State of Colorado

Department of Health Care Policy & Financing

Office of Medical Assistance

Quality Improvement Section

FY2005 SITE REVIEW REPORT *for* DENVER HEALTH AND HOSPITAL AUTHORITY

March 2005

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I. History, Purpose and Origin of Medicaid Managed Care Entity Site Review

As part of the Colorado Department of Health Care Policy & Financing's (the Department's) overall effort and commitment to ensure quality of care and access to services for Medicaid members, the Department developed and implemented an annual site review process in 1999. The objective of the site review is to evaluate all managed care entities (MCEs) that contract with the Department for contractual and regulatory compliance. The Balanced Budget Act of 1997 specified additional requirements for MCEs. These requirements were incorporated into all FY03-04 MCE contracts. The Department began monitoring MCEs for the new requirements in addition to the existing requirements during the FY03-04 site review schedule.

Each site review involves the development of a monitoring tool. Development of the tool begins at the Department, where areas of contract compliance are selected and general questions are drafted. The draft tool is distributed to various areas within the Department for feedback. Once approved, the final tool is then distributed to the MCEs and a site review schedule is determined. In FY03-04, the Department adopted the Centers for Medicare & Medicaid Services (CMS) External Quality Review Monitoring Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans Protocol (Final Version 1.0, February 11, 2003) as a guideline for the site review process.

The site review process (as outlined in II.H.4.b.of the contract between the Department and the managed care entity) consists of a desk audit and a site review to the MCE. Sixty (60) days prior to the site review, the Department requests documentation from the MCE in order to determine contractual and regulatory compliance. The MCE is required to submit materials (in electronic format) within thirty (30) days after receiving the desk audit request. The materials submitted by the MCE are reviewed by the site review team to evaluate compliance with contractual and regulatory requirements. The evaluation of materials submitted during the desk audit (document review) allow for development of additional interview questions and further clarification during the interview sessions conducted on site.

Document review is an important part of determining compliance. A greater understanding of the document content can be determined by interviewing MCE personnel as part of the site review. Interviews are also an effective method in order to determine the degree of compliance with the requirements. Interviews provide clarification, by revealing the extent to which what is documented is actually implemented. Interviews also provide an opportunity to explore any issues that were not fully addressed in documents, and provide a better understanding of the MCE's performance. A broad overview of the preliminary site review findings is presented to the MCE at the conclusion of the site review.

Thirty days (30) after the site review, a Preliminary Site Review Report is sent to the MCE for their review and comment on any inaccuracies found in the initial report. The MCE has thirty (30) days to respond to the Department. Comments from the MCE are reviewed and corrections may be made to the final report. The Final Site Review Report indicates areas that require the MCE to produce a Corrective Action Plan (CAP). The CAP is developed by the MCE and submitted for approval to the Department within thirty (30) days of the final report. The CAP

shall be specific and include timeframes for completion. The Department monitors the MCE's corrective action plan objectives and timeframes.

II. Site Review Protocol

On May 1, 2004, the Department entered into a contract with Denver Health and Hospital Authority (DHHA) to serve as a Managed Care Organization. This is the first site review of DHHA. This review is designed to determine DHHA's compliance with various contractual and regulatory requirements and to review the MCE's records for evidence of case management and care coordination as well as compliance with grievance, appeals, denials, credentialing/recredentialing and encounter data. The Preliminary Site Review Report documents the results of the FY04-05 site review for DHHA. This report provides findings for DHHA regarding its performance in complying with the 16 evaluation standards, the elements of the record review and feedback acquired throughout the interview sessions for each evaluation standard.

The 16 evaluation standards are derived from the requirements as set forth in the contract agreement between the Department and DHHA, Colorado Regulations 10 CCR 2505-10, 8.000 *et seq*. and the requirements as specified by the CMS regulations. These 16 standards include: Covered Services, Access and Availability, Continuity of Care, Member Rights and Responsibilities, Grievance and Appeal, Confidentiality, Marketing, Licensure and Credentialing, Provider Issues, Advance Directives, Subcontracts, Utilization Management, Certifications and Program Integrity, Practice Guidelines, Quality Assessment and Performance Improvement and Coordination with Early Periodic Screening, Diagnosis, and Treatment (EPSDT).

III. Site Review Findings

The findings for this annual site review were determined following a desk audit of documents submitted to the Department prior to the site review, observations, interviews with key DHHA staff and record reviews conducted during the site review. The site review team assigned DHHA a finding for each element and aggregately, for each standard. Details regarding DHHA's compliance with the evaluation standards, including the findings DHHA received for each of the elements in each standard, can be found in Section V of this report.

The individual elements of each standard in the evaluation tool were rated "Met," "Partially Met," "Not Met," or "Not Applicable." A summary finding for each evaluation tool standard was then determined by adding the number of compliant elements DHHA received out of the number of applicable elements.

For the records reviewed, each record was evaluated based on the total number of DHHA's compliant elements out of the applicable elements. A finding for each set of records reviewed was determined based on the number of DHHA's compliant elements out of the applicable elements.

IV. Conclusions

DHHA received eleven (11) “Met” findings, four (4) “Partially Met” findings and one (1) Not Met finding out of sixteen total applicable evaluation standards.

Details of the findings are provided, by standard element, in Section V and summarized in the table below. Specific strengths and opportunities identified for each standard are provided within each particular section. DHHA is required to submit a CAP for any standard elements receiving a finding of *Partially Met* or *Not Met*. The corrective action plan(s) will be submitted to the Department for review and approval prior to implementation. The CAP(s) should identify the areas of noncompliance, the proposed changes to achieve compliance, the individual(s) responsible and the timeline for completion of the proposed changes.

