Colorado Medicaid
Managed Care Program

FY 2008–2009 Site Review Report

for

Denver Health Medicaid Choice

April 2009

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

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Overview of FY 2008–2009 Compliance Monitoring Activities

The Balanced Budget Act of 1997, Public Law 105-33 (BBA), requires that states conduct an annual evaluation of their managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to determine compliance with regulations, contractual requirements, and the State's quality strategy. The Department of Health Care Policy & Financing (the Department) has elected to complete this requirement for the Colorado MCOs by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This is the first year that HSAG has performed compliance monitoring reviews of the MCO. For the fiscