State of Colorado

Department of Health Care Policy & Financing

Office of Medical Assistance

Quality Improvement Section

FY 06 Final Site Review Findings for Denver Health and Hospital Authority (DHHA)

May 2006

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

As part of the Colorado Department of Health Care Policy and Financing's (the Department's) overall effort and commitment to ensure equitable and appropriate access, quality outcomes and timely care and services for Medicaid members, the Department developed and implemented an annual site review process in 1999. The Balanced Budget Act of 1997 specified additional requirements for managed care entities (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. The objective of the site review is to evaluate all contracted MCEs for contractual and regulatory compliance.

II. Site Review Process

In FY03-04, the Department adopted the Centers for Medicare and Medicaid Services (CMS) protocol "Monitoring Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans" (Final Version 1.0, February 11, 2003) as a guideline for the site review process. The site review process consists of a desk audit and a visit to the MCE's administrative offices.

A monitoring tool is used as a guide to assess contractual and regulatory compliance. Monitoring tool content is based on the MCE contract provisions, Colorado Regulations 10 CCR 2505-10, 8.000 *et seq* and 42 C.F.R. Section 438. *et seq*. Each provision is segmented into easy-to-measure elements, usually a sentence or sub-section of the contract or regulation. Each year the tool is updated with any changes and distributed to the MCEs for comment. The Department then considers the MCE comments and modifies the tool as necessary. Once approved, the tool is tailored to each MCE by removing some provisions scored as "Met" during the previous year's site review. The final monitoring tool is then used in the site reviews and a site review schedule is determined in conjunction with the MCEs.

After the monitoring tool is finalized, the desk audit begins. The desk audit consists of a document request, document submission and subsequent document review. A list of documents related to each provision is developed and requested from the MCE. The MCE is given thirty days to assemble and produce the requested documents. Department staff then read each document for compliance with the applicable provision. Questions are noted for MCE staff interviews, which are conducted during the MCE office visit. Interview questions clarify desk audit material and assess process and procedure compliance. 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.

The site review team then conducts a visit, usually two days in length, to the MCE's administrative offices. MCE staff meet with the site review team, explain related processes and procedures, and answer any questions the team may have. The team also reviews a record sample to assess compliance in the areas of Credentialing/Recredentialing, Encounters, Continuity of Care, Utilization Denials and Grievances and Appeals. Results of the record reviews are reflected in the rating assigned to the respective provision or element.

The site review team rates each monitoring tool element as "Met", "Partially Met", "Not Met" or "Not Applicable". Any element receiving a rating of "Partially Met" or "Not Met" will require a MCE corrective action. These ratings form the basis of the preliminary site review score.

Thirty days after the visit, a written 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 days to respond to the Report. The Department reviews comments from the MCE and may make corrections based on those comments. The Final Site Review Report indicates areas of compliance and areas that require some type of action to achieve compliance. The MCE must submit its action plan to the Department for approval within thirty days of receiving the final report. The Department reviews and approves the corrective actions and related documents when completed until compliance is demonstrated.

III. FY06 Site Review Summary

This site review evaluated DHHA's compliance with 11 of 18 contractual and/or regulatory provisions. The 11 provisions reviewed this year included provisions that received a score of "Not Met" (one) and "Partially Met" (four) during theFY05 site review and six additional provisions related to quality, access and timeliness. CMS requires an annual review of the quality, timeliness and access to the services covered under each MCO contract (42 C.F.R. Section 438.204(d).

DHHA received a total score of 92%. DHHA demonstrated strength in several provisions during this site review. These provisions include the Quality Assessment and Performance Improvement program, the grievance and appeal process, Certifications and Program Integrity and Compliance and Monitoring. DHHA's policies and procedures are very well written and easy to understand. The electronic medical record system and computer system capabilities facilitated the record reviews.

There are six corrective actions required as a result of this review, in the areas of Access and Availability, Continuity of Care, Member Rights and Responsibilities and Provider Issues.

DHHA has addressed all elements scored "Partially Met" and "Not Met" from the FY05 site review. There were ratings of "Partially Met" in the general topics of Access and Availability Member Rights and Responsibilities for the FY 05 and FY06 site reviews. The specific contract provision and elements rated "Partially Met" differed between FY05 and FY06, therefore there were no trends identified.

IV. FY06 Site Review Scoring

DHHA's compliance with 11 contractual and regulatory provisions was assessed during this year's site review. The provisions were derived from the FY 05-06 contract between the Department and DHHA, Colorado Regulations 10 CCR 2505-10, 8.000 *et seq.* and the requirements 42 C.F.R. Section 438.*et seq*. The site review team rated each regulatory/contractual element and tallied the ratings for each provision. DHHA's overall score

for this site review is 92%, computed by dividing the total number of provisions met by the total number of provisions rated.

Regulatory/Contractual Topics	# Provisions	# Provisions Met	# Provisions Partially Met	# Provisions Not Met	# Provisions N/A	Page
1. Enrollment and Disenrollment	3	3	0	0	0	6
2. Covered Services	9	9	0	0	0	7
3. Access and Availability	12	11	0	1	0	11
4. Continuity of Care	19	14	5	0	0	18
5. Member Rights and Responsibilities	12	10	1	0	1	32
6. Grievance and Appeal	21	21	0	0	0	43
10. Provider Issues	10	7	2	0	1	52
11. Certifications and Program Integrity	3	3	0	0	0	59
12. Advance Directives	2	2	0	0	0	62
15. Compliance and Monitoring	4	4	0	0	0	63
17. Quality Assessment and Performance Improvement	18	16	0	0	2	66
Total	**113**	**100**	**8**	**1**	**4**	

Details regarding DHHA's compliance with the provisions, including ratings for each element, can be found in Section V of this report. A score of "Met" was assigned for 100 provisions, eight provisions were deemed "Partially Met" and one provision was "Not Met". Four of the provisions were not applicable.

Required Corrective Actions for "Partially Met" and "Not Met" provisions:

Regulatory/Contract Provision 3.9 – Access and Availability

3. Develop and implement an effective process for monitoring compliance with scheduling and wait time requirements so that:
   a. all clinics are included and a statistically significant number of calls are made;
   b. interventions are implemented whenever actual performance falls below minimal standards; and
   c. increased monitoring continues until minimal standards are met routinely.

Regulatory/Contract Provisions 4.1, 4.3, 4.6, 4.8, 4.10 – Continuity of Care

4a. Implement practices that reflect current DHHA policies for continuity of care and evaluate compliance with the policies.

4b. Establish policies, procedures and practices that distinguish the differences between DHHA's care management and case management programs.

Regulatory/Contract Provision 5.4 – Member Rights and Responsibility

5. Continue to work with the Department to obtain approval of the revised Member Handbook.

Regulatory/Contract Provisions 10.3 and 10.7 – Provider Issues

10a. Implement a tracking system to monitor the quality of care concern process so that concerns are reviewed and necessary actions are taken and documented.

10b. Develop a method to communicate to members whose providers have terminated that these members have the option to disenroll as stated in provision 10.7.

V. Compliance with Provisions

Standard 1: Enrollment and Disenrollment		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
1.1 A Member may request Disenrollment without cause during the Open Enrollment Period. A Member may request Disenrollment upon automatic Reenrollment if the temporary loss of Medicaid eligibility has caused the Member to miss the annual Disenrollment opportunity. Managed Care Entity (MCE) Contract II.C.5.b (Page 10)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Examples of open enrollment letters were provided. The member handbook on page 3 describes the disenrollment during the open enrollment period. Page 8 under member rights states: "to disenroll during the times when rules and regulation allow you to make a choice" DHHA routinely provides quarterly enrollment and disenrollment information and analysis to the Department.
1.2 The Contractor shall notify a Member of his or her ability to terminate or change Enrollment at least sixty (60) calendar days before the end of the Open Enrollment Period. II.C.5.c	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	As noted above.
1.3 The Contractor shall include in its Member handbook and marketing information a provision clearly stating that Enrollment in the Contractor's Plan is voluntary and shall also include information about how to request Disenrollment. II.F.1.d.3	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	The member handbook provides minimum information related to disenrollment.

Results for STANDARD 1	
# provisions scored as "Met"	3
# provisions scored as "Partially Met"	0
# provisions scored as "Not Met"	0
# provisions scored as "N/A"	0

Recommendation: Expand the information in the member handbook to describe in more detail the voluntary nature of the plan and about methods and reasons to request disenrollment.

