CHP+

Child Health Plan *Plus*

Fiscal Year 2023–2024 Compliance Review Report

for

Denver Health Medical Plan

April 2024

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Summary of Results

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

Denver Health Medical Plan (DHMP) showed a moderate understanding of federal regulations. DHMP demonstrated a comprehensive quality assessment and performance improvement program and showed improvement with provider selection and program integrity requirements compared with the prior review. However, for all other standards, DHMP's scores declined when compared with the prior review.

Table 1-1 presents the scores for DHMP for each of the standards. Findings for all requirements are summarized in the Assessment and Findings 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)
V. Member Information Requirements	21	21	18	3	0	0	86%v
VII. Provider Selection and Program Integrity	16	16	15	1	0	0	94%^
IX. Subcontractual Relationships and Delegation	4	4	1	3	0	0	25%v
X. Quality Assessment and Performance Improvement (QAPI)**	17	17	17	0	0	0	100%~
Totals	**58**	**58**	**51**	**7**	**0**	**0**	**88%**

*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.

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

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

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

**The full name of Standard X is Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems.

Standard V—Member Information Requirements

Evidence of Compliance and Strengths

DHMP used a process to provide member information to members during their initial enrollment as well as when requested, at no cost, in English and prevalent non-English languages and in alternative formats. DHMP staff members reported that health plan services assisted members by providing members with guidance with questions and concerns during calls. Health plan services representatives were trained on member benefits via onboarding, periodic training, and real-time communications. The member materials sent to the member upon enrollment consisted of a new member ID and a quick reference guide, which directed members to the current member handbook hosted on DHMP's website.

DHMP described in detail how member materials were reviewed and tested for reading level and compliance with Section 508 of the Rehabilitation Act. Member materials were tested using Flesch-Kincaid for grade-level accuracy and Siteimprove for Section 508 compliance. When asked how errors were found and addressed, DHMP staff members described the process to identify errors and communicate with points of contact, and how they quickly resolved the errors. DHMP reported that the threshold for errors is zero. HSAG tested the accessibility of the content located on DHMP's website using the Web accessibility evaluation tool (WAVE) and found a low number of errors.

DHMP submitted a policy that described a process to notify members affected by a contracted provider termination at least 30 calendar days prior to the effective termination date or 15 days after the receipt of the termination notice. When asked about the real-time process, staff members reported that when providers are terminated from the network, a marketing ticket is submitted in the SharePoint tracking system within 48 hours. The marketing team is responsible for delivering the printed material request to the outsourced printing vendor, Turbo Press, Inc.

Opportunities for Improvement and Recommendations

HSAG identified no opportunities for improvement for this standard.

Required Actions

DHMP staff members reported having a process in place to review member materials to ensure that all required member information is easily understood and readily accessible for the member. HSAG reviewed the member notices and found that most member notices met the sixth-grade reading level requirement. However, the language located in the provider termination notices was not easily understood and did not test at a sixth-grade reading level. DHMP must review and revise the provider

termination notices to ensure that the manner and format of the letters are easily understood and meet the sixth-grade reading level requirement.

Taglines required to be included in the member materials must be in conspicuously visible font size and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service number, and availability of materials in alternative formats. Most of DHMP's documents included the components of the tagline requirement. However, the formulary drug list had a tagline that was not in a conspicuously visible font size. DHMP must revise the tagline in the formulary drug list.

DHMP's provider directory was available in electronic and paper form and included most requirements. The electronic provider directory located on the website did not include the direct URL to the provider website where applicable. Although DHMP submitted examples of how to find the URL, these included multiple required steps that were not intuitive and would be difficult for the member to locate. Additionally, the provider directory did not include whether the provider completed cultural competency training and whether the provider has accommodations for people with disabilities. DHMP must make corrections to the provider directory to include: the direct URL to the provider website; whether the provider completed cultural competency training; and whether the provider has accommodations for people with disabilities.

Standard VII—Provider Selection and Program Integrity

Evidence of Compliance and Strengths

DHMP submitted policies, procedures, and other evidence demonstrating a comprehensive provider participation and compliance program. During the interview, DHMP provided an overview of its credentialing program, including how it addresses recruitment and retention, how it reviews provider applications, and how the credentialing process captures the required information for vetting. All providers that undergo credentialing are credentialed to participate in all DHMP lines of business.

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

During the interview, the chief compliance officer for both the Denver Health Authority and DHMP described the compliance program. He was new to the position, with a tenure of less than a year, and noted that the position for compliance lead at the plan level (i.e., for DHMP) was an open position during the time of the interview. Submitted documents described DHMP's processes for complying with federal, State, and contract requirements related to detecting and preventing fraud, waste, and abuse.

These included the clear responsibilities of the chief executive officer, board of directors, compliance committee, and chief compliance and audit officer. Onboarding and annual trainings were required for general staff members, and in-person, individualized trainings were conducted for board members. The compliance officer gained additional compliance education through monitoring Health Care Compliance Association updates, as well as updates from law blogs and other relevant resources.

Opportunities for Improvement and Recommendations

HSAG identified no opportunities for improvement for this standard.

Required Actions

DHMP did not include "suspended" in its policy or provider manual as a reason for not working with an entity. DHMP must include "suspended" in its policy and provider manual.

Standard IX—Subcontractual Relationships and Delegation

Evidence of Compliance and Strengths

DHMP submitted written delegation agreements for the following services: pharmacy benefit management, claims processing, printing, utilization management, interpretation, survey administration, and provider directory management. HSAG reviewed a sample of the delegation agreements to determine compliance with federal requirements.

During the compliance interview, DHMP staff members presented a high-level overview of the contract management process, from initiation to execution of subcontractor agreements. It was also reported that the legal department participates in review of subcontractor agreements and amendments to ensure their compliance with regulatory requirements. Per DHMP staff members, oversight and monitoring of the subcontractor agreements is program specific and assigned to "contract owners."

Opportunities for Improvement and Recommendations

To secure the relationship with Turbo Press, Inc., and other frequently used vendors, HSAG recommends that DHMP develop an agreement to delineate ongoing expectations and oversight of activities and reporting responsibilities.

HSAG also recommends that DHMP develop policies for monitoring vendors and how to document those monitoring activities.

Required Actions

HSAG reviewed a sample of contracts across the delegated activities and found the written agreements did not include all required language.

DHMP's contract with Certified Languages International did not specify a provision for revocation of the delegation of activities or obligations or specify other remedies in instances where DHMP determines that the subcontractor has not performed satisfactorily. DHMP must ensure, via revisions or amendments, that the subcontractor agreement includes the required language.

DHMP's contract with Clarity Software Solutions, Inc., did not include language that the subcontractor's agreement must comply with all applicable Child Health Plan *Plus* (CHP+) laws and regulations, including applicable subregulatory guidance and contract provisions. DHMP must ensure, via revisions or amendments, that the subcontractor agreement includes the required language.