Standard	Score
1: Covered Services	Met
2: Access and Availability	Partially Met
3: Continuity of Care	Met
4: Member Rights and Responsibilities	Partially Met
5: Grievance and Appeal	Partially Met
6: Confidentiality	Met
7: Marketing	Met
8: Licensure and Credentialing	Met
9: Provider Issues	Met
10: Advance Directives	Not Met
11: Subcontracts	Met
12: Utilization Management	Met
13: Certifications and Program Integrity	Partially Met
14: Practice Guidelines	Met
15: Quality Assessment and Performance Improvement	Met
16: Coordination with Early Periodic Screening, Diagnosis and Treatment	Met

V. Evaluation Overview

This section of the report describes the strengths and opportunities for improvement for each of the 16 standards included in the Department's FY04-05 MCE Evaluation Tool. The evaluation tool was used to conduct a site review of DHHA from March 7 - March 9, 2005.

Standard 1: Covered Services

Staff Present at Site Review:
DHHA: Daniel Lewis, Janice Tucker and Dr. Barbara Warren.

Department: Craig Gurule (Lead), Jerry Smallwood and Maureen Wallner.

Department Summary of Review:
Covered Services to members are primarily provided through DHHA providers rather than external contracted providers. A wheelchair assessment clinic, women, infants and children's (WIC) unit and vision services are available within the DHHA network. Certain clinical services such as cardiovascular surgery, transplants and pediatric subspecialty services are provided through either University of Colorado Hospital or Children's Hospital.

DHHA case management is designed to assist providers and members with coordination of care by accessing community resources, wrap-around benefits and facilitating referrals when necessary. The PCP, specialist, member or member's family can initiate care management services.

Score for this Area:
Met

Corrective Action Plan:
None

Area of Opportunity:
None

Standard 2: Access and Availability-Service Delivery

Staff Present at Site Review:
DHHA: Ron Aguilar, Daniel Lewis, Mary Pinkney, Janice Tucker, Marcia Tuell and Dr. Barbara Warren.

Department: Craig Gurule (Lead), Jerry Smallwood, Diane Stayton and Maureen Wallner.

Department Summary of Review:
DHHA currently has 85 Primary Care Physicians (PCPs) and 259 specialists within their network. These practitioners support Denver Health Medical Center, nine Family Health Centers and eleven School-Based Clinics located within Denver County. All PCP panels are open as of December 2004 based upon feedback from physician team leaders within the DHHA network. DHHA is required to monitor providers regarding scheduling and wait time availability. DHHA will continue to monitor grievances related to access to care and beginning in 2005, conduct Secret Shopper calls on provider offices.

A weekly report identifying members (based upon zip code) residing outside of DHHA's service area is created by their Information Systems Department. This information is provided to the Department's Managed Care Benefits Section for review. However, this report does not identify whether providers are located within 30 miles or 30 minutes of members as contractually required.

Medicaid eligible individuals are able to select a MCE through the Department's enrollment broker without choosing a specific PCP. DHHA is required to notify members when a member fails to elect a PCP and one is assigned by the health plan. Documentation submitted by DHHA outlining the process regarding the selection and assignment of PCPs did not include notifying the member when their PCP is assigned.

Score for this Area:
Partially Met

Corrective Action Plan: The Contractor shall submit a corrective action plan to be approved by the Department. The CAP shall include the steps and timeframes to implement the following corrective action(s):

1. Monitor providers for scheduling and wait time availability.
2. Identify members who reside 30 minutes or 30 miles beyond their nearest provider and include this information in future quarterly network adequacy report submissions.
3. Notify members who fail to select a PCP and one is assigned by DHHA.

Area of Opportunity:
None

Standard 3: Continuity of Care

Staff Present at Site Review:
DHHA: Michael Faris, Erica Gosselin, Daniel Lewis, Janice Tucker, Marcia Tuell and Dr. Barbara Warren.

Department: Craig Gurule, Jerry Smallwood and Maureen Wallner (Lead).

Department Summary of Review:
DHHA has written policies and procedures in place for continuity of care and provision of covered services. The procedures include mechanisms for identifying members who may need assistance with transition of care when there is a change in the source of medical care or health care coverage or if there is a request for assistance. The policy does not specifically discuss the coordination of care with other medical and behavioral health plans, however DHHA indicated in the interview that this coordination does occur. DHHA also provided a document onsite prior to the interview that states that coordination with physical health and behavioral health plans as well as referrals to external services for members with special health care needs are a part of their process. Written policies and procedures are in place to ensure member confidentiality is maintained.

DHHA does have a care coordination system in place, which is documented by a Care Management Tracking Log. This log tracks demographic information, provider information, diagnosis, special health care needs, inpatient days, emergency room utilization, behavioral health diagnosis and medications and interventions to reduce hospital utilization. In addition to care coordination, case management is also provided to members. Weekly Case Management meetings are held to discuss the needs, progress and outcomes of members. Meetings minutes were provided as documentation.

Newly enrolled members are screened via Welcome Calls to identify any special health care needs as well as to prevent the disruption of any current ongoing treatment. Cultural and linguistic needs are also identified during these calls. Written policies and procedures are in place for members identified has having special health care needs to allow for standing referrals to specialists and ensure that adequate network of providers is in place. Newly enrolled members are informed of their rights to continue to receive services via the Member Handbook as required in the contract.

Written policies and procedures are in place that ensure covered services for members with special health care needs will be provided in such a manner that will promote independent living and member participation in the community. Some examples of this include a Durable Medical Equipment (DME) Repair Timeliness Report and a Decision Turnaround Time Report. Both reports ensure providers as well as DHHA's utilization review department are adequately meeting the needs of DHHA members by conducting repairs and providing utilization review decisions in a timely manner. The policies and procedures also state the members with special health care needs will have access to the same preventive health care services as other members.