Standard 2: Covered Services		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
2.1 The Contractor shall ensure that Members within the Service Area shall have access to Emergency Services on a 24 Hour, seven day-a-week basis. MCE Contract II.D.4.a.1 (page 15)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Compliance demonstrated through policies and procedures (P&P) MBR 805 and PRR 701, Member Handbook and other desk audit materials.
2.2 The Contractor shall not require prior authorization for Emergency Services or Urgently Needed Services. II.D.4.a.3	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Compliance demonstrated through Document # 006 from the desk audit materials
2.3 The Contractor may not deny payment for Emergency Services if a non-contracted Provider provides the Emergency Services or when a representative of the Contractor instructs the Enrollee to seek Emergency Services. II.D.4.a.4	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Compliance demonstrated through Document # 007 from the desk audit materials and discussion regarding denial codes on-site.
2.4 The attending emergency Physician, or the Provider actually treating the Member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor as responsible for coverage and payment. II.D.4.a.5	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Met by P&P UMG1006
2.5 The Contractor may require that all claims for Emergency Services be accompanied by sufficient documentation to verify nature of the services. The Contractor shall not deny benefits for conditions which a prudent lay person would perceive as Emergency Medical Conditions and shall not limit what constitutes an Emergency	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Met by on-site record review and Document # 009 from the desk audit materials

Standard 2: Covered Services		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
2.5-*continued* Medical Condition on the basis of lists of diagnoses or symptoms. II.D.4.c.		
2.6 New prescription drugs shall be a Covered Service subject to the Contractor's formulary. The Contractor may submit a written request to the Department, requesting the Department to review the appropriateness of including a prescription drug as a Covered Service. The Department reserves the right to make the final decision. II.D.4.e.1 & 2 (page 16)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Met by discussion at site review and Documents # 010, 011, P&Ps Drug Authorization Procedure, Medication UR Procedures and Formulary Management
2.7 The Contractor shall provide for prescription drugs approved for use and reimbursed by the Medicaid Program, including those products that require prior authorization by the Medicaid Program. Such Covered Drugs shall be prescribed and dispensed within the Contractor's parameters for pharmaceuticals, and as follows: The Contractor may establish a drug formulary, for all Medically Necessary Covered Drugs with its own prior authorization criteria provided the Contractor includes each therapeutic drug category in the Medicaid program. The Contractor shall provide a Covered Drug if there is a Medical Necessity which	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Compliance demonstrated by Documents # 013, 014 and P&P Drug Authorization Procedure

Standard 2: Covered Services		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
2.7-*continued* is unmet by the Contractor's formulary product. The Contractor may authorize at least a seventy-two (72) hour supply of an outpatient Covered Drugs in an Emergency situation when the prior authorization request is incomplete or additional information is needed. Emergency prior authorization may be given retroactively if the drug had to be dispensed immediately for the Member's well being. II.D.4.f. 1.a-c		
2.8 If a Member requests a brand name for a prescription that is included on the Contractor's drug formulary in generic form, the member may pay the cost difference between the generic and brand name. The Member shall sign the prescription stating that he/she is willing to pay the difference to the pharmacy. II.D.4.f. 2	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Compliance demonstrated by Document # 016 from the desk audit materials
2.9 The Contractor shall be financially responsible for all Covered Services associated with a Member's outpatient Hospital Services Covered Services, including all psychiatric, medical and facility Covered Services, if: The procedure(s) is billed on a UB-92/ANSI 8371 claim form; and,	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	No desk audit information was required from DHHA regarding provision 2.9. No issues regarding this provision have been identified through grievances, appeals, member calls to the Department or problems referred to Managed Care Benefits Section.

Standard 2: Covered Services		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
2.9-*continued* The principal diagnosis is a medical diagnosis. **OR** The procedure(s) is billed on a HCFA-1500/ANSI 837P claim form; and, The Covered Services are not listed as a required Behavioral Health Organization (BHO) Covered Service as defined in 10 C.C.R. 2505-10, Section 8.212.05. Diagnoses and procedures covered by the BHOs are listed in Exhibit H. II.D.4.g.3		

Results for STANDARD 2	
# provisions scored as “Met”	9
# provisions scored as “Partially Met”	0
# provisions scored as “Not Met”	0
# provisions scored as “N/A”	0

Standard 3: Access and Availability		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
3.1 The Contractor shall comply with Section 10-16-704 C.R.S. (2004) access requirements. In establishing and maintaining the Provider network, the Contractor shall consider including both Essential Community Providers as designated at 10 C.C.R. 2505-10, Section 8.205.5.A and other Providers. MCE Contract II.E.1.a.1 (page 19)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	DHHA has considered and contracts with most of the ECPs in their service area.
3.2 The Contractor shall maintain and monitor a network of appropriate Providers that is supported by written agreements with those Providers and is sufficient to provide adequate access to all Covered Services. The Contractor shall ensure a Provider to Member caseload ratio as follows: 1:2000 Primary Care Physician to Member ratio. Primary Care Physician includes Physicians designated to practice Family Medicine and General Medicine. 1:2000 Physician specialist to Member ratio. Physician specialist includes all specialist Physicians designated to practice Cardiology, Otolaryngology/ENT, Endocrinology, Gastroenterology, Neurology, Orthopedics, Pulmonary Medicine, General Surgery, Ophthalmology and Urology.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Network adequacy reports are submitted by DHHA on a quarterly basis. The reports indicate the number of providers and their location in relation to members within the service area. The reports show DHHA met the standards.

Standard 3: Access and Availability		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
3.2-*continued* Physician specialists designated to practice Gerontology, Internal Medicine, OB/GYN and Pediatrics shall be counted as either a Primary Care Physician or Physician specialist, but not both. II.E.1.a.2		
3.3 The Contractor shall consider the following when establishing and maintaining the Provider network: The anticipated Medicaid Enrollment; The expected utilization of Covered Services; The numbers and types of Providers required to furnish the Covered Services; The number of network Providers who are not accepting new Medicaid patients; and The geographic location of Providers and Members considering distance, travel time, the means of transportation ordinarily used by Members and whether the location provides physical access to Members with Disabilities. II.E.1.a.3	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	The Network Adequacy Strategic plan and policies and procedures provided indicate these criteria are used in establishing and maintaining the provider network.
3.4 The Contractor shall provide female Members with direct access to a women's health	☒ Met ☐ Partially Met	DHHA provided a description of the process used to obtain an appointment with a women's health specialist and the information

Standard 3: Access and Availability		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
3.4-*continued* specialist within the network for Covered Services necessary to provide women's routine and preventive health care services. This is in addition to the Member's designated Primary Care Physician if that source is not a women's health specialist. II.E.1.a.4 (page 20)	☐ Not Met ☐ N/A	used to inform members of this service.
3.5 The Contractor shall provide for a second opinion from a qualified health care professional within the network or arrange for the Member to obtain one outside the network at no cost to the Member. II.E.1.a.5	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Information regarding the percentage of second opinions provided by DHHA per 1,000 members was provided.
3.6 If the Contractor is unable to provide Covered Services to a particular Member, the Contractor shall adequately and timely provide the Covered Services out of network at no cost to the Member. The Contractor shall ensure that cost to the Member is not greater than it would be if the Covered Services were furnished within the Contractor's network. The Contractor shall coordinate with the out-of-network Provider with respect to payment. II.E.1.b	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	DHHA monitors the number and types of out of network services.
3.7 The Contractor shall ensure that Members, including Members with Disabilities, have a point of access to appropriate services available	☒ Met ☐ Partially Met ☐ Not Met	Policies and procedures that meet this provision are in place. This information is made available to all members via the member handbook and the Denver Health Nurse Line.

Standard 3: Access and Availability		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
3.7-*continued* on a 24-hour per day basis and have written policies and procedures for how this will be achieved. II.E.1.d	☐ N/A	
3.8 The Contractor shall communicate this information *(regarding 24 Hour availability of services- previous Regulatory/Contractual Provision)* to Participating Providers and Members, and have a routine monitoring mechanism to ensure that Participating Providers promote and comply with these policies and procedures. These policies and procedures shall address the following requirements: Emergency Services shall be available 24 hours per day, 7 days per week; The Contractor shall have a comprehensive plan for Triage of requests for services on a 24 hour 7 day per week basis, including: Immediate Medical Screening Exam by the Primary Care Physician or Hospital emergency room; Access to a qualified health care practitioner via live telephone coverage either on-site, call-sharing, or answering service; and	Communicate information to Participating Providers and Members ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A Monitoring Mechanism ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A Polices and Procedures address contractual requirements ☒ Met ☐ Partially Met ☐ Not Met	Members and providers are made aware of 24-hour availability of services through the member handbook and provider manual. The Denver Health Nurse Line is available 24 hours a day, 7 day a week for health advice with immediate access to the provider on-call system for adult and pediatric providers. Policies and procedures specify the provider's responsibilities including 24 hour availability of services.

Standard 3: Access and Availability		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
3.8-*continued* Practitioner back up covering all specialties. II.E.1.d (page 21)	☐ N/A	
3.9 The Contractor shall establish clinically appropriate scheduling guidelines for various types of appointments necessary for the provision of primary and specialty care including but not limited to: routine physicals, diagnosis and treatment of acute pain or injury, and follow-up appointments for chronic conditions. The Contractor shall communicate its guidelines in writing to Participating Providers in the Contractor's network. The Contractor shall have an effective organizational process for monitoring, scheduling and wait times, identifying excessive practices, and taking appropriate corrective action. The Contractor shall ensure that the following minimum standards are met including: Non-urgent health care, is scheduled within 2 weeks; Adult, non-symptomatic well care physical examinations scheduled within 4 months; and, Urgently Needed Services provided within 48 hours of notification of the Primary Care Physician or Contractor.	Establish scheduling guidelines ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A Communicate scheduling guidelines ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A Monitor scheduling guidelines ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A Minimum scheduling standards	DHHA has established scheduling guidelines. These guidelines are specified in the member handbook and provider manual. Scheduling guidelines are monitored through a secret shopper survey. Secret shoppers call DHHA clinics and try to request an appointment date. The results of the secret shopper survey conducted during the 1st quarter of 2005 indicate that a total of 8 calls were made. Of these 8 calls, 87.5% resulted in the clinic failing to return the call or make an appointment. There was no monitoring conducted for the 2nd quarter. The results of the secret shopper survey conducted during the 3rd quarter of 2005 indicate that a total of 40 calls were made. Of these 40 calls, none of the calls for adult preventative care resulted in an appointment. Only 30% of the calls for children during the 3rd quarter were within the appointment standards.

