delegates and following up on opportunities for improvement, when applicable. The required actions below indicate a long-term opportunity to partner with the credentialing delegate, Verified, and increase monitoring and communication regarding Colorado standards.

Summary of Required Actions

The Credentialing Plan and associated procedures included accurate details regarding credentialing and recredentialing verification of licensure, education, work history, and professional liability claims. However, one record review indicated that the practitioner was licensed in Kansas and did not meet Colorado educational standards for this practitioner type. The practitioner was not on the Colorado Department of Regulatory Agencies' (DORA's) license search and was not licensed in Colorado. **FHP** must expand its procedural details to (1) accurately detail expectations for practitioners and associated education and training required by the State of Colorado.

FHP did not submit evidence of medical director or PAC credentialing approval for two of the sample recredentialing files. Without this information, HSAG could not verify whether recredentialing was conducted within the time limits. **FHP**'s credentialing program outputs indicated approval dates that were inconsistent with actual medical director or PAC approval; medical director approval was frequently completed at a later date than the credentialing software dates listed. Additionally, the credentialing file universe submitted inaccurately recorded recredentialing dates that had not yet taken place and also included a significant number of terminated providers within the data. **FHP** must update its credentialing procedures to consistently document medical director or PAC approval of its files and must accurately document the actual date of approval in the system and should be able to separately record internal dates for when **FHP** initiates seeking recredentialing documents.

The Credentialing Plan outlined how **FHP** collects and reviews information regarding Medicaid sanctions and licensure sanctions or limitations. However, one organizational provider sample included an Inspections and Occurrences report from the Colorado Department of Public Health and Environment that indicated escalating issues at the facility. The report was included with credentialing documentation, yet staff members were not able to confirm if the report was reviewed by the PAC. Although the credentialing and recredentialing checklists included a line item for "Chart Review or other [Quality Improvement] QI issues" in the PAC review checklists, staff members stated that no associated information was regularly reviewed by the PAC in relation to the quality line item. Staff members described that any chart review or QI issues would be addressed upon identification, but there was no mechanism to track and trend the details. **FHP** must:

- Update its procedures for monitoring information collected during credentialing and other available information related to credentialing decisions to develop a process that will ensure monitoring of quality-related issues. Specifically, when gathering chart review and other QI issues, **FHP** must

ensure this information is tracked and trended in a way that can be reviewed by the PAC (or other relevant committee and senior leadership).

- Enhance its procedures to ensure that when quality issues are identified, they are addressed by the PAC (or other relevant committees and senior leadership) and appropriate action is taken.

Although record review samples showed that **FHP** was consistently monitoring for accreditation or site reviews, key details regarding a CMS or State quality review in lieu of a site visit were not present in the Credentialing Plan. The updated language that was submitted as part of the FY 2018–2019 CAP was not included in section 17.a. of the Credentialing Plan submitted for the FY 2021–2022 review. **FHP** must update its Credentialing Plan and associated desktop procedures, checklists, and other monitoring documents to ensure that if an organizational provider is not accredited, an on-site quality assessment is conducted.

One organizational provider file was not recredentialed within the 36-month time frame, even with consideration to the two-month extension for coronavirus disease 2019 (COVID-19) delays. **FHP** must enhance its procedures and monitoring mechanisms to ensure organizational providers are recredentialed every 36 months.

Although the Credentialing Plan described the components of annual delegation monitoring, during the review, staff members were not able to speak to the annual delegation monitoring procedures. **FHP** must expand the details of its standards for CHP+ providers to ensure that **FHP** and its delegates are monitoring in accordance with Colorado standards. Furthermore, **FHP** must update its delegate monitoring to include these standards in annual evaluations. Due to the various record review findings, HSAG suggests monitoring regularly during the CAP process.

Standard X—Quality Assessment and Performance Improvement

Summary of Strengths and Findings as Evidence of Compliance

FHP's quality assessment and performance improvement (QAPI) program contained the core elements such as a Quality Management Program Committee (QMPC), which reviewed quality reports, initiatives, and provided oversight of policies and procedures. The QMPC reports to the board of directors and the chief operating officer. The QMPC charter and program plan described a diverse attendance from compliance, quality, operations, finance, sales, and medical staff members to provide feedback on current initiatives. Staff members described monitoring measures, such as Healthcare Effectiveness Data and Information Set (HEDIS®),[1-2] across the entire organization and setting focus measurements (i.e., well-child checks and expansion of telehealth visits). At the time of the review, **FHP** reported annual HEDIS measurement but described an opportunity to move to a more real-time HEDIS measurement platform in the near future.

[1-2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

The current performance improvement project (PIP) focused on depression screening for members ages 12 to 17 and leveraged multiple providers to ensure an adequate population to evaluate. Staff members described a root cause analysis that revealed coding issues and **FHP**'s efforts to educate providers regarding the correct billing codes moving forward.

FHP described an improvement project working with a local hospital that serviced the majority of **FHP** members, San Louis Valley Health. **FHP** staff members conducted additional parent and guardian outreach to provide information about Saturday clinic hours and the benefits of well-child visits.

Practice guidelines were available for providers and members on the **FHP** website and included considerations from "UpToDate," which included peer reviewed articles based on types of care and diagnosis.

Summary of Findings Resulting in Opportunities for Improvement

HSAG recommends additional steps to build a robust QAPI program that integrates available data, reviews successes and barriers regularly, and ensures follow-up procedures to act on issues when identified. HSAG recommends developing more detailed QMPC agendas, capturing additional CHP+ related topics and discussion points within QMPC minutes, and expanding upon the existing quality work plan to further develop goals and monitoring mechanisms.

Summary of Required Actions

FHP described multiple mechanisms used to regularly monitor overutilization, such as inpatient and emergency room reports. Staff members detailed a daily and weekly procedure for reviewing this type of overutilization data, and QMPC minutes also included a placeholder for outlier discussions. However, **FHP** did not have a mechanism to detect underutilization of services at the time of the review. **FHP** must develop a mechanism to detect underutilization of services. HSAG noted that **FHP** staff members described some initial thoughts regarding topics to include in underutilization reporting such as enrollment with lack of claims data, lack of claims for chronically ill members during the previous year, and other examples that could serve as a good starting point.

The Professional Quality of Care/Service Concerns policy outlined a definition and operating procedure regarding reporting and investigating quality of care (QOC) concerns; however, staff members reported no quality issues from the last year. The ongoing trend from the lack of grievances during the FY 2020–2021 review and ongoing lack of quality issues being identified and reported in calendar year (CY) 2021 shows a distinct trend in which staff members are not adequately trained to identify and report issues within the **FHP** system, specifically on behalf of the CHP+ members. **FHP** must enhance its training and identification mechanisms to ensure members, staff members, and providers all understand the definition of a QOC concern and how to report these types of issues. **FHP** must detail steps to identify, track, and trend issues within the system as well as identify individual care concerns.

Similar to FY 2018–2019 findings, although **FHP**'s population size is relatively small, the case management program was not adequately identifying and supporting members with special health care needs. Staff members were able to speak to individualized procedures to support member's unique needs, however, could not speak to overall trends within the population with respect to common diagnoses groups and efforts surrounding those members. The software system for case management was described to have diagnosis-specific assessments; however, **FHP** clinical staff members were not able to describe how members and population groups were reviewed over the course of treatment to assess care or health outcomes. **FHP** must develop a procedure and mechanism to periodically assess the quality and appropriateness of care furnished to members with special health care needs. HSAG recommends that the procedure detail definitions of members with special health care needs, timelines for initial and ongoing assessment, exit or discharge assessments as appropriate, and also include a method to review programmatic-level data for overall member outcomes.

Although **FHP** updated the Quality Assurance Plan (QAP) in September 2021, **FHP** did not submit evidence to support the evaluation of impact from the prior year. The March 2021 QMPC meeting minutes and agenda listed a review and approval of policies and procedures across multiple states and did not detail an annual evaluation or discussion of the CHP+ QAP, work plan, or program review worksheet. The CHP+ section of the meeting minutes stated, "No updates." The QAP described an annual QAP analysis; however, no QAP analysis was submitted upon request. An additional annual program review worksheet was also submitted but not filled out. Furthermore, the QAP detailed that an annual review would be conducted by the board of directors; however, no evidence was submitted to confirm this had taken place. **FHP** must expand its current process to ensure annual evaluation of the QAPI program and should update the QAP to reflect this process. HSAG suggests using the work plan and annual program review worksheet as a basis to this evaluation, ensuring an end-of-year review of the work plan and annual program review worksheet are completed and discussed with key leadership (i.e., QMPC and the board of directors). The evaluation by senior leadership should be taken into consideration in planning for the upcoming year and integrated into the QAP and work plan in a manner that can be tracked and trended to assess successes and barriers periodically.

FHP did not have a method to disseminate practice guidelines to providers. Staff members reported that practice guidelines could be found on the website and would be printed if requested; however, not all guidelines discussed by **FHP** staff members were present on the website. Furthermore, the provider manual only discussed and included links to the United States (U.S.) Preventive Services website and did not direct providers to the **FHP** website where a more comprehensive list of practice guidelines was accessible. Additional documents submitted included a provider newsletter but did not mention practice guidelines. **FHP** must develop documentation that is available to providers and communicates practice guidelines or points providers to the website where the full practice guidelines are listed. Additionally, **FHP** must develop a procedure to ensure providers are notified when practice guidelines are updated.

While **FHP** included Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-3] data as part of the quality plan consideration and reflected on results within the plan and report, staff members

[1-3] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

did not report any additional monitoring regarding members' perceptions of accessibility and adequacy of services (i.e., surveys, anecdotal information, grievances or complaints, appeals, call center data). Staff members noted that a call center survey was currently under consideration but had not yet reached the planning phases at the time of the review. A report of survey data was submitted as additional evidence, but the topic focused on how members selected their healthcare plan and included only one survey question regarding member services or access to services (free telehealth). Staff members mentioned a consumer advisory board and provided a detailed charter but were not able to describe any examples of consumer feedback that were communicated or utilized in the quality program. **FHP** must utilize other sources of member feedback in addition to the CAHPS survey in order to build well-rounded feedback loops to analyze members' feedback regarding access and adequacy of services.

2. Overview and Background

Overview of FY 2021–2022 Compliance Monitoring Activities

For the FY 2021–2022 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard III—Coordination and Continuity of Care, Standard IV—Member Rights, Protections, and Confidentiality, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement. Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Site Review Methodology

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

HSAG also reviewed a sample of the health plan's administrative records related to CHP+ credentialing and recredentialing to evaluate implementation of federal healthcare regulations. Reviewers used standardized monitoring tools based on NCQA credentialing standards and guidelines to review records and document findings. HSAG used a sample of 10 records with an oversample of five records (to the extent that a sufficient number existed) for each of credentialing and recredentialing, and three records with an oversample of an additional three records for organizational providers. Using a random sampling technique, HSAG selected the sample from all CHP+ credentialing and recredentialing records that occurred between January 1, 2021, and December 31, 2021. For the record review, the health plan received a score of *Met (M)*, *Not Met (NM)*, or *Not Applicable (NA)* for each required element. Results of record reviews were considered in the review of applicable requirements in Standard VIII—Credentialing and Recredentialing. HSAG separately calculated a record review score for each record review requirement and an overall record review score.

The site review processes were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS EQR protocol. The four standards chosen for the FY 2021–2022 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard V—Member Information Requirements, Standard VI—Grievance and Appeal Systems, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontractual Relationships and Delegation.

Objective of the Site Review

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

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

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

FY 2020–2021 Corrective Action Methodology

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

Summary of FY 2020–2021 Required Actions

In FY 2020–2021, HSAG reviewed Standard V—Member Information Requirements, Standard VI—Grievance and Appeal Systems, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontractual Relationships and Delegation.

Related to Standard V—Member Information Requirements, **FHP** was required to complete six required actions, including:

- Develop a mechanism to ensure member informational materials are easily understood.
- Ensure key definitions within the member handbook are consistent with the Department's definition.
- Update taglines in critical member materials.
- Ensure the **FHP** website follows Section 508 guidelines, specifically removing any contrast error issues and ensuring key member materials are easily accessible.
- Update provider directories to include required information regarding accommodations for members with physical disabilities.
- Ensure key member materials are available in a Portable Document Format (PDF) format that meets Section 508 guidelines.

Related to Standard VI—Grievance and Appeal Systems, **FHP** was required to complete 16 required actions, including:

- Clarify information in the member handbook regarding the definition of a notice of adverse benefit determination and instances when a member may appeal a denial.
- Correct time frames regarding grievance, appeal, and State fair hearings in all relevant documents.

- Update letter templates to include correct timelines and procedural information.
- Ensure staff members, providers, and members receive clear information that a complaint and grievance are treated the same way.
- Clarify that there is only one level of appeal and how a member exhausts their appeal procedures if **FHP** fails to adhere to appeal time frames.
- Implement mechanisms to monitor the timely resolution of grievances and appeals, including details in member letters regarding extension timelines.
- Inform the member of their right to file a grievance if they do not agree with the extension.
- Update expedited appeal timelines to be consistent with the 72-hour processing requirement.
- Ensure accurate documentation of grievances and appeals.
- Consolidate all of the above edits into the provider manual; member handbook; and internal policies, procedures, and templates.

Related to Standard VII—Provider Participation and Program Integrity, **FHP** was required to complete four required actions, including:

- Develop additional training and education requirements for the compliance officer and compliance staff members.
- Ensure staff members understand the need for prompt referral of fraud, waste, and abuse issues.
- Develop a method to sample if member services that were billed were received by the member.
- Create and implement a procedure to outline how **FHP** provides disclosures of ownership as well as prohibited affiliation information to the Department.

Related to Standard IX—Subcontractual Relationships and Delegation, **FHP** was required to complete two required actions, including:

- Update its contracts to ensure delegation agreements specify the delegate's activities or obligations and related reporting responsibilities.
- Ensure contracts include the provision related to State, CMS, and U.S. Department of Health and Human Services Office of Inspector General rights to audit.

Summary of Corrective Action/Document Review

FHP submitted a proposed CAP in February 2021. HSAG and the Department reviewed and approved portions of the proposed plan and responded to **FHP**. **FHP** submitted updated planned interventions in March 2021 and proceeded to implement the previously approved interventions. **FHP** submitted evidence throughout June, July, August, and November and met with HSAG and the Department for technical assistance calls as needed.