Written policies and procedures are in place that address how DHHA responds to requests for interpreter services. Many of the staff are bilingual and the language line is utilized if necessary. Written materials provided to members are available and provided to prevalent non-English speaking member populations as required. Currently, materials are only provided in Spanish as this is the only prevalent non-English speaking population.

Record Review Findings

Care Management and Case Management Record Review				
Case ID	Primary Clinician or Case Manager Responsible for Coordination Involved	Assessment of Special Health Care Needs	Service Plan for Special Health Care Needs	Coordination with other Service Agencies
Care Management Records				
H619355	Yes	Yes	Yes	N/A
B980258	Yes	No	No	N/A
Q437955	Yes	Yes	Yes	Yes
P479016	Yes	Yes	Yes	N/A
I26574	Yes	Yes	Yes	Yes
Case Management Records				
R912329	Yes	Yes	Yes	N/A
Y341022	Yes	Yes	Yes	N/A
V436646	Yes	Yes	No	No
Y357362	Yes	No	Yes	N/A
D401170	Yes	Yes	Yes	Yes

Score for this Area:
Met

Corrective Action Plan:
None

Area of Opportunity:
None

Standard 4: Member Rights and Responsibilities

Staff Present at Site Review:
DHHA: Michael Faris, Daniel Lewis, Daniel Schirmer, Marcia Tuell and Dr. Barbara Warren.

Department: Craig Gurule, Jerry Smallwood (Lead) and Maureen Wallner.

Department Summary of Review:
DHHA is required to inform members of their rights as specified in 10 CCR 2505-10.8.205.3. This information is provided to members through the DHHA Member Handbook. While member's rights are enumerated in the handbook, the member's right to obtain a copy of their medical records and to make corrections to information contained in their medical records is not included.

Staff training is provided; providers are informed of members' rights and responsibilities. Providers are aware of information provided to members, and the appropriate policies and procedures regarding members' rights and responsibilities are in place.

Score for This Area:
Partially Met

Corrective Action Plan: The Contractor shall submit a corrective action plan to be approved by the Department. The CAP shall include the steps and timeframes to implement the following corrective action(s):

1. Include the fact that members' have the right to obtain a copy of their medical records and make corrections to information contained in their records in member and provider materials (e.g. member handbook, provider manual, etc.).

Area of Opportunity:
None

Standard 5: Grievance and Appeal

Staff Present at Site Review:
DHHA: Michael Faris, Daniel Lewis, Daniel Schirmer, Janice Tucker and Marcia Tuell.

Department: Craig Gurule, Jerry Smallwood and Maureen Wallner (Lead).

Department Summary of Review:
Written policies and procedures are in place for a grievance and appeal process and describe a process compliant with the requirements of the managed care appeal rules at 10 C.CR. 2505-10, Section 8.209. DHHA utilizes the reporting tool as required in Exhibit G of the contract to document grievances and appeals. Third and fourth quarter grievance and appeals reports were submitted as evidence of this requirement in the desk audit materials.

DHHA staff indicated in the interview that a description of the grievance, appeal and fair hearing procedures and timeframes is not distributed to all providers via the provider manual. However, the provider manual is available in all the clinics and in the hospital. Updates and information about the process are also included in the Provider Update newsletter. Grievances and appeals are shared during the Quality Improvement Committee meetings. Information flows from this committee to department heads as additional communication. Grievances are reported to the Utilization Management staff.

Written notice is sent to members for each action. The notices are available in English and Spanish and copies were submitted with the desk audit materials. Notices contain all of the required elements as described in the contract. While the policies and procedures indicated the correct timeframes for notices to be sent and for adjudication of grievances and appeals, the record review reflected that timeframes were not met. DHHA staff indicated that they were aware of the problem and stated that an employee had been following timeframes for a different line of business. They indicate that they have since corrected the problem.

Policies and procedures indicate that DHHA will give members reasonable assistance in the grievance and appeal process. They also reflect that individuals who make decisions on appeals are individuals not involved in any previous level of review and who have appropriate clinical expertise in treating the member's condition. The Medical Director ensures this requirement is met.

Members are notified that the grievance and appeal process need not be exhausted at the contractor level before requesting a State fair hearing. This statement is reflected in the policies and procedures and is communicated to members via the Member Handbook. Members are also notified via the Member Handbook and in grievance disposition notices that if they are not satisfied with disposition of a grievance that they may bring the unresolved grievance to the Department.

Problems were identified during the record review with meeting timeframes for resolving appeals and sending out acknowledgement letters for grievances. Policies and procedures are correctly written however; in practice the timeframes as stated above were not met.

Score for This Area:
Partially Met

Corrective Action Plan: The Contractor shall submit a corrective action plan to be approved by the Department. The CAP shall include the steps and timeframes to implement the following corrective action(s):

1. Comply with the Managed Care Benefits Section's letter dated April 26, 2005 regarding the MCE's notice to members.

Area of Opportunity:
None

Standard 6: Confidentiality

Staff Present at Site Review:
DHHA: Michael Faris, Daniel Lewis, Daniel Schirmer, Janice Tucker and Marcia Tuell.

Department: Craig Gurule (Lead), Jerry Smallwood and Maureen Wallner.

Department Summary of Review:
DHHA has developed HIPAA general privacy training that is required for all employees. This training is administered either hard copy or via web based training. Employees who score less than 90% on the privacy training are given the opportunity to review their answers with their supervisor prior to retaking the training and receiving a score of at least 90% to receive credit. In addition, all employees receive a code of conduct manual during orientation. This manual provides an overview of the integrity program, lists the various rules and regulations that pertain to employees and provides specific examples applicable to all employees as well as specific areas within DHHA.