Standard 3: Access and Availability		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
3.9-*continued* II.E.1.e	included ☐ Met ☐ Partially Met ☒ Not Met ☐ N/A	
3.10 The Contractor shall allow, to the extent possible and appropriate, each Member to choose a Primary Care Physician. II.E.3.a	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Members are informed of their ability to select a PCP through the member handbook.
3.11 If a Member does not select a Primary Care Physician, the Contractor shall assign the Member to a Primary Care Physician and notify the Member, by telephone or in writing, of his/her Primary Care Physician's name, location, and office telephone number. II.E.3.b	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	DHHA uses a template letter to inform the member of PCPs selected by DHHA. The letter was reviewed during the interview.
3.12 The Contractor shall ensure that all Members have appropriate access to certified nurse practitioners (NP) and certified nurse midwives (CNM), as set forth at 42 C.F.R. 438.102(a), as amended, and Section 26-4-202(1)(j), C.R.S., as amended, through either Provider agreements or Referrals. This provision shall in no way be interpreted as requiring the Contractor to provide any services that are not Covered Services under this contract. II.G.5.d (page 37)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	There are 14 CNMs and 69 NPs at 10 locations throughout the service area. The number and geographic distribution was deemed acceptable.

Results for STANDARD 3	
# provisions scored as “Met”	11
# provisions scored as “Partially Met”	1
# provisions scored as “Not Met”	1
# provisions scored as “N/A”	0

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

3. Develop and implement an effective process for monitoring compliance with scheduling and wait time requirements so that:
   a. all clinics are included and a statistically significant number of calls are made;
   b. interventions are implemented whenever actual performance falls below minimal standards; and
   c. increased monitoring continues until minimal standards are met routinely.

Standard 4: Continuity of Care		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
4.1 The Contractor shall have written policies and procedures to ensure timely coordination of the provision of Covered Services to its Members to promote and assure service accessibility, attention to individual needs, continuity of care, maintenance of health, and Independent Living. The policies and procedures shall also address the coordination and provision of Covered Services in conjunction with other medical and behavioral health plans that may be providing services to the Member and ensure that, in the process of coordinating care, each Member's privacy is protected consistent with the confidentiality requirements in 45 C.F.R. Parts 160 and 164. MCE Contract II.E.4.a (page 23)	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A	Policies reviewed for this standard included CMG1201, UMG1004, DME1101, UMG1002, QIM1301; policies reflect member identification, transition to services, stratification and prioritizing needs and development of a treatment plan. Additional documents that were provided included Denver Health Managed Care Department's Care Management Program Description, DHMC Care Management Program Plan Report and UM Tracking Logs. Review of 11 client records did not demonstrate consistency with these policies or documents. Only one record had all of the components including an assessment, service plan, treatment and coordination with other services. None of the records listed outcomes. The DHMC Care Management Program Description and Plan listed an integrated view to collaborate and provide care coordination direction using levels A-F. The corresponding chart reviews did not reflect these levels or the strategies identified in the plan and description. At this time DHHA reports that they are in transition with the continuity of care program. Care management will incorporate disease management and case management will include new client, transition of care, and care for special needs. This will primarily be electronic and will be accessible by the primary physician. The current records and policies do not reflect this transition.
4.2 The Contractor shall coordinate with the Member's mental health Providers to facilitate the delivery of mental health services, as appropriate. II.E.4.b	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	One record was reviewed for this provision and the record showed evidence of coordination. During the interview discussion of the process with case management and quality staff confirmed coordination occurred.

Standard 4: Continuity of Care		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
4.3 In addition to efforts made as part of the Contractor's internal quality assessment and improvement program, the Contractor shall have an effective Care Coordination system that includes but is not limited to: Procedures and capacity to implement the provision of the individual needs assessment after Enrollment and at any other necessary time, including the screening for Special Health Care Needs (e.g. mental health, high risk health problems, functional problems, language or comprehension barriers; and other complex health problems); the development of an individual treatment plan as necessary based on the needs assessment; the establishment of treatment objectives, treatment follow-up, the monitoring of outcomes, and a process to insure that treatment plans are revised as necessary. These procedures shall be designed to accommodate the specific cultural and linguistic needs of the Contractor's Members and shall allow Members with Special Health Care Needs direct access to a specialist as appropriate for the Member's condition and medical needs; Procedures designed to address those Members who may require services from multiple Providers, facilities and agencies and require complex coordination of benefits and services, and members who	1.Care Coordination System ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A 2.Needs Assessment ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A 3.Screening SHCNs ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A 4. Development of Treatment Plan ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A 5. Procedures Address Cultural	Policies and procedures are present; chart review does not reflect consistency with the policies and procedures. Of the 11 records reviewed, needs assessments were documented on two of the written records. DHHA has a "Care Management Assessment" form that was not used in the other nine records. A preview of an electronic case management record was also reviewed. This e-record had a complete needs assessment. Of the 11 records reviewed only two had evidence of screening for special health care needs. These two were the electronic record and a high risk pregnancy record. In the charts reviewed only two had individualized treatment plans. None describe monitoring of outcomes or revision of plans. The treatment plan template was not consistent. There was a discrepancy between the care management flowchart and the records that were submitted. Linguistic needs are identified during the initial contact with the member.

Standard 4: Continuity of Care		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
4.3-*continued* require complex coordination of benefits and services, and Members who require ancillary services, including social services and other community resources; A strategy to ensure that all Members and/or authorized family members or guardians are involved in <u>treatment planning</u> and consent to the medical treatment; and <u>Procedures and criteria for making Referrals and coordinating care</u> by specialist, subspecialists, and community-based organizations that will promote continuity as well as cost-effectiveness of care. <u>Procedures</u> to provide <u>continuity of care for newly Enrolled Members</u> to prevent disruption in the provision of Medically Necessary services that include but are not limited to: appropriate Care Coordination staff trained to evaluate and handle individual case transition and care planning; assessment for appropriate technology and equipment; procedures for evaluating adequacy of Participating Providers; and clearly written criteria and procedures that are made available to all Participating Providers, staff and Members regarding how to initiate case planning. II.E.4.c	& Linguistic Needs ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A 6. Direct Access for Members with Special Health Care Needs ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A 7.Appropriate Parties Involved in Treatment Planning ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A 8.Referral & Care Coordination Procedures/Criteria ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Information regarding Special Health Care Needs clients having direct access to a specialist is included in the member handbook. In four of the eleven review records, there was evidence that the client and family were involved with case management. Based on discussion during the interview with the case management staff and based on the desk audit material submitted, referrals are common. An example of a referral was evident with a perinatal client.

Standard 4: Continuity of Care		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
4.3-*continued*	9. Procedures regarding continuity of care for new members ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A	The welcome calls may identify a member with special needs; however, there was no demonstration of this information being transferred to case management.
	10. P&P regarding case planning ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A	As noted earlier, case planning policies and procedures were available; however, charts that were reviewed were not consistent with listed policies.
4.4 The Contractor shall inform a new Member who is a Person with Special Health Care Needs, as defined in 8.205.9 that the Member may continue to receive Medically Necessary Covered Services from his or her Provider for sixty (60) calendar days from the date of Enrollment in the Contractor's Plan, if the Member is in an ongoing course of treatment with the previous Provider and only if the previous Provider agrees specified in 26-4-117 (1) (g), C.R.S. (2004). II.E.4.d (page 24)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	This information is described to new members during welcome calls and is listed on page 8 of member handbook.

Standard 4: Continuity of Care		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
4.5 The Contractor shall inform a new Member with Special Health Care Needs that the Member may continue to receive Medically Necessary Covered Services from ancillary Providers at the level of care received prior to Enrollment in the Contractor's Plan, for a period of seventy-five (75) calendar days, as specified in 26-4-117 (1)(g), C.R.S. (2004). II.E.4.e	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	This information is described during new member welcome calls and is listed on page 8 of member handbook.
4.6 The Contractor shall inform a new Member who is in her second or third trimester of pregnancy, that she may continue to see her Provider until the completion of post-partum care directly related to the delivery, as specified in 26-4-117 (1)(g), C.R.S. (2004). II.E.4.f	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A	This provision was discussed during the interview. However, no documentation was provided ***that the Member*** was notified of her right to continue to seek care from her existing Provider, despite a plan change. The Member handbook made no reference to this right, nor did DHHA provide copies of letters or other notifications specifically given to new Members who were in the second or third trimester of pregnancy.
4.7 The Contractor shall have sufficient experienced Providers with the ability to meet the unique needs of Persons with Special Health Care Needs (SHCNs). If necessary primary or specialty care cannot be provided within the network, the Contractor shall make arrangements for Members to access these Providers outside the network. The Contractor shall implement procedures to share with other Providers serving the Member with Special Health Care Needs, the results of its identification and assessment of that Member's needs to prevent duplication of those activities. II.E.5.a	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	This provision was demonstrated in desk audit materials and during the interview. DHHA contracts with other agencies such as University of Colorado Health Science Center and The Children's Hospital to provide needed care to members.