Summary of Continued Required Actions

FHP completed all but four items in the FY 2020–2021 CAP, resulting in ongoing work regarding the provider directory and grievance and appeal systems items during the FY 2021–2022 CAP.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements procedures to deliver care to and coordinate services for all members. These procedures meet State requirements, including: • Ensuring timely coordination with any of a member's providers, including mental health providers, for the provision of covered services. • Addressing those members who may require services from multiple providers, facilities, and agencies; and who require complex coordination of benefits and services. • Ensuring that all members and authorized family members or guardians are involved in treatment planning and consent to any medical treatment. • Criteria for making referrals and coordinating care with specialists, subspecialists, and community-based organizations. • Providing continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services. *42 CFR 438.208(b)* Contract: Exhibit B-2—10.5.1, 10.5.2, 10.5.3.3	**Documents:** 1. Case Management Policy 2. Prenatal Case Management policy **Narrative:** Friday Health Plans follows the Case Management Policy and Prenatal Case Management Policy in addressing the delivery of care and to coordinate services for members.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The overall documentation and description of FHP's case management program did not meet State minimum expectations to adequately identify and deliver care coordination services. Out of a population of approximately 1,900 members, only two members were engaged in case management services at the time of the review. Furthermore, procedures and mechanisms to ensure timely and collaborative coordination were not adequately outlined in documentation. Throughout the review, staff members described an individualized approach to case management for the CHP+ population; however, process documentation as evidence of these practices on a day-to-day basis was lacking.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: FHP must further develop operational procedures to ensure timely coordination with the member, the member's family or guardians, and the treatment team to ensure the provision of covered services; the identification and support of members requiring services from multiple providers with complex coordination needs; and the involvement of family or guardians and treatment teams in medical treatment. FHP should also document its steps to ensure continuity of care for newly enrolled members.		
2. The Contractor ensures that each member has an ongoing source of care appropriate to the member's 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 the designated person or entity. *42 CFR 438.208(b)(1)* Contract: Exhibit B-2—10.5.3.1	**Documents:** 1. Case Management Policy, #3000 2. Prenatal Case Management Policy **Narrative:** Friday Health Plans follows the Case Management Policy and Prenatal Case Management Policy in ensuring that each member has an ongoing source of care for the member's needs.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor implements procedures to coordinate services the Contractor furnishes 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 from community and social support providers. *42 CFR 438.208(b)(2)* Contract: Exhibit B-2—10.5.3.2.1, 10.5.3.2.1.1-2, 10.5.3.2.1.4	**Documents:** 1. Case Management Policy, #3000 2. Prenatal Case Management Policy **Narrative:** Friday Health Plans follows the Case Management Policy and Prenatal Case Management Policy in addressing the delivery of care and to coordinate services for members.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: During the interview, staff members described ways to coordinate care between other managed care plans, levels of care such as short-term and long-term hospital and institutional stays, and general resource documents used to identify community and social supports; however, FHP did not submit evidence of implementing procedures to ensure coordination of care in these situations.		
Required Actions: FHP must develop and implement general procedures to outline key steps in coordinating care between settings of care, managed care plans, and with community and social support providers.		
4. The Contractor provides best efforts to conduct an initial screening of each new member's needs within 90 days of enrollment, including: • Subsequent attempts if the initial attempt to contact the member is unsuccessful. • An assessment for special health care needs including mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems. • Using the results of the assessment to inform member outreach and care coordination activities. *42 CFR 438.208(b)(3)* Contract: Exhibit B-2—10.4.1, 10.4.1.1, 10.4.1.2, 10.4.1.4	**Documents:** 1. Case Management Policy, #3000 2. Prenatal Case Management 3. Prenatal Risk Assessment 4. HRA WITH Spanish 5. Initial Assessment English 6. PN Initial Assessment form Spanish 7. Prenatal High Risk Assessment 8. Prenatal Plus Psychosocial Form 9. SMCNHighRiskPrenatalDefinition **Narrative:** Friday Health Plans follows the Case Management Policy and Prenatal Case Management in conducting an initial screening. Friday Health Plans utilizes the Prenatal Risk Assessment, HRA and Form for Health Risk Assessments.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Staff members were able to describe the steps for conducting the initial HRA and submitted details regarding how data are entered and a log as evidence; however, the policies and procedures did not detail the 90-day timeline. The HRA Count spreadsheet captured HRA calls; HRAs sent by mail; and completed HRAs, which often showed a large gap between the total number of newly enrolled members and total completed HRAs		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
for the month. The HRA Nurse Spreadsheet log included dates from enrollment to initial HRA and space to document further clinical follow-up. Comments within the Nurse Spreadsheet log included notes with members' self-reported health issues and referral needs; however, at the time of the review, only two members in the CHP+ population were enrolled in case management.		
Required Actions: FHP must further outline in policy its procedure to make its best effort to collect HRA information within 90 days. FHP's procedures and tracking mechanisms must further detail using HRA information to inform additional member outreach and engagement in care coordination activities. HSAG also suggests using other available data in addition to the HRA to identify other issues such as chronic illness, recent emergency room/inpatient visits, etc.		
5. The Contractor shares with other entities serving the member the results of identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR 438.208(b)(4)* Contract: Exhibit B-2—10.4.1.3	**Documents:** 1. Case Management Policy, #3000 2. Prenatal Case Management **Narrative:** Friday Health Plans follows the Case Management Policy and Prenatal Case Management Policies in identification and assessment of member's needs.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The Contractor ensures that each provider furnishing services to members maintains and shares, as appropriate, a member health record, in accordance with professional standards. *42 CFR 438.208(b)(5)* Contract: Exhibit B-2—10.5.6	**Documents:** 1. Provider Handbook 2. Provider Contract **Narrative:** Friday Health Plans enters into a contract with all providers wherein the providers are required to maintain and share member information. Provider Handbook also outlines these requirements for providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor ensures that, 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 applicable. *42 CFR 438.208(b)(6)* Contract: Exhibit B-2—10.5.5.9, 13.1.2	**Documents:** 1. HIPAA Confidentiality, Uses & Disclosures of Protected Health Information 2. Privacy Notice 3. Authorization for release of Protected Health Information Policy and Procedure 4. Provider Manual **Narrative:** Friday Health Plans follows the HIPAA confidentiality. These polices address confidentiality, uses and disclosures. Members receive a privacy notice identifying privacy requirements. Employees have HIPAA training on all basis.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor implements mechanisms to comprehensively assess each CHP+ member identified by the State as having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. • The assessment must be completed within 30 calendar days from the completion of the initial screening, if the initial screening identified special health care needs. *42 CFR 438.208(c)(2)* Contract: Exhibit B-2—10.5.9.1.1	**Documents:** 1. Case Management Policy, #3000 2. Prenatal Case Management **Narrative:** Friday Health Plans follows the Case Management Policy and Prenatal Case Management policy to assess CHP+ member needs.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: Although FHP submitted various initial HRA assessments, staff members were not able to describe any additional follow-up assessments used for members who indicated special health care needs or other case management needs based on the initial HRA assessment. Policies and procedures submitted did not detail the 30-calendar-day follow-up timeline or associated monitoring to ensure additional assessment when indicated. The Nurse Spreadsheet log indicated that out of the 14 members documented in September 2021, many issues were identified by FHP clinical staff members and included in the spreadsheet. For example, one member reported a recent hospitalization and mental health issues, another indicated barriers to care, another reported a recent suicide attempt, another reported poor mental health, and one of the last notes for the month indicated mental health facility resources were provided to the member. Out of all these notes, only two members were enrolled in case management services at the time of the review and the log indicated that none of the members received a second or third clinical contact or case management letter as a follow-up.		
Required Actions: FHP must develop procedures and mechanisms to utilize HRA data to consistently follow-up within 30 calendar days and outreach members for additional screenings as indicated. The procedures should detail common types of special health care needs and associated assessments and next steps. Documentation should further detail the entry, intermediate, and upper classifications and expectations regarding regular care monitoring.		
9. The Contractor produces a treatment or service plan for members with special health care needs who are determined, through assessment, to need a course of treatment or regular care monitoring. The treatment plan must be: • Approved by the Contractor in a timely manner (if such approval is required by the Contractor). • In accordance with any applicable State quality assurance and utilization review standards. • Reviewed and revised upon reassessment of functional need, at least every 12 months, when the member's circumstances or needs change significantly, or at the request of the member. *42 CFR 438.208(c)(3)* Contract: Exhibit B-2—10.5.9.1.2-3	**Documents:** 1. Case Management Policy, #3000 2. Prenatal Case Management **Narrative:** Friday Health Plans follows the Case Management Policy and the Prenatal Case Management Policy in developing the treatment plans for members.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: Staff members described a mechanism within the case management software to track member reassessment time periods; however, staff members were not able to describe required timelines associated with treatment plan updates. Policies and procedures lacked details regarding treatment plan updates or other instances when a reassessment is clinically indicated.		
Required Actions: FHP must expand policies and procedures to ensure members with special health care needs receive a timely assessment, the course of treatment is monitored, and the member is reassessed at least every 12 months or as indicated based on significant changes.		
10. For members with special health care needs determined to need a course of treatment or regular care monitoring, the Contractor must have a mechanism in place to allow members direct access to a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. *42 CFR 438.208(c)(4)* Contract: Exhibit B-2—10.5.9.1.4	**Documents:** 1. Standing Referral Policy **Narrative:** Friday Health Plans coordinates with providers through the standing referral process. Friday Health Plans strives to provide uninterrupted, continuous medical care for members who require medically necessary, ongoing and frequent treatment. To help alleviate the burden of paperwork, Friday Health Plans allows a member to receive a standing referral.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	5	X	1.00	=	5
	Partially Met	=	5	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	10	**Total Score**		=	5
				Total Score ÷ Total Applicable		=	50%

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has written policies regarding the member rights specified in this standard. *42 CFR 438.100(a)(1)* Contract: Exhibit B-2—7.3.6.1	**Documents:** 1. Member Rights and Responsibilities Policy **Narrative:** Friday Health Plans follows the Member Rights and Responsibilities policy regarding member rights.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor 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)* Contract: Exhibit B-2—15.10.9.2	**Documents:** 1. Member Rights and Responsibilities Policy **Narrative:** Friday Health Plans follows the Member Rights and Responsibilities policy regarding member rights.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor'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 the member's dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding their health care, including the right to refuse treatment.	**Documents:** 1. Member Rights and Responsibilities Policy **Narrative:** Friday Health Plans follows the Member Rights and Responsibilities policy regarding member rights.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• 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)* Contract: Exhibit B-2—7.3.6.2-6		
Findings: The Member Rights and Responsibilities policy did not include all requirements specified in 42 CFR §438.100(b)(2) and (3).		
Required Actions: FHP must update the policy to ensure it explicitly details all required member rights as required by regulations. • Receive information in accordance with information requirements (42 CFR §438.10). • Be treated with respect and with due consideration for the member's dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding their healthcare, 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 healthcare services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR §438.206 through 42 CFR §438.210).		

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor ensures that each member is free to exercise their rights and that the exercise of those rights does not adversely affect how the Contractor, its network providers, or the Department treat(s) the member. *42 CFR 438.100(c)* Contract: Exhibit B-2—7.3.6.3.7	**Documents:** 1. Member Rights and Responsibilities **Narrative:** Friday Health Plans follows the Member Rights and Responsibilities policy regarding member rights.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. For medical records and any other health and enrollment information which identify a particular member, the Contractor 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* Contract: Exhibit B-2—10.5.5.9, 13.1.2	**Documents:** 1. HIPAA Policy **Narrative:** Friday Health Plans follow the HIPAA policy in in disclosing individually identifiable health information.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard IV—Member Rights, Protections, and Confidentiality							
Total	Met	=	4	X	1.00	=	4
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	5	**Total Score**		=	4
				Total Score ÷ Total Applicable		=	80%

