COLORADO

Department of Health Care Policy & Financing

# Fiscal Year 2023–2024 Compliance Review Report

*for*

# Denver Health Medical Plan

*Region 5 Managed Care Organization*

*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 member information requirements compared with the prior review. However, for all other standards reviewed, 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 Standards**

| Standard | # of Elements | # of Applicable Elements | # Met | # Partially Met | # Not Met | # Not Applicable | Score* (% of Met Elements) |
|---|---|---|---|---|---|---|---|
| V. Member Information Requirements | 18 | 18 | 15 | 3 | 0 | 0 | 83%^ |
| VII. Provider Selection and Program Integrity | 16 | 16 | 15 | 1 | 0 | 0 | 94%v |
| IX. Subcontractual Relationships and Delegation | 4 | 4 | 1 | 3 | 0 | 0 | 25%v |
| X. Quality Assessment and Performance Improvement (QAPI)** | 16 | 16 | 16 | 0 | 0 | 0 | 100%^ |
| **Totals** | **54** | **54** | **47** | **7** | **0** | **0** | **87%** |

*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 in the member material must be comprised of conspicuously visible font size and prevalent non-English languages, describe how to request auxiliary aids and services, include written translation or oral interpretation and the toll-free and TTY/TDY customer service number, and have available materials in alternative formats. Most of DHMP's documents included the components of the tagline requirement. However, the formulary drug list and welcome letter's taglines were not in a conspicuously visible font size. DHMP must revise the taglines in the formulary drug list and the welcome letter to be in a conspicuously visible font size. Likewise, during the compliance monitoring review in FY 2021–2022, HSAG reviewed the taglines in multiple documents submitted as evidence by DHMP. HSAG found the formulary drug list and the welcome letter were included in a corrective action plan (CAP) for the incorrect taglines, which resulted in revisions to the documents. HSAG and the Department of Healthcare Policy & Financing (the Department) approved the revised documents during the CAP process. However, the documents submitted for FY 2023–2024 did not include the same tagline format or revisions.

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 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

In accordance with its authority under Colorado Revised Statute 25.5-1-101 et seq., the Department executed a contract with DHMP, effective January 1, 2020, to serve as a managed care capitation initiative within the Accountable Care Collaborative (ACC) program. DHMP provides the managed care capitation initiative physical health (PH) benefits and the capitated behavioral health (BH) benefits for the Region 5 Medicaid population enrolled with DHMP. Per the Code of Federal Regulations, Title 42 (42 CFR)—federal Medicaid managed care regulations published May 6, 2016—DHMP qualifies as a managed care organization (MCO). 42 CFR requires Primary Care Case Management (PCCM) entities, Prepaid Inpatient Health Plans (PIHPs), and MCOs to comply with specified provisions of 42 CFR §438—managed care regulations—and requires that states conduct a periodic evaluation of their managed care entities (MCEs), including PCCM entities, PIHPs, and MCOs, to determine compliance with Medicaid managed care regulations published May 6, 2016. Additional revisions were released in December 2020 and February 2023. The Department has elected to complete this requirement for the MCOs by contracting with an external quality review organization (EQRO), HSAG.

In order to evaluate the DHMP's 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, MCO, and Department personnel who participated in some way in the compliance review process. Appendix C describes the CAP process that the 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: Oct 4, 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 MCO's contract requirements and regulations specified by the federal Medicaid managed care regulations published May 6, 2016. Additional revisions were released in December 2020 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 MCO personnel to determine compliance with applicable federal managed care regulations and contract requirements. Documents consisted of policies and procedures, staff training materials, reports, committee meeting minutes, and member and provider informational materials.

The compliance review processes were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Appendix 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; Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT); and Standard XII—Enrollment and Disenrollment.

## Objective of the Compliance Review

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

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

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

## FY 2022–2023 Corrective Action Methodology

As a follow-up to the FY 2022–2023 compliance review, each MCO that received one or more *Partially Met* or *Not Met* scores was required to submit a CAP to the Department addressing those requirements found not to be fully compliant. If applicable, the MCO was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the MCO and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with DHMP until it completed each of the required actions from the FY 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 revise new requests to indicate the date that the determination was made, or for a concurrent review, the date that the concurrent authorization expires. For the first nonauthorized day, clarify that they may receive a full copy of their record at no cost, upon request, 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:

- Make changes to its Medicaid member handbook to include behavioral health appointment timeliness standards and its 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:

- Ensure that timely written acknowledgement letters for appeals are sent.
- Modify 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.

- Update its Medicaid appeal acknowledgement and resolution templates to state that both the State fair hearing and continuation of benefits must be requested within 10 days of receipt of the appeal resolution letter not in the member's favor.
- Update the "Continuation of Benefits" section of its Medicaid website and the "Effectuation of Appeal Resolutions" section of the provider manual to state that DHMP will 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 if the services were not furnished while the appeal was pending.
- Revise its provider manual to accurately state the following information:
  - On page 40, update the language to correctly reflect the accurate time frame of a decision on an expedited appeal.
  - On page 42, update the language to say time frame to file a State fair hearing is 120 days from date of the adverse *appeal* resolution not the *notice of adverse determination* letter.
  - Reword the first bullet on page 43 to accurately state the time frames of an appeal request and continuation of benefits request.
  - Clarify that the end of the service authorization expiration only impacts the continuation of benefits when requesting an appeal but not during a State fair hearing.