Standard 4: Continuity of Care		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
4.8 The Contractor shall implement mechanisms to assess each Medicaid Member identified as having Special Health Care Needs in order to identify any ongoing special conditions of the Member that require a course of treatment or regular care monitoring. The assessment mechanism shall use appropriate health care professionals. II.E.5.b	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A	The DHHA Care Management Program Description and Plan discusses these mechanisms. Chart review indicated inconsistency with these plans. Currently, there is not a mechanism to inform providers of case management or care management services.
4.9 The Contractor shall allow Persons with Special Health Care Needs who use specialists frequently for their health care to maintain these types of specialists as PCPs or be allowed direct access/standing referral to specialists for the needed care. II.E.5.c	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	This provision is met based on the interview and quarterly reports submitted by DHHA.
4.10 The Contractor shall establish and maintain procedures and policies to coordinate health care services for Children with Special Health Care Needs with other agencies (e.g., mental health and substance abuse, public health, transportation, home and community based care, Developmental Disabilities, local school districts, child welfare, IDEA programs, Title V, families, caregivers and advocates) II.E.5.d (page 25)	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A	As noted above, polices, procedures and program plans are evident but chart review demonstrates compliance inconsistencies.
4.11 The Contractor shall promote accessibility and availability of Medically Necessary Covered Services, either directly or through subcontracts, to ensure that appropriate services	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Policies and procedures are present, also found information about wrap around benefits and the care management program in the member handbook.

Standard 4: Continuity of Care		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
4.11-*continued* and accommodations are made available to Members with a Disability or any Members with Special Health Care Needs. Covered Services for Members with Disabilities or Special Health Care Needs shall be provided in such a manner that will promote Independent Living and Member participation in the community at large. II.E.6.a		
4.12 The Contractor shall: Respond within twenty-four (24) hours, after written or oral notice to the Contractor by the Member, the Member's parents, guardian or Designated Client Representative, to any diminishment of the capacity of a Member with a Disability to live independently (e.g., a broken wheelchair), and, Deliver Medically Necessary Covered Services that will restore the Member's ability to live independently (e.g., an appropriate wheelchair) with the greatest possible expedience. II.E.6.b	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Documentation in policy UMG1004 and demonstrated on site with records from rehab clinic.
4.13 The Contractor shall establish and maintain a comprehensive program of preventive health services for Members.	1.Members with a Disability have access to	Evident in member mailings, provider newsletters, the quality plan and information in member the handbook.

Standard 4: Continuity of Care		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
4.13-*continued* The Contractor shall assure that Members with a Disability have the same access as other Members to preventive health services. The program shall include written policies and procedures, involve Participating Providers and Members in their development and ongoing evaluation, and are a part of the Contractor's comprehensive quality assurance program as specified in Section II.I. of this contract. The Contractor's program of preventive health services shall include, but is not limited to: Risk assessment by a Member's Primary Care Provider or other qualified professionals specializing in risk prevention who are part of the Contractor's Participating Providers or under contract to provide such services, to identify Members with chronic/high risk illnesses, a Disability, or the potential for such conditions; Health education and promotion of wellness programs, including the development of appropriate preventive services for Members with a Disability to prevent further deterioration.	Preventive Health Services ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A 2.Policies & Procedures regarding Preventive Health Services ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A 3.Provider and Members involved in Development and Evaluation of Preventive Health Services ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A 4.Risk Assessment provided to Members ☒ Met	Risk assessment is conducted by the PCP.

Standard 4: Continuity of Care		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
4.13-*continued* The Contractor's responsibility shall also include the distribution of information to Members to encourage Member responsibility for following guidelines for preventive health;	☐ Partially Met ☐ Not Met ☐ N/A	
Evaluation of the effectiveness of health preventive services, including monitoring and evaluation of the use of select preventive health services by at-risk Members;	5.Development of Health Education & Wellness Programs ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	DHHA has many mechanisms in place to promote wellness. One unique method is through use of screen savers displaying general health information. The screen savers are located throughout the clinics, affording members and staff the opportunity to learn. During the site review, the screen saver was about car safety seats for children.
Procedures to identify priorities and develop guidelines for appropriate preventive services;	6.Monitoring and Evaluation of Preventive Health Services ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Monitoring and evaluation of preventive health services was demonstrated in QI plan and report.
Integration of preventive health programs into the Contractor's quality assurance program and describing specific preventive care priorities, services, accomplishments, and goals as part of required reporting in the Quality Improvement Plan, Program Impact Analysis and annual report; and,	7.Preventive Health Services Priorities Identified and Guidelines Developed ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Practice guidelines are used that include adult and child preventive care.
Processes to inform and educate Participating Providers about preventive services, involve Participating Providers in the development of programs, evaluate the effectiveness of Participating Providers in providing such services		
II.E.6.d. (Page 28)		

Standard 4: Continuity of Care		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
4.14 The Contractor shall ensure that appropriate staff participates in periodic training programs sponsored by the Department designed to provide technical assistance to the Contractor with policy interpretation and coordination of services to maximize compliance with requirements. The Contractor shall be responsible for training Participating Providers and any Subcontractors. II.E.6.f (page 28)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	DHHA provided a list of training topics, training conducted and attendance sign in records.
4.15 The Contractor may offer to Members additional benefits and services beyond Covered Services. These benefits and services shall be identified in the Member handbook and a written description provided to the Department in a format and on a schedule to be determined in consultation with the Contractor. The Contractor shall submit written notification to the Department at least thirty (30) calendar days prior to the targeted effective date for offering the additional benefits and services. II.D.4.h (Page 18)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Additional benefits and services are documented in the member handbook and provider manual.
4.16 The Contractor shall communicate to its Participating Providers and Members information about Medicaid Wrap Around Benefits, which are not Covered Services under this contract but are available to Members under Medicaid fee-for service (FFS). II.D.4.i.1	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Information about wrap around services is provided via the member handbook and provider manual. DHHA has also worked with the EPSDT staff at the Department to enhance awareness of wrap around benefits to staff and providers.

Standard 4: Continuity of Care		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
4.17 The Contractor shall instruct its Participating Providers on how to refer a Member for such services. The Contractor shall advise Participating Providers of EPSDT support services that are available through local public health departments. The Contractor shall also advise post partum or breast-feeding or pregnant women of the special supplemental food program (WIC), state's special assistance program for substance abusing pregnant women, and enhanced prenatal care services. II.D.4.i.2	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Increased compliance with EPSDT has been a priority at DHHA in the past year and has included trainings by the state EPSDT staff. Social workers in the clinics help facilitate EPSDT services to members.
4.18 The Contractor shall inform its Home Health Services Providers and Members that Home Health Services after the 60 consecutive calendar days are not Covered Services but are available to Members under FFS and require prior authorization. If Home Health Services after 60 consecutive calendar days are anticipated, the Contractor shall ensure that, at least 30 days prior to the 60th day of Home Health Services, its Home Health Services Providers coordinate prior authorization with the Single Entry Point Agency for adult Members and with the Medicaid Fiscal Agent for children. II.D.4.i.3	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	This change in payor source was documented in the member handbook, and coordination with home health service providers was discussed. DHHA met this provision.
4.19 The Contractor shall comply with all requirements of EPSDT regulations at 42 C.F.R. 441.50 through 441.62, as amended to assure Members' access to EPSDT benefits.	Procedures regarding EPSDT Benefits ☒ Met	As noted in 4.16 and 4.17.

Standard 4: Continuity of Care		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
4.19-*continued* The Contractor must inform all of its Members through age 20 that EPSDT services are available including such benefits which are not Covered Services pursuant to this contract. The Contractor shall provide or arrange for the provision of all of the required screening, diagnostic and treatment components according to state and federal EPSDT standards and periodicity schedule, as contained in this contract, as described in Exhibit A. The Contractor may offer additional preventive services beyond these required standards; The Contractor shall complete and submit the annual EPSDT report, resulting from the preventive screenings, to the Department's EPSDT program administrator, on Form CMS-416, no later than February 1st, for the October 1st through September 30th period within the previous contract year. MCE Contract II.E.6.e (page 28); and 10 CCR 2505-10, Section 8.280	☐ Partially Met ☐ Not Met ☐ N/A Member Notification regarding EPSDT Benefits ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A Screening/Exam requirement regarding Periodicity Schedule ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A Screening/Exam Components ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A Documentation regarding results of Screening/Exam	Provision was demonstrated in the member handbook and open enrollment information sent to members. EPSDT requirements are listed in the provider manual. Periodicity schedule and health maintenance forms following EPSDT recommendations are available on-line for providers.

Standard 4: Continuity of Care		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
4.19-*continued*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A Diagnosis & Treatment Guidelines ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A EPSDT Outreach & Case Management ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A EPSDT Expanded Services ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	

Results for STANDARD 4	
# provisions scored as "Met"	14
# provisions scored as "Partially Met"	5
# provisions scored as "Not Met"	0
# provisions scored as "N/A"	0

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

4a. Implement practices that reflect current DHHA policies for continuity of care and evaluate compliance with the policies.

4b. Establish policies, procedures and practices that distinguish the differences between DHHA's care management and case management programs.