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 Contract: Exhibit B-2—9.2.3.1	**Documents:** 1) Credentialing Plan **Narrative:** Friday Health Plans follows the credentialing plan for evaluating and selecting licensed independent practitioners to provide care to its members. The credentialing plan complies with the standards for NCQA for initial credentialing and recredentialing of participating providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners it credentials and recredentials. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. *Examples of BH practitioners include psychiatrists, physicians, addiction medicine specialists, doctoral or master's-level psychologists, master's-level clinical social workers, master's-level clinical nurse specialists or psychiatric nurse practitioners, and other behavioral health care specialists.* *Examples of HP practitioners include medical doctors, chiropractors, osteopaths, podiatrists, NPs, etc.* *42 CFR 438.214(a)* NCQA CR1—Element A1	**Documents:** 1.) Credentialing Plan, Page 2, 1. Who is Credentialed 2.) Credentialing Plan, Page 3, 3. Initial Credentialing 3.) Credentialing Plan, Page 4-5, 4. Recredentialing **Narrative:** Friday Health Plans follows the credentialing plan that outlines the types of practitioners to credential and recredential. Friday Health Plans does not discriminate in its willingness to credential providers. Friday Health Plans is dedicated to	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	expanding our provider network and maintaining provider relationships.	
2.B. The verification sources it uses. NCQA CR1—Element A2	**Documents/Sources:** 1. Credentialing Plan, Pages 5-6, 5. Primary and Secondary Verification Sources: National Practitioner Data Bank - http://www.npdb-hipdb.hrsa.gov/ CMS Sanctions - http://exclusions.oig.hhs.gov/search.aspx ABMS - http://www.certifacts.org/ DO Certification - https://www.doprofiles.org/ P.A. Certification – https://www.nccpa.net/pa/CredentialPublicSend.aspx Colorado License & Discipline Action - https://www.colorado.gov/dora/licensing/ **Narrative:** Friday Health Plans follows the Credentialing Plan regarding verification sources used for the selection and retention of providers. The above sources are used to verify credentialing and recredentialing information. In following the credentialing plan, Friday Health Plans credentialing staff shall use accepted primary sources to verify the following for all individual providers: Licensure (licensing board), Certification for PA-Cs (National Commission on the Certification of Physician Assistants), Board certification (American Board of Medical Specialties or AOA) and	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Medicare/Medicaid sanctions and exclusions from Federal programs (OIG and GSA's EPLS websites)	
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	**Documents:** 1. Credentialing Plan, Guidelines Page 8-9, 8. Credentialing Guidelines **Narrative:** Friday Health Plans follows criteria found in its Credentialing Plan for selection and retention of providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	**Documents:** 1. Credentialing Plan, Page 3-4, 3. Initial Credentialing: and Page 4-5, 4. Recredentialing 2. DTP Credentialing Application Review **Narrative:** Friday Health Plans follows criteria found in its Credentialing Plan when making credentialing and recredentialing decisions during the selection and retention of provider process. The Provider Operations Specialist utilizes a checklist, to ensure that all files are complete, accurate and do not contain conflicting information, before the files are presented to the Physician Advisory Committee (PAC). Upon completion, it is reviewed by the Medical Director for final approval or denial of providers.	☒ 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	**Documents:** 1. Credentialing Plan, Page 9-10, 11. Credentialing File Maintenance and Confidentiality 2. DTP Credentialing File Maintenance **Narrative:** Friday Health Plans follows the Credentialing Plan and the DTP Credentialing File Maintenance for managing credentialing/recredentialing files that meet the established criteria.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.F. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. *Examples include: non-discrimination of applicant, process for preventing and monitoring discriminatory practices, and monitoring the credentialing/recredentialing process for discriminatory practices at least annually.* NCQA CR1—Element A6	**Documents:** 1. Credentialing Plan, Page 2, Objective 2. Non-Discrimination Statement **Narrative:** Friday Health Plans in its credentialing plan outlines that it does not discriminate against any provider seeking qualification as a participating provider. Members of the Physician Advisory Committee also sign a Non-Discrimination Statement outlining that credentialing review follows the Credentialing Plan.	☒ 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	**Documents:** 1. Credentialing Plan, Page 11, 15. Discrepancies and Missing Information **Narrative:** Friday Health Plans follows the Credentialing Plan process for notifying practitioners if information	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	obtained during the Contractor's credentialing/recredentialing process varies substantially from the information they provided to the Contractor. Friday Health Plans will contact the provider to explain the discrepancy.	
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	**Documents:** 1. Credentialing Plan, Page 4, Paragraph 5, Initial Credentialing 2. Credentialing Plan, Page 5, 4, Last bullet point Recredentialing 3. Credentialing Plan, Page 8, 7, Last bullet point PAC Credentialing Program Oversight **Narrative:** Friday Health Plans follows the Credentialing Plan for notification of credentialing and recredentialing decisions. Providers are notified whether they were approved or denied/terminated by the PAC within 10 business days of the meeting, or by the deadlines set forth in the appeals processes.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.I. The medical director or other designated physician's direct responsibility and participation in the credentialing program. NCQA CR1—Element A9	**Documents:** 1. Credentialing Plan, Page 6, 7, Medical Director Oversight 2. DTP Credentialing Application Review 3. Physician Advisory Committee (PAC) Charter, page 2 Membership **Narrative:** Friday Health Plans follows the Credentialing Plan and DTP Credentialing Application Review	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	regarding medical director direct responsibility and participating in the credentialing/recredentialing program. Medical Director reviews the credentialing or recredentialing application and signs the internal checklist. The Medical Director is also a member of the PAC Committee, and as such conducts the meetings, signs and reviews the letters sent to providers.	
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	**Documents:** 1. Credentialing, Plan, Page 9-10, 11. Credentialing File Maintenance and Confidentiality 2. DTP Credentialing File Maintenance **Narrative** All credentialing files are kept by the Provider Operations Specialist who prepares a confidential file for each provider. Provider credentialing and recredentialing files are kept in a secured electronic file that is password protected and available for the PAC and Medical Director to review. The Provider Operations Department utilize security passwords that are never shared, credentialing files are not viewed by unauthorized personnel and authorized personnel includes Provider Operations staff, Credentialing Committee and PAC members.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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	**Documents:** 1. DTP: Provider Directory Maintenance, page 1 Procedure **Narrative:** A Quarter of the Friday Health Plans directory is audited on a quarterly basis. A full audit of the directory is completed annually. A full file of in network providers is updated and reviewed. If an update has not been received from a provider within 6 months from the date of the audit, we contact the provider to receive a complete, updated roster.	☒ 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, and peer-review protected information available.* NCQA CR1—Element B1	**Documents:** 1. Credentialing Plan, Page 9, 9, Provider Review of Credentialing Information and Request for Status. 2. Colorado Health Care Professional Credentials Application, Page 23, #12 **Narrative:** Friday Health Plans follows the Credentialing Plan in its credentialing and recredentialing process. Providers are informed of their right to review credentialing information via a statement that accompanies the credentialing/recredentialing applications (Colorado Health Care Professional Credentials Application).	☒ 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	**Documents:** 1. Credentialing Plan, Page 9, 9. Provider Review of Credentialing Information and Request for Status 2. Colorado Health Care Professional Credentials Application, Page 23, #12 **Narrative:** Friday Health Plans follows the Credentialing Plan in its credentialing and recredentialing process. Providers are informed of their right to correct erroneous information via a statement that accompanies the credentialing/recredentialing applications (Colorado Health Care Professional Credentials Application).	☒ 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	**Documents:** 1. Credentialing Plan, Page 9, 9. Provider Review of Credentialing Information and Request for Status 2. Colorado Health Care Professional Credentials Application, Page 23, #12 **Narrative:** Friday Health Plans follows the Credentialing Plan in its credentialing and recredentialing process. Providers are informed of their right to receive the status of their credentialing or recredentialing application, upon request. Provider is informed of this right in the Colorado Health Care Professional Credentials Application.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing and recredentialing decisions. NCQA CR2—Element A1	**Documents:** 1. Credentialing Plan, pages 6-8, 7. PAC Credentialing Program Oversight 2. Physician Advisory Committee (PAC) Charter, page 2. Membership **Narrative:** Friday Health Plans follows the Credentialing Plan in designating a Committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions. Friday Health Plans' committee is the Physician Advisory Committee. Friday Health Plans has outlined in the Physician Advisory Committee how the membership is comprised. Membership of the committee includes Friday Health Plans Medical Director, Participating Community Providers, and Nurse Manager (who is a non-voting member).	☒ 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 A	**Documents:** 1.) Credentialing Plan, page 6-8, 7 PAC Credentialing Program Oversight **Narrative:** Providers are listed on the "PAC" Meeting Agenda and are reviewed by the Committee. Approved files are signed off by the Medical Director (Committee Chair).	☒ 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 = 180 calendar days). • A valid, current Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (verification time limit = prior to the credentialing decision). • Education and training—the highest of the following: graduation from medical/professional school graduate; completion of residency; or board certification (verification time limit = prior to the credentialing decision; if board certification, time limit = 180 calendar days). • Work history—most recent five years—if less, from time of initial licensure—from practitioner's application or CV (verification time limit = 365 calendar days). – If a gap in employment exceeds six months, the practitioner clarifies the gap verbally or in writing and notes clarification in the credentialing file. If the gap in employment exceeds one year, the practitioner clarifies the gap in writing. • History of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner—most recent five years (verification time limit = 180 calendar days). – The organization is not required to obtain this information for practitioners who had a hospital insurance policy during a residency or fellowship.	**Documents:** 1. Colorado Health Care Professional Credentials Application, page 3 2. Desktop Procedure: Credentialing File Verification **Narrative:** The Colorado Health Care Professional Credentials Application is used, which includes on Page 3, the list of documents that should be included with the application. Our verification time limit is 180 days which is also listed on the letter we send with application materials. An internal checklist is prepared and reviewed to ensure the criteria was met for credentialing/recredentialing. Friday Health Plans follows the DTP Credentialing File Verification in conducting the verification of information.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Note: Education/training and work history are NA for recredentialing. Verification of board certification does not apply to nurse practitioners or other health care professionals unless the organization communicates board certification of those types of providers to member. NCQA CR3—Element A		
Findings: One practitioner maintained board certified behavior analyst (BCBA) through the Behavior Analyst Certification Board (BACB) as a licensed behavior analyst (LBA) in Kansas; however, the practitioner was not listed on the Colorado Department of Regulatory Agencies (DORA) license search and was not licensed in Colorado. The practitioner did not meet the education level for Colorado requirements in this specific specialty. While there was a COVID-19 CMS waiver in place for telehealth and physical health supervision across states, there was no waiver in place for behavioral health supervision across state lines.		
Required Actions: FHP must expand its procedural details to accurately capture practitioners and associated education and training required by the State of Colorado to conduct services for the CHP+ population.		