DHMP must ensure, via revisions or amendments, that all subcontractor agreements include the following language:

- The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State.
  - The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems related to members.
  - The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
  - If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems

Evidence of Compliance and Strengths

The DHMP Quality Assessment and Performance Improvement (QAPI) program included a comprehensive system for reviewing member care and outcomes at various levels of the organization. The quality improvement manager was new to DHMP and described the functions of the quality workgroups and the Quality Management Committee (QMC). Submitted documentation and discussion during the interview outlined a clear structure from the workgroups up to the QMC, and eventually to the board of directors, which approved the annual work plan and analysis. During the interview, DHMP staff members discussed efforts to address data points around health equity, pediatric care, and maternal care.

DHMP provided a sample of the QMC minutes, which outlined a range of discussion topics not limited to population health, health plan services, grievance and appeals, provider relations, and care management. In the QMC minutes, DHMP documented an attendance record indicating that a number of both clinical and nonclinical stakeholders were present and that the meetings were well attended.

Staff members reported that DHMP operated health information systems that effectively managed data inputs, outputs, and some platform connectivity. Staff members described various automated and manual checks for claims data integrity and quality assurance. DHMP submitted documentation reflecting the regular monitoring of member services and oversight of quality activities, such as performance improvement projects, performance measures, over- and under-utilization, development and dissemination of clinical practice guidelines, and mechanisms to monitor members' perceptions of accessibility and adequacy of services provided. During the interview, staff members noted that DHMP had upgraded its TriZetto QNXT Enterprise Core Administration System claims and enrollment features and in August 2023, and it would be upgrading its QNXT encounter submission software for pharmacy and medical visit encounter data in February 2024.

Opportunities for Improvement and Recommendations

HSAG identified no opportunities for improvement for this standard.

Required Actions

HSAG identified no required actions for this standard.

3. Background and Overview

Background

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) to comply with provisions of the Code of Federal Regulations, Title 42 (42 CFR)—Medicaid and CHIP managed care regulations published May 6, 2016, which became applicable to CHIP MCOs effective July 1, 2018. Additional revisions were released in December 2020 and February 2023. The Department administers and oversees the CHP+ program (Colorado's implementation of CHIP).

The CFR requires that states conduct a periodic evaluation of their MCOs and PIHPs (collectively referred to as managed care entities [MCEs]) to determine compliance with federal healthcare regulations and managed care contract requirements. The Department of Health Care Policy & Financing (the Department) has elected to complete this requirement for Colorado's CHP+ MCOs by contracting with an external quality review organization (EQRO), HSAG.

In order to evaluate the CHP+ MCOs' compliance with federal managed care regulations and State contract requirements, the Department determined that the review period for fiscal year (FY) 2023–2024 was calendar year (CY) January 1, 2023, through December 31, 2023. This report documents results of the FY 2023–2024 compliance review activities for DHMP. Section 1 includes the summary of scores for each of the standards reviewed this year. Section 2 contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 3 describes the background and methodology used for the FY 2023–2024 compliance monitoring review. Section 4 describes follow-up on the corrective actions required as a result of the FY 2022–2023 compliance review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B lists HSAG, CHP + MCO, and Department personnel who participated in some way in the compliance review process. Appendix C describes the corrective action plan (CAP) process the CHP+ MCO will be required to complete for FY 2023–2024 and the required template for doing so. Appendix D contains a detailed description of HSAG's compliance review activities consistent with the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023.[3-1]

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Aug 8, 2023.

Overview of FY 2023–2024 Compliance Monitoring Activities

For the FY 2023–2024 compliance review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard V—Member Information Requirements, Standard VII—Provider Selection and Program Integrity, Standard IX—Subcontractual Relationships and Delegation, and Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems. Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the CHP+ MCO's contract requirements and regulations specified by the federal Medicaid and CHIP managed care regulations published May 6, 2016. Additional revisions were released in December 2020 and February 2023. HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable.* The Department determined that the review period was CY January 1, 2023, through December 31, 2023. HSAG reviewed materials submitted prior to the compliance review activities, materials requested during the compliance review, and considered interviews with key CHP+ MCO personnel to determine compliance with federal managed care regulations and contract requirements. Documents consisted of policies and procedures, staff training materials, reports, committee meeting minutes, and member and provider informational materials.

The compliance review processes were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Appendix D contains a detailed description of HSAG's compliance review activities consistent with those outlined in the CMS EQR protocol. The four standards chosen for the FY 2023–2024 compliance reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services; Standard II—Adequate Capacity and Availability of Services; Standard III—Coordination and Continuity of Care; Standard IV—Member Rights, Protections, and Confidentiality; Standard VI—Grievance and Appeal Systems; Standard VIII—Credentialing and Recredentialing; and Standard XII—Enrollment and Disenrollment.

Objective of the Compliance Review

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

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

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

FY 2022–2023 Corrective Action Methodology

As a follow-up to the FY 2022–2023 compliance review, each CHP+ MCO that received one or more *Partially Met* or *Not Met* scores was required to submit a CAP to the Department addressing those requirements found not to be fully compliant. If applicable, the CHP+ MCO was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the CHP+ MCO and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with DHMP until it completed each of the required actions from the FY 2022–2023 compliance monitoring review.

Summary of FY 2022–2023 Required Actions

For FY 2022–2023, HSAG reviewed Standard I—Coverage and Authorization of Services, Standard II—Adequate Capacity and Availability of Services, Standard VI—Grievance and Appeal Systems, and Standard XII—Enrollment and Disenrollment.

Related to Standard I—Coverage and Authorization of Services, DHMP was required to complete one required action:

- Update its Notice of Adverse Benefit Determination (NABD) template to clarify that the member must ask for a State fair hearing within 120 days after the *adverse appeal resolution* and that any additional peer-to-peer efforts after receipt of the NABD need to occur as part of the appeals process. Additionally, DHMP must develop a process to ensure that the updated NABD is used consistently.

Related to Standard II—Adequate Capacity and Availability of Services, DHMP was required to complete one required action:

- Revise its CHP+ member handbook to include the Bright Futures Periodicity schedule with regard to well-care appointment timeliness standards and revise the Network Plan to include the 24-hour urgent care timeliness requirement.

Related to Standard VI—Grievance and Appeal Systems, DHMP was required to complete seven required actions:

- Remove any language from both the Appeal Process and CHP+ member handbook that requires the member to sign and return a written appeal to DHMP.

