State of Colorado

Department of Health Care Policy & Financing

Medical & CHP+ Program Administration Office

Quality Improvement Section

FY 08 Site Review Findings for Denver Health Medicaid Choice (DHMC)

August 2008

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

As part of the Colorado Department of Health Care Policy 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 to review records on-site and interview relevant staff.

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. The final monitoring tool is used in the site reviews and a site review schedule is determined in collaboration with the MCEs.

In 2008, the site review team completed a focused site review. The four contract provisions focused on were: the grievance and appeals process, the quality assurance program, credentialing and recredentialing of providers, and the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. These contract provisions were chosen based on Departmental priorities as well as the need to review all contract provisions within a three year cycle.

When 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 conducts a visit 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 may also review a sample of records to assess compliance in any area where on-site record review is required due to patient or provider privacy laws. 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" requires 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. FY08 Site Review Findings

Denver Health Medicaid Choice's (DHMC) compliance with 4 contractual and regulatory provisions was assessed during this year's site review. The site review team assigned a score for each regulatory/contractual element and aggregated these scores to arrive at a finding for each provision as shown below. DHHA's overall score for this site review is 98%.

Summary of Findings, FY08 Site Review, DHHA					
Regulatory/Contractual Topics	**# Provisions**	**# Provisions Met**	**# Provisions Partially Met**	**# Provisions Not Met**	**# Provisions not applicable**
Standard 1: Grievance and Appeals	20	12	0	1	7
Standard 2: Quality Assurance Program	14	13	1	0	0
Standard 3: Credentialing and Recredentialing	39	38	0	0	1
Standard 4: Early and Periodic Screening Diagnosis and Treatment (EPSDT) Program	10	10	0	0	0
Total	**83**	**73**	**1**	**1**	**8**
Percent of 2007 corrective actions completed: 33%					

Details regarding DHMC's compliance with the provisions, including the scores for each element, can be found in Appendix I of this report. A summary finding for each contract provision was determined by adding the number of compliant provisions DHMC received out of the number of applicable provisions. For the records reviewed, each record was evaluated based on the total number of DHMC's compliant elements out of the applicable elements. A finding for each record review area was determined based on the number of DHMC's compliant elements out of the applicable elements.

DHMC earned a score of "Met" for 73 provisions. One contract provision was deemed "Not Met" and 1 provision was deemed "Partially Met". Details of these scores are provided, by provision element, in Appendix I.

IV. Required Corrective Actions for "Partially Met" and "Not Met" Provisions

Standard 1: Grievance and Appeals

Provision 1.5 DHMC shall accept appeals orally or in writing.

Finding: Provision not met. Record review shows requests for appeals are not processed as appeals. Denver Health commented that their other lines of business follow different guidelines in regard to processing appeals and it's difficult to carve out a procedure solely for Medicaid.

Colorado Regulation 10 CCR 2505-10, Section 8.209; The Medicare Managed Care Manual (http://www.cms.hhs.gov/manuals/downloads/mc86c13.pdf), Section 10-16-113 C.R.S., and the Colorado Division of Insurance (http://www.dora.state.co.us/Insurance/consumer/2007docs/) all require complaints against an organization's determination concerning the benefits to which an enrollee is, or believes he/she is, entitled, i.e., payment or provision of services, to be processed as an appeal.

Corrective action: Plan shall provide evidence that the appeals process is revised to ensure that requests for appeals are processed as appeals.

Additional recommendation: Denial letters should be addressed to the member and carbon copied (cc'd) to the requesting provider. Currently, denials are addressed to the provider and cc'd to the member. This may give the member the impression that the provider is appealing the denial. Additionally, this makes it appear that the member is a bystander in the decision making process about their care.

Standard 2: Quality Assessment and Performance Management

Provision 2.6 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.

Finding: Provision met, however, although the plan reviews member satisfaction data from several sources, there is no one system in place that compiles several sources for member information in a way that would help staff recognize a pattern from which to develop a corrective action plan as needed.

Recommendation: Plan should consider developing a system that compiles several sources for member information in a way that would help staff recognize a pattern from which to develop a corrective action plan as needed.

Provision 2.7 The Contractor shall implement and maintain a mechanism to assess the quality and appropriateness of care for Persons with Special Health Care Needs.

Finding: Provision is partially met. DHMC uses an intake form upon enrollment that can identify persons with special health care needs. However, there is no evidence that the care for people with special health care needs within the case management program is re-assessed for appropriateness and quality on a periodic basis. Additionally, DHMC's case management program does not specifically address the Departmental definition of Persons with Special Health Care Needs and, therefore, may not be appropriate for members whose conditions meet the definition.

Although Denver Health makes a good effort to identify clients with special health care needs during the initial intake process; it is not clear that Denver Health has a mechanism to identify those who attain the definitional status of special health care needs after they have become a member.

Corrective Action: Plan shall provide evidence of a system to identify special health care needs clients as that term is defined in contract and Department rules. The Plan shall describe how it assesses the quality and appropriateness of care on an on-going basis to assure that the specific contractual requirements for this population are being met. Finally, the plan shall provide evidence of a mechanism to identify those who attain the definitional status of special health care needs after they have become a member.

Standard 4: Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program

Provision 4.5 The plan provides eligible members screening according to the Periodicity Schedule.

Finding: Compliance evidenced by: on-site chart reviews; interviews with case managers, medical director and QI staff. However, DHHA does not track wrap-around EPSDT benefits such as routine dental appointments and hearing and vision examinations according to the periodicity schedule.

Recommendation: The Department acknowledges that dental, vision and hearing screenings are oftentimes completed out of network. It is difficult for a plan to track services if the plan does not have an associated claim for the service. However, the standard of comprehensive and coordinated care is only met when the plan conveys to its providers all of the services a client receives and alerts a provider when a client is in need of routine screening services, regardless of where those services are obtained.

DHHA and the Department will work together to discover solutions to this problem. It is imperative that, as a managed care entity, DHHA ensures that routine pediatric screening services are tracked according to the established periodicity schedule, even if those services are delivered out-of-network.

IV. Summary of FY 07Corrective Action Plan Progress

During this year's site review process, the Department reviewed DHMC's progress on the 2007 Corrective Action Plans (CAPs). A complete list of the DHMC 2007 corrective actions is in Appendix II. The expectation is that the MCE will make significant progress on all approved CAPs by the time the next year site review occurs. The following chart shows the progress DHMC has made in completing its 2007 CAPs.

Summary of FY07 Corrective Action Plan (CAP) Progress, DHMC		
Regulatory/Contractual Topics	**Status of CAP: Completed (C), Partially Completed (PC), Incomplete (I)**	**Comments**
Audits and Reporting Section		
CAP 1: accurate encounter data submission	I	There is no evidence that corrective measures were taken (such as the adoption of error-checking policies and procedures) to assure that the encounter data is always accurate and always accompanied by the proper certification.
CAP 2: fiscal agent notification of TPL	I	No evidence of activity was taken to complete this CAP.
Claims Processing Section		
CAP 3: Internal audit of claims encounter data	I	The internal audit did not review the necessary 411 records, nor did the audit validate that the medical records were coded correctly (i.e. there was no upcoding or unbundling of services).
CAP 4: Plan to guard against fraud/abuse in provider billing	I	There was no evidence of changes to policies, procedures, nor the adoption of any mechanisms to guard against fraud and abuse in provider billings.
CAP 5: Compliance with claims payment procedures	I	The test of 60 claims for timely payment does not demonstrate that the hundreds of thousands of processed claims in 2007 were compliant with CRS 10-16-106.5.
CAP 6: Compliance with 42 C.F.R. Section 441(F)	I	No evidence of activity was taken to complete this CAP.
CAP 7: Medical records maintenance	I	No evidence of activity was taken to complete this CAP.
Confidentiality Section		
CAP 8: Compliance with privacy laws	C	
CAP 9: Coordination with behavioral health providers	I	There was no evidence presented that Denver Health coordinates care and services with any BHO, other than to require the Member to make a once-yearly PCP appointment to assure compliance with 340B pricing rules.

CAP 10: Clearly written criteria and procedures	PC	While providers are notified that case planning exists, there is no evidence that providers are informed that providers should, or even know how to, initiate case planning. There was no evidence provided that members were advised of case planning.
CAP 11: prn Needs assessments	I	The list of clients receiving case management does not demonstrate that Members are receiving appropriate needs assessments.
CAP 12: services for people with SHCN	I	The evidence provided the Site reviewer was not responsive to the CAP.
CAP 13: Implementing advanced directives	I	No evidence of activity was taken to complete this CAP.
CAP 14: Cultural competency training	I	No evidence of activity was taken to complete this CAP.
CAP 15: Culturally appropriate care	I	No evidence of activity was taken to complete this CAP.
CAP 16: Policies r/t cultural competency	I	No evidence of activity was taken to complete this CAP.
CAP 17: Supporting members w. hearing impairments	C	
CAP 18: Member materials at 6th grade level	PC	Polices and procedures exist, however, no evidence was provided of any mechanism to assure that the policies and procedures were followed. The pattern denial letter provided to the Site Reviewers was not at the appropriate 6th grade reading level.
CAP 19: Coordination of care and community services	I	The evidence provided the Site reviewer was not responsive to the CAP.
CAP 20: Referrals process promotes coordination of care	I	The evidence provided the Site reviewer was not responsive to the CAP.
CAP 21: Accommodation for members with visual impairments	PC	Polices and procedures exist to provide materials to Members with visual impairments, however, no evidence was provided that Denver Health had identified such Members to provide them with notification that the materials exist.
CAP 22: Information available on audiotape	PC	Polices and procedures exist to provide audio materials to Members who cannot read, however, no evidence was provided that Denver Health had identified such Members in order to inform them that the audio materials exist.
CAP 23: Written materials for members' rights	C	
CAP 24: Member rights and responsibilities in handbook	C	