7. The Contractor verifies the following sanction information for credentialing and recredentialing (verification time limit = 180 days): • State sanctions, restrictions on licensure or limitations on scope of practice. • Medicare and Medicaid sanctions. NCQA CR3—Element B	**Documents:** 1. Credentialing Plan, page 3-6, 2 Credentialing Application, 3 Initial Credentialing, 4 Recredentialing, 5 Primary and Secondary Verification Sources **Narrative:** Friday Health Plans follows the Credentialing Plan and Ongoing Monitoring of Participating Providers Policy and Procedure to verify DORA and CMS sanctions for the initial credentialing and recredentialing process.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. Applications for credentialing include the following (attestation verification time limit = 365 days): • Reasons for inability to perform the essential functions of the position, with or without accommodation. • Lack of present illegal drug use. • History of loss of license and felony convictions. • 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	**Documents:** 1. Credentialing Plan, pages 3, 2. Credentialing Application 2. Colorado Health Care Professional Credentials Application, Pages 16, X Professional Liability Insurance, 19-20 XII Attestation Questions, 21 XIII Attestation and Signature, 26-27 Supplemental A, Supplemental B **Narrative:** Friday Health Plans follows the Credentialing Plan for credentialing and recredentialing practitioners. The Colorado Health Care Professional Credentials Application is the credentialing application used by Friday Health Plans. Page 26, Item 2, covers reasons for inability to perform the essential functions of the position, with or without accommodation. Page 25, items 3 and 4 of the application cover lack of present illegal drug use, Page 20, covers history of loss of license and felony convictions, Page 17 covers history of loss or limitation of privileges or disciplinary actions and current insurance coverage. Page 21, outlines the attestation for correctness and completeness of the application.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor formally recredentials its practitioners within the 36-month time frame. NCQA CR4	**Documents:** 1. Credentialing Plan, page 4-5, 4 Recredentialing **Narrative:** Friday Health Plans follows the Credentialing Plan for recredentialing of practitioners. Friday Health Plans uses same format for recredentialing and primary sources are validated.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: FHP did not submit evidence of medical director or PAC credentialing approval for two of the sample recredentialing files. Without this information, HSAG could not verify whether credentialing was conducted within the time limits. FHP's credentialing program outputs indicated approval dates that were inconsistent with actual medical director or PAC approval; medical director approval was frequently completed at a later date than the credentialing software dates listed. Additionally, the credentialing file universe submitted inaccurately recorded recredentialing dates that had not yet taken place and also included a significant number of terminated providers within the data.		
Required Actions: FHP must update its credentialing procedures to consistently document medical director or PAC approval of its files and accurately document in the system the date of approval and should be able to separately record internal dates for when FHP initiates seeking recredentialing documents.		
10. The Contractor implements policies and procedures for ongoing monitoring and takes appropriate action, including: • Collecting and reviewing Medicare and Medicaid sanctions. • Collecting and reviewing sanctions or limitations on licensure. • Collecting and reviewing complaints. • Collecting and reviewing information from identified adverse events. • Implementing appropriate interventions when it identifies instances of poor quality related to the above. NCQA CR5—Element A	**Documents:** 1. Credentialing Plan, page 11, 14 Monitoring for Adverse Actions 2. DTP CHP+ Appeals & Grievances Procedures, page 3-7, Grievance Process, Appeals Process, State Fair Hearing, Reporting, Monitoring and Training **Narrative:** Friday Health Plans follows the Ongoing Monitoring of Participating Providers for Medicaid/Medicare sanctions monthly.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The Credentialing Plan outlined how FHP collects and reviews information regarding Medicaid sanctions and licensure sanctions or limitations. However, one organizational provider sample included an Inspections and Occurrences report from the Colorado Department of Public Health and Environment that indicated escalating issues. The report was included with credentialing documentation, yet staff members were not able to confirm if the report was reviewed by the PAC. Furthermore, although the credentialing and recredentialing checklists included a line item for "Chart Review or other [Quality Improvement] QI issues" in the PAC review checklists, staff members stated that no information was regularly reviewed by the PAC in relation to the quality line item. Staff members described that any chart review or QI issues would be addressed upon identification, but there was no mechanism to track and trend instances of poor quality care.		
Required Actions: FHP must update its procedures for monitoring information collected throughout the organization and during the credentialing process to ensure monitoring of quality-related issues. Specifically, when gathering chart review and other QI issues, FHP must ensure this information is tracked and trended in a way that can be reviewed by the PAC (or other relevant committee and senior leadership).		
11. The Contractor has policies and procedures for taking action against a practitioner who does not meet quality standards: • The range of actions available to the Contractor. • Making the appeal process known to practitioners. *Examples of range of actions: how the organization reviews practitioners whose conduct could adversely affect members' health or welfare; the range of actions that may be taken to improve practitioner performance before termination; reporting actions taken to the appropriate authorities.* NCQA CR6—Element A	**Documents:** 1. Provider Manual **Narrative:** Friday Health Plans follows the Provider Manual in taking action against practitioners who do not meet quality standards.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: While FHP's policies and provider documents addressed quality standards and the range of actions available to FHP, staff members were not able to confirm if the PAC reviewed this information or took any further action. Regarding the PAC application line item "Chart review and QI issues," staff members stated that no information was regularly reviewed in relation to the quality line item. Staff members described that any chart review or QI issues would be addressed upon identification, but there was no mechanism to track and trend these details and therefore no procedure for taking action against a practitioner.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: FHP must enhance its procedures to ensure that when quality issues are identified in credentialing documents or other available resources, they are addressed by the PAC (or other relevant committees and senior leadership) and appropriate action is taken. Additionally, FHP must update its procedures for reviewing and taking action regarding chart review and other QI issues that are reported through the PAC.		
12. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of *organizational* health care delivery providers and specifies that before it contracts with a provider, and for at least every 36 months thereafter: 12.A. The Contractor confirms that the organizational provider is in good standing with State and federal regulatory bodies. *Policies specify the sources used to confirm--which may only include applicable state or federal agency, agent of the applicable state or federal agency, or copies of credentials (e.g., state licensure) from the provider. Attestations are not acceptable.* NCQA CR7—Element A1	**Documents:** 1. Credentialing Plan, Pages 12-13,17. Institutional Credentialing **Narrative:** Friday Health Plans follows the Credentialing Plan for the initial and ongoing assessment of (organizational) providers. Friday Health Plans confirms that the organizational provider is in good standing with state and federal regulatory bodies.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12.B. The Contractor confirms that the organizational provider has been reviewed and approved by an accrediting body. *Policies specify the sources used to confirm—which may only include applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, copies of credentials—e.g., licensure, accreditation report or letter—from the provider. Attestations are not acceptable.* NCQA CR7—Element A2	**Documents:** 1. Credentialing Plan, pages 12-13, 17. Institutional Credentialing, III **Narrative:** Friday Health Plans follows the Credentialing Plan for organizational credentialing, where applicable from nationally recognized accrediting bodies.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12.C. The Contractor conducts an on-site quality assessment if the organizational provider is not accredited. *Policies include: on-site quality assessment criteria for each type of unaccredited organizational provider; a process for ensuring that the provider credentials its practitioners.* *The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: The CMS or State review is no more than three years old; the organization obtains a survey report or letter from CMS or the State, from either the provider or from the agency, stating that the facility was reviewed and passed inspection; the report meets the organization's quality assessment criteria or standards. (Exception: Rural areas.)* NCQA CR7—Element A3	**Documents:** 1. Credentialing Plan **Narrative:** Friday Health Plans follows the Credentialing Plan in determining need for quality assessment of organizations providers not accredited.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Although record review samples showed that FHP was consistently monitoring for accreditation or site reviews, key details regarding a CMS or State quality review in lieu of a site visit were not present in the Credentialing Plan. The updated language that was submitted as part of the FY 2018–2019 CAP was not included in section 17.a. of the Credentialing Plan submitted for the FY 2021–2022 review.		
Required Actions: FHP must update its Credentialing Plan and associated desktop procedures, checklists, and other monitoring documents to ensure that if an organizational provider is not accredited, an on-site quality assessment is conducted.		
13. The Contractor's organizational provider assessment policies and process includes: • For behavioral health, facilities providing mental health or substance abuse services in the following settings: – Inpatient – Residential	**Documents:** 1. Credentialing Plan, Page 12, 17, Institutional Credentialing **Narrative:** Friday Health Plans follows the Facility Credentialing and Recredentialing P&P for	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Ambulatory • For physical health, at least the following providers: – Hospitals – Home health agencies – Skilled nursing facilities – Free-standing surgical centers NCQA HP CR7-Elements B&C	assessing organizational providers. The assessment of organizational providers includes but is not limited to hospitals, home health agencies, skilled nursing facilities, free-standing surgical centers; inpatient, residential, or ambulatory behavioral healthcare facilities providing mental health or substance abuse services; diagnostic, laboratory, and imaging centers; and rehabilitation and other therapeutic health settings.	
14. The Contractor has documentation that it assesses behavioral health and/or physical health providers every 36 months. NCQA HP CR7-Elements D&E	**Documents:** 1. Credentialing Plan, page 3, 3 Initial Credentialing 2. Credentialing Plan, page 12, 17 Institutional Credentialing **Narrative:** Per our Credentialing Plan, we use the same process for all participating providers.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Similar to findings during the FY 2018–2019 credentialing review results, one organizational provider file was not recredentialed within the 36-month time frame, even with consideration to the two-month extension for COVID-19 delays.		
Required Actions: FHP must enhance its procedures and monitoring mechanisms to ensure organizational providers are recredentialed every 36 months.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. 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 (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	**Documents:** 1. Credentialing Delegation Addendum **Narrative:** Friday Health Plans has a written Credentialing Delegation Addendum for those delegates who provide any NCQA-required credentialing activities. These agreements are mutually agreed upon (Page 4, C.). The Delegation Addendum describes the delegated activities (credentialing). The Delegation Addendum Exhibit 1 outlines that the provider will submit to Plan performance quarterly reports no later than the 5th of the month following the close of each quarter.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. For new delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity to meet NCQA requirements before delegation began. *NA if the contractor does not delegate or if delegation arrangements have been in effect for longer than the look-back period.* NCQA CR8—Element B	**Documents:** 1. Credentialing Plan, page 10, 12 Credentialing Delegation **Narrative:** Friday Health Plans requires full delegation which means that the entity is responsible for policies, procedures and systems to perform the delegated	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	functions. In order to ensure these entities perform delegated credentialing functions appropriately, on-site audits shall be conducted within the first year of the agreement.	
Findings: FHP did not report any new delegation agreements.		
17. For delegation agreements in effect 12 months or longer, the Contractor: • Annually reviews its delegate's credentialing policies and procedures. • Annually audits credentialing and recredentialing files against its standards for each year that delegation has been in effect. • Annually evaluates delegate performance against its standards for delegated activities. • Semiannually evaluates regular reports specified in the written delegation agreement. NCQA CR8—Element C	**Documents:** 1. Credentialing Plan, page 10, 12 Credentialing Delegation **Narrative:** Friday Health Plans audits the consistency of applications of credentialing and recredentialing policies and procedures at least annually and shall forward a report showing the outcome of such audit to the provider group. Onsite surveys are conducted at least once every 12 months or randomly selected credentialing files are requested from the delegated entity for review/audit by Friday Health Plans.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Although the Credentialing Plan described the components of annual delegation monitoring, during the review, staff members were not able to speak to the annual delegation monitoring procedures.		
Required Actions: FHP must expand the details of its standards for CHP+ providers to ensure that FHP and its delegates are monitoring in accordance with Colorado standards. Furthermore, FHP must update its delegate monitoring to include these standards in annual evaluations. Due to the various record review findings, HSAG suggests monitoring regularly during the CAP process.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. For delegation agreements that have been in effect for more than 12 months, at least once in each of the past two years, the Contractor identified and followed up on opportunities for improvement, if applicable. NCQA CR8—Element D	**Documents:** N/A **Narrative:** There were no areas in which the Contractor identified and follows up on opportunities for improvement.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	24	X	1.00	=	24
	Partially Met	=	7	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	31	**Total Score**		=	24
				Total Score ÷ Total Applicable		=	77%