Confidentiality agreements exist specific to the type of individual(s) and/or entity that may receive personal health information (PHI). Employee confidentiality agreements are signed at the time of orientation. Confidentiality requirements are included in provider contracts. Any committee participant who is not a DHHA employee is required to sign the appropriate confidentiality statement on an annual basis. At the time an initial contract is executed and upon renewal any entity that performs services on behalf of DHHA is required to sign a contracted provider confidentiality agreement. The legal department maintains these agreements.

Access to PHI for employees, providers, vendors, subcontractors, consultants or anyone acting on behalf of DHHA is limited to only what is necessary to perform their specific job function. Specific areas identified within DHHA have safeguards in place to protect PHI such as fax machines, printers, nurses' stations and computer terminals. Additional requirements regarding PHI and the use of email, an interpreter, medical records and various information systems have also been implemented.

Score for This Area:
Met

Corrective Action Plan:
None

Area of Opportunity:
None

Standard 7: Marketing

Staff Present at Site Review:
DHHA: Daniel Lewis.

Department: Craig Gurule, Jerry Smallwood (Lead) and Maureen Wallner.

Department Summary of Review:
DHHA submitted marketing material to the Department for approval prior to using the material. The material submitted included posters, buttons and informational literature for potential members. The material did not offer other types of private insurance as a bonus for enrollment. DHHA did not intend to use the material in any door-to-door, telephone or other cold-call marketing activities. The material was approved by the Department on April 19, 2005 and will be distributed throughout DHHA's entire service area.

Score for this Area:
Met

Corrective Action Plan:
None

Area of Opportunity:
None

Standard 8: Licensure and Credentialing

Staff Present at Site Review:
DHHA: Daniel Lewis, Mary Pinkney, Sandra Taylor and Dr. Barbara Warren.

Department: Craig Gurule, Jerry Smallwood, Diane Stayton and Maureen Wallner (Lead).

Department Summary of Review:
DHHA has written policies and procedures in place for the selection and retention of providers. The Medical Staff Offices conducts all credentialing and recredentialing for the organization. DHHA complies with the National Committee for Quality Assurance (NCQA) standards for credentialing and recredentialing.

DHHA's credentialing program reflects a process in place for reporting incidents of questionable practice. Any party can refer a case to the Medical Staff Office. The case will be routed to the Associate Medical Director. The case may be addressed with an ad hoc peer review or a formal committee peer review. DHHA monitors the State Board of Medical Examiners web site on a monthly basis to ensure no actions have been taken against any prospective or current practitioners. DHHA monitors the complaints and grievances as well as reports from the Office of the Inspector General to ensure no issues have arisen with providers.

Documentation in the form of the Clinical Laboratory Improvement Amendments (CLIA) form was provided verifying the accreditation from CMS for all of the laboratories affiliated with DHHA.

A sample of ten (10) credentialing and recredentialing records was reviewed by the Department for Primary Source Verification factors. These factors were documented and within the prescribed time limits for each record reviewed.

Score for this Area:
Met

Corrective Action Plan:
None

Standard 9: Provider Issues

Staff Present at Site Review:
DHHA: Ron Aguilar, Daniel Lewis, Janice Tucker, Marcia Tuell and Pamela Senneff.

Department: Craig Gurule, Jerry Smallwood and Maureen Wallner (Lead).

Department Summary of Review:
DHHA has written policies and procedures in place for participating providers to ensure compliance with all applicable local, state and federal insurance requirements. This is handled and monitored by Provider Relations. DHHA stated in the interview that no incentive plans of any kind are utilized. Contracts for all providers are developed by the DHHA legal department.

Quality of care concerns are sent to the Medical Director for review. If additional peer review is appropriate, the Medical Director decides what types of providers should be involved in the review and coordinates.

The policies and procedures reflect that access to certified nurse practitioners and certified nurse midwives is available. These providers are listed in the provider directory and on the website and many of them provide services in the clinics. Both types of providers are credentialed.

Pharmacy services are monitored closely and DHHA staff ensures covered services are provided and appropriately paid for by monthly random sampling of claims.

Staff indicated in the interview that no member incentives are in place. DHHA ensures no discrimination of providers exists by using the Medicaid fee schedule for all providers. Reimbursement is negotiated for one-time service agreements, such as highly specialized transplants. Minimal problems have been noted with regard to reimbursement in these cases indicating no barriers when accessing services.

Score for This Area:
Met

Corrective Action Plan:
None

Area of Opportunity:
None

Standard 10: Advance Directives

Staff Present at Site Review:
DHHA: Michael Faris, Daniel Lewis, Daniel Schirmer, Janice Tucker and Dr. Barbara Warren.

Department: Craig Gurule, Jerry Smallwood (Lead) and Maureen Wallner.

Department Summary of Review:
DHHA is required to provide members with information regarding its advance directive policies, member rights regarding advance directives and a description of the Colorado statutes applicable to Advance Directives. DHHA defines an advance directive in the member handbook; however the information provided in the handbook does not specify the types of advance directives or how to file a complaint when an advance directive is not followed. In addition, information regarding advance directives is not included in the provider manual.

Score for This Area:
Not Met

Corrective Action Plan: The Contractor shall submit a corrective action plan to be approved by the Department. The CAP shall include the steps and timeframes to implement the following corrective action(s):

1. Include information in the member handbook and provider manual regarding the types of advance directives and how to file a complaint when an advance directive is not followed.