Totals	4 of 24 CAPS are Completed 4 of 24 CAPS are Partially Completed (see comments) 16 of 24 CAPS are Incomplete (see comments)	

Appendix I - State of Colorado
Department of Health Care Policy & Financing
Medical and CHP+ Program Administration Office
Quality Improvement Section

Site Audit Findings – Denver Health Managed Choice

May 2008

Regulatory/Contractual Provision	Scoring	Site Review Results
1.1 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: -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.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 1 Grievance and Appeals\1.1\1.1.doc Evidence of compliance was provided by: Policy & Procedures Appeal letters Member handbook

Regulatory/Contractual Provision	Scoring	Site Review Results
10 CCR 2505-10, Section 8.209.3.B		
1.2 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	..\Desk Audit Materials\Standard 1 Grievance and Appeals\1.2\1.2.doc Evidence of compliance was provided by: Member handbook
1.3 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	..\Desk Audit Materials\Standard 1 Grievance and Appeals\1.3\1.3.doc No appeals recorded
1.4 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	..\Desk Audit Materials\Standard 1 Grievance and Appeals\1.4 Evidence of compliance was provided by: Policy & Procedures 11 denial files

Regulatory/Contractual Provision	Scoring	Site Review Results
1.5 The Contractor shall accept appeals orally or in writing. Exhibit I. Section 8.209.4.F.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A	..\Desk Audit Materials\Standard 1 Grievance and Appeals\1.5\1.5.doc Reviewed: Policy & Procedure 11 denial files reviewed Record review shows requests for appeals are not processed as appeals. See CAP
1.6 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	..\Desk Audit Materials\Standard 1 Grievance and Appeals\1.6\1.6.doc Evidence of compliance was provided by: Policy & Procedure
1.7 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	..\Desk Audit Materials\Standard 1 Grievance and Appeals\1.7\1.7.doc Evidence of compliance was provided by: Member handbook
1.9 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)	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A	..\Desk Audit Materials\Standard 1 Grievance and Appeals\1.9\1.9.doc No appeals recorded

Regulatory/Contractual Provision	Scoring	Site Review Results
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.		
1.10 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	..\Desk Audit Materials\Standard 1 Grievance and Appeals\1.10\1.10.doc Evidence of compliance was provided by: Member handbook
1.11 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	..\Desk Audit Materials\Standard 1 Grievance and Appeals\1.11\1.11.doc Evidence of compliance was provided by: Member handbook Denial letter

Regulatory/Contractual Provision	Scoring	Site Review Results
1.12 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	..\Desk Audit Materials\Standard 1 Grievance and Appeals\1.12\1.12.doc Evidence of compliance was provided by: Policy & Procedures Member handbook Denial letter
1.13 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	..\Desk Audit Materials\Standard 1 Grievance and Appeals\1.13\1.13.doc Evidence of compliance was provided by: Provider handbook
1.14 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	..\Desk Audit Materials\Standard 1 Grievance and Appeals\1.14\1.14.doc Evidence of compliance was provided by: Policy & Procedures

Regulatory/Contractual Provision	Scoring	Site Review Results
1.15 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	..\Desk Audit Materials\Standard 1 Grievance and Appeals\1.15\1.15.doc No appeals recorded
1.16 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	..\Desk Audit Materials\Standard 1 Grievance and Appeals\1.16\1.16.doc No appeals recorded
1.17 If the final agency decision or State fair hearing officer reversed a Contractor's 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.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A	..\Desk Audit Materials\Standard 1 Grievance and Appeals\1.17\1.17.doc No appeals recorded

Regulatory/Contractual Provision	Scoring	Site Review Results
Exhibit I. Section 8.209.4.U.		
1.18 If the State hearing officer or final agency decision reversed the Contractor's 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	..\Desk Audit Materials\Standard 1 Grievance and Appeals\1.18\1.18.doc No appeals recorded
1.19 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	..\Desk Audit Materials\Standard 1 Grievance and Appeals\1.19\1.19.doc This element is appropriately addressed in 1.4
1.20 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	..\Desk Audit Materials\Standard 1 Grievance and Appeals\1.20\1.20.doc Evidence of compliance was provided by: 11 grievance files reviewed