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 MCO provides all required member information to members in a manner and format that may be easily understood and is readily accessible by members.<br>• The MCO ensures that all member materials (for large-scale member communications) have been member tested.<br>*Note: Readily accessible means electronic information which complies with Section 508 guidelines, Section 504 of the Rehabilitation Act, and World Wide Web Consortium's Web Content Accessibility Guidelines 2.0 Level AA and successor versions.*<br>*42 CFR 438.10(c)(1)*<br>DHMP Contract: Exhibit B-8—7.2.5 and 7.2.7.9 | • Creation Review and Readability of Member Materials Policy<br>• Cultural and Linguistic Appropriate Services Policy- Pg. 2<br>• Member Testing on Member Materials DOP | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>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:**<br>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 MCO has in place a mechanism to help members understand the requirements and benefits of the plan.<br>*42 CFR 438.10(c)(7)*<br>DHMP Contract: Exhibit B-8—7.3.8.1 | • MCD website screenshots<br>• Medicaid Member Handbook<br>• Medicaid QRG | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ 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 MCO uses the following as developed by the State, when applicable and when available:<br>• Definitions for managed care terminology, including: appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, participating provider, physician services, plan, preauthorization, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care.<br>• Model member handbooks and member notices.<br>*42 CFR 438.10(c)(4)*<br>DHMP Contract: Exhibit B-8—3.6 | • Medicaid Member Handbook<br>• Handbook Definitions | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 4. The MCO makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost.<br>• 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. | • Creation Review and Readability of Member Materials Policy- Pg.3 (A.1.b)<br>• Notice of NonDiscrimination and Foreign Language Taglines Policy- Pg. 2<br>• Attachment 1 Notice of non discrimination<br>• Attachment 2- Multi Language Insert | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard V—Member Information Requirements | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| • All written materials for members must:<br>– Use easily understood language and format.<br>– Use a font size no smaller than 12-point.<br>– Be available in alternative formats and through provision of auxiliary aids and service that take into consideration the special needs of members with disabilities or limited English proficiency.<br>– 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/TDD customer service numbers and availability of materials in alternative formats.<br>– Be member tested.<br><br>*42 CFR 438.10(d)(2-3) and (d)(6)*<br><br>DHMP Contract: Exhibit B-8—7.2.2, 7.2.7.3–9, and 7.3.13.3 | • Attachment 3 Medicaid.CHP Taglines 2022_SPA | |
| **Findings:**<br>The DHMP formulary drug list and welcome letter had most of the requirements of a tagline in the documents; however, the taglines were not in a conspicuously visible font size. | | |
| **Required Actions:**<br>DHMP must revise the taglines in the formulary drug list and the welcome letter to be in a conspicuously visible font size. | | |