- Update its NABDs and the Medicaid Choice Grievance and Appeals "After you file an appeal" section of its website to inform the members and the member representatives that this information must be provided upon request, free of charge and sufficiently in advance of the appeal resolution time frame.
- Ensure that the member appeal resolution letters are written so that members can easily understand them and remove any language that is deemed confusing and that could potentially confuse the member.
- Make changes to the CHP+ website sections "Filing an expedited (quick) appeal" and "After you file an appeal" to reflect the accurate 72-hour time frame set forth by federal and State regulations.
- Remove all language that references continuation of benefits in its CHP+ appeal resolution letters, CHP+ member handbook, and on its CHP+ website, as this does not apply to the CHP+ line of business. If documents are used across multiple lines of business, they must clarify that continuation of benefits during appeals and State fair hearings does not apply to CHP+.
- Revise the "State Fair Hearing" section of its CHP+ website and the "Effectuation of Appeal Resolutions" section of its provider manual to inform the member that the contractor must provide the disputed services as promptly and as expeditiously as the member's health condition requires *but no later than 72 hours* from the date it receives notice reversing the determination.
- Update the provider manual to remove references to continuation of benefits related to CHP+ or clarify that this only applies to Medicaid. Revise the time frame of a decision for an expedited appeal, which is 72 hours from the request, and clarify that the time frame to file a State fair hearing is 120 days from the adverse appeal resolution.

Related to Standard XII—Enrollment and Disenrollment, HSAG identified no required actions.

Summary of Corrective Action/Document Review

DHMP submitted a proposed CAP in May 2023. HSAG and the Department reviewed and approved the proposed CAP and responded to DHMP. DHMP submitted final documentation and completed the CAP in September 2023.

Summary of Continued Required Actions

DHMP successfully completed the FY 2022–2023 CAP, resulting in no continued corrective actions.

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor provides all required member information to members in a manner and format that may be easily understood and is readily accessible by members. *Note: Readily accessible means electronic information which complies with 508 guidelines, Section 504 of the Rehabilitation Act, and World Wide Web Consortium Web Content Accessibility Guidelines 2.0 Level AA and successor versions.* *42 CFR 438.10(c)(1)* CHP+ Contract Amendment 2: Exhibit B2—7.2.5 and 7.2.7.5	• Creation Review and Readability of Member Materials Policy • Cultural and Linguistic Appropriate Services Policy- Pg. 2 • Member Testing on Member Materials DOP	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DHMP staff members reported having a process in place to review member materials to ensure that all required member information is easily understood and readily accessible for the member. HSAG found that the language in the DHMP provider termination notices was not easily understood and did not test at or below a sixth-grade reading level.		
Required Actions: DHMP must review and revise the provider termination notices to ensure that the manner and format of the letters are easily understood and meet the sixth-grade reading level requirement.		
2. The Contractor has in place a mechanism to help members understand the requirements and benefits of the plan. *42 CFR 438.10(c)(7)* CHP+ Contract Amendment 2: Exhibit B2—7.3.7.2.1.5	• New Member Orientation video • CHP+ Member Handbook • CHP+ QRG	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. For consistency in the information provided to members, the Contractor uses the following as developed by the State: • Definitions for managed care terminology, including appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. • Model member handbooks and member notices. *42 CFR 438.10(c)(4)* CHP+ Contract Amendment 2: Exhibit B2—3.2 and 7.2.7.5	• CHP+ Member Handbook • CHP+ Handbook Definitions	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • Written materials that are critical to obtaining services include, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices. • All written materials for members must: – Use easily understood language and format. – Use a font size no smaller than 12 point. – Be available in alternative formats and through provision of auxiliary aids and service that takes into consideration the special needs of members with disabilities or limited English proficiency. – Include taglines in conspicuously visible font size and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service number, and availability of materials in alternative formats. *42 CFR 438.10(d)(2-3) and (d)(6)* CHP+ Contract Amendment 2: Exhibit B2—7.2.7.3.1 and 7.2.7.5-7	• Creation Review and Readability of Member Materials Policy- Pg.3 (A.1.b) • Medicaid Member Handbook (tagline, pg.3) • Notice of NonDiscrimination and Foreign Language Taglines Policy- Pg. 2 • Attachment 1 Notice of non discrimination • Attachment 2- Multi Language Insert • Attachment 3 Medicaid.CHP Taglines 2022_SPA	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DHMP's formulary list had most of the requirements of a tagline in the document; however, the tagline was not in a conspicuously visible font size.		