Regulatory/Contractual Provision	Scoring	Site Review Results
1.21 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	..\Desk Audit Materials\Standard 1 Grievance and Appeals\1.21\1.21.doc Evidence of compliance was provided by: 11 grievance files reviewed

Results for Standard 1	
# provisions scored as "Met"	12
# provisions scored as "Partially Met"	0
# provisions scored as "Not Met"	1
# provisions scored as "N/A"	7
Total provisions	20

Regulatory/Contractual Provision	Scoring	Site Review Results
2.1 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	../Desk%20Audit%20Materials/Standard%202%20Quality%20Assessment%20and%20Performance%20Improvement/2.1/ Compliance demonstrated by: PIPs submitted to Department's EQRO for validation on-time and correctly.
2.2 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	..\Desk Audit Materials\Standard 2 Quality Assessment and Performance Improvement\2.2 Compliance demonstrated by: PIPs submitted to Department's EQRO for validation on-time and correctly
2.3 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	..\Desk Audit Materials\Standard 2 Quality Assessment and Performance Improvement\2.3 Compliance demonstrated by DHMC QI team meeting minutes and Program Impact Analysis Report submitted to the Department annually.

Regulatory/Contractual Provision	Scoring	Site Review Results
2.4 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	../Desk%20Audit%20Materials/Standard%202%20Quality%20Assessment%20and%20Performance%20Improvement/2.4 Compliance demonstrated by: annual submission of CAHPS survey, DHMC QI secret shopper calls, and Program Impact Analysis report submitted yearly to the Department.
2.5 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	..\Desk Audit Materials\Standard 2 Quality Assessment and Performance Improvement \2.5 Compliance demonstrated by: CAHPS survey is conducted annually and results are reported in the Annual QI report.
2.6 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	..\Desk Audit Materials\Standard 2 Quality Assessment andPerformance Improvement\2.6 – Compliance demonstrated by: DHHA collects data via the CAHPS client survey and reports in QI plan as well as QI team meeting minutes. Unable to assess how *patterns* are detected related to patient satisfaction

Regulatory/Contractual Provision	Scoring	Site Review Results
2.7 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	..\Desk Audit Materials\Standard 2 Quality Assessment andPerformance Improvement\2.7 Compliance demonstrated by: plan provided a copy of the initial member assessment to help ID members' needs upon enrollment. The plan also provided evidence of a case management program that addresses many needs of those with chronic health care issues. However, there is no evidence that the care for people with special health care needs within the case management program is re-assessed for appropriateness and quality on a periodic basis. Additionally, DHMC's case management program does not specifically address the Departmental definition of Persons with Special Health Care Needs and, therefore, may not be appropriate for members whose conditions meet the definition. Although Denver Health makes a good effort to identify clients with special health care needs during the initial intake process; it is not clear that Denver Health has a mechanism to identify those who attain the definitional status of special health care needs after they have become a member.
2.9 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	..\Desk Audit Materials\Standard 2 Quality Assessment andPerformance Improvement\2.9 Compliance demonstrated by: DHHA reported 2 QOC incidents as part of desk audit information, both reported as grievances and investigated.
2.10 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.	☒ Met ☐ Partially Met ☐ Not Met	..\Desk Audit Materials\Standard 2 Quality Assessment andPerformanceImprovement\2.10 : nothing in this folder Compliance demonstrated by: QI staff meeting minutes shows

Regulatory/Contractual Provision	Scoring	Site Review Results
II.I.2.h.1	☐ N/A	discussion of QI program impact analysis as well as an annually submitted work plan and Program Impact Analysis report.
2.11 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	..\Desk Audit Materials\Standard 2 Quality Assessment andPerformanceImprovement\2.11 – this is an empty folder Compliance demonstrated by: QI plan and program analysis submitted to the Department in a timely and complete manner.
2.12 Upon request, this information (Program Impact Analysis and Annual Report) shall be made available to Providers and Members at no cost. II.J.2.h.4	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 2 Quality Assessment andPerformanceImprovement\2.12 Compliance demonstrated by: information cited in member handbook.