| Standard V—Member Information Requirements | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 5. *If the MCO makes information available electronically:* Information provided electronically must meet the following requirements:<br>• The format is readily accessible (see definition of "readily accessible" above).<br>• The information is placed in a website location that is prominent and readily accessible.<br>• The information can be electronically retained and printed.<br>• The information complies with content and language requirements.<br>• The member is informed that the information is available in paper form without charge upon request and is provided within five business days.<br>• Provide a link to the Department's website on the MCO's website for standardized information such as member rights and handbooks.<br>*42 CFR 438.10(c)(6)*<br>DHMP Contract: Exhibit B-8—7.3.9.3 and 7.3.14.1 | • MCD website screenshots<br>• Medicaid Member Handbook- Pg. 5<br>• Notice of NonDiscrimination and Foreign Language Taglines Policy- taglines are included on all Medicaid documents on the website and include language on requesting a free physical copy<br>• Attachment 3 Medicaid.CHP Taglines 2022_SPA | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 6. The MCO makes available to members in electronic or paper form information about its formulary:<br>• Which medications are covered (both generic and name brand).<br>• What tier each medication is on.<br>• Formulary drug list must be available on the MCO's website in a machine-readable file and format.<br>*42 CFR 438.10(h)(4)(i)* | • Medicaid.CHP Formulary<br>• Website.Formulary | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard V—Member Information Requirements | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| DHMP Contract: Exhibit B-8—7.3.8.1.12 and 13.2.1.6.3.1.1-2 | | |
| 7. The MCO makes interpretation services (for all non-English languages) and use of auxiliary aids such as TTY/TDD and American Sign Language available free of charge, notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and informs about how to access those services.<br>*42 CFR 438.10 (d)(4) and (d)(5)*<br>DHMP Contract: Exhibit B-8—7.2.6.2–4 | • Cultural and Linguistic Appropriate Services Policy- Pg. 4-5<br>• Creation Review and Readability of Member Materials Policy- Pg. 3, 4 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 8. The MCO ensures that:<br>• Language assistance is provided at all points of contact, in a timely manner and during all hours of operation.<br>• Customer service telephone functions easily access interpreter or bilingual services.<br>DHMP Contract: Exhibit B-8—7.2.6.1 and 7.2.6.4 | • Interpreter and Translation Services Policy- Pg. 3-4<br>• HPS-26 Member Language Line-Workflow to use interpretation service for Health Plan Service (call center)<br>• UM Access to Staff- Pg. 2 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 9. The MCO provides each member with a member handbook within a reasonable time after receiving notification of the member's enrollment.<br>*42 CFR 438.10(g)(1)*<br>DHMP Contract: Exhibit B-8—7.3.8.1 | • MCD.new member enrollment example | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard V—Member Information Requirements | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 10. The MCO gives members written notice of any significant change (as defined by the State) in the information required at 438.10(g) at least 30 days before the intended effective date of the change.<br>*42 CFR 438.10(g)(4)*<br>DHMP Contract: Exhibit B-8—7.3.8.3 | • Member Handbook Content Requirements Policy- Pg. 7<br>• Medicaid Member Handbook- Pg. 13 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 11. For any MCO member handbook or supplement to the member handbook provided to members, the MCO ensures that information is consistent with federal requirements in 42 CFR 438.10(g).<br>• The MCO ensures that its member handbook or supplement includes a link to the online Health First Colorado member handbook.<br>*42 CFR 438.10*<br>DHMP Contract: Exhibit B-8—7.3.8.1 | • Medicaid Member Handbook- Pg. 54 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 12. The MCO makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice or 30 days prior to the effective date of the termination, whichever is later, to each member who received their primary care from, or was seen on a regular basis by, the terminated provider.<br>*42 CFR 438.10(f)(1)*<br>DHMP Contract: Exhibit B-8—7.3.10.1 | • Provider Terminations Policy- Pg. 1 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard V—Member Information Requirements | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 13. The MCO shall develop and maintain a customized and comprehensive website that includes:<br>• The MCO's contact information.<br>• Member rights and handbooks.<br>• Grievance and appeal procedures and rights.<br>• General functions of the MCO.<br>• Trainings.<br>• Provider directory.<br>• Access to care standards.<br>• Health First Colorado Nurse Advice Line.<br>• Colorado Crisis Services information.<br>• A link to the Department's website for standardized information such as member rights and handbooks.<br><br>DHMP Contract: Exhibit B-8—7.3.9 | • MCD website screenshots | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 14. The MCO makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, pharmacies, (and for DHMP, behavioral health providers):<br>• The provider's name and group affiliation, street address(es), telephone number(s), website URL, specialty (as appropriate), and whether the provider will accept new members.<br>• The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office. | • Required Provider Directory Information Policy- Pg. 2<br>• Provider Directory Screenshots<br>• BH Provider Directory<br>• Denver Health Clinic Accessibility Accommodations | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard V—Member Information Requirements | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| • Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment.<br><br>*Note: Information included in a paper provider directory must be updated at least monthly if the MCO does not have a mobile-enabled, electronic directory; or quarterly if the MCO has a mobile-enabled, electronic provider directory; and electronic provider directories must be updated no later than 30 calendar days after the contractor receives updated provider information.*<br><br>*42 CFR 438.10(h)(1-3)*<br><br>DHMP Contract: Exhibit B-8—7.3.9.2.6 | | |
| **Findings:**<br>The provider directory is available in electronic and paper form, both of which included most requirements. The provider directory located on the website did not include the following components:<br>• Direct URL to the provider website, where applicable<br>• Whether the provider completed cultural competency training<br>• Whether the provider has accommodations for people with disabilities<br><br>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. | | |
| **Required Actions:**<br>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 V—Member Information Requirements | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 15. Provider directories are made available on the MCO's website in a machine-readable file and format.<br>*42 CFR 438.10(h)(4)*<br><br>DHMP Contract: Exhibit B-8—7.3.9.2.9 | • Usability Testing for Web-Based Physician and Hospital Directories Policy<br>• Required Provider Directory Information Policy- Pg. 4<br>• Provider Directory Machine Readable | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 16. The MCO shall develop electronic and written materials for distribution to newly enrolled and existing members that include all of the following:<br>• The MCO's single toll-free customer service phone number.<br>• The MCO's email address.<br>• The MCO's website address.<br>• State relay information.<br>• The basic features of the MCO's managed care functions as a primary care case management (PCCM) entity and prepaid inpatient health plan (PIHP).<br>• The service area covered by the MCO.<br>• Medicaid benefits, including State Plan benefits and those in the limited managed care capitation initiative.<br>– And for DHMP those in the Capitated Behavioral Health Benefit.<br>• Any restrictions on the member's freedom of choice among network providers.<br>• The requirement for the MCO to provide adequate access to behavioral health services included in the Capitated Behavioral Health Benefit, including the network adequacy standards (*DHMP only*). | • Medicaid QRG<br>• Medicaid Member Handbook<br>• MCD website screenshots<br>• Member Handbook Content Requirements Policy | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard V—Member Information Requirements | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| • The MCO's responsibilities for coordination of member care.<br>• Information about where and how to obtain counseling and referral services that the MCO does not cover because of moral or religious objections.<br>• To the extent possible, quality and performance indicators for the MCO, including member satisfaction.<br><br>DHMP Contract: Exhibit B-8—7.3.6.1 | | |
| 17. The MCO provides member information by either:<br>• Mailing a printed copy of the information to the member's mailing address.<br>• Providing the information by email after obtaining the member's agreement to receive the information by email.<br>• Posting the information on the website of the MCO and advising the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost.<br>• Providing the information by any other method that can reasonably be expected to result in the member receiving that information.<br>*42 CFR 438.10(g)(3)*<br><br>DHMP Contract: Exhibit B-8—None | • Medicaid QRG<br>• Medicaid Welcome Letter 2023 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard V—Member Information Requirements | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 18. The MCO must make available to members, upon request, any physician incentive plans in place.<br>*42 CFR 438.10(f)(3)*<br><br>DHMP Contract: Exhibit B-8—None | • Member Handbook Content Requirements Policy- Pg. 6<br>• Medicaid Member Handbook- Pg. 18 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Results for Standard V—Member Information Requirements | | | | | | |
|---|---|---|---|---|---|---|
| **Total** | Met | = | 15 | X | 1.00 | = 15 |
| | Partially Met | = | 3 | X | .00 | = 3 |
| | Not Met | = | 0 | X | .00 | = 0 |
| | Not Applicable | = | 0 | X | NA | = NA |
| **Total Applicable** | | = | 18 | **Total Score** | | = 15 |
| | | | | | | |
| | | | | **Total Score ÷ Total Applicable** | | = 83% |