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: DHMP must revise the tagline in the formulary list to be in a conspicuously visible font size.		
5. If the Contractor makes information available electronically—Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of readily accessible above). • The information is placed in a website location that is prominent and readily accessible. • The information can be electronically retained and printed. • The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge upon request and is provided within five (5) business days. *42 CFR 438.10(c)(6)* CHP+ Contract Amendment 2: Exhibit B2—7.3.12.1.1-5	• CHP Website Screenshots • CHP Member Handbook- Pg. 6 • Notice of NonDiscrimination and Foreign Language Taglines Policy- taglines are included on all CHP+ documents on the website and include language on requesting a free physical copy • Attachment 3 Medicaid.CHP Taglines 2022_SPA	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor makes available to members in electronic or paper form information about its formulary: • Which medications are covered (both generic and name brand). • What tier each medication is on. • Formulary drug list must be available on the Contractor's website in a machine readable file and format. *42 CFR 438.10(h)(4)(i)* CHP+ Contract Amendment 2: Exhibit B2—7.3.7.1.2-3	• Medicaid.CHP Formulary • Website.Formulary	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The Contractor makes interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and how to access them. • This includes oral interpretation and use of auxiliary aids such as TTY/TDY and American Sign Language. *42 CFR 438.10(d)(4)* CHP+ Contract Amendment 2: Exhibit B2—7.2.6.2, 7.2.6.4, and 7.2.6.5	• Cultural and Linguistic Appropriate Services Policy- Pg. 4-5 • Creation Review and Readability of Member Materials Policy- Pg. 3, 4	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor notifies members that oral interpretation is available for any language, written translation is available in prevalent languages, and auxiliary aids and services are available upon request at no cost for members with disabilities, and how to access them. *42 CFR 438.10(d)(5)* CHP+ Contract Amendment 2: Exhibit B2—7.2.6.4.1-3	• Creation Review and Readability of Member Materials Policy- Pg. 2 • Cultural and Linguistic Appropriate Services Policy- Pg. 5	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor provides each member with a member handbook in both electronic and paper format within a reasonable time after receiving notification of the member's enrollment. *42 CFR 438.10(g)(1)* CHP+ Contract Amendment 2: Exhibit B2—7.3.7.1	• CHP.834 member enrollment example	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor gives members written notice of any significant change (as defined by the State) in the information required at 438.10(g) at least 30 days before the intended effective date of the change. *42 CFR 438.10(g)(4)* CHP+ Contract Amendment 2: Exhibit B2—7.2.7.5	• Member Handbook Content Requirements Policy- Pg. 7 • CHP Member Handbook- Pg. 14	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor makes a good faith effort to give written notice of termination of a contracted provider by the later of 30 calendar days prior to the effective date of the termination, or within 15 days after the receipt or issuance of the termination notice to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. *42 CFR 438.10(f)(1)* CHP+ Contract Amendment 2: Exhibit B2—7.3.9.1	• Provider Terminations Policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor shall develop and maintain a customized and comprehensive website that includes: • The CHP+ MCO's contact information. • Member rights and responsibilities. • Member handbook. • Grievance and appeal procedures and rights. • General functions of the CHP+ MCO. • Provider directory. • Access to care standards. • Colorado Crisis Services information. • A link to the Department's website for standardized information such as member rights and handbooks. CHP+ Contract Amendment 2: Exhibit B2—7.3.8	• CHP website screenshots	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, pharmacies, and behavioral health providers, and LTSS providers (as applicable): • The provider's name and group affiliation, street address(es), telephone number(s), website URL, specialty (as appropriate), whether the providers will accept new members. • The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training. • Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment. *Note: Information included in a paper provider directory must be updated at least monthly and quarterly for a mobile enabled or electronic directory.* *Electronic provider directories must be updated no later than 30 calendar days after the Contractor receives updated provider information.* *42 CFR 438.10(h)(1-3)* CHP+ Contract Amendment 2: Exhibit B2—7.3.8.1.7-8	• Required Provider Directory Information Policy • Denver Health Clinic Accessibility Accommodations • Provider Directory Screenshot	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: DHMP's provider directory was available in electronic and paper form and included most requirements. The provider directory located on the website did not include the following components: • Direct URL to the provider's website where applicable • Whether the provider completed cultural competency training • Whether the provider has accommodations for people with disabilities Although, DHMP submitted samples of how to find the URL, it required multiple steps that would be difficult for the member to locate.		
Required Actions: DHMP must make corrections to the provider directory to include: a direct URL to the provider website; whether the provider completed cultural competency training; and whether the provider has accommodations for people with disabilities.		
14. Provider directories are made available on the Contractor's website in a machine readable file and format. *42 CFR 438.10(h)(4)* CHP+ Contract Amendment 2: Exhibit B2—7.3.8.1.9	• Required Provider Directory Information Policy • Usability Testing for Web-Based Physician and Hospital Directories Policy • Provider Directory Machine Readable	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. The member handbook provided to members following enrollment includes: • The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled. • Procedures for obtaining benefits, including authorization requirements and/or referrals for specialty care and for other benefits not furnished by the member's primary care provider.	• Member Handbook Content Requirements Policy- Pgs. 2, 4, 7 • CHP Member Handbook- Pgs. 12, 13, 35-53 (benefit tables) • CHP QRG	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The extent to which and how members may obtain benefits, including family planning services, from out-of-network providers. This includes an explanation that the Contractor cannot require the member to obtain a referral before choosing family planning provider. • The process of selecting and changing the member's primary care provider. • Any restrictions on the member's freedom of choice among network providers. • In the case of a counseling or referral service or CHP+ covered benefit that the Contractor does not cover due to moral or religious objections, the Contractor informs the member that the service is not covered because of moral or religious objections and how and where the member can obtain the services. *42 CFR 438.10(g)(2)(iii, iv, vi, vii, x) and (g)(ii)(A-B)* CHP+ Contract Amendment 2: Exhibit B2—7.3.7.2.1.5-7, 7.2.7.2.1.9-10, and 10.3.2		
16. The member handbook provided to members following enrollment includes the following member rights and protections as specified in 42 CFR 438.100. Members have the right to: • Receive information in accordance with information requirements (42 CFR 438.10).	• Member Handbook Content Requirements Policy- Pg. 2 • CHP Member Handbook- Pg. 21-22 • CHP QRG- Pg 8-10	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Be treated with respect and with due consideration for his or her 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 his or her health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. • Request and receive a copy of his or her medical records, and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for access, coverage, and coordination of medically necessary services. • Freely exercise his or her rights, and the exercising of those rights will not adversely affect the way the Contractor, its network providers, or the State Medicaid agency treats the member. *42 CFR 438.10(g)(2)(ix)* CHP+ Contract Amendment 2: Exhibit B2—7.3.6.3 and 7.3.7.2.1.16.		

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The member handbook provided to members following enrollment includes the following information regarding the grievance, appeal, and fair hearing procedures and time frames: • The right to file grievances and appeals. • The requirements and time frames for filing a grievance or appeal. • The right to a request a State fair hearing after the Contractor has made a determination on a member's appeal which is adverse to the member. • The availability of assistance in the filing process. *42 CFR 438.10(g)(2)(xi)* CHP+ Contract Amendment 2: Exhibit B2—7.3.7.2.1.23	• Member Handbook Content Requirements Policy • CHP Member Handbook- Pgs. 58-63 • CHP QRG- Pg. 11-15	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
18. The member handbook provided to members following enrollment includes the extent to which and how after-hours and emergency coverage are provided, including: • What constitutes an emergency medical condition and emergency services. • The fact that prior authorization is not required for emergency services. • The fact that the member has the right to use any hospital or other setting for emergency care. *42 CFR 438.10(g)(2)(v)* CHP+ Contract Amendment 2: Exhibit B2—7.3.7.2.1.8.1-2, 7.3.7.2.1.8.4, and 7.3.7.2.1.8.7	• Member Handbook Content Requirements Policy- Pg. 3,8 • CHP Member Handbook- Pg. 23,39 • CHP QRG- Pg. 4-5	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
19. The member handbook provided to members following enrollment includes: • Cost-sharing, if any is imposed under the State plan. • How and where to access any benefits that are available under the State plan but not covered under the CHP+ managed care contract. • How transportation is provided. • The toll-free telephone number for member services, medical management, and any other unit providing services directly to members. • Information on how to report suspected fraud or abuse. • How to access auxiliary aids and services, including information in alternative formats or languages. *42 CFR 438.10(g)(2)(ii, viii, xiii, xiv, xv)* CHP+ Contract Amendment 2: Exhibit B2—7.3.7.2, 7.3.7.2.1.2, 7.3.7.2.1.19.1, and 7.3.7.2.1.21	• Member Handbook Content Requirements Policy- Pg. 2, 6 • CHP Member handbook- Pg. 5, 33, 38, 57 • CHP QRG- Pg. 1,3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
20. The Contractor provides member information by either: • Mailing a printed copy of the information to the member's mailing address. • Providing the information by email after obtaining the member's agreement to receive the information by email. • Posting the information on the Contractor's website and advising the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with	• CHP Member Handbook- Pg. 6 • CHP QRG	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost. • Providing the information by any other method that can reasonably be expected to result in the member receiving that information. *42 CFR 438.10(g)(3)* CHP+ Contract Amendment 2: Exhibit B2—7.3.12		
21. The Contractor must make available to members, upon request, any physician incentive plans in place. *42 CFR 438.10(f)(3)* CHP+ Contract Amendment 2: Exhibit B2—7.3.5.1.13	• Member Handbook- Pg. 18	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard V—Member Information Requirements							
Total	Met	=	18	X	1.00	=	18
	Partially Met	=	3	X	.00	=	3
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	21	**Total Score**		=	18
				Total Score ÷ Total Applicable		=	86%

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements written policies and procedures for selection and retention of providers. *42 CFR 438.214(a)* CHP+ Contract Amendment 2: Exhibit B2—9.1.7 and 9.1.10	• Provider Selection and Retention Policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor follows a documented process for credentialing and recredentialing of providers that complies with the standards of the National Committee for Quality Assurance (NCQA). The Contractor shall assure that all laboratory-testing sites providing services under this contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration. *42 CFR 438.214(b)* CHP+ Contract Amendment 2: Exhibit B2—9.2.3 and 9.2.3.3	• Credentialing and Recredentialing of Practitioners Policy- Pg. 1, pg 2-D	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's provider selection policies and procedures include provisions that the Contractor does not: • Discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. • Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42 CFR 438.12(a)(1) and (2)* *42 CFR 438.214(c)* CHP+ Contract Amendment 2: Exhibit B2—9.1.8-9	• Provider Selection and Retention Policy- Pg.2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This is not construed to: • Require the Contractor to contract with providers beyond the number necessary to meet the needs of its members. • Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. • Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members.	• Provider Selection and Retention Policy- Pg. 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.12(a-b) CHP+ Contract Amendment 2: Exhibit B2—9.1.11		
5. The Contractor has a signed contract or participation agreement with each provider. *42 CFR 438.206(b)(1)* CHP+ Contract Amendment 2: Exhibit B2—9.5.1.1	• Denver Health Contract • UCHealth Contract • STRIDE Contract	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The Contractor does not employ or contract with providers or other individuals or entities excluded for participation in federal health care programs under either Section 1128 or 1128 A of the Social Security Act. • The Contractor performs monthly monitoring against HHS_OIG's List of Excluded Individuals. *(This requirement also requires a policy.)* *42 CFR 438.214(d)* *42 CFR 438.610* CHP+ Contract Amendment 2: Exhibit B2—9.1.20	• Sanction Screening of Individuals and Entities P&P- Pg. 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (owning 5 percent or more of the Contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549. *42 CFR 438.610* CHP+ Contract Amendment 2: Exhibit B2—15.9.4.2	• Sanction Screening of Individuals and Entities P&P- Pg. 2 • Provider Manual 2023- Pg. 7	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DHMP did not include "suspended" in its policy or provider manual as a reason for not working with an entity.		
Required Actions: DHMP must include "suspended" in its policy and provider manual.		
8. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: • The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered. • Any information the member needs in order to decide among all relevant treatment options. • The risks, benefits, and consequences of treatment or non-treatment. • The member's right to participate in decisions regarding his or her health care, including the right to refuse	• Provider Manual 2023- Pg. 8	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
treatment, and to express preferences about future treatment decisions. *42 CFR 438.102(a)(1)* CHP+ Contract Amendment 2: Exhibit B2—11.11.10		
9. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: • To the State upon contracting or when adopting the policy during the term of the contract. • To members before and during enrollment. • To members within 90 days after adopting the policy with respect to any particular service. *42 CFR 438.102(a)(2)-(b)* CHP+ Contract Amendment 2: Exhibit B2—11.7	• Provider Manual 2023- Pg. 7 • Member Handbook Content Requirements Policy- Pg. 3, 8 • CHP Member Handbook- Pg 11 • Religious Accommodations and Conscience Objections Relative to Provision of Care	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor has administrative and management arrangements or procedures, including a compliance program to detect and prevent fraud, waste, and abuse and includes: • Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal, State, and contract requirements. • The designation of a compliance officer who is responsible for developing and implementing policies, procedures, and practices to ensure compliance with	• Compliance Program- Pgs.1, 2, 3, 4 • CodeofConduct-Final_English	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
requirements of the contract and reports directly to the Chief Executive Officer and Board of Directors. • The establishment of a Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program. • Training and education of the compliance officer, management, and organization's staff members for the federal and State standards and requirements under the contract. • Effective lines of communication between the compliance officer and the Contractor's employees. • Enforcement of standards through well-publicized disciplinary guidelines. • Implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks. • Procedures for prompt response to compliance issues as they are raised, investigation of potential compliance problems identified in the course of self-evaluation and audits, corection of such problems quickly and thoroughly to reduce the potential for reoccurence, and ongoing compliance with the requirements under the contract. *42 CFR 438.608(a)(1)* CHP+ Contract Amendment 2: Exhibit B2—15.1.1 and 15.1.5.1-7		

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor's administrative and management procedures to detect and prevent fraud, waste, and abuse include: • Written policies for all employees, subcontractors or agents that provide detailed information about the False Claims Act, including the right of employees to be protected as whistleblowers. • Provisions for prompt referral of any potential fraud, waste, or abuse to the Department and any potential fraud to the State Medicaid Fraud Control Unit. • Provisions for suspension of payments to a network provider for which the State determines there is credible allegation of fraud (in accordance with 455.23.) *42 CFR 438.608 (a)(6-8)* CHP+ Contract Amendment 2: Exhibit B2—1.14.1, 15.1.5.9, 15.1.6, and 15.7.1 10 CCR 2505-10, Section 8.076	• Fraud, Waste, and Abuse Policy- pg. 2,3, 6 • False Claims, Fraud, Waste, and Abuse Policy- Pgs. 2, 6, 7 • Provider Vendor Subcontractor Overpayments Policy- Pg. 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor's Compliance Program includes: • Provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potenial fraud. • Provision for prompt notification to the State about member circumstances that may affect the member's eligibility, including change in residence and member death. • Provision for notification to the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including termination of the provider agreement with the Contractor. • Provision for a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. *42 CFR 438.608 (a)(2-5)* CHP+ Contract Amendment 2: Exhibit B2—15.1.5.7.6, 15.3.1.1, and 15.3.1.3.2.1	• Provider Vendor Subcontractor Overpayments Policy- Pg. 4 • Verification of Services Policy • Change in Circumstance Report Job Aid • Monthly and Semiannual FWA notification report DOP- bullet 3, reporting change in provider circumstances	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor ensures that all network providers are enrolled with the State as CHP+ providers consistent with the provider disclosure screening, and enrollment requirements of the State. • The Contractor may execute network provider agreements pending the outcome of the State's screening and enrollment process of up to one-hundred and twenty (120) days, but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one one-hundred and twenty (120)-day period without enrollment of the provider, and notify affected members. *42 CFR 438.608 (b)* CHP+ Contract Amendment 2: Exhibit B2—15.9.2	• DHH Provider Maintenance BRD 10312023 (pg 24) • Provider Selection and Retention Policy (pg 2)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor has procedures to provide to the State: • Written disclosure of any prohibited affiliation (as defined in 438.610). • Written disclosure of ownership and control (as defined in 455.104) • Identification within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract. *42 CFR 438.608(c)* CHP+ Contract Amendment 2: Exhibit B2—15.3.1.5.1.1, 15.9.4.3, and 15.10.4.2	• Mbr Paid when Mbr not Assigned to DH_DLP • DH_OwnshpCntrlDis_FY23-24 • Excluded Provider Sanction Search DOP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The Contractor has a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days of identifying the overpayment, and to notify the Contractor in writing of the reason for the overpayment. • The Contractor reports semi-annually to the State on recoveries of overpayments. *42 CFR 438.608(d)(2) and (3)* CHP+ Contract Amendment 2: Exhibit B2—15.1.5.8 and 15.3.1.2.4.4	• Provider Vendor Subcontractor Overpayments Policy- Pgs. 3, 4	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. The Contractor provides that members are not held liable for: • The Contractor's debts in the event of the Contractor's insolvency. • Covered services provided to the member for which the State does not pay the Contractor. • Covered services provided to the member for which the State or the Contractor does not pay the health care provider that furnishes the services under a contractual, referral, or other arrangement. • Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. *42 CFR 438.106* CHP+ Contract Amendment 2: Exhibit B2—15.12.2-4	• Provider Manual 2023- Pg. 67 • DHMP Contract Requirements for DHMP Providers-Practitioners- Pg 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard VII—Provider Selection and Program Integrity							
Total	Met	=	15	X	1.00	=	15
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	16	**Total Score**		=	15
				Total Score ÷ Total Applicable		=	94%

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. Notwithstanding any relationship(s) with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. *42 CFR 438.230(b)(1)* CHP+ Contract Amendment 2: Exhibit B2—2.5.4.4	Please see submitted contracts	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. All contracts or written arrangements between the Contractor and any subcontractor specify— • The delegated activities or obligations and related reporting responsibilities. • That the subcontractor agrees to perform the delegated activities and reporting responsibilities. • Provision for revocation of the delegation of activities or obligations or specify other remedies in instances where the Contractor determines that the subcontractor has not performed satisfactorily. *Note: Subcontractor requirements do not apply to network provider agreements. In addition, wholly-owned subsidiaries of the health plan are not considered subcontractors.* *42 CFR 438.230(b)(2) and (c)(1)* CHP+ Contract Amendment 2: Exhibit B2—2.5.4.4	Please see submitted contracts	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: DHMP's contract with Certified Languages International did not include language that specified a provision for revocation of the delegation of activities or obligations or specify other remedies in instances where DHMP determines that the subcontractor has not performed satisfactorily.		
Required Actions: DHMP must ensure, via revisions or amendments, that the subcontractor agreements include the required language.		
3. The Contractor's written agreement with any subcontractor includes: • The subcontractor's agreement to comply with all applicable CHP+ laws, regulations, including applicable subregulatory guidance and contract provisions. *42 CFR 438.230(c)(2)* CHP+ Contract Amendment 2: Exhibit B2—2.5.4.6	Please see submitted contracts	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DHMP's contract with Clarity Software Solutions, Inc., did not include language that the subcontractor's agreement must comply with all applicable CHP+ laws and regulations, including applicable subregulatory guidance and contract provisions.		
Required Actions: DHMP must ensure, via revisions or amendments, that the subcontractor agreements include the required language.		
4. The written agreement with the subcontractor includes: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State.	Please see submitted contracts	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems related to members. – The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. – If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. *42 CFR 438.230(c)(3)* CHP+ Contract Amendment 2: Exhibit B2—15.10.11		
Findings: HSAG reviewed a sample of contracts across the delegated activities and found that the written agreements did not include all required information.		
Required Actions: DHMP must ensure, via revisions or amendments, that subcontractor agreements include: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State. – The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems related to members. – The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.		

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.		

Results for Standard IX—Subcontractual Relationships and Delegation							
Total	Met	=	1	X	1.00	=	1
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	4	**Total Score**		=	1
				Total Score ÷ Total Applicable		=	25%

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
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)* CHP+ Contract Amendment 2: Exhibit B-2—14.1.1	• 2022-2023 MCD CHP+ QI Prog Description, p. 16-18 • 2022-2023 MCD CHP+ Evaluation p. 4-5, 6-8 • 2023-2024 QI Work Plan- Lines 2,3,4 • QMC Minutes 9.28.23 p.1-2	☒ 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)* CHP+ Contract Amendment 2: Exhibit B-2—14.2.1.1 and 14.3	• 2022-2023 MCD CHP+ Evaluation p.14-15 • 2023 QI Work Plan- Line 40 • CO2020-21_MCO_PIP-Val_Module 4_Submission Form_F1_V6-CHP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
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)* CHP+ Contract Amendment 2: Exhibit B2—14.4	• QMC Minutes 9.28.2023 p. 2-5. • MY2022 CHP State Measure Performance	☒ 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)* CHP+ Contract Amendment 2: Exhibit B-2—14.6	• 2022-2023 QI MCD CHP+ Evaluation p.7, 30 • 2023-2024 QI Work Plan- Row 27 • MMC Minutes 10.24.2023 p.4-5 • Over-Under Utilization Report- Pg. 7, 12, 25	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. *Note: Persons with special health care needs shall mean persons having ongoing health conditions that have a biological, psychological, or cognitive basis; have lasted or are estimated to last for at least one year; and produce one or more of the following: (1) a significant limitation in areas of physical, cognitive, or emotional function; (2) dependency on medical or assistive devices to minimize limitation of function or activities; (3)*	• 2022-2023 QI MCD CHP+ Prog Description p. 24 • 2022-2023 MCD_CHP+ Evaluation p. 46-52 • 2023-2024 QI Work Plan- Line 25 • QMC Minutes 7.11.23 p.5-6 • MMC Minutes 10.24.23 p.5	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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)* CHP+ Contract Amendment 2: Exhibit B2—14.6.1		
6. 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. CHP+ Contract Amendment 2: Exhibit B-2—14.5.2-3	• 2022-2023 QI MCD CHP Program Description p. 32-33 • 2023-2024 QI Work Plan- Line 6 • QMC Minutes 7.11.23 p.2-3 • 2023 QMC 11.14.2023 Deck pgs. 16, 21, 25-27, 62	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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)* CHP+ Contract Amendment 2: Exhibit B-2—14.2.5	• 2022-2023 MCD_CHP+ Evaluation p. 5 • 2022-2023 QI Program Description, p.34 • 2023-2024 QI Work Plan- Line 4	☒ 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 (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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)* CHP+ Contract Amendment 2: Exhibit B-2—10.5.8.2-4	• QI Website Guidelines • Clinical Guidelines Folder	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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. CHP+ Contract Amendment 2: Exhibit B-2—10.5.8.1	• QI Website Guidelines • Clinical Guidelines Folder	☒ 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)* CHP+ Contract Amendment 2: Exhibit B-2—10.5.8	• QI Website Guidelines • Clinical Guidelines Folder • Clinical Practice Guidelines Provider Newsletter	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
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)* CHP+ Contract Amendment 2: Exhibit B-2—10.5.8.5	• QI Website Guidelines • Clinical Guidelines Folder	☒ 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)* CHP+ Contract Amendment 2: Exhibit B-2—13.1.1 and 15.10.2	• DHMP DW Technical Architecture - V5.PDF • Highlevel DHMP Foot Print V3.PDF • DHH QNXT 6.0 - TMS - EDM - HOC 3 - Logical Diagrams_V3.3 • AltruistaHealth-DHHA-ETL-Process-1510	☒ 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)* CHP+ Contract Amendment 2: Exhibit B-2—8.1 and 13.1.1	• qnxt-core-admin-ebook.pdf • QNXT600-Product Overview • CHP - Information System-Summary.asd • HealthEdge GuidingCare - utilization-management-appeals-and-grievances	☒ 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 transfer protocol. The 837-format encounter claims	• CHP - Information System-Summary.asd • EDMC600 – ProductOverview • QNXT600-Product Overview • Encounter_Submission_ExampleWithMemberProviderDetails_CHP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
(reflecting claims paid, adjusted, and/or denied by the Contractor) shall be submitted via a regular batch process. *42 CFR 438.242(b)(1)* CHP+ Contract Amendment 2: Exhibit B-2—13.1.6.3		
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)* CHP+ Contract Amendment 2: Exhibit B-2—13.1.5.1 and 13.1.6.2	• Encounter_Submission_ExamplewithMemberProviderDetails_CHP • EDMC600 - ProductOverview • Highlevel DHMP Foot Print V3.PDF	☒ 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)* CHP+ Contract Amendment 2: Exhibit B-2—13.1.6 and 13.1.7.1.2.1	• CHP - Information System-Summary.asd	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
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)* CHP+ Contract Amendment 2: Exhibit B-2—13.1.6.2-3 and 13.1.6.4-5	• EDMC600 – ProductOverview • Highlevel DHMP Foot Print V3.PDF	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems							
Total	Met	=	17	X	1.00	=	17
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	17	**Total Score**		=	17
				Total Score ÷ Total Applicable		=	100%

Appendix B. Compliance Review Participants

Table B-1 lists the participants in the FY 2023–2024 compliance review of **DHMP**.

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

HSAG Review Team	Title
Gina Stepuncik	Associate Director
Courtney Bishop (Observer)	Senior Project Manager
Cynthia Moreno	Program Manager III
Crystal Brown	Program Manager I
DHMP Participants	**Title**
Murielle Blaise	Provider Relations and Contracting Analyst
Deb Harris	Credentialing Coordinator
Shannon Godbout	Project Manager I
Elizabeth Flood	Senior Manager, Population Health
Shelly Siedelberg	Program Manager, Quality
Viv Duval	Project Manager I, Administration
Natalie Score	Director, Insurance Products
Pellan Robin	Contractor
Christine Seals-Messersmith	Medical Director, Managed Care
Joseph IV Caldwell	Chief Financial Officer
Greg McCarthy	Executive Director
Landon Palmer	Chief Compliance and Audit Officer
Ruie Winters	Senior Director, Health Plan Pharmacy
Mike Wagner	Chief Administrative Officer
Alexa Muccioli	Supervisor, Pharmacy
Lucas Wilson	Associate Chief Operating Officer
Bryant Wiltrout	Director, Information Systems
Chad Frankfather	Clinical Manager of Health
Katie Egan	Manager, Health Plan Quality Improvement
Robin Bun	Analyst Health Plan Compliance
Jessica Stockmyer	Manager, Medical Economics
Christopher White	Manager Enrollment Services
Dawn Robinson	Director, Health Plan Care Management

DHMP Participants	Title
Marissa Schillaci-Kayton	Manager, Business Operations
Barbra Camps-Sierra	Contractor
Jeffery Scribner	Payment Integrity Manager
Jeffery Cole	Health Plan Manager
Andrea Chavez	Pharmacy Technician Supervisor
Alicia Persich	Marketing and Engagement Manager
Elaina Holland	Director, Health Plan Services
Jeremy Sax	Government Products Manager
Katie Gaffney	Lead Health Plan Compliance Analyst
Arjanea Williams	Analyst, Health Plan Compliance
Jason Casey	Analyst, Health Plan Compliance
Department Observers	**Title**
Russell Kennedy	Quality and Compliance Specialist
Lindsey Folkerth	Contract Specialist, Health Programs Office
Helen Desta-Fraser	Quality Section Manager
Tyller Kerrigan-Nichols	Managed Care Contract Specialist

Appendix C. Corrective Action Plan Template for FY 2023–2024

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

Table C-1—Corrective Action Plan Process

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

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

The CAP template follows on the next page.

Table C-2—FY 2023–2024 Corrective Action Plan for DHMP

Standard V—Member Information Requirements
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
1. The Contractor provides all required member information to members in a manner and format that may be easily understood and is readily accessible by members. *Note: Readily accessible means electronic information which complies with 508 guidelines, Section 504 of the Rehabilitation Act, and World Wide Web Consortium Web Content Accessibility Guidelines 2.0 Level AA and successor versions.* *42 CFR 438.10(c)(1)* CHP+ Contract Amendment 2: Exhibit B2—7.2.5 and 7.2.7.5
Findings
DHMP staff members reported having a process in place to review member materials to ensure that all required member information is easily understood and readily accessible for the member. HSAG found that the language in the DHMP provider termination notices was not easily understood and did not test at or below a sixth-grade reading level.
Required Actions
DHMP must review and revise the provider termination notices to ensure that the manner and format of the letters are easily understood and meet the sixth-grade reading level requirement.
Planned Interventions
Person(s)/Committee(s) Responsible

Standard V—Member Information Requirements
Training Required
Monitoring and Follow-Up Activities Planned
Documents to Be Submitted as Evidence of Completion
HSAG Initial Review:
Documents Included in Final Submission: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***
Date of Final Evidence:

Standard V—Member Information Requirements
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
4. The Contractor makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • Written materials that are critical to obtaining services include, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices. • All written materials for members must: – Use easily understood language and format. – Use a font size no smaller than 12 point. – Be available in alternative formats and through provision of auxiliary aids and service that takes into consideration the special needs of members with disabilities or limited English proficiency. – Include taglines in conspicuously visible font size and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service number, and availability of materials in alternative formats. *42 CFR 438.10(d)(2-3) and (d)(6)* CHP+ Contract Amendment 2: Exhibit B2—7.2.7.3.1 and 7.2.7.5-7
Findings
DHMP's formulary list had most of the requirements of a tagline in the document; however, the tagline was not in a conspicuously visible font size.
Required Actions
DHMP must revise the tagline in the formulary list to be in a conspicuously visible font size.
Planned Interventions