Regulatory/Contractual Provision	Scoring	Site Review Results
2.13 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	..\Desk Audit Materials\Standard 2 Quality Assessment andPerformanceImprovement\2.13 Compliance demonstrated by: QI plan provided in a timely manner and is complete.
2.14 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	..\Desk Audit Materials\Standard 2 Quality Assessment andPerformanceImprovement\2.14 Compliance demonstrated by: description of Managedcare.com system satisfies this provision along with quarterly reports DHHA submits to the Department re: Grievance and Appeals, Network Adequacy, and Enrollment and Disenrollment.
2.15 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	..\Desk Audit Materials\Standard 2 Quality Assessment andPerformanceImprovement\2.15 Compliance demonstrated by: demonstration of EHR admission fields.

Results for Standard 2	
# provisions scored as "Met"	13
# provisions scored as "Partially Met"	1

# provisions scored as “Not Met”	0
# provisions scored as “N/A”	0
Total provisions	14

Regulatory/Contractual Provision	Scoring	Site Review Results
3.1 The Contractor shall have written policies and procedures for the selection and retention of Providers. MCE Contract II.G.1.a (page 34)	☒ Met	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.1 Evidence of compliance provided in desk audit request via policy and procedures documents.
3.1.1 The credentialing policies and procedures specify the types of practitioners to credential and recredential.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.1.1 Compliance demonstrated by: 3.1a Health Professional Supervision and Competency Assessment, 3.1a Allied Health Credentialing P&P, 3.1a 3.3 3.7 Choice CRE 1501
3.1.2 The credentialing policies and procedures specify the verification sources used.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.1.2 Compliance demonstrated by: 3.1a Allied Health Credentialing P&P, 3.1 b Exc Providers P&P, 1701G Sanction Lisa
3.1.3 The credentialing policies and procedures specify the criteria for credentialing and recredentialing.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.1.3 Compliance demonstrated by: 3.1 g, I, k 3.5 Appointment Procedures Jan 08
3.1.4 The credentialing policies and procedures specify the process for making credentialing and recredentialing decisions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.1.4 Compliance demonstrated by: 3.1 g, I, k 3.5 Appointment Procedures Jan 08, 3.1 g MSO Bylaws May 2001
3.1.5 The credentialing policies and procedures specify the process for managing credentialing files that meet the plan's established criteria.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.1.5 Compliance demonstrated by: 3.1a 3.3 3.7 Choice CRE 1501, 3.3.18 Site Visit Result Letter
3.1.6 The credentialing policies and procedures specify the process for notifying practitioners if information obtained during the credentialing	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.1.6 Compliance demonstrated by: 3.1a 3.3 3.7 Choice CRE 1501

Regulatory/Contractual Provision	Scoring	Site Review Results
process varies substantially from the information they provided.		
3.1.7 The credentialing policies and procedures specify the process for ensuring that practitioners are notified of the credentialing and recredentialing decision within 60 calendar days of the Credentialing Committee's decision.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.1.7 Compliance demonstrated by: 3.1a 3.3 3.7 Choice CRE 1501, Correspondence from record review
3.1.8 The credentialing policies and procedures specify the process for delegating credentialing or recredentialing.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.1.8 Compliance demonstrated by: 3.1e Delegating/Credentialing
3.1.9 The credentialing policies and procedures specify the process for ensuring that credentialing and recredentialing are conducted in a nondiscriminatory manner.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.1.9 Compliance demonstrated by: 3.1.g, I, k 3.5 Appointment Procedures
3.1.10 The credentialing policies and procedures specify the medical director or other designated physician's direct responsibility and participation in the credentialing program.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.1.10 Compliance demonstrated by: 3.1g MSO Bylaws May 2007
3.1.11 The credentialing policies and procedures specify the process for ensuring the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.1.11 Compliance demonstrated by: 3.1 g, I, k 3.5 Appointment Procedures
3.1.12 The credentialing policies and procedures specify the process for ensuring that listings in provider directories are consistent with	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.1.12 Compliance demonstrated by: 3.1a 3.3 3.7 Choice CRE 1501, 2007 Provider Directory

Regulatory/Contractual Provision	Scoring	Site Review Results
credentialing data.		
3.2. The languages spoken of all physicians are captured in a manner to enable reporting to members. II.E.6.c.8	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.2 Evidence of compliance provided by: record review documentation shows that DHHA captures languages spoken on application and in the provider handbook available to members.
3.3. The Contractor's credentialing program shall comply with the standards of the National Committee on Quality Assurance (NCQA) for initial credentialing and re-credentialing of Participating Providers. The Contractor may use information from the accreditation of primary care clinics by the Joint Commission on Accreditation of Health Care Organization (JCAHO) to assist in meeting NCQA credentialing standards. II.G.1.c	☒ Met	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.3 Compliance demonstrated by: 3.1a 3.3 3.7 Choice CRE 1501, 3.1.g, I, k 3.5 Appointment Procedures, 3.1 e DHHA delegated audit Sep 24 07 Sandra
3.3.1 Physicians have a current valid license to practice, no older than 180 days at the time of the credentialing decision (initial credentialing and recredentialing)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.3.1 Found evidence of in the record review.
3.3.2 Physicians have a valid DEA or CDS certificate (initial credentialing and recredentialing)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.3.2 Found evidence of in the record review.
3.3.3 If Board certification is stated on the application, verification of Board certification is conducted. The	☒ Met ☐ Partially Met ☐ Not Met	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.3.3 Found evidence of in the record review.