| 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.<br>*42 CFR 438.214(a)*<br><br>DHMP Contract: Exhibit B-8—9.1.8 | • Provider Selection and Retention Policy | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 2. The Contractor follows a documented process for credentialing and recredentialing providers that complies with the standards of the National Committee for Quality Assurance (NCQA).<br>• The Contractor ensures that all laboratory testing sites providing services under this contract have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration.<br>*42 CFR 438.214(b)*<br><br>DHMP Contract: Exhibit B-8—9.2.1, 9.2.2, 9.2.7, and 9.3.6 | • Credentialing and Recredentialing of Practitioners Policy- Pg. 1 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 3. The Contractor's provider selection policies and procedures include provisions that the Contractor does not:<br>• 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.<br>• Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. | • Provider Selection and Retention Policy- Pg. 2 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VII—Provider Selection and Program Integrity | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| *42 CFR 438.12(a)(1) and (2)*<br>*42 CFR 438.214(c)*<br><br>DHMP Contract: Exhibit B-8—9.1.8.1 and 9.1.8.2 | | |
| 4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.<br>This is not construed to:<br>• Require the Contractor to contract with providers beyond the number necessary to meet the needs of its members.<br>• Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.<br>• 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.<br>*42 CFR 438.12(a-b)*<br><br>DHMP Contract: Exhibit B-8—9.1.8.4, 9.1.11, 13.4.11, and 14.4.10 | • Provider Selection and Retention Policy- Pg. 3 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 5. The Contractor has a signed contract or participation agreement with each provider.<br>*42 CFR 438.206(b)(1)*<br><br>DHMP Contract: Exhibit B-8—9.1.16 | • Denver Health Contract<br>• STRIDE Contract<br>• UCHealth Contract | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VII—Provider Selection and Program Integrity | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 6. The Contractor does not employ or contract with providers or other individuals or entities excluded for participation in federal health care programs under either Section 1128 or 1128 A of the Social Security Act.<br>• The Contractor performs monthly monitoring against HHS_OIG's List of Excluded Individuals.<br><br>*(This requirement also requires a policy.)*<br><br>*42 CFR 438.214(d)*<br>*42 CFR 438.610*<br><br>DHMP Contract: Exhibit B-8—9.1.18 and 17.9.4.2.5 | • Sanction Screening of Individuals and Entities P&P- Pg. 2 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 7. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549.<br><br>*42 CFR 438.610*<br><br>DHMP Contract: Exhibit B-8—17.9.4.2.1-4 | • Sanction Screening of Individuals and Entities P&P- Pg. 2<br>• Provider Manual 2023- Pg. 7 | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ 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. | | |

| Standard VII—Provider Selection and Program Integrity | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 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:<br>• The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered.<br>• Any information the member needs in order to decide among all relevant treatment options.<br>• The risks, benefits, and consequences of treatment or non-treatment.<br>• The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.<br>*42 CFR 438.102(a)(1)*<br>DHMP Contract: Exhibit B-8—14.7.3 | • Provider Manual 2023- Pg. 7 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 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:<br>• To the State upon contracting or when adopting the policy during the term of the contract.<br>• To members before and during enrollment.<br>• To members 30 days prior to adopting the policy with respect to any particular service. | • Provider Manual 2023- Pg. 7<br>• Member Handbook Content Requirements Policy- Pg. 3, 8<br>• Medicaid Member Handbook- Pg. 13<br>• Religious Accommodations and Conscience Objections Relative to Provision of Care | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VII—Provider Selection and Program Integrity | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| *42 CFR 438.102(a)(2)-(b)*<br><br>DHMP Contract: Exhibit B-8—7.3.6.1.12-13 and 14.4.7 | | |
| 10. The Contractor has administrative and management arrangements or procedures, including a compliance program to detect and prevent fraud, waste, and abuse and includes:<br>• Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal, State, and contract requirements.<br>• The designation of a compliance officer who is responsible for developing and implementing policies, procedures and practices to ensure compliance with requirements of the contract and reports directly to the Chief Executive Officer and Board of Directors.<br>• 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.<br>• Training and education of the compliance officer, management, and organization's staff members for the federal and State standards and requirements under the contract.<br>• Effective lines of communication between the compliance officer and the Contractor's employees.<br>• Enforcement of standards through well-publicized disciplinary guidelines. | • Compliance Program- Pgs.1, 2, 3, 4<br>• CodeofConduct-Final_English | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VII—Provider Selection and Program Integrity | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| • Implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks.<br>• 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, correction of such problems quickly and thoroughly to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.<br>*42 CFR 438.608(a)(1)*<br>DHMP Contract: Exhibit B-8—17.1 | | |
| 11. The Contractor's administrative and management procedures to detect and prevent fraud, waste, and abuse include:<br>• 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.<br>• 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.<br>• 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).<br>*42 CFR 438.608(a)(6-8)* | • Fraud, Waste, and Abuse Policy- pg. 2,3, 6<br>• False Claims, Fraud, Waste, and Abuse Policy- Pgs. 2, 6, 7<br>• Provider Vendor Subcontractor Overpayments Policy- Pg. 3 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VII—Provider Selection and Program Integrity | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| DHMP Contract: Exhibit B-8—17.1.5.9, 17.1.6, 17.5.1, and 17.7.1<br>10 CCR 2505-10, Section 8.076 | | |
| 12. The Contractor's Compliance Program includes:<br>• Provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potential fraud.<br>• Provision for prompt notification to the State about member circumstances that may affect the member's eligibility, including change in residence and member death.<br>• 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.<br>• 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.<br>*42 CFR 438.608 (a)(2-5)*<br><br>DHMP Contract: Exhibit B-8—17.1.5.7.1-6, 17.3.1.1.2, 17.3.1.3.1.1, and 17.3.1.3.2.1 | • Provider Vendor Subcontractor Overpayments Policy- Pg. 4<br>• Verification of Services Policy<br>• Change in Circumstance Report Job Aid<br>• Monthly and Semiannual FWA notification report DOP- bullet 3, monthly reporting on change in provider circumstances | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ 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 Medicaid providers consistent with the provider disclosure screening, and enrollment requirements of the State.<br>• The Contractor may execute network provider agreements pending the outcome of the State's screening and enrollment process of up to one-hundred and twenty days (120) days, but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one one-hundred and twenty days (120)-day period without enrollment of the provider, and notify affected members.<br>*42 CFR 438.608(b)*<br>DHMP Contract: Exhibit B-8—9.2.8.1, 9.3.2, and 17.9.2 | • DHH Provider Maintenance BRD 10312023 (pg 24)<br>• Provider Selection and Retention Policy (pg 2) | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VII—Provider Selection and Program Integrity | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 14. The Contractor has procedures to provide to the State:<br>• Written disclosure of any prohibited affiliation (as defined in 438.610).<br>• Written disclosure of ownership and control (as defined in 455.104)<br>• Identification within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract.<br>*42 CFR 438.608(c)*<br>DHMP Contract: Exhibit B-8—17.3.1.5, 17.9.4.3, and 17.10.2.1 | • Mbr Paid when Mbr not Assigned to DH_DLP<br>• DH_OwnshpCntrlDis_FY23-24<br>• Excluded Provider Sanction Search- Pg. 5 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 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.<br>• The Contractor reports semi-annually to the State on recoveries of overpayments.<br>*42 CFR 438.608 (d)(2) and (3)*<br>DHMP Contract: Exhibit B-8—17.1.5.8 and 17.3.1.2.4.4 | • Provider Vendor Subcontractor Overpayments Policy- Pgs. 3, 4 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VII—Provider Selection and Program Integrity | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 16. The Contractor provides that members are not held liable for:<br>• The Contractor's debts in the event of the Contractor's insolvency.<br>• Covered services provided to the member for which the State does not pay the Contractor.<br>• 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.<br>• 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.<br>*42 CFR 438.106*<br><br>DHMP Contract: Exhibit B-8—13.12.1-2, 14.14.1-2, 17.13.2, and 17.13.5 | • DHMP Contract Requirements for DHMP Providers-Practitioners (pg 2)<br>• Provider Manual (pg 67) | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ 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.<br><br>*42 CFR 438.230(b)(1)*<br><br>DHMP Contract: Exhibit B-8—4.2.13.2 | Please see submitted contracts | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 2. All contracts or written arrangements between the Contractor and any subcontractor specify:<br>• The delegated activities or obligations and related reporting responsibilities.<br>• That the subcontractor agrees to perform the delegated activities and reporting responsibilities.<br>• 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.<br><br>*Note: Subcontractor requirements do not apply to network provider agreements. In addition, wholly owned subsidiaries of the health plan are not considered subcontractors.*<br><br>*42 CFR 438.230(b)(2) and (c)(1)*<br><br>DHMP Contract: Exhibit B-8—4.2.13.6 | Please see submitted contracts | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard IX—Subcontractual Relationships and Delegation | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| **Findings:** DHMP's contract with Clarity Software Solutions, Inc., and 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:<br>• The subcontractor's agreement to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions.<br>*42 CFR 438.230(c)(2)*<br><br>DHMP Contract: Exhibit B-8—4.2.13.6 | Please see submitted contracts | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ 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 Medicaid 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:<br>• 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.<br>– 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. | Please see submitted contracts | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard IX—Subcontractual Relationships and Delegation | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| – 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.<br>– 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.<br>*42 CFR 438.230(c)(3)*<br>DHMP Contract: Exhibit B-8—4.2.13.6 | | |
| **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:<br>• 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.<br>– 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.<br>– 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.<br>– 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.<br><br>*42 CFR 438.330(a)(1)*<br><br>DHMP Contract: Exhibit B-8—16.1.1 | • 2022-2023 MCD CHP+ QI Prog Description, p. 16-18<br>• 2022-2023 MCD CHP+ Evaluation p. 4,6-8<br>• 2023-2024 QI Work Plan<br>• QMC Minutes 9.28.23 p.1-2 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 2. The Contractor's QAPI Program includes conducting and submitting (to the State) annually performance improvement projects (PIPs) that focus on both clinical and nonclinical areas. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. Each PIP includes the following:<br>• Measurement of performance using objective quality indicators.<br>• Implementation of interventions to achieve improvement in the access to and quality of care.<br>• Evaluation of the effectiveness of the interventions based on the objective quality indicators.<br>• Planning and initiation of activities for increasing or sustaining improvement.<br><br>*For DHMP, two PIPs are required, one administrative and one clinical.*<br><br>*42 CFR 438.330(b)(1) and (d)(2) and (3)*<br><br>DHMP Contract: Exhibit B-8—16.2.1.1, 16.3.5, and 16.3.8 | • CO2020-21_MCO_PIP-Val_Module 4_Submission Form_F1_V6-2_DepressionScreening-Follow-up_Medicaid<br>• 2023-2024 QI Work Plan- Line 40<br>• 2022-2023 MCD CHP+ Evaluation p.14-15 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ 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):<br>• Annual performance measure data using standard measures identified by the State.<br>• Data, specified by the State, which enables the State to calculate the Contractor's performance using the standard measures identified by the State.<br>• A combination of the above activities.<br>*42 CFR 438.330(b)(2) and (c)*<br>DHMP Contract: Exhibit B-8—16.4.1 and 16.4.4 | • QMC Minutes 9.28.2023 p. 2-5<br>• MY2022 MCD State Measure Performance | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 4. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services.<br>*42 CFR 438.330(b)(3)*<br>DHMP Contract: Exhibit B-8—16.6.1 | • 2022-2023 QI MCD CHP+ Evaluation p.7, 30<br>• 2023-2024 QI Work Plan- Line 27<br>• MMC Minutes 10.24.2023 p.4-5<br>• Over-Under Utilization QMC p.7, 12, 23 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ 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.<br>*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* | • 2022-2023 QI MCD CHP+ Prog Description p. 24<br>• 2022-2023 QI Evaluation p. 46-52<br>• 2023-2024 QI Work Plan- Line 25<br>• MMC Minutes 10.24.23 p.5<br>• QMC Minutes 7.11.23 p.5-6 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ 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** |
| *minimize limitation of function or activities; 3) for children: significant limitation in social growth or developmental function; need for psychological, educational, medical, or related services over and above the usual for the child's age; or special ongoing treatments such as medications, special diets, interventions, or accommodations at home or at school.*<br>*42 CFR 438.330(b)(4)*<br><br>DHMP Contract 1: Exhibit B-8—16.2.1.4 and 16.5.5<br>10 CCR 2505-10, Section 8.205.9 | | |
| 6. The Contractor monitors member perceptions of accessibility and adequacy of services provided. Tools shall include, at a minimum:<br>• Member surveys.<br>• Anecdotal information.<br>• Grievance and appeals data.<br>• Call center data.<br>• Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[A-1] surveys.<br><br>DHMP Contract: Exhibit B-8—16.5.1-3 and 16.5.8 | • 2022-2023 QI MCD CHP Program Description p. 32-33<br>• 2023-2024 QI Work Plan- Row 6, 63<br>• QMC Minutes 7.11.23, p.2-3, 5<br>• 2023 QMC 11.14.2023 Deck- pgs. 16, 22, 25-27, 62 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ 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** |
| 7. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis.<br><br>*42 CFR 438.330(e)(2)*<br><br>DHMP Contract 1: Exhibit B-8—16.2.5 | • 2022-2023 MCD_CHP+ Evaluation p. 5<br>• 2022-2023 QI Program Description, p.34<br>• 2023-2024 QI Work Plan | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 8. The Contractor adopts practice guidelines that meet the following requirements:<br>• Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.<br>• Consider the needs of the Contractor's members.<br>• Are adopted in consultation with contracted health care professionals.<br>• Are reviewed and updated periodically as appropriate.<br><br>*42 CFR 438.236(b)*<br><br>DHMP Contract: Exhibit B-8—13.6.9.1-3 and 14.8.9.1-3 | • QI Website Guidelines<br>• Clinical Guidelines Folder | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 9. The Contractor disseminates the guidelines to all affected providers, and upon request, to members and potential members.<br><br>*42 CFR 438.236(c)*<br><br>DHMP Contract: Exhibit B-8—13.6.9 and 14.8.9 | • QI Website Guidelines<br>• Clinical Guidelines Folder<br>• Clinical Practice Guidelines Provider Newsletter | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ 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** |
| 10. 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.<br>*42 CFR 438.236(d)*<br>DHMP Contract: Exhibit B-8—13.6.13 | • QI Website Guidelines<br>• Clinical Guidelines Folder | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 11. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data.<br>*42 CFR 438.242(a)*<br>DHMP Contract: Exhibit B-8—15.1.1 | • DHMP DW Technical Architecture - V5.PDF<br>• Highlevel DHMP Foot Print V3.PDF<br>• DHH QNXT 6.0 - TMS - EDM - HOC 3 - Logical Diagrams_V3.3<br>• AltruistaHealth-DHHA-ETL-Process-1510 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 12. The Contractor's health information system provides information on areas including, but not limited to, utilization, encounters, claims, grievances and appeals, and disenrollment (for reasons other than loss of Medicaid eligibility).<br>*42 CFR 438.242(a)*<br>DHMP Contract: Exhibit B-8—8.1.3 and 15.1.1 | • qnxt-core-admin-ebook.pdf<br>• QNXT600-Product Overview<br>• Information System-Summary<br>• HealthEdge GuidingCare - utilization-management-appeals-and-grievances | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ 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** |
| 13. 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.<br>• Contractor electronically submits encounter claims data in the interchange ANSI X12N 837 format directly to the Department's fiscal agent using the Department's data transfer protocol. The 837-format encounter claims (reflecting claims paid, adjusted, and/or denied by the Contractor) shall be submitted via a regular batch process.<br>*42 CFR 438.242(b)(1)*<br>DHMP Contract: Exhibit B-8—15.2.4.1 and 15.2.4.3 | • Information System-Summary.asd<br>• EDMC600 - ProductOverview<br>• QNXT600-Product Overview<br>• Encounter_Submission_ExampleWithMemberProviderDetails | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 14. 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).<br>*42 CFR 438.242(b)(2)*<br>DHMP Contract: Exhibit B-8—15.2.2 and 15.2.3 | • Encounter_Submission_ExamplewithMemberProviderDetails<br>• EDMC600 - ProductOverview<br>• Highlevel DHMP Foot Print V3.PDF | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 15. The Contractor ensures that data received from providers are accurate and complete by:<br>• Verifying the accuracy and timeliness of reported data, including data from network providers compensated through capitation payments. | • Information System-Summary.asd | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ 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** |
| • Screening the data for completeness, logic, and consistency.<br>• Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for Medicaid quality improvement and care coordination efforts.<br>• Making all collected data available to the State and upon request to CMS.<br><br>*42 CFR 438.242(b)(3) and (4)*<br><br>DHMP Contract: Exhibit B-8—15.2.4.1 and 15.2.4.6 | | |
| 16. The Contractor:<br>• Collects and maintains sufficient member encounter data to identify the provider who delivers any items or services to members.<br>• Submits member encounter data to the State in standardized ASC X12N 837 formats as appropriate.<br>• Submits member encounter data to the State at the level of detail and frequency specified by the State (within 120 days of an adjudicated provider claim).<br><br>*42 CFR 438.242(c)*<br><br>DHMP Contract: Exhibit B-8—15.2.2.1-2, 15.2.4.3, and 15.2.4.7 | • EDMC600 - ProductOverview<br>• Highlevel DHMP Foot Print V3.PDF | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Results for Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Total** | Met | = | 16 | X | 1.00 | = | 16 |
| | Partially Met | = | 0 | X | .00 | = | 0 |
| | Not Met | = | 0 | X | .00 | = | 0 |
| | Not Applicable | = | 0 | X | NA | = | NA |
| **Total Applicable** | | = | 16 | **Total Score** | | = | 16 |
| | | | | | | | |
| | | | | **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.<br>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:<br>• Review and approve the planned interventions and instruct the MCE to proceed with implementation, or<br>• 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.<br>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.<br>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.<br>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.<br>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<br>☐ Plan(s) of Action on Track for Completion<br>☐ Plan(s) of Action Not on Track for Completion |
| **Requirement** |
| 1. The MCO provides all required member information to members in a manner and format that may be easily understood and is readily accessible by members.<br>• The MCO ensures that all member materials (for large-scale member communications) have been member tested.<br><br>*Note: Readily accessible means electronic information which complies with Section 508 guidelines, Section 504 of the Rehabilitation Act, and World Wide Web Consortium's Web Content Accessibility Guidelines 2.0 Level AA and successor versions.*<br><br>*42 CFR 438.10(c)(1)*<br><br>DHMP Contract: Exhibit B-8—7.2.5 and 7.2.7.9 |
| **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** |
| |

| 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<br>☐ Plan(s) of Action on Track for Completion<br>☐ Plan(s) of Action Not on Track for Completion |
| **Requirement** |
| 4. The MCO makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost.<br>• 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.<br>• All written materials for members must:<br>– Use easily understood language and format.<br>– Use a font size no smaller than 12-point.<br>– Be available in alternative formats and through provision of auxiliary aids and service that take into consideration the special needs of members with disabilities or limited English proficiency.<br>– 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/TDD customer service numbers and availability of materials in alternative formats.<br>– Be member tested.<br>*42 CFR 438.10(d)(2-3) and (d)(6)*<br>DHMP Contract: Exhibit B-8—7.2.2, 7.2.7.3–9, and 7.3.13.3 |
| **Findings** |
| The DHMP formulary drug list and welcome letter had most of the requirements of a tagline in the documents; however, the taglines were not in a conspicuously visible font size. |
| **Required Actions** |
| DHMP must revise the taglines in the formulary drug list and the welcome letter to be in a conspicuously visible font size. |

| 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 V—Member Information Requirements |
|---|
| ☐ Plan(s) of Action Complete<br>☐ Plan(s) of Action on Track for Completion<br>☐ Plan(s) of Action Not on Track for Completion |
| **Requirement** |
| 14. The MCO makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, pharmacies, (and for DHMP, behavioral health providers):<br>• The provider's name and group affiliation, street address(es), telephone number(s), website URL, specialty (as appropriate), and whether the provider will accept new members.<br>• The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office.<br>• Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment.<br><br>*Note: Information included in a paper provider directory must be updated at least monthly if the MCO does not have a mobile-enabled, electronic directory; or quarterly if the MCO has a mobile-enabled, electronic provider directory; and electronic provider directories must be updated no later than 30 calendar days after the contractor receives updated provider information.*<br><br>*42 CFR 438.10(h)(1-3)*<br><br>DHMP Contract: Exhibit B-8—7.3.9.2.6 |
| **Findings** |
| The provider directory is available in electronic and paper form, both of which included most requirements. The provider directory located on the website did not include the following components:<br>• Direct URL to the provider website, where applicable<br>• Whether the provider completed cultural competency training<br>• Whether the provider has accommodations for people with disabilities<br><br>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. |

| Standard V—Member Information Requirements |
|---|
| **Required Actions** |
| 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. |
| **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 V—Member Information Requirements |
| --- |
| **Date of Final Evidence:** |

| Standard VII—Provider Selection and Program Integrity |
|---|
| ☐ Plan(s) of Action Complete<br>☐ Plan(s) of Action on Track for Completion<br>☐ 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.<br>*42 CFR 438.610*<br>DHMP Contract: Exhibit B-8—17.9.4.2.1-4 |
| **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<br>☐ Plan(s) of Action on Track for Completion<br>☐ Plan(s) of Action Not on Track for Completion |
| **Requirement** |
| 2. All contracts or written arrangements between the Contractor and any subcontractor specify:<br>• The delegated activities or obligations and related reporting responsibilities.<br>• That the subcontractor agrees to perform the delegated activities and reporting responsibilities.<br>• 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.<br>*Note: Subcontractor requirements do not apply to network provider agreements. In addition, wholly owned subsidiaries of the health plan are not considered subcontractors.*<br>*42 CFR 438.230(b)(2) and (c)(1)*<br>DHMP Contract: Exhibit B-8—4.2.13.6 |
| **Findings** |
| DHMP's contract with Clarity Software Solutions, Inc., and 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** |
| |
| **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<br>☐ Plan(s) of Action on Track for Completion<br>☐ Plan(s) of Action Not on Track for Completion |
| **Requirement** |
| 3. The Contractor's written agreement with any subcontractor includes:<br>• The subcontractor's agreement to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions.<br>*42 CFR 438.230(c)(2)*<br>DHMP Contract: Exhibit B-8—4.2.13.6 |
| **Findings** |
| DHMP's contract with Clarity Software Solutions, Inc., did not include language that the subcontractor's agreement must comply with all applicable Medicaid 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** |
| |
| **Training Required** |
| |

| Standard IX—Subcontractual Relationships and Delegation |
| --- |
| **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<br>☐ Plan(s) of Action on Track for Completion<br>☐ Plan(s) of Action Not on Track for Completion |
| **Requirement** |
| 4. The written agreement with the subcontractor includes:<br>• 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.<br>– 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.<br>– 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.<br>– 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.<br>*42 CFR 438.230(c)(3)*<br>DHMP Contract: Exhibit B-8—4.2.13.6 |
| **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:<br>• 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.<br>– 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. |

| Standard IX—Subcontractual Relationships and Delegation |
|---|
| – 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.<br>– 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:** |

| Standard IX—Subcontractual Relationships and Delegation |
| --- |
| **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:** |

# 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:<br>• HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies.<br>• HSAG collaborated with the Department to develop desk request forms, compliance monitoring tools, report templates, agendas; and set review dates.<br>• HSAG submitted all materials to the Department for review and approval.<br>• 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.<br>• HSAG confirmed a primary MCE contact person for the review and assigned HSAG reviewers to participate in the review.<br>• 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.<br>• 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.<br>• 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.<br>• HSAG requested, collected, and reviewed additional documents as needed.<br>• 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.<br>• HSAG analyzed the findings and calculated final scores based on Department-approved scoring strategies.<br>• 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.<br>• HSAG submitted the draft Compliance Review Report to the MCE and the Department for review and comment.<br>• HSAG incorporated the MCE and Department comments, as applicable, and finalized the report.<br>• HSAG included a pre-populated CAP template in the final report for all elements determined to be out of compliance with managed care regulations.<br>• HSAG distributed the final report to the MCE and the Department. |