Standard V—Member Information Requirements
Person(s)/Committee(s) Responsible
Training Required
Monitoring and Follow-Up Activities Planned
Documents to Be Submitted as Evidence of Completion
HSAG Initial Review:
Documents Included in Final Submission: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***
Date of Final Evidence:

Standard V—Member Information Requirements
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
13. The Contractor makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, pharmacies, and behavioral health providers, and LTSS providers (as applicable): • The provider's name and group affiliation, street address(es), telephone number(s), website URL, specialty (as appropriate), whether the providers will accept new members. • The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training. • Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment. *Note: Information included in a paper provider directory must be updated at least monthly and quarterly for a mobile enabled or electronic directory. Electronic provider directories must be updated no later than 30 calendar days after the Contractor receives updated provider information.* *42 CFR 438.10(h)(1-3)* CHP+ Contract Amendment 2: Exhibit B2—7.3.8.1.7-8
Findings
DHMP's provider directory was available in electronic and paper form and included most requirements. The provider directory located on the website did not include the following components: • Direct URL to the provider's website where applicable • Whether the provider completed cultural competency training • Whether the provider has accommodations for people with disabilities Although, DHMP submitted samples of how to find the URL, it required multiple steps that would be difficult for the member to locate.
Required Actions
DHMP must make corrections to the provider directory to include: a direct URL to the provider website; whether the provider completed cultural competency training; and whether the provider has accommodations for people with disabilities.

Standard V—Member Information Requirements
Planned Interventions
Person(s)/Committee(s) Responsible
Training Required
Monitoring and Follow-Up Activities Planned
Documents to Be Submitted as Evidence of Completion
HSAG Initial Review:
Documents Included in Final Submission: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***
Date of Final Evidence:

Standard VII—Provider Selection and Program Integrity
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
7. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (owning 5 percent or more of the Contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549. *42 CFR 438.610* CHP+ Contract Amendment 2: Exhibit B2—15.9.4.2
Findings
DHMP did not include "suspended" in its policy or provider manual as a reason for not working with an entity.
Required Actions
DHMP must include "suspended" in its policy and provider manual.
Planned Interventions
Person(s)/Committee(s) Responsible
Training Required

Standard VII—Provider Selection and Program Integrity
Monitoring and Follow-Up Activities Planned
Documents to Be Submitted as Evidence of Completion
HSAG Initial Review:
Documents Included in Final Submission: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***
Date of Final Evidence:

Standard IX—Subcontractual Relationships and Delegation
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
2. All contracts or written arrangements between the Contractor and any subcontractor specify— • The delegated activities or obligations and related reporting responsibilities. • That the subcontractor agrees to perform the delegated activities and reporting responsibilities. • Provision for revocation of the delegation of activities or obligations or specify other remedies in instances where the Contractor determines that the subcontractor has not performed satisfactorily. *Note: Subcontractor requirements do not apply to network provider agreements. In addition, wholly-owned subsidiaries of the health plan are not considered subcontractors.* *42 CFR 438.230(b)(2) and (c)(1)* CHP+ Contract Amendment 2: Exhibit B2—2.5.4.4
Findings
DHMP's contract with Certified Languages International did not include language that specified a provision for revocation of the delegation of activities or obligations or specify other remedies in instances where DHMP determines that the subcontractor has not performed satisfactorily.
Required Actions
DHMP must ensure, via revisions or amendments, that the subcontractor agreements include the required language.
Planned Interventions

Standard IX—Subcontractual Relationships and Delegation
Person(s)/Committee(s) Responsible
Training Required
Monitoring and Follow-Up Activities Planned
Documents to Be Submitted as Evidence of Completion
HSAG Initial Review:
Documents Included in Final Submission: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***
Date of Final Evidence:

Standard IX—Subcontractual Relationships and Delegation
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
3. The Contractor's written agreement with any subcontractor includes: • The subcontractor's agreement to comply with all applicable CHP+ laws, regulations, including applicable subregulatory guidance and contract provisions. *42 CFR 438.230(c)(2)* CHP+ Contract Amendment 2: Exhibit B2—2.5.4.6
Findings
DHMP's contract with Clarity Software Solutions, Inc., did not include language that the subcontractor's agreement must comply with all applicable CHP+ laws and regulations, including applicable subregulatory guidance and contract provisions.
Required Actions
DHMP must ensure, via revisions or amendments, that the subcontractor agreements include the required language.
Planned Interventions
Person(s)/Committee(s) Responsible

Standard IX—Subcontractual Relationships and Delegation
Training Required
Monitoring and Follow-Up Activities Planned
Documents to Be Submitted as Evidence of Completion
HSAG Initial Review:
Documents Included in Final Submission: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***
Date of Final Evidence:

Standard IX—Subcontractual Relationships and Delegation
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
4. The written agreement with the subcontractor includes: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State. – The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems related to members. – The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. – If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. *42 CFR 438.230(c)(3)* CHP+ Contract Amendment 2: Exhibit B2—15.10.11
Findings
HSAG reviewed a sample of contracts across the delegated activities and found that the written agreements did not include all required information.
Required Actions
DHMP must ensure, via revisions or amendments, that subcontractor agreements include: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State. – The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems related to members. – The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

Standard IX—Subcontractual Relationships and Delegation
– If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.
Planned Interventions
Person(s)/Committee(s) Responsible
Training Required
Monitoring and Follow-Up Activities Planned
Documents to Be Submitted as Evidence of Completion
HSAG Initial Review:
Documents Included in Final Submission: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***

Standard IX—Subcontractual Relationships and Delegation
Date of Final Evidence:

Appendix D. Compliance Monitoring Review Protocol Activities

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

Table D-1—Compliance Monitoring Review Activities Performed

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

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct the Review**
	• During the review, HSAG met with groups of the MCE's key staff members to obtain a complete picture of the MCE's compliance with federal healthcare regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the MCE's performance. • HSAG requested, collected, and reviewed additional documents as needed. • At the close of the review, HSAG provided MCE staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2023–2024 Department-approved Compliance Review Report template to compile the findings and incorporate information from the pre-review and review activities. • HSAG analyzed the findings and calculated final scores based on Department-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the Department**
	• HSAG populated the Department-approved report template. • HSAG submitted the draft Compliance Review Report to the MCE and the Department for review and comment. • HSAG incorporated the MCE and Department comments, as applicable, and finalized the report. • HSAG included a pre-populated CAP template in the final report for all elements determined to be out of compliance with managed care regulations. • HSAG distributed the final report to the MCE and the Department.