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. *42 CFR 438.330(a)(1)* Contract: Exhibit B-2—14.1.1	**Documents:** 1. Quality Assurance Work Plan 2. Quality Assurance Plan **Narrative:** Friday Health Plans has a Quality Assurance work Plan along with a Quality Assurance Plan as an ongoing method of monitoring services to members.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor's QAPI Program includes conducting and submitting (to the State) annually and when requested by the Department performance improvement projects (PIPs) that focus on both clinical and nonclinical areas. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. Each PIP includes the following: • Measurement of performance using objective quality indicators. • Implementation of interventions to achieve improvement in the access to and quality of care. • Evaluation of the effectiveness of the interventions based on the objective quality indicators. • Planning and initiation of activities for increasing or sustaining improvement. *42 CFR 438.330(b)(1) and (d)(2) and (3)* Contract: Exhibit B-2—14.2.1.1, 14.3	**Documents:** 1. PIP Reference Guide **Narrative:** Friday Health Plans participates with state required PIP projects.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's QAPI Program includes collecting and submitting (to the State) annually: • Performance measure data using standard measures identified by the State. • Data, specified by the State, which enable the State to calculate the Contractor's performance using the standard measures identified by the State. • A combination of the above activities. *42 CFR 438.330(b)(2) and (c)* Contract: Exhibit B-2—14.4	**Documents:** 1. HEDIS template **Narrative:** Friday Health Plans submits HEDIS data to the State annually.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42 CFR 438.330(b)(3)* Contract: Exhibit B-2—14.6	**Documents:** 1. Quality Assurance Work Plan 2. Quality Assurance Plan **Narrative:** Friday Health Plans has a Quality Assurance work Plan along with a Quality Assurance Plan as an ongoing method of monitoring utilization.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: FHP described multiple mechanisms used to regularly monitor overutilization, such as inpatient and emergency room reports. Staff members detailed a daily and weekly procedure for reviewing this type of overutilization data, and QMPC minutes also included a placeholder for outlier discussions. However, FHP did not have a mechanism to detect underutilization of services at the time of the review.		
Required Actions: FHP must develop a mechanism to detect underutilization of services. HSAG noted that FHP staff members described some initial thoughts regarding topics to include in underutilization reporting such as enrollment with lack of claims data, lack of claims for chronically ill members during the previous year, and other examples that could serve as a good starting point.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor's QAPI Program includes mechanisms for identifying, investigating, analyzing, tracking, trending, and resolving any alleged quality of care concerns. Contract: Exhibit B-2—14.7.1-2	**Documents:** 1. Quality Assurance Work Plan 2. Quality Assurance Plan **Narrative:** Friday Health Plans has a Quality Assurance work Plan along with a Quality Assurance Plan as an ongoing method of monitoring quality of care concerns.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Professional Quality of Care/Service Concerns policy outlined a definition and operating procedure regarding reporting and investigating quality of care (QOC) concerns; however, staff members reported no quality issues from the last year. The ongoing trend from the lack of grievances during the FY 2020–2021 review and ongoing lack of quality issues being identified and reported in CY 2021 shows a distinct trend in which staff members are not adequately trained to identify and report issues within the FHP system, specifically on behalf of the CHP+ members.		
Required Actions: FHP must enhance its training and identification mechanisms to ensure members, staff members, and providers all understand the definition of a QOC concern and how to report these types of issues. FHP must detail steps to identify, track, and trend issues within the system as well as identify individual care concerns.		
6. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. *Note: Persons with special health care needs shall mean persons having ongoing health conditions that have a biological, psychological, or cognitive basis; have lasted or are estimated to last for at least one year; and produce one or more of the following: (1) a significant limitation in areas of physical, cognitive, or emotional function; (2) dependency on medical or assistive devices to minimize*	**Documents:** 1. Quality Assurance Work Plan 2. Quality Assurance Plan **Narrative:** Friday Health Plans has a Quality Assurance work Plan along with a Quality Assurance Plan as an ongoing method of assessing quality.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
limitation of function or activities; (3) for children: significant limitation in social growth or developmental function; need for psychological, educational, medical, or related services over and above the usual for the child's age; or special ongoing treatments such as medications, special diets, interventions or accommodations at home or at school. *42 CFR 438.330(b)(4)* Contract: Exhibit B-2—14.6.1		
Findings: Similar to FY 2018–2019 findings, although FHP's population size is relatively small, the case management program was not adequately identifying and supporting members with special health care needs. Staff members were able to speak to individualized procedures to support member's unique needs, however, could not speak to overall trends within the population with respect to common diagnoses groups and efforts surrounding those members. The software system for case management was described to have diagnosis-specific assessments; however, FHP clinical staff members were not able to describe how members and population groups were reviewed over the course of treatment to assess care or health outcomes.		
Required Actions: FHP must develop a procedure and mechanism to periodically assess the quality and appropriateness of care furnished to members with special health care needs. HSAG recommends that the procedure detail definitions of members with special health care needs, timelines for initial and ongoing assessment, exit or discharge assessments as appropriate, and also include a method to review programmatic-level data for overall member outcomes.		
7. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program at least annually. *42 CFR 438.330(e)(2)* Contract: Exhibit B-2—14.2.5	**Documents:** 1. Quality Assurance Work Plan 2. Quality Assurance Plan **Narrative:** Friday Health Plans has a Quality Assurance work Plan along with a Quality Assurance Plan as an ongoing method of evaluating quality.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: Although FHP updated the QAP in September 2021, FHP did not submit evidence to support the evaluation of impact from the prior year. The March 2021 QMPC meeting minutes and agenda listed a review and approval of policies and procedures across multiple states and did not detail an annual evaluation or discussion of the CHP+ QAP, work plan, or program review worksheet. The CHP+ section of the meeting minutes stated, "No updates." The QAP described an annual QAP analysis; however, no QAP analysis was submitted upon request. An additional annual program review worksheet was also submitted but not filled out. Furthermore, the QAP detailed that an annual review will be conducted by the board of directors, however, no evidence was submitted to confirm this had taken place.		
Required Actions: FHP must expand its current process to ensure annual evaluation of the QAPI program and should update the QAP to reflect this process. HSAG suggests using the work plan and annual program review worksheet as a basis to this evaluation, ensuring an end-of-year review of the work plan and annual program review worksheet are completed and discussed with key leadership (i.e., QMPC and the board of directors). The evaluation by senior leadership should be taken into consideration in planning for the upcoming year and integrated into the QAP and work plan in a manner that can be tracked and trended to assess successes and barriers periodically.		
8. The Contractor adopts or develops practice guidelines that meet the following requirements: • Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. • Consider the needs of the Contractor's members. • Are adopted in consultation with participating providers. • Are reviewed and updated periodically, as appropriate. *42 CFR 438.236(b)* Contract: Exhibit B-2—10.5.8.2-4	**Documents:** **www.fridayhealthplans.com** **Narrative:** Guidelines are developed considering needs of population.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor adopts or develops practice guidelines for the following: • Perinatal, prenatal, and postpartum care. • Conditions related to persons with a disability or special health care needs. • Well-child care. Contract: Exhibit B-2—10.5.8.1	**Documents:** **www.fridayhealthplans.com** **Narrative:** Guidelines are found on the website.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor disseminates the guidelines to all affected providers and, upon request, members and potential members. *42 CFR 438.236(c)* Contract: Exhibit B-2—10.5.8	**Documents:** **www.fridayhealthplans.com** **Narrative:** **All guidelines are disseminated to providers through Friday Health Plans website.**	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: FHP did not have a method to disseminate practice guidelines to providers. Staff members reported that practice guidelines could be found on the website and would be printed if requested; however, not all guidelines discussed by FHP staff members were present on the website. Furthermore, the provider manual only discussed and included links to the U.S. Preventive Services website and did not direct providers to the FHP website where a more comprehensive list of practice guidelines was accessible. Additional documents submitted included a provider newsletter but did not mention practice guidelines.		
Required Actions: FHP must develop documentation that is available to providers and communicates practice guidelines or points providers to the website where the full practice guidelines are listed. Additionally, FHP must develop a procedure to ensure providers are notified when practice guidelines are updated.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42 CFR 438.236(d)* Contract: Exhibit B-2—10.5.8.5	**Documents:** 1. Milliman Care Guidelines 2. UpToDate.com **Narrative:** Friday Health Plans utilizes programs such as Milliman Care guidelines to ensure that decisions are consistent with guidelines.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42 CFR 438.242(a)* Contract: Exhibit B-2—13.1.1	**Documents:** 1. HRP **Narrative:** Friday Health Plans utilizes Health Rules Payor to house information related to health information data.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
13. The Contractor's health information system provides information about areas including but not limited to utilization, claims, grievances and appeals, and disenrollment for other than loss of CHP+ eligibility. *42 CFR 438.242(a)* Contract: Exhibit B-2—13.1.1, 8.1	**Documents:** 1. HRP **Narrative:** Friday Health Plans utilizes Health Rules Payor to house information related to health information for CHP+ members.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor's claims processing and retrieval systems collect data elements necessary to enable the mechanized claims processing and information retrieval systems operated by the State. • Contractor electronically submits encounter claims data in the interChange ANSI X12N 837 format directly to the Department's fiscal agent using the Department's data	**Documents:** 1. HRP **Narrative:** Friday Health Plans utilizes Health Rules Payor as its claim processing and retrieval system.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
transfer protocol. The 837-format encounter claims (reflecting claims paid, adjusted, and/or denied by the Contractor) shall be submitted via a regular batch process. *42 CFR 438.242(b)(1)* Contract: Exhibit B-2—13.1.6.2		
15. The Contractor collects data on member and provider characteristics and on services furnished to members through an encounter data system (or other methods specified by the State). *42 CFR 438.242(b)(2)* Contract: Exhibit B-2—13.1.5.1, 13.1.6.2	**Documents:** 1. HRP **Narrative:** Friday Health Plans has a Health Rules Payor data system wherein member and provider characteristics are stored.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. The Contractor ensures that data received from providers are accurate and complete by: • Verifying the accuracy and timeliness of reported data, including data from network providers compensated through capitation payments. • Screening the data for completeness, logic, and consistency. • Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies used for CHP+ quality improvement and care coordination efforts. *42 CFR 438.242(b)(3) and (4)* Contract: Exhibit B-2—13.6.1, 13.1.6.5.1	**Documents:** 1. Credentialing Application Review **Narrative:** Friday Health Plans follows the Credentialing Application Review process to ensure data received from providers is accurate and complete.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The Contractor: • Collects and maintains sufficient member encounter data to identify the provider who delivers any items or services to members. • Submits member encounter data to the State in Accredited Standards Committee (ASC) X12N 837, National Council for Prescription Drug Programs (NCPDP), and ASC X12N 835 formats as appropriate. • Submits member encounter data to the State at the level of detail and frequency specified by the State. *42 CFR 438.242(c)* Contract: Exhibit B-2—13.1.6.2, 13.1.6.3.1, 13.1.6.4-5	**Documents:** **N/A** **Narrative:** Encounter data is submitted to the state through 837 transactions.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
18. The Contractor monitors members' perceptions of accessibility and adequacy of services provided, including: • Member surveys. • Anecdotal information. • Grievance and appeals data. • Call center data. • Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[A-1] surveys. Contract: Exhibit B-2—14.5.1-2	**Documents:** 1. CAHPS SURVEY **Narrative:** Friday Health Plans coordinates with the state in the CAHPS Survey	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

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

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: While FHP included CAHPS data as part of the quality plan consideration and reflected on results within the plan and report, staff members did not report any additional monitoring regarding members' perceptions of accessibility and adequacy of services (i.e., surveys, anecdotal information, grievances or complaints, appeals, call center data). Staff members noted that a call center survey was currently under consideration but had not yet reached the planning phases at the time of the review. A report of survey data was submitted as additional evidence, but the topic focused on how members selected their healthcare plan and included only one survey question regarding member services or access to services (free telehealth). Staff members mentioned a consumer advisory board and provided a detailed charter but were not able to describe any examples of consumer feedback that were communicated or utilized in the quality program.		
Required Actions: FHP must utilize other sources of member feedback in addition to the CAHPS survey in order to build well-rounded feedback loops to analyze members' feedback regarding access and adequacy of services.		

Results for Standard X—Quality Assessment and Performance Improvement							
Total	Met	=	12	X	1.00	=	12
	Partially Met	=	6	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	18	**Total Score**		=	12
Total Score ÷ Total Applicable						=	67%

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2021–2022 Credentialing Record Review Tool
for Friday Health Plans

Review Period:	January 1, 2021—December 31, 2021
Date of Review:	November 9, 2021
Reviewer:	Gina Stepuncik
Health Plan Participant:	Rita Naranjo

Sample #	1	2	3	4	5	6	7	8	9	10
	Valid License/No Sanctions	DEA/CDS Certificate	Education/ Training	Board Certified	Work History	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits
File #1 Provider ID: **** Credentialing Date: 07/16/21	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #2 Provider ID: **** Credentialing Date: 03/23/21	Y ☐ N ☒	Y ☐ N ☐ NA☒	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments: This practitioner is a board certified behavior analyst (BCBA) through the Behavior Analyst Certification Board (BACB), licensed as a behavior analyst (LBA) in Kansas. The practitioner does not appear on the Colorado Department of Regulatory Agencies (DORA) license search and is not licensed in Colorado. Colorado does not offer LBA licensure; however, Colorado does license behavior analysts as licensed psychologists with the completion of a doctoral-level psychology degree (Colorado Practice Act 12-43-304. https://sehd.ucdenver.edu/cpce-internships/files/2010/08/Statute.pdf). This practitioner has a master's level degree. There is no reciprocity for this license between Colorado and Kansas. This practitioner owns an applied behavioral analysis (ABA) company, based out of Kansas, with an office in Colorado Springs, Colorado. Based on the services described on the company website, the practitioner meets with parents in Colorado to develop a treatment plan for the child and supervises staff members who practice ABA in Colorado. While there is a coronavirus disease 2019 (COVID-19) CMS waiver in place for telehealth and physical health supervision across states, there is no waiver in place for behavioral health supervision across state lines.										
File #3 Provider ID: **** Credentialing Date: 08/06/21	Y ☒ N ☐	Y ☐ N ☐ NA☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #4 Provider ID: **** Credentialing Date: 03/08/21	Y ☒ N ☐	Y ☐ N ☐ NA☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2021–2022 Credentialing Record Review Tool
for Friday Health Plans