Regulatory/Contractual Provision	Scoring	Site Review Results
verification must have been done within 180 days of the credentialing decision (initial credentialing and recredentialing).	☐ N/A	
3.3.4 Verification of either medical school graduation or residency training is conducted upon initial credentialing).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.3.4 Found evidence of in the record review.
3.3.5 Physicians provide a list of any professional liability claims (malpractice history) that resulted in either settlement or judgment during the last five years (3 years if recredentialing)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.3.5 Found evidence of in the record review.
3.3.6 Physicians provide a 5 year work history of relevant experience for initial credentialing.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.3.6 Found evidence of in the record review.
3.3.7 Physician applications ask for any past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the physician has had privileges.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.3.7 Found evidence of on the application.
3.3.8 Physician applications ask for any loss of license or felony convictions (initial credentialing and recredentialing).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.3.8 Found evidence of on the application.
3.3.9 Physician applications ask for any reasons for an inability to perform the essential functions of the position, with or without accommodation (initial credentialing and recredentialing).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.3.9 Found evidence of on the application.

Regulatory/Contractual Provision	Scoring	Site Review Results
3.3.10 Verification of state license sanctions, restrictions and/or limitations on the scope of practice within the last 5 years of the application date for initial credentialing and 3 years for recredentialing is conducted	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.3.10 Found evidence of in the record review
3.3.11 Physician attests to having malpractice (professional liability) insurance coverage in the amount of $500,000 per incident and $1,500,000 in aggregate per year (initial credentialing and recredentialing).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.3.11 Found evidence of in the record review.
3.3.12 Physician applications are signed within 180 days of the credentialing/recredentialing decision**.**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.3.12 Found evidence of in the record review.
3.3.13 Physician application contains a statement as to the correctness and completeness of the information contained on the application (initial credentialing and recredentialing).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	.\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.3.13 Found evidence of on the application.
3.3.14 A mechanism exists to verify that a physician has not been sanctioned by Medicare or Medicaid for the past 5 years (3 years if recredentialing).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.3.14 Found evidence of in the record review.
3.3.15 Physician applications are signed and dated within 180 days of credentialing decision (initial credentialing and recredentialing)..	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.3.15 This standard is the same as 3.3.12. Did not rate this standard.

Regulatory/Contractual Provision	Scoring	Site Review Results
3.3.16 If a physician's application is denied, the affected physician is provided written notice of the reason for the denial (initial credentialing and recredentialing).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.3.16 Compliance demonstrated by: 3.1h 3.6 ATTB Fair Hearing Plan, 3.3.16 2007 no provisions denied for credentialing
3.3.17 Site visits to assess record keeping processes are conducted to all high volume offices of physicians upon initial credentialing.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.3.17 Found evidence of in the record review.
3.3.18 The site visit survey process includes standards and thresholds for physical accessibility, physical appearance, adequacy of waiting time, adequacy of exam room space, availability of appointments and adequacy of treatment record keeping.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.3.18 Compliance demonstrated by: CRE 1503 P&P, 3.3.18 Site Visit Result Letter, verified records.
3.3.19 The Credentialing Committee is comprised of a range of participating physicians.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.3.19 Compliance demonstrated by: 3.1a 3.3 3.7 Choice CRE 1501

Regulatory/Contractual Provision	Scoring	Site Review Results
3.4. The Contractor shall assure that all laboratory-testing sites providing services under this contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration along with a CLIA registration number. Those laboratories with Certificates of Waiver will provide only the nine (9) types of tests permitted under the terms of the Waiver. Laboratories with Certificates of Registration may perform a full range of laboratory tests. II.G.1.e	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.4 Compliance demonstrated by: 3.4 DHA CLIA 2008
3.5. The Contractor's Provider selection policies and procedures shall not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment. II.G.1.f (page 35)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.5 Compliance demonstrated by: 3.1 g, I, k 3.5 Appointment Procedures
3.6 A defined professional review process is used to investigate any alleged quality of care concerns against physicians.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.6 Compliance demonstrated by: 3.1b Exc Providers P&P, 1701G Sanction List, 3.1h 3.6 ATTB Fair Hearing Plan