Standard 5: Member Rights and Responsibilities		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
5.1 The Contractor shall establish and maintain written policies and procedures for treating all Members in a manner that is consistent with all the following rights: To be treated with respect and with due consideration for his/her dignity and privacy. To receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand. To participate in decisions regarding his/her health care, including the right to refuse treatment. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. To obtain family planning services directly from any Provider duly licensed or certified to provide such services without Referral. To request and receive a copy of his/her medical records and to request that they be amended or corrected, as specified in 45 C.F.R. Part 164. To exercise his/her rights without any adverse effect on the way he/she is treated. MCE Contract II.F.1.a (page 29)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	This provision was met by P&P MBR 805 and the Member Handbook.

Standard 5: Member Rights and Responsibilities		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
5.2 The Contractor shall establish and maintain written requirements for Member participation and the responsibilities of Members in receiving Covered Services that are consistent with all responsibilities enumerated in 10 C.C.R. 2505-10, Section 8.205.2 and any amendments thereto. II.F.1.b	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	The Contractor demonstrated compliance through the Member Handbook.
5.3 The Contractor shall establish and maintain written policies and procedures regarding the rights and responsibilities of Members that incorporate the rights and responsibilities identified by the Department in this contract. These policies and procedures shall include the components described in this section and address the elements listed in Exhibit D, Member handbook requirements. II.F.1.c (page 30)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Compliance was demonstrated through P&P MBR 805.

Standard 5: Member Rights and Responsibilities		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
5.4 The Contractor shall provide to all Members, including new Members, a Member handbook that shall include general information about services offered by the Contractor and complete statements concerning Member rights and responsibilities as listed in this section within a reasonable time after the Contractor is notified of the Enrollment. Minimum requirements for information to be included in the Member handbook are listed in Exhibit D, and shall be available for review by the Department. II.F.1.d.1	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A	The Member Handbook in effect for most of the audit period did not contain some of the required information. For example, it did not contain the hours of operation of the Family Health Centers; the procedures to get the names and qualifications of providers (such as contact information); information on transportation services; contact information for the Utilization Management program; and it did not identify additional information that is available to Members only upon a request (e.g. regarding any physician incentive plans, a consumer advisory committee, or the MCO's structure and operation). A new handbook draft was under review by the Department at the time of the site visit. DHHA should take steps to assure that the new version of the Handbook contains the missing items described above.
5.5 Written information provided to Members shall be written, to the extent possible, at the sixth (6^{th}) grade level, unless otherwise directed by the Department, translated into other non-English languages prevalent in the Service Area, and provided in alternative formats as required in the contract. Members shall be informed that oral interpretation services are available for any language that written information is available in prevalent languages and how to access interpretation services. II.F.1.d.2	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	This provision was met through Document # 096 in the desk audit materials.

Standard 5: Member Rights and Responsibilities		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
5.6 The Contractor may provide Members with similar information, in the form of newsletters, etc., as is provided to private/commercial enrollees, but shall also provide Members with additional information as appropriate to promote compliance with this contract. II.F.1.d.4	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	This provision was met through Document # 097 in the desk audit materials.
5.7 The Contractor shall provide periodic updates to the Member handbook when needed to explain changes to the above policies. Prior to printing, the Contractor shall submit the updates to the Department for review and approval, at least thirty (30) calendar days prior to the targeted printing date. II.F.1.d.5	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	This provision was met through discussion during the interview and through submitted desk audit materials.
5.8 The Contractor shall provide a copy of the policies on Members' rights and responsibilities to all Participating Providers and ensure that Participating Providers are aware of information being provided to Members. II.F.1.d.6	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	The Contractor demonstrated compliance through Documents #99 and #100 in the desk audit materials.
5.9 The Contractor and its representatives shall not knowingly provide untrue or misleading information, as defined at 10-16-413 (1) (a)-(c), C.R.S. (2004), regarding the Contractor's Plan or Medicaid eligibility, to Clients or Members. II.F.1.d.7 (page 31)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Compliance was demonstrated through the Integrity Program Code of Conduct.

Standard 5: Member Rights and Responsibilities		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
5.10 The Contractor shall notify all Members of their right to request and obtain the information listed in Exhibit D at least once a year. II.F.1.d.8	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Provision was met with Document # 102.
5.11 Members shall also be notified of any significant changes in the following information at least thirty (30) days prior to the effective date of the change: The amount, duration and scope of Covered Services available in sufficient detail to ensure that Members understand the benefits to which they are entitled. Procedures for obtaining Covered Services, including authorization requirements. The extent to which, and how, Members may obtain benefits, including family planning services, from out-of-network Providers. The extent to which, and how, after-hours and Emergency Services are provided including: What constitutes an Emergency Medical Condition, Emergency Services and Post-Stabilization Care Services.	Notice 30 Days Prior ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A Description of Covered Services ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A Description of Obtaining Covered Services ☐ Met ☐ Partially Met	There were no significant changes during the previous year to the information listed in this provision.

Standard 5: Member Rights and Responsibilities		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
5.11-*continued* The fact that prior authorization is not required for an Emergency Services. The process and procedures for obtaining Emergency Services, including use of the 911 telephone system or its local Equivalent. The locations of any emergency settings and other locations at which Providers and Hospitals furnish Emergency Services and Post-Stabilization Care Services covered under the contract. The fact that, subject to the provisions of this section, the Member has the right to use any Hospital or other setting for Emergency Services. Policy on Referrals for specialty care and for other benefits not furnished by the Member's Primary Care Physician. Cost sharing, if any. How and where to access Wrap Around Benefits, including any cost sharing and how transportation is provided. For a counseling or Referral service that the Contractor does not cover because of	☐ Not Met ☒ N/A Description of Family Planning Services ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A Description of Emergency Services ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A Policy on Referrals for Specialty Care ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A Cost Sharing ☐ Met ☐ Partially Met ☐ Not Met	

Standard 5: Member Rights and Responsibilities		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
5.11-*continued* moral or religious objections, the Contractor need not furnish information on how and where to obtain the service. II.F.1.d.8 (Page 32)	☒ N/A Wrap Around Benefits ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A	
5.12 The Contractor shall facilitate culturally and linguistically appropriate care, by implementing the following requirements: Establish and maintain policies to reach out to specific cultural and ethnic Members for prevention, health education and treatment for diseases prevalent in those groups; Maintain policies to provide health care services that respect individual health care attitudes, beliefs, customs and practices of Members related to cultural affiliation; Make a reasonable effort to identify Members whose cultural norms and practices may affect their access to health care. Such efforts may include inquiries conducted by the Contractor of the language proficiency of Members during the Contractor's orientation calls or being served by Participating Providers, or improving access to health care through	1. Policies that address Prevention, Health Education and Treatment of Diseases ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A 2. Policies that consider Cultural Affiliations ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	This provision was met through discussion during the interview, through P&P MBR 802 and through Documents # 112-124 in the desk audit materials.

Standard 5: Member Rights and Responsibilities		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
5.12-*continued* community outreach and Contractor publications; Develop and/or provide cultural competency training programs, as needed, to the network Providers and Contractor staff regarding (a) health care attitudes, values, customs, and beliefs that affect access to and benefit from health care services, and (b) the medical risks associated with the Client population's racial, ethnic and socioeconomic conditions; Make available written translation of Contractor materials, including Member handbook, correspondence and newsletters. Written Member information and correspondence shall be made available in languages spoken by prevalent non-English speaking Member populations within the Contractor's Service Area. Prevalent populations shall consist of 500 or more Members speaking each language; Develop policies and procedures, as needed, on how the Contractor shall respond to requests from Participating Providers for interpreter services by a	3. Identify Members Cultural Norms and Practices ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A 4. Provide Cultural Competency Training ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A 5. Written Translation of Contractor Materials Available ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A 6. Written Materials available for	

Standard 5: Member Rights and Responsibilities		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
5.12-*continued* Qualified Interpreter. This shall occur particularly in Service Areas where language may pose a barrier so that Participating Providers can: (a) conduct the appropriate assessment and treatment of non-English speaking Members (including Members with a Communication Disability) and (b) promote accessibility and availability of Covered Services, at no cost to Members; Develop policies and procedures on how the Contractor will respond to requests from Members for interpretive services by a Qualified Interpreter or publications in alternative formats; Make a reasonable effort, when appropriate, to develop and implement a strategy to recruit and retain qualified, diverse and culturally competent clinical Providers that represent the racial and ethnic communities being served; and, Provide access to interpretative services by a Qualified Interpreter for Members with a hearing impairment in such a way that it shall promote accessibility and availability of Covered Services. Develop and maintain written policies and	prevalent non-English Speaking Members ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A 7. Policies & Procedures regarding Interpretive Services ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A 8. Strategy regarding Cultural Competent Clinical Providers ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	

Standard 5: Member Rights and Responsibilities		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
5.12-*continued* procedures to ensure compliance with requirements of the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973; Arrange for Covered Services to be provided through agreements with non-Participating Providers when the Contractor does not have the direct capacity to provide Medically Necessary Covered Services in an appropriate manner, consistent with Independent Living, to Members with Disabilities; Provide access to TDD or other equivalent methods for Members with a hearing impairment in such a way that it will promote accessibility and availability of Covered Services; and, Make Member information available upon request for Members with visual impairments, including, but not limited to, Braille, large print, or audiotapes. For Members who cannot read, member information shall be available on audiotape. II.E.6.c (page 27)	9. Access to Interpretative Services ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A 10. Policies and Procedures regarding ADA and Section 504 ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A 11. Arrangement of Services through Provider Agreements ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A 12. Access to Services for Members with Hearing Impairment	

Standard 5: Member Rights and Responsibilities		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
5.12-*continued*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A 13. Member Information Available for Members with visual impairments ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	

Results for STANDARD 5	
# provisions scored as "Met"	10
# provisions scored as "Partially Met"	1
# provisions scored as "Not Met"	0
# provisions scored as "N/A"	1

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

5. Continue to work with the Department to obtain approval of the revised Member Handbook.

Standard 6: Grievance and Appeal		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
6.1 The Contractor shall provide a Department approved description of the grievance, appeal and fair hearing procedures and timeframes to all providers and subcontractors at the time the provider or subcontractor enters into a contract with the Contractor. The description shall include: The member's right to a State fair hearing for appeals. The method to obtain a hearing, and The rules that govern representation at the hearing. The member's right to file grievances and appeals. The requirements and timeframes for filing grievances and appeals. The availability of assistance in the filing process. The toll-free numbers that the member can use to file a grievance or an appeal by telephone. The fact that, when requested by a member:	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	DHHA's description of the grievance, appeal and fair hearings procedure and timeframes has been approved by the Department and is provided to all providers and subcontractors.