Area of Opportunity:
None

Standard 11: Subcontracts

Staff Present at Site Review:
DHHA: Michael Faris, Daniel Lewis, Janice Tucker, Marcia Tuell and Dr. Barbara Warren.

Department: Craig Gurule, Jerry Smallwood (Lead) and Maureen Wallner.

Department Summary of Review:
DHHA has policies and procedures in place for subcontracts but has no subcontracts at present.

Score for this Area:
Met

Corrective Action Plan:
None

Area of Opportunity:
None

Standard 12: Utilization Management

Staff Present at Site Review:
DHHA: Daniel Lewis, Janice Tucker, Marcia Tuell and Dr. Barbara Warren.

Department: Craig Gurule, Jerry Smallwood and Maureen Wallner (Lead).

Department Summary of Review:
Written policies and procedures are in place for a mechanism to ensure consistent application of review criteria for authorization decision and consultation with the requesting provider when appropriate. DHHA currently utilizes InterQual criteria and develops internal guidelines for situations not covered by InterQual or DHHA's policies and procedures.

Processes are in place for distributing utilization management and review information to members. Members receive information via the Member Handbook, which is provided upon enrollment to the plan. Information is also shared in Member newsletters and is posted throughout the hospital and clinics. Specific changes that effect certain populations of the plan are also shared via a letter to the member. For example, recent changes to the formulary regarding a specific drug were shared in letters to members directly impacted by the change. A copy of this letter was provided as documentation.

Processes are also in place for distributing information to providers. Providers are informed of the criteria and about utilization management via the Provider Manual. They are informed about what services require a prior authorization and what services require a referral. Periodic provider education on an ad hoc basis also assists in communicating this information to the providers.

Data systems are in place to maintain and manage utilization data. These systems can generate reports on a scheduled and ad hoc basis. Examples of these reports include reports on all admissions to inpatient facilities. These reports include data on the type of admission, the average length of stay for that type of admission, the actual length of stay for the particular admission and goals for inpatient days/thousand members.

Medical necessity denials are routed through the medical director who is responsible to ensure that clinicians with appropriate medical expertise are utilized in making the denial determination. The medical director utilizes the existing network of providers to consult with before issuing denials. If a provider with the appropriate medical expertise is not available from the existing pool of physicians, the medical director will seek consultation with providers partnering facilities such as University or Children's Hospital.

Score for This Area:
Met

Corrective Action Plan:
None

Area of Opportunity:
None

Standard 13: Certifications and Program Integrity

Staff Present at Site Review:
DHHA: Ron Aguilar, Daniel Lewis and Dan Schirmer.

Department: Craig Gurule (Lead), Jerry Smallwood and Maureen Wallner.

Department Summary of Review:
DHHA's compliance plan and administrative arrangements are the responsibility of the Denver Health Integrity Office and the integrity officer. The Integrity Office's primary mission is to assist the Denver Health Board of Directors and executive staff with their responsibilities for establishing and maintaining an effective system of internal control and regulatory compliance.

The integrity officer reports to the Chairperson of the DHHA Finance Committee of the Board of Directors and to the Chief Executive Officer. The Integrity Office works in conjunction with DHHA management to: anticipate and reduce business risks, ensure management accountability at all levels and ensure the integrity of operational and financial information. In addition, the Integrity Office communicates to appropriate management or operating personnel in the form of written reports, consultation or advice.

Written reports include both recommendations and management comments itemizing specific actions taken or planned to mitigate identified risks and to ensure that operational objectives are achieved. These outcomes are also communicated to the Integrity Committee, the Finance Committee and the DHHA Board of Directors. An overview of all of the integrity programs within DHHA is complied on an annual basis at the end of the calendar year in a corporate integrity plan.

All DHHA employees are required to participate in code of conduct training. A hard copy of the code of conduct is provided to staff and is also located on the intranet. The code of conduct outlines DHHA responsibility regarding topics such as: member care and rights, confidential information, trade practices and antitrust laws, conflicts of interest and marketing, use of DHHA assets, billing for services, dealing with suppliers and referring providers, books and records and health care regulatory compliance. The various types of action that may apply as a result of an internal investigation when a violation of the code of conduct has occurred are also included in the training and described in the code of conduct. DHHA has set up a phone line called ValuesLine, which allows employees, contractors, vendors, etc. to report potential cases of fraud and abuse or any violations of the code of conduct anonymously.

DHHA is required to report any possible instances of Medicaid fraud to the Department within ten (10) business days of receipt of information. None of the documentation provided included this requirement.

Score for This Area:
Partially Met

Corrective Action Plan: The Contractor shall submit a corrective action plan to be approved by the Department. The CAP shall include the steps and timeframes to implement the following corrective action(s):

1. Update applicable documentation so that potential instances of fraud are reported to the Department within specified timeframe.

Area of Opportunity:
None

Standard 14: Practice Guidelines

Staff Present at Site Review:
DHHA: Daniel Lewis, Mark Pinkney, Marcia Tuell and Dr. Barbara Warren.

Department: Craig Gurule, Jerry Smallwood, Diane Stayton and Maureen Wallner (Lead).

Department Summary of Review:
DHHA has adopted written practice guidelines for perinatal, prenatal and postpartum care for women, conditions related to Persons with Disability or Special Health Care Needs and for well child care. These guidelines were submitted in writing during the interview. DHHA utilizes a Quality Assurance Committee (QAC) Guideline Taskforce, which is a formally delegated team of peers and/or clinical experts functioning as ad hoc advisory group to the QAC, to develop, implement, review and update these guidelines.

The guidelines are disseminated to all affected providers via the Provider Manual, the Provider Newsletter and targeted provider mailings as appropriate. The guidelines can be hand delivered during onsite physician/clinic visits, as well. All guidelines are also posted on the DHHA website. Policies and procedures also reflect when members will receive copies of the guidelines.

Score for This Area:
Met

Corrective Action Plan:
None

Area of Opportunity:
None

Standard 15: Quality Assessment and Performance Improvement

Staff Present at Site Review:
DHHA: Daniel Lewis, Mark Pinkney, Janice Tucker, Marcia Tuell and Dr. Barbara Warren.

Department: Craig Gurule (Lead), Jerry Smallwood and Maureen Wallner.

Department Summary of Review:
The Denver Health Managed Care Operations Team provides oversight of the Quality Improvement (QI) program. The Director of Managed Care, the Medical Director for Managed Care and the Denver Health Managed Care Quality Assurance Committee are responsible for developing, managing and monitoring the QI program. The Medical Director for Managed Care coordinates, advises and participates in the execution of the QI program through oversight of the Medical Management department and the QI department.

The objectives of the DHHA quality improvement and utilization management (QI/UM) program are to monitor and measure the levels of quality of care, identify opportunities to improve patient care, optimize program compliance, assure services are medically necessary and provided in the most appropriate setting, control costs and resolve identified problems through appropriate intervention and education. The continuous monitoring of quality indicators provides for both the evaluation of individual outcomes as well as for the development of comparative performance and outcome benchmarks.

The QI/UM program was developed to measure the quality and continued improvement of clinical care and services. A process to measure member satisfaction is in development. Components of the program that are in place include:

- Quality management and improvement through the selection of appropriate clinical, cost and service indicators, continuous monitoring of indicators, feedback and focused studies
- Utilization management
- Credentialing and recredentialing
- Monitoring use of available preventive health services and improving utilization of these services, and
- Medical records standards and review.

The Department randomly selected ten (10) medical records for review. Diagnosis and procedure codes within these records were compared to the encounter data previously submitted to the Department by the MCE. All of the diagnosis and procedure codes contained within the encounter data were documented within the medical records.

Score for This Area:
Met

Corrective Action Plan:
None

Area of Opportunity:
None

Standard 16: Coordination with Early Periodic Screening, Diagnosis and Treatment

Staff Present at Site Review:
DHHA: Michael Faris, Erica Gosselin, Daniel Lewis, Mark Pinkney, Janice Tucker, Marcia Tuell and Dr. Barbara Warren.

Department: Craig Gurule, Jerry Smallwood (Lead), Diane Stayton and Maureen Wallner.

Department Summary of Review:
The documents submitted and ensuing interviews demonstrated a range of organizational activities being performed regarding EPSDT. These include the provision of services, tracking and monitoring of utilization, and providing members with in depth information regarding EPSDT services.

Score for This Area:
Met

Corrective Action Plan:
None

Area of Opportunity:
None

VI. Summary Corrective Action(s) Required.

Standard 2: Access and Availability.

1. Monitor providers for scheduling and wait time availability.
2. Identify members who reside 30 minutes or 30 miles beyond their nearest provider and include this information in future quarterly network adequacy report submissions.
3. Notify members who fail to select a PCP and one is assigned by DHHA.

Standard 4: Member Rights and Responsibilities.

1. Include the fact that members' have the right to obtain a copy of their medical records and make corrections to information contained in their records in member and provider materials (e.g. member handbook, provider manual, etc.)

Standard 5: Grievance and Appeal.

1. Comply with the Managed Care Benefits Section's letter dated April 26, 2005 regarding the MCE's notice to members.

Standard 10: Advance Directives.

1. Include information in the member handbook and provider manual regarding the types of advance directives and how to file a complaint when an advance directive is not followed.

Standard 13: Certifications and Program Integrity.

1. Update applicable documentation so that potential instances of fraud are reported to the Department within specified timeframe.

VII. Documents Submitted by Contractor

Standard 1: Covered Services

Documentation Provided for Desk Audit:

- Denver Health Medicaid Choice Medical Management Procedure- Emergency Service Coverage for Denver Health Medicaid Choice
- Policy & Procedure (P&P) Choice_UMG1002 Attachment Timetable
- P&P Choice _UMG1005- Assignment of Members to Specialty Care Providers
- P&P Choice_UMG1005 Attachment A- PCP Change Form
- Utilization Management Plan 2004-2005
- P&P Choice_UMG1006-Concurrent Utilization Management of Inpatient and
- P&P Choice_UMG1001-Utilization Management Program
- P&P Choice_DME1101- Guidelines for Ordering and Authorization of DME
- Attachment A for Choice_DME1101
- Denver Health Medical Plan P&P UMG1007
- Denver Medical Plan P&P UMG1003
- P&P Choice_CMG1201
- P&P Choice_UMG1002
- Denver Health Medical Plan Provider Update Newsletter Fourth Quarter 2004
- Denver Health Medicaid Choice Medical Management Procedure- Drug Authorization Procedure- Medication Utilization Review Procedures and Formulary Management
- Member Handbook Information on Emergency Transportation

Standard 2: Access and Availability

Documentation Provided for Desk Audit:

- P&P Choice_PRR701- Access to Care/Services Plan
- P&P Choice_QIM1302- Clinical Practice Guidelines and Preventive Care Guidelines
- P&P Choice_CTS302-Provider Selection and Retention
- Network Adequacy Report 10/04-12/04
- Enrollment/Disenrollment Analysis 5/04-9/04
- Enrollment/Disenrollment Report 5/04-9/04
- Enrollment/Disenrollment Analysis 10/04-12/04
- Enrollment/Disenrollment Report 10/04-12/04
- Standard 2-10 Policy on Medicaid Eligibility and Member Enrollment/Disenrollment
- Chart- PCP to Member Ratio 5/04
- Chart- PCP to Member Ratio 11/04
- Denver Health Medicaid Choice Membership Forecast Calendar year 2005
- P&P Out of Zip Code Report Processing
- Network Adequacy Report 5/04-9/04
- Utilization Data on Dual Eligibles
- ADA Building Survey
- P&P Choice_MBR805- Member Rights and Responsibilities

- Provider Newsletter 3rd quarter
- Provider Newsletter 4th quarter
- Member Handbook

Standard 3: Continuity of Care

Documentation Provided for Desk Audit:
- P&P Choice_CMG1201- Continuity of Care
- P&P Choice_HIP901- Confidentiality, Privacy and Security of DHHA and Medicaid Choice Member Information
- P&P Choice_MBR805- Member Rights and Responsibilities
- P&P Choice_UMG1004- Special Health Care Needs and/or Disabilities
- Care Management Tracking Log
- Case Management Meeting Minutes
- Member Handbook

Standard 4: Member Rights and Responsibilities

Documentation Provided for Desk Audit:
- Policy on Member Rights and Responsibilities
- Policy on ADA Act
- Policy on Readability and Non-English Needs
- Provider Manual
- Provider Newsletter 3rd Quarter 2004
- Provider Newsletter 4th Quarter 2004
- Letter to CAT Member – Spanish
- Open Enroll Member Letter
- Policy on Cultural and Linguistics Competency
- SP Member Administrative Complaint
- SP Notification 14 Day Extension
- SP QOC Notification 2 Days
- SP Notification 2 Days
- Policy on Grievance and Appeals
- Medicaid Choice Load Report Process
- Policy on Concurrent Utilization Mgmt of Inpatient Care
- Policy on Emergency Services
- Policy on Utilization Review Determination
- DH 3Q04 Complaint-Appeals Analysis
- DH 3Q04 Complaint-Appeals Report
- DH 4Q04 Complaint-Appeals Analysis
- DH 4Q04 Compliant Appeals Report
- DH 3Q04 Enrollment Analysis
- DH 3Q04 Enrollment Report
- DH 4Q04 Enrollment Analysis
- DH 4Q04 Enrollment Reports

- MCD Welcome Call Script inc SHCN
- Policy on Care of Special Needs Members
- Policy on Special Health Care Needs
- Special Health Care Needs Form
- AND AB Flow
- AND_AB report
- EPSDT and Special Needs ID Flow
- Member Services Referral
- No PCP Visit Report Criteria
- Provider EPSDT and Special Needs Flow
- Special Needs Database
- Special Needs Letter 1-20-05
- Special Needs Letter 12-2004
- Welcome Call Flow
- Policy on Cultural and Linguistics
- Staff Training Update 1-27-05
- Staff Training Update 2004
- Member Handbook- English
- Member Handbook- Spanish
- Readability and Staff Training
- Interpretation Translation Services MC Retreat
- Medical Interpreter Needs Assessment Tool
- Medical Interpreter Survey

Standard 5: Grievance and Appeal

Documentation Provided for Desk Audit:

- Policy on Grievances and Appeals
- Policy on Utilization Review
- Member Handbook- English
- Member Handbook- Spanish
- Provider Newsletter 3rd Quarter 2004
- Provider Newsletter 4th Quarter 2004
- Additional Dr Info Appeal
- Additional Dr Info
- After 24 hrs not sufficient information
- Appeal Process
- Denial Inpatient Hospitalization #2
- Denial Inpatient Hospitalization
- Medical Review
- Member Administrative Complaint
- No Additional DR Info
- Not Authorized Service
- Notification 2 days 112503

- Notification 14 day extension
- QOC notification 2 days
- Retrospective Review of Admission for Medical Necessity
- Some Authorized Some Not Authorized
- SP Member Administrative Compliant
- SP Notification 14 day extension
- SP QOC Notification 2 days 112503
- SP Notification 2 days 112503
- Policy on Member Rights and Responsibilities

Standard 6: Confidentiality

Documentation Provided for Desk Audit:
- DH Code of Conduct
- DHHA-NOPP
- HIPAA Privacy Notice-English
- HIPAA Privacy Notice- Spanish
- Choice Confidentiality Policy
- Information Services User Agreement
- Policy on Electronic Messaging
- Policy on Network Security
- Contract Template for Provider Subcontractors
- HIPAA Rights and Responsibilities I
- HIPAA Rights and Responsibilities II
- HIPAA Training Modules

Standard 7: Marketing

Documentation Provided for Desk Audit:
- Choice letter from Doug
- Handbook cover in Spanish and English
- HIPAA-English
- HIPAA- Spanish
- Member Handbook-English
- Member Handbook-Spanish
- Provider Directory- English
- Provider Directory- Spanish
- Provider Manual
- Medicaid ID Card

Standard 8: Licensure and Credentialing

Documentation Provided for Desk Audit:
- Policy on Credentialing

- Policy on Excluded Providers
- Policy on Provider Selection and Retention
- Email Oversight 804
- MSEC 6-14-04
- Operation minutes 09-08-04
- MSEC 5-10-04
- Allied Committee Minutes August 2004
- Allied Committee Minutes December 2004
- Allied Committee Minutes June 2004
- Allied Committee Minutes October 2004
- MSEC 7-12-04
- MSEC 8-9-04
- MSEC 9-13-04
- MSEC 10-11-04
- MSEC 11-8-04
- MSEC 12-13-04
- Fair Hearing Plan
- Policy on Credentialing and Recredentialing Allied

Standard 9: Provider Issues

Documentation Provided for Desk Audit:
- Policy on Provider Selection and Retention
- CLIA Certificates
- Policy on Subcontracting Services
- Physician Other Professional Subcontract
- DH Code of Conduct
- Staff Training Update 1-27-05
- Staff Training Update 2004
- Training on Compliance Manual
- Conflict of Interest Certification Policy
- DHHA Conflicts of Interest Policy
- OB Allied Privileges 2004
- Policy on Credentialing and Recredentialing Providers
- Allied Committee Minutes June 2004
- Allied Committee Minutes August 2004
- Allied Committee Minutes December 2004
- Allied Committee Minutes October 2004
- Midlevel Provider Task Force 2004

Standard 10: Advance Directives

Documentation Provided for Desk Audit:
- Policy on Advance Directives

- Advance Directives- English
- Advance Directives- Spanish
- Member Handbook Material provided on Advance Directives
- Policy on Member Rights and Responsibilities

Standard 11: Subcontracts

Documentation Provided for Desk Audit:
- Termination Notice 60 days
- Termination Notice 120 days

Standard 12: Utilization Management

Documentation Provided for Desk Audit:
- OPS and QAC minutes for Updating P&P
- Pharmacy and Therapeutics Minutes
- Educational Services to Members
- 9-29-04 Minutes Medicaid Choice
- Policy on Utilization Program Description
- Policy on Prior Authorizations
- Over Under on Network Adequacy Report 3rd Quarter 2004
- Over Under on Network Adequacy Report 4th Quarter 2004
- Job Description of UM Clinician
- Policy on Care Coordination Case Management
- Member Assessment Member Services Referral
- Member Assessment Welcome Call Script
- Drug Formulary Request Form
- UM Program Evaluation
- Procedure for Prescription Drugs
- Member Handbook for Appeals Adverse Decisions
- Policy Adverse Determinations in Grievance and Appeals
- Policy on Grievance and Appeals
- Pharmacy Procedure for Prescription Drugs
- Educational Documents from Internet
- Flu Shot Letter
- Member Handbook for Member Education
- Perinatal letter for DH Medicaid Choice
- Pharmacy Letter Medicaid
- Policy on Cultural Competency for Education Services
- Vioxx recall1
- Diabetes Education letter patient education material
- Policy on Member Rights Legal Representative Participation
- Policy on Credentialing and Recredentialing
- Policy on Utilization Management Program

- Policy on Utilization Review Determination
- Policy on Concurrent Utilization Management
- MCP 2005
- Medicaid Choice Case Management List

Standard 13: Certifications and Program Integrity

Documentation Provided for Desk Audit:

- Policy on Program Integrity Purpose
- Management Reporting
- Management Support
- Internal Reporting
- Code of Conduct
- Investigations
- Education and Training
- Auditing & Monitoring
- DH Policies and Procedures
- OIG Designation of High Risk Areas
- Manager Performance Evaluation-Reviews
- Conflict of Interest
- OCR Privacy Review
- Training Status Managed Care
- Annual Mandatory Training
- HIPAA Rights and Responsibilities I
- HIPAA Rights and Responsibilities II
- HIPAA Training Modules
- OIG High Risk Areas 031004
- Encounter Data 050104 063004
- Code of Conduct Handbook
- Physician Training Manual 2.1

Standard 14: Practice Guidelines

Documentation Provided for Desk Audit:

- Practice Guidelines (QAC) meeting minutes
- Policy on Development, Update, Dissemination, Practice Guidelines
- Provider Newsletter 3Q 2004 for Provider Education
- Provider Newsletter 4Q 2004 for Provider Education
- Asthma PIP Tool from version D2-12-04
- Child Immunization PIP Tool D21
- Diabetes Committee Minutes July
- Diabetes Committee Minutes August
- Diabetes Committee Minutes December
- Diabetes Committee Minutes June

- Diabetes Committee Minutes September
- Flu Shot Letter
- PIP Diabetes
- Retreat Agenda related to Quality Initiatives

Standard 15: Quality Assessment and Performance Improvement

Documentation Provided for Desk Audit:
- Quality Committee Meeting Minutes
- Member Handbook-English
- Provider Newsletter 3Q for Staff Training
- Provider Newsletter 4Q for Staff Training
- Policy on Member Rights
- Policy on Availability of Quality Information
- QI Work Plan
- Program Impact Analysis
- QI Program Evaluation
- Asthma PIP Tool from version
- Child Immunization PIP Tool D21
- Diabetes PIP
- Flu Letter 1204
- Important Facts Regarding EPSDT jan05rev
- QI Program additional documentation

Standard 16: Coordination with Early Periodic Screening, Diagnosis and Treatment (EPSDT)

Documentation Provided for Desk Audit:
- Policy on EPSDT service
- EPSDT Tracking Report Feb 1 2005
- EPSDT CMS 416
- No PCP Visit Report Criteria
- No PCP 2004 Report
- Additional Outreach Efforts
- AND AB Flow
- EPSDT and Special Needs ID Flow
- EPSDT Case Management
- EPSDT Letter 1-20-05
- EPSDT Letter 12-2004
- EPSDT Medicaid Choice Contacts
- EPSDT Planning Mtg122904
- EPSDT Planning Mtg1-12-05
- EPSDT Well Child Guideline
- EPSDT PowerPoint presentation

- EPSDT Special Needs Letter English
- EPSDT Special Needs Letter Spanish
- Flu letter regarding EPSDT
- Important facts regarding EPSDT
- Member Handbook-English
- Provider Education Important Facts regarding EPSDT
- Provider EPSDT and Special Needs Flow
- Provider newsletter 4Q for EPSDT education
- Questions for EPSDT Program Administrator
- Welcome Call Flow
- Member Handbook- Spanish