Regulatory/Contractual Provision	Scoring	Site Review Results
3.7 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	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.7 Compliance demonstrated by: 3.1 g, I, k 3.5 Appointment Procedures Jan 08, Choice CRE 1501.
3.8 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.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 3 Licensure and Credentialing\3.8 Compliance demonstrated by: 3.8 MCD Facilities Roster and record review

Results for Standard 3	
# elements scored as "Met"	38
# elements scored as "Partially Met"	0
# elements scored as "Not Met"	0
# elements scored as "N/A"	1
Total Provisions	39

Regulatory/Contract Provision	Scoring	Site Review Results
4.1 The Contractor shall comply with all requirements of EPSDT rules at 42 C.F.R. 441.50 through 441.62, as amended to assure Members' access to EPSDT benefits including such benefits which are not Covered Services pursuant to this contract. MCE Contract II.E.6.e (page 28); and 10 CCR 2505-10, Section 8.280	**Scoring for this provision was broken down into more measurable parts; please see below.	..\Desk Audit Materials\Standard 4 EPSDT\4.1
4.2 The Contractor must inform all Medicaid – eligible persons under 21 that EPSDT services are available including where and how to obtain those services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 4 EPSDT\4.2 Evidence of compliance was provided by: Member Handbook, member postcards
4.3 The Contractor must offer members that **assistance with necessary transportation** and scheduling is available to the child upon request.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 4 EPSDT\4.3 Interviews w/ case managers and Medical Director provided evidence of meeting this provision.

Regulatory/Contract Provision	Scoring	Site Review Results
4.4 The plan provides **EPSDT information** to members that is clear and non-technical and has the ability to effectively inform those who are blind or deaf or who cannot read or understand the English language exists.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 4 EPSDT\4.4 – this folder is empty Upon enrollment, member is assessed for special needs as evidenced by interview with case managers and
4.5 The plan provides eligible members screening according to the **Periodicity Schedule**. (If written verification exists that the most recent age-appropriate screening has already been done the plan need not provide the service.)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 4 EPSDT\4.5 Compliance evidenced by: on-site chart reviews; interviews with case managers, medical director and QI staff.
4.6 The plan provides **diagnosis and treatment** necessary to address conditions indicated by the screening.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 4 EPSDT\4.6 Interview with case managers and Medical Director provides evidence of this provision
4.7 The plan provides for the **timely provision** of EPSDT services which meet reasonable standards of medical and dental practice (generally within an outer limit of 6 months after the request for screening svcs).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 4 EPSDT\4.7 Compliance provided by: interview with case managers and Medical Director shows evidence that efforts are made to ensure timely provision of preventive care physical check-ups.

Regulatory/Contract Provision	Scoring	Site Review Results
4.8 The plan provides for a **continuing care provider** that documents the screening, diagnosis, treatment and referral as required.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 4 EPSDT\4.8 Compliance demonstrated through Member assignment a provider at the time of enrollment.

4.9 The plan provides for **referral assistance** for treatment not covered by the plan but found to be needed as a result of conditions identified through screening and diagnosis.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 4 EPSDT\4.9 Compliance demonstrated by interview with case management staff and Medical Director.
4.10 The plan makes appropriate referrals to State health agencies, WIC, Head Start, maternal and child health programs, etc.)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 4 EPSDT\4.10 – empty folder Evidenced by interview with case management team.
4.11 The Contractor shall complete and submit the annual **EPSDT report**, resulting from the preventive screenings, to the Department's HPM, on Form CMS-416, no later than February 1st, for the October 1st through September 30th period within the previous contract year.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A	..\Desk Audit Materials\Standard 4 EPSDT\4.11 – empty folder Compliance demonstrated by report submission to Department by DHMC on a timely basis.

Results for Standard 4	
# elements scored as “Met”	10
# elements scored as “Partially Met”	0
# elements scored as “Not Met”	0
# elements scored as “N/A”	0
Total provisions	10

Appendix II: 2007 Corrective Actions, DHHA
Audits and Reporting Section
1. DHHA shall demonstrate that it has taken corrective measures to assure that all encounter data submissions in the future will be accurate and will be accompanied by the proper certification.
2. DHHA shall demonstrate that it notifies the Department's fiscal agent on a monthly basis, by telephone or in writing, of any third party payers, excluding Medicare, that it has identified.
Claims Processing Section
3. DHHA shall conduct at least one statistically valid internal audit of encounter claims data in the next contract cycle.
4. DHHA shall demonstrate a mandatory compliance plan and administrative and management arrangements or procedures that are designed to guard against fraud and abuse in provider billings.
5. DHHA shall demonstrate compliance with the claims payment procedures as required by Section 10-16-106.5, C.R.S. (2004), as amended.
6. DHHA shall demonstrate compliance with the requirements and limitations regarding abortions, hysterectomies and surgical sterilizations, including maintaining certifications and documentation, as specified in 42 C.F.R. Section 441(F).
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7. DHHA shall demonstrate that each Member's medical record accurately represents the full extent of care provided to the Member, that the record is legible and that it is maintained in detail consistent with good medical and professional practices.
Confidentiality Section
8. DHHA shall assure the Department there will be full compliance with 45 CFR part 164 subpart E and other privacy laws and regulations.
Member Facilitation and Accommodation Section
9. DHHA shall demonstrate effective coordination with the Member’s mental health providers to facilitate the delivery of mental health services, as appropriate.
10. DHHA shall demonstrate that clearly written criteria and procedures are made available to all Participating Providers, staff and Members regarding how to initiate case planning.
11. DHHA shall demonstrate that individuals receive needs assessments at necessary times other than at initial enrollment.
12. DHHA shall demonstrate that it advises newly enrolled Members with Special Health Care Needs that they may continue to receive Covered Services from ancillary Providers at the level of care received prior to enrollment, for a period of seventy-five (75) calendar days, as specified in Section 25.5-5-406(1)(g), C.R.S. (2006).
13. DHHA shall demonstrate that it and its providers are fully in compliance with 42 C.F.R. Section 489.102(d) and, by reference, 42 C.F.R. 417.436(d) concerning the implementation of Advance Directives.
14. DHHA shall demonstrate that it develops and/or provides cultural competency training programs, as needed, to the network Providers and 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, ethical and socioeconomic conditions.
15. DHHA shall demonstrate that it facilitates culturally and linguistically appropriate care

by establishing and maintaining policies, and then effectively implementing them, to reach out to specific cultural and ethnic Members for prevention, health education and treatment for diseases prevalent in those groups.
16. DHHA shall demonstrate that it maintains and implements policies to provide health care services that respect individual health care attitudes, beliefs, customs and practices of Members related to cultural affiliation.
17. DHHA shall demonstrate that it provides Members with hearing impairments access to TDD, or other equivalent methods, in a way that promotes accessibility and availability of Covered Services.
18. DHHA shall demonstrate that it reviews all Member print materials for a sixth grade reading level and appropriate cultural references.
6
19. DHHA shall demonstrate that its physicians initiate referrals and coordinate care by specialists, subspecialists and community-based organizations in a way that effectively promotes continuity as well as cost-effectiveness of care.
20. DHHA shall demonstrate that its procedures and criteria for making Referrals and coordinating care by specialists, subspecialists and community-based organizations effectively promote continuity as well as cost-effectiveness of care.
21. DHHA shall demonstrate that Member information is available for Members with visual impairments, including, but not limited to, Braille, large print, or audiotapes.
22. For Members who cannot read, DHHA shall demonstrate that member information is available on audiotape.

Member Rights and Responsibilities Section

23. DHHA shall demonstrate that it has established and maintains written policies and procedures acknowledging the Member's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
24. DHHA shall demonstrate that its Member Handbook includes general information about services and complete statements concerning Member rights and responsibilities as listed in the contract and Exhibit D.

Appendix III

FY 07–08 Site Review Agenda *for* Denver Health Managed Choice
April 21 – 22, 2008

Monday, April 21, 2008	
	Sessions and Activities
8:00–8:30	**Opening Session** ◆ Introductions ◆ DHHA presentation of organizational structure ◆ Department overview and process of FY 07–08 site review activities
8:30–8:45	**Department and DHHA staff will:** ◆ Confirm locations and staff for the record reviews and interviews. ◆ Identify key DHHA staff to be available to the reviewer for questions and requests. ◆ Confirm location and content of on-site documents.
8:45–9:00	**Review of FY 06–07 corrective action plan status**
9:00–11:30	Credentialing and re-credentialing record review *concurrent with* Grievance and Appeals record review *concurrent with* EPSDT record review (please have either two rooms available or one room large enough for three people to review records)
11:30–12:30	***Lunch***
12:30–1:30	Meet with credentialing and re-credentialing staff for Q & A *concurrent with* Meet with grievance and appeals staff for Q & A (please have 2 rooms available for these interviews)
1:30–2:15	Meet with EPSDT staff & EPSDT case managers for Q & A
2:15-3:00	Meet with Quality Improvement staff for Q & A
3:00–4:00	Closed session—prepare for exit conference
4:00–5:00	**Exit conference** ◆ Overview of preliminary findings