Standard 6: Grievance and Appeal		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
6.1-*continued* Benefits will continue if the member files an appeal or a request for State fair hearing within the timeframes specified for filing; and The member may be required to pay the cost of services furnished while the appeal is pending in the final decision is adverse to the member. Exhibit I. 10 CCR 2505-10, Section 8.209.3.B		
6.2 The Contractor shall give members reasonable assistance in completing any forms required by the Contractor, putting oral requests for a State fair hearing into writing and taking other procedural steps, including, but not limited to, providing interpretive services and toll-free numbers that have adequate TTY/TTD and interpreter capability. Exhibit I. Section 8.209.4.C.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	DHHA has information about the availability of this assistance in the member handbook and in various policies and procedures.
6.3 The Contractor shall send the member written acknowledgement of each appeal within two (2) working days of receipt, unless the member or designated client representative requests an expedited resolution. Exhibit I. Section 8.209.4.D.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	A description of DHHA's appeal process and the appeal acknowledgement letter sent to the member was provided. An acknowledgement letter was sent within the required timeframe for all of the appeal records reviewed.

Standard 6: Grievance and Appeal		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
6.4 The Contractor shall ensure that the individuals who make decisions on appeals are individuals who were not involved in any previous level of review or decision-making and who have the appropriate clinical expertise in treating the member's condition or disease if deciding any of the following: an appeal of a denial that is based on lack of medical necessity, a grievance regarding denial of expedited resolution of an appeal, or a grievance or appeals that involves clinical issues. Exhibit I. Section 8.209.4.E.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Policy and procedure describing DHHA's process regarding appeal decision making was provided and meets the provision.
6.5 The Contractor shall accept appeals orally or in writing. Exhibit I. Section 8.209.4.F.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	The policy and procedure indicate a member can communicate an appeal orally or in writing.
6.6 The Contractor shall provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The Contractor shall inform the member of the limited time available in the case of expedited resolution. Exhibit I. Section 8.209.4.G.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	The policy and procedure states members have an opportunity to present evidence. A template letter regarding the limited time available in expedited appeal was reviewed and met the provision.

Standard 6: Grievance and Appeal		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
6.7 The Contractor shall provide the member and the designated client representative opportunity, before and during the appeal process, to examine the member's case file, including medical records and any other documents and records considered during the appeal process. Exhibit I. . Section 8.209.4.H.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Policies and procedures indicate opportunity for member to examine case file.
6.8 The Contractor shall include as parties to the appeal, the member and the designated client representative or the legal representative of a deceased member's estate. Exhibit I. Section 8.209.4.I.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Policies and procedures identify designated member representative and legal representative as parties that may be involved in the appeal process.
6.9 The Contractor shall resolve each appeal, and provide notice as expeditiously as the member's health condition requires, not to exceed the following: For standard resolution of an appeal and notice to the affected parties, ten (10) working days from the day the Contractor receives the appeal. For expedited resolution of an appeal and notice to affected parties, three (3) working days after the Contractor receives the appeal. Exhibit I. Section 8.209.4.J.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Software is used by DHHA in appeals process in order to track the resolution of appeals. Polices and procedures adhere to notification and timeframe requirements. A resolution letter was sent within the required timeframe for all of the appeal records reviewed.

Standard 6: Grievance and Appeal		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
6.10 The Contractor may extend timeframes for the resolution of appeals by up to fourteen (14) calendar days: If the member requests the extension; or The Contractor shows that there is a need for additional information and that the delay is in the member's best interest. Exhibit I. Section 8.209.4.K.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Percentage of appeals extended by DHHA and member during previous fiscal year was provided. DHHA provided the template letter sent to members when requesting an extension. The template letter specified the required timeframes. Records reviewed demonstrated compliance with required timeframes.
6.11 Member's need not exhaust the Contractor level appeal process before requesting a State fair hearing. The member shall request a State fair hearing within twenty (20) calendars days from the date of the Contractor's notice of action. Exhibit I. Section 8.209.4.N.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Information provided to member indicates ability of member to request a state fair hearing.
6.12 The Contractor shall establish and maintain an expedited review process for appeals when the Contractor determines, or the provider indicates, that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. Exhibit I. Section 8.209.4.O.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Documentation outlines expedited review process for appeals may be utilized.

Standard 6: Grievance and Appeal		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
6.13 The Contractor shall ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. Exhibit I. Section 8.209.4.P.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	DHHA informs providers that punitive action will not be taken against them when requesting an expedited resolution or supporting a member's appeal.
6.14 If the Contractor denies a request for expedited resolution, it shall transfer the appeal in the timeframe for standard resolution, make reasonable effort to give the member prompt oral notice of the denial and send a written notice of the denial for an expedited resolution within two (2) calendar days. Exhibit I. Section 8.209.4.Q.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Policies and procedures specify that if a request for an expedited resolution is denied, the timeframe for a standard resolution apply.
6.15 The Contractor shall provide for the continuation of benefits while the Contractor level appeal and the State fair hearing are pending if the member files the appeal timely, the appeal involves the termination, suspension or reduction of a previously authorized course of treatment, the services were ordered by an authorized provider, the original period covered by the original authorization has not expired and the member requests extension of benefits. Exhibit I. Section 8.209.4.R.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Documentation showed DHHA informs members and providers that benefits will continue while the appeal and state fair hearing are pending.

Standard 6: Grievance and Appeal		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
6.16 If at the member's request, the Contractor continues or reinstates the member's benefits while the appeal is pending, the benefits shall be continued until the member withdraws the appeal, ten (10) days pass after the Contractor mails the notice providing the resolution of the appeal against the member, a State fair hearing office issues a final agency decision adverse to the member, or the time period or service limits of a previously authorized service has been met. Exhibit I. Section 8.209.4.S.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Documentation provided states the requirements as outlined in 6.16.
6.17 If the Contractor or State fair hearing officer reverses a final agency decision to deny, limit or delay services that were not furnished while the appeal was pending, the Contractor shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires. Exhibit I. Section 8.209.4.U.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	DHHA provided five examples of instances where disputed services were received after a service denial decision was reversed.
6.18 If the Contractor or State fair hearing officer reverses a final agency decision to deny authorization of services and the member received the services while the appeal was pending, the Contractor must pay for those services. Exhibit I. Section 8.209.4.V.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	DHHA provided an example of a service denial decision that was reversed and the member continued to receive services while the appeal was pending.

Standard 6: Grievance and Appeal		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
6.19 The Contractor shall ensure that the individuals who make decisions on grievances are individuals who were not involved in any previous level of review or decision-making and who have the appropriate clinical expertise in treating the member's condition or disease if deciding a grievance that involves clinical issues. Exhibit I. Section 8.209.5.C.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Policy and procedure describing DHHA's process for grievance decision making was provided and met the provision.
6.20 The Contractor shall accept grievances orally or in writing. The Contractor shall dispose of each grievance and provide notice as expeditiously as the member's health condition requires, not to exceed fifteen (15) working days from the day the Contractor receives the grievance. Exhibit I. Section 8.209.5.D.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	DHHA's policy and procedure indicate a member can communicate a grievance either orally or in writing. Records reviewed demonstrated compliance with timeframes.

Standard 6: Grievance and Appeal		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
6.21 The Contractor may extend timeframes for the disposition of grievances by up to fourteen (14) calendar days: If the member requests the extension; or The Contractor shows that there is a need for additional information and that the delay is in the member's best interest. The Contractor shall give the member prior written notice of the reason for delay if the timeframe is extended. Exhibit I. Section 8.209.5.E.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	DHHA provided information regarding the number of grievance extensions by both DHHA and the member during FY 05. Records reviewed demonstrated compliance with requirements and timeframes.