Sample #	1	2	3	4	5	6	7	8	9	10
	Valid License/No Sanctions	DEA/CDS Certificate	Education/ Training	Board Certified	Work History	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits
File #5 Provider ID: **** Credentialing Date: 07/06/21	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #6 Provider ID: **** Credentialing Date: 08/04/21	Y ☒ N ☐	Y ☐ N ☐ NA☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #7 Provider ID: **** Credentialing Date: 02/23/21	Y ☒ N ☐	Y ☐ N ☐ NA☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #8 Provider ID: **** Credentialing Date: 07/06/21	Y ☒ N ☐	Y ☐ N ☐ NA☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #9 Provider ID: **** Credentialing Date: 06/30/21	Y ☒ N ☐	Y ☐ N ☐ NA☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #10 Provider ID: **** Credentialing Date: 08/03/21	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
Number of Applicable Elements	**10**	**3**	**10**	**2**	**10**	**10**	**10**	**10**	**10**	**10**
Number of Compliant Elements	**9**	**3**	**10**	**2**	**10**	**10**	**10**	**10**	**10**	**10**
Percentage Compliant	**90%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Total Number of Applicable Elements	**85**
Total Number of Compliant Elements	**84**
Overall Percentage Compliant	**99%**

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

Instructions:

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

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

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2021–2022 Recredentialing Record Review Tool
for Friday Health Plans

Review Period:	January 1, 2021—December 31, 2021
Date of Review:	November 9, 2021
Reviewer:	Gina Stepuncik
Health Plan Participant:	Rita Naranjo

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
File #1 Provider ID: **** Current Recredentialing Date: Prior Credentialing or Recredentialing Date: 09/14/18	Y ☐ N ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Comments: HSAG removed this file from the sample because FHP reported that this provider had been terminated from the network.									
File #2 Provider ID: **** Current Recredentialing Date: Prior Credentialing or Recredentialing Date: 12/03/18	Y ☐ N ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Comments: HSAG removed this file as FHP reported that the provider was not due for credentialing at the time of the submission and had been accidentally included in the sample.									
File #3 Provider ID: **** Current Recredentialing Date: Prior Credentialing or Recredentialing Date: 08/23/18	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☒
Comments: FHP did not submit evidence of medical director or PAC credentialing approval. Without this information, HSAG could not verify whether credentialing was conducted within the time limits.									

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
File #4 Provider ID: **** Current Recredentialing Date: 10/06/21 Prior Credentialing or Recredentialing Date: 08/03/18	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments: Recredentialing extension allowed due to COVID-19.									
File #5 Provider ID: **** Current Recredentialing Date: Prior Credentialing or Recredentialing Date: 12/03/18	Y ☐ N ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Comments: HSAG removed this file as FHP reported that the provider was not due for credentialing at the time of the submission and had been accidentally included in the sample.									
File #6 Provider ID: **** Current Recredentialing Date: Prior Credentialing or Recredentialing Date: 08/30/18	Y ☐ N ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Comments: HSAG removed this file from the sample because FHP reported that this provider had been termed from the network.									
File #7 Provider ID: **** Current Recredentialing Date: Prior Credentialing or Recredentialing Date: 11/09/18	Y ☐ N ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
Comments: HSAG removed this file from the sample because FHP reported that this provider had been termed from the network.									
File #8 Provider ID: **** Current Recredentialing Date: Prior Credentialing or Recredentialing Date: 12/06/18	Y ☐ N ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Comments: HSAG removed this file as FHP reported that the provider was not due for credentialing at the time of the submission and had been accidentally included in the sample.									
File #9 Provider ID: **** Current Recredentialing Date: 10/04/2021 Prior Credentialing or Recredentialing Date: 08/23/18	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments: Recredentialing extension allowed due to COVID-19.									
File #10 Provider ID: **** Current Recredentialing Date: Prior Credentialing or Recredentialing Date: 10/26/18	Y ☐ N ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Comments: HSAG removed this file from the sample because FHP reported that this provider had been termed from the network.									

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
File #OS1 Provider ID: **** Current Recredentialing Date: Prior Credentialing or Recredentialing Date:	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☒
Comments: FHP did not submit evidence of medical director or PAC credentialing approval. Without this information, HSAG could not verify whether credentialing was conducted within the time limits.									
File #OS2 Provider ID: **** Current Recredentialing Date: 07/28/21 Prior Credentialing or Recredentialing Date: 06/12/18	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments: HSAG found that the provider's DEA certificate was expired as of 2020; however, FHP reported that the DEA date was an error, and the provider likely never obtained DEA certification (which was not required for this role). Although insurance information did not detail policy coverage/limits, the practitioner appeared to be covered under the facility insurance.									
File #OS3 Provider ID: **** Current Recredentialing Date: Prior Credentialing or Recredentialing Date: 10/01/18	Y ☐ N ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Comments: HSAG removed this file as FHP reported that the provider was not due for credentialing at the time of the submission and had been accidentally included in the sample.									
File #OS4 Provider ID: **** Current Recredentialing Date: 07/13/21 Prior Credentialing or Recredentialing Date: 05/26/21	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2021–2022 Recredentialing Record Review Tool
for Friday Health Plans

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
File #OS5 Provider ID: **** Current Recredentialing Date: Prior Credentialing or Recredentialing Date: 02/20/19	Y ☐ N ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Comments: HSAG removed this file as FHP reported that the provider was not due for credentialing at the time of the submission and had been accidentally included in the sample.									
Number of Applicable Elements	**6**	**6**	**5**	**6**	**6**	**6**	**6**	**6**	**6**
Number of Compliant Elements	**6**	**6**	**5**	**6**	**6**	**6**	**6**	**6**	**4**
Percentage Compliant	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**67%**

Total Number of Applicable Elements	**53**
Total Number of Compliant Elements	**51**
Overall Percentage Compliant	**96%**

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

Instructions:

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

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

8. Verification time limits:

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

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

Appendix C. Site Review Participants

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

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

HSAG Review Team	Title
Sarah Lambie	Project Manager III
Gina Stepuncik	Associate Director
Eva Ogbon	Project Manager I
Lauren Gomez	Project Manager I
FHP Participants	**Title**
Amy Norris	Clinical Director
Bethany Escobar	Director of Provider Operations
Cassandra VanZalinge	Strategic Medical Operations Manager
Ed Ochal	Director of Provider Operations
Emily Kenison	Provider Operations Specialist
Gentry Skinner	Senior Director of Operations
Jennifer Clutter	Senior Director of Operations
Jennifer Mueller	Chief Operating Officer
Manuela Heredia	Senior Director of Regulatory Operations
Mugabe Walker	Medical Director
Patricia Lara	Quality Specialist
Ray Seggelke	Chief Information Officer
Rita Naranjo	Provider Operations Specialist
Rosalie Sandoval	Non-Clinical Director
Tammie Gonzales	Provider Operations Manager
Department Observers	**Title**
Elizabeth Mattes	Project Coordinator
Jeff Helm	Program Design and Policy
Russell Kennedy	Quality and Compliance Specialist

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

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

Table D-1—Corrective Action Plan Process

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

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

With the impending exit of **FHP** from the CHP+ market in Colorado, the Department will not be requiring **FHP** to complete a CAP as a result of FY 2021–2022 compliance monitoring activities.

Appendix E. Compliance Monitoring Review Protocol Activities

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

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the review to assess compliance with federal managed care regulations and Department contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all reviewers to ensure consistency in scoring across health plans.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided health plans with proposed review dates, group technical assistance, and training, as needed. • HSAG confirmed a primary health plan contact person for the review and assigned HSAG reviewers to participate in the review. • Sixty days prior to the scheduled date of the review, HSAG notified the health plan in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and review agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and the review activities. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. • Documents submitted for the review consisted of the completed desk review form, the compliance monitoring tool with the health plan's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. • The health plans also submitted a list of all credentialing, recredentialing, and organizational provider records that occurred between January 1, 2021, and December 31, 2021 (to the extent available at the time of the review). Health plans submitted the lists to HSAG 10 days following receipt of the desk review request. HSAG used a random sampling technique to select records for the review. HSAG notified the health plan five days following receipt of the lists of records regarding the sample records selected.

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