Results for STANDARD 6	
# provisions scored as "Met"	21
# provisions scored as "Partially Met"	0
# provisions scored as "Not Met"	0
# provisions scored as "N/A"	0

Standard 10: Provider Issues		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
10.1 The Contractor shall ensure that Participating Providers comply with all applicable local, state and federal insurance requirements necessary in the performance of this contract. Minimum insurance requirements shall include, but not be limited to the following: Physicians participating in the Contractor's Plan shall be insured for malpractice, in an amount equal to a minimum of $0.5 million per incident and $1.5 million in aggregate per year. Facilities participating in the Contractor's Plan shall be insured for malpractice, in an amount equal to a minimum of $0.5 million per incident and $3.0 million in aggregate per year. Provision (1) and (2) of this section above shall not apply to Physicians and facilities in the Contractor's network which: Are public entities or employees pursuant to the Colorado Governmental Immunity Act, 24-10-103, C.R.S., as amended; or, Maintain any other security acceptable to the Colorado Commissioner of Insurance, which may include approved plan of self-insurance, pursuant to 13-64-301, C.R.S., as amended.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	DHHA is a public entity pursuant to Colorado Governmental Immunity Act, 24-10-103 C.R.S. and therefore for Provision (1) and (2) do not apply. Providers are employees of DHHA. Pharmacy contracts provided in the desk audit meet the requirements of this provision

Standard 10: Provider Issues		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
10.1-*continued* The Contractor shall, upon request, provide the Department with acceptable evidence that such insurance is in effect. In the event of cancellation of any such coverage, the Contractor shall, within two (2) business days, notify the Department of such cancellation. MCE Contract II.G.2 (page 35)		
10.2 No specific payment can be made directly or indirectly under a Provider incentive plan to a Provider as an inducement to reduce or limit Medically Necessary services furnished to a Member. The Contractor shall disclose to the Department or any Member or Member's Designated Client Representative, at the Department's request, information on any Provider incentive plan. The Contractor shall ensure that subcontracts containing Physician incentives comply with 42 C.F.R. 438.6, as described in Exhibit E of this contract. II.G.3	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A	DHHA does not provide incentives.

Standard 10: Provider Issues		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
10.3 For alleged quality of care concerns involving Physician Providers, the Contractor may use the process of its professional review committee, as set forth in 12-36.5-104, C.R.S., (2004) when a quality of care concern is brought to its attention. Notwithstanding any other provision in this contract, the Contractor is not required to disclose any information that is confidential by law. II.G.4 (page 36)	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A	During the previous 12 months there was a discrepancy with quality of care concerns and tracking. DHMC is currently implementing a tracking system to monitor the processing of quality of care concerns.
10.4 The Contractor shall provide or enter into subcontracts with qualified pharmacy Providers for the provision of Covered Drugs as required, and in the manner specified, by Department regulations at 10 C.C.R. 2505-10, Section 8.205.8. All subcontracts with pharmacy Providers shall be subject to all standards set forth in this contract. II.G.6	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Desk audit material documented this provision. Based on the results of pharmacy audits, DHHA is conducting a Performance Improvement Program to improve member satisfaction with pharmacy services.
10.5 The Contractor shall promptly pay claims submitted by Providers, consistent with the claims payment procedures as required by Section 10-16-106.5, C.R.S. (2004), as amended. II.G.8 (page 38)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	This provision was deemed to be met based on information shared during the interview.

Standard 10: Provider Issues		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
10.6 The Contractor shall notify the Department, in writing, of its decision to terminate any existing Participating Provider agreement where such termination will cause the delivery of Covered Services to be inadequate in a given area. The written notice shall be provided to the Department at least sixty (60) calendar days prior to termination of the services unless the termination is based upon quality or performance issues. The notice to the Department shall include a description of how the Contractor will replace the provision of Covered Services at issue. In the event that the Contractor is unable to adequately replace the affected services to the extent that accessibility will be inadequate in a given area, the Department may impose limitations on Enrollment in the area or eliminate the area from the Contractor's Service Area. II.G.9.a.	Subcontract termination notification ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A Notification 60 days prior ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A Notification includes description ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	One vision service office was termed in the last year. This office closed without notification. DHHA supplied documentation of the notification provided to the members who were waiting to receive eyeglasses from this provider. The members were directed to a different facility where the prescription was filled.
10.7 The Contractor shall make a reasonable effort to provide written notice of termination of Participating Provider agreements to Members. This shall occur within fifteen (15) calendar days after receipt, issuance of, or notice of such termination to all Members receiving Covered	Written notice ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A 15 day timeframe	Examples of the notification letters were provided in the desk audit and discussed during the interview. The letters met all of the provisions except the fact that the member may chose to disenroll from DHHA when a provider's contract is terminated.

Standard 10: Provider Issues		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
10.7-*continued*. Services on a regular basis from or through a Provider whose agreement is terminating with the Contractor, regardless of whether the termination is for cause or without cause. Where a termination involves a Primary Care Physician, all Members that receive Covered Services through that Primary Care Physician shall also be notified. Such notice shall describe how services provided by the Participating Provider will be replaced, and inform the Members of Disenrollment procedures. The Contractor shall allow Members to continue receiving care for sixty (60) calendar days from the date a Participating Provider is terminated without cause when proper notice as specified in this section has not been provided to the Members. II.G.9.b.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A Members notified regarding PCP ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A Notification includes description ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A 60 day continuation ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	See statement above.

Standard 10: Provider Issues		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
10.8 The Contractor and Participating Providers are prohibited from providing material incentives unrelated to the provision of service as an inducement to the Members to Enroll or Disenroll in the Contractor's Plan or to use the services of a particular Provider. II.G.10 (page 38)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	DHHA did not provide member incentive in this contract period.
10.9 The Contractor shall not discriminate with regards to the participation, reimbursement or indemnification of any provider who is acting within the scope of his/her license or certification under applicable state law, solely on the basis of that license or certification. If the Contractor declines to include an individual Provider or group of Providers in its network, it shall give the affected Provider/s written notice of the reasons for its decision. II.G.11 (page 39)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	This discrimination statement is documented in provider agreements. All physicians are employed by DHHA so the issue of network membership is not applicable.

Standard 10: Provider Issues		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
10.10 The Contractor shall in no way prohibit or restrict a Participating Provider, who is acting within the lawful scope of practice, from advising a Member about any aspect of his or her health status or medical care, advocating on behalf of a Member, advising about alternative treatments that may be self administered, including the risks, benefits and consequences of treatment or non-treatment so that the Member receives the information needed to decide among all available treatment options and can make decisions regarding his/her health care, regardless of whether such care is a Covered Service under this contract. II.E.3.c (page 22)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	This provision is documented in the provider contract.

Results for STANDARD 10	
# provisions scored as “Met”	7
# provisions scored as “Partially Met”	2
# provisions scored as “Not Met”	0
# provisions scored as “N/A”	1

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

10a. Implement a tracking system to monitor the quality of care concern process so that concerns are reviewed and necessary actions are taken and documented.

10b. Develop a method to communicate to members whose providers have terminated that these members have the option to disenroll as stated in provision 10.7.

Standard 11: Certifications and Program Integrity		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
11.1 The Contractor shall have a mandatory compliance plan and administrative and management arrangements or procedures that are designed to guard against fraud and abuse. The following shall be included: Written policies, procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and state requirements. Designation of a compliance officer and compliance committee that are accountable to senior management. Effective training and education for the compliance officer and the Contractor's employees. Effective lines of communication between the compliance officer and the Contractor's employees for reporting violations. Enforcement of standards through well-publicized disciplinary guidelines. Provision for internal monitoring and auditing; Provisions for prompt response to	Policies and Procedures ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A Compliance Officer Designation ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A Training and Education ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A Lines of Communication ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A Enforcement of Standards	Policies and procedures specified business conduct standards and corporate compliance program education and training. A description of the role and relationship of the compliance officer and compliance committee to senior management was provided. Fraud and abuse materials specify the training and education provided to new and existing employees. Information provided describes the lines of communication available to report fraud and abuse and how this information is conveyed to employees, providers and members. A description regarding the enforcement of standards and a provision outlining how DHHA detects offenses met the

Standard 11: Certifications and Program Integrity		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
11.1-*continued*. detected offenses and for development of corrective action initiatives. MCE Contract II.G.5.a (page 36)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A Prompt Response Provision ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	provision. DHHA also promptly develops corrective actions to prevent re-occurrence of an offense.
11.2 The Contractor shall report possible instances of Medicaid fraud to the Department within ten (10) business days of receipt of information. The Referrals shall include specific background information, the name of the Provider, and a description of how the Contractor became knowledgeable about the occurrence. II.G.5.b	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	DHHA policies and procedures regarding possible instances of fraud specify DHHA will report such instances within 10 days and meets other reporting requirements for related information.

Standard 11: Certifications and Program Integrity		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
11.3 The Contractor shall not knowingly have a relationship with the following: An individual who is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under federal Executive Order No. 12. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph "a" above. The Contractor shall not employ or contract with Providers excluded from participation in federal health care programs under either section 1128 or section 1128a of the Social Security Act. II.G.5.c (Page 37)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	A description of the process used to ensure DHHA does not knowingly have a relationship with an individual specified in 11.3 was provided.

Results for STANDARD 11	
# provisions scored as "Met"	3
# provisions scored as "Partially Met"	0
# provisions scored as "Not Met"	0
# provisions scored as "N/A"	0

Standard 12: Advance Directives		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
12.1 Contractor shall maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care by or through the contractor, as provided in 42 C.F.R. Section 489. MCE Contract II.G.7.b. (page 37)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	The Contractor demonstrated compliance with this provision through Document # 189 from desk audit materials.
12.2 The Contractor shall provide written information to those individuals with respect to the following: Their rights under the law of the state. The Contractor's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience. Contractor must inform individuals that complaints concerning noncompliance with advance directive requirements may be filed with the State survey and certification agency. II.G.7.c.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Compliance was demonstrated by Document # 190 from the desk audit materials.

Results for STANDARD 12	
# provisions scored as "Met"	2
# provisions scored as "Partially Met"	0
# provisions scored as "Not Met"	0
# provisions scored as "N/A"	0

Standard 15: Compliance and Monitoring		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
15.1 The Contractor shall comply with requirements and limitations regarding abortions, hysterectomies and surgical sterilizations and shall maintain certifications and documentation specified in 42 C.F.R. 441, Subpart F. The certifications and documentations, as well as any summary reports, shall be available to the Department within ten (10) business days of the Department's request. MCE Contract II.I.2.c (page 41)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	The Contractor demonstrated compliance through Document # 191 from the desk audit materials.

Standard 15: Compliance and Monitoring		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
15.2 The Contractor and all Subcontractors shall maintain a complete file of all records, documents, communications, and other materials which pertain to the operation of the program/project or the delivery of services under this contract sufficient to disclose fully the nature and extent of services/goods provided to each Member. These records shall be maintained according to statutory or general accounting principles and shall be easily separable from other Contractor records. Such files shall be sufficient to properly reflect all direct and indirect costs of labor, materials, equipment, supplies and services, and other costs of whatever nature for which contract payments was made and shall include but are not limited to: All Medical Records, service reports, and orders prescribing treatment plans; Records of goods, including such things as drugs and medical equipment and supplies, and copies of original invoices for such goods; and, Records of all payments received for the provision of such services or goods. II.I.5.b.1 (page 45)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	The contractor demonstrated compliance through Document # 191 from desk audit materials, demonstration of their electronic record keeping and their medical records systems at the site audit.

Standard 15: Compliance and Monitoring		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
15.3 The Contractor shall maintain records or shall have a system in place to retrieve information sufficient to identify the Physician who delivered services to the patient. II.H.5.b.2	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Contractor was able to show compliance through a demonstration of their electronic record keeping and medical records systems.
15.4 All such records, documents, communications, and other materials shall be maintained by the Contractor, for a period of six (6) years from the date of any monthly payment under this contract, or for such further period as may be necessary to resolve any matters which may be pending, or until an audit has been completed with the following qualification: If an audit by or on behalf of the federal and/or state government has begun but is not completed at the end of the six (6) year period, or if audit findings have not been resolved after a six (6) year period, the materials shall be retained until the resolution of the audit finding. II.H.5.b.3	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Compliance was demonstrated through Document # 196 from the desk audit materials.

Results for STANDARD 15	
# provisions scored as “Met”	4
# provisions scored as “Partially Met”	0
# provisions scored as “Not Met”	0
# provisions scored as “N/A”	0

Standard 17: Quality Assessment and Performance Improvement		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
17.1 The Contractor shall conduct performance improvement projects that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction. II.J.2.b.1.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Documented through desk audit materials including MQIC minutes and agenda. DHHA participates in the statewide quality initiatives and has met requirements for performance improvement projects. 2006 will be the first year for collection of HEDIS and CAHPS. DHHA has instituted a secret shopper for access to care.
17.2 The Contractor shall complete performance improvement projects in a reasonable time period in order to facilitate the integration of project findings and information into the overall quality assessment and improvement program and to produce new information on quality of care each year. II.J.2.b.4	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Performance improvement projects required by CMS have been validated for 2005. Site review discussion included an update of the current PIPs. The clinical PIP is Immunization Rates for Children Under 2 Years of Age. This is the second baseline year and 7 of 10 activities have been completed. For the validation DHHA received a met and 97%. The non-clinical PIP is Member Satisfaction with Pharmacy Services. This is the initial year of this PIP and 3 of 10 activities were completed with a partially met and 92%. Additionally, DHHA is collaborating with other groups in the health setting working with CHF disease management.
17.3 The Contractor shall analyze and respond to results indicated in the HEDIS measures. II.J.2.c.1.b	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A	DHHA will be collecting HEDIS in 2006 for the first time.

Standard 17: Quality Assessment and Performance Improvement		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
17.4 The Contractor shall monitor Member perceptions of accessibility and adequacy of services provided by the Contractor. Tools shall include the use of Member surveys, anecdotal information, grievance and appeals data and Enrollment and Disenrollment information. The monitoring results shall be included as part of the Contractor's Program Impact Analysis and Annual Report submission. II.J.2.d.1	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	DHHA will be involved in CAHPS for the first time in 2006. Currently DHHA provides quarterly grievance and appeal reports and has not identified any trends.
17.5 The Contractor shall fund an annual Member satisfaction survey, determined by the Department, and administered by a certified survey vendor, according to survey protocols. In lieu of a satisfaction survey conducted by an external entity, the Department, at the Department's discretion, may conduct the survey. In addition, the Contractor shall report to the Department results of internal satisfaction surveys of Members designed to identify areas of satisfaction and dissatisfaction by June 30th of each fiscal year. II.J.2.d.2 (page 54)	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A	CAHPS to begin in 2006. DHHA has conducted one secret shopper survey about obtaining appointments. The results were mixed and an internal corrective action is currently being implemented.
17.6 The Contractor shall develop a corrective action plan when Members report statistically significant levels of dissatisfaction, when a pattern of complaint is detected, or when a serious complaint is reported. II.J.2.d.3	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Each clinic is completing the PDSA cycle to determine the clinic hours that will meet the needs of the client and the staff.

Standard 17: Quality Assessment and Performance Improvement		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
17.7 The Contractor shall implement and maintain a mechanism to assess the quality and appropriateness of care for Persons with Special Health Care Needs. II.J.2.d.4	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Policies submitted for the desk audit documented this mechanism. During the interview there was discussion about welcome calls for clients with special needs. DHHA's quality department has participated in the state focus study addressing EPSDT services which has a component for the special needs population.
17.8 The Contractor shall implement and maintain a mechanism to detect over and under utilization of services. II.J.2.e	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Desk audit provided a utilization report and met the provision.
17.9 The Contractor shall investigate any alleged quality of care concerns, upon request of the Department. II.J.2.f.1	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	During the previous 12 months there has been a discrepancy with quality of care concerns and tracking these. DHMC is currently implementing a tracking system to monitor the processing of quality of care concerns (identified in provision 10).
17.10 The Contractor shall maintain a process for evaluating the impact and effectiveness of the quality assessment and improvement program on at least an annual basis. II.I.2.h.1	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	Documented with QI annual report, QI plan and MQIC minutes.

Standard 17: Quality Assessment and Performance Improvement		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
17.11 The Contractor shall submit an annual report to the Department, detailing the findings of the program impact analysis. The report shall describe techniques used by the Contractor to improve performance, the outcome of each performance improvement project and the overall impact and effectiveness of the quality assessment and improvement program. The report shall be submitted by the last business day of September for the preceding fiscal year's quality activity or at a time the contract has been terminated. II.J.2.h.2	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	All reports were reviewed and accepted. All reports met time requirements. The annual QI report met all of the recommended elements. Baseline measurements for all categories and stratification of the population with an emphasis on diabetes, EPSDT, and prenatal care.
17.12 The Program Impact Analysis and Annual Report shall provide sufficient detail for Department staff to validate the Contractor's performance improvement projects according to 42 C.F.R. parts 433 and 438, External Quality Review of Medicaid Managed Care Organizations. II.J.2.h.3	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	PIPs for 2005 were validated successfully by EQRO.
17.13 Upon request, this information shall be made available to Providers and Members at no cost. II.J.2.h.4	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	This statement is listed on page 16 of member handbook.

Standard 17: Quality Assessment and Performance Improvement		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
17.14 The Contractor shall provide a quality improvement plan, to the Department by the last business day in September. The plan shall delineate current and future quality assessment and performance improvement activities. The plan shall integrate finding and opportunities for improvement identified in focused studies, HEDIS measurements, enrollee satisfaction surveys and other monitoring and quality activities. The plan is subject to the Department's approval. II.J.2.i	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	QI plan was submitted, reviewed, approved and met all time requirements.
17.15 The Contractor shall participate in the annual external independent review of quality outcomes, timeliness of, and access to the services covered under this contract. The external review may include but not be limited to all of any of the following: Medical Record review, performance improvement projects and studies, surveys, calculation and audit of quality and utilization indicators, administrative data analyses and review of individual cases. II.J.2.j.1	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	DHHA participated in the annual Technical Report submitted to CMS.
17.16 For external review activities involving Medical Record abstraction, the Contractor shall be responsible for obtaining copies of the Medical Records from the sites in which the services reflected in the encounter occurred. II.J.2.j.2 (page 56)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	DHHA is contracting with an external agency to conduct medical record abstraction. This agency is NCQA certified to conduct this audit.

Standard 17: Quality Assessment and Performance Improvement		
Regulatory/Contractual Provision	**Elements**	**Site Review Results**
17.17 The Contractor shall maintain a health information system that collects, analyzes, integrates and reports data. The system shall provide information on areas including, but not limited to, utilization, grievances and appeals, encounters and Disenrollment. II.J.2.k.1	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	This provision was met through the desk audit and during the site visit.
17.18 The Contractor shall collect data on Member and Provider characteristics and on services furnished to Members. II.J.2.k.2	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	The required information is reported in quarterly reports to the Department and is in the quality improvement plan.

Results for STANDARD 17	
# provisions scored as “Met”	16
# provisions scored as “Partially Met”	0
# provisions scored as “Not Met”	0
# provisions scored as “N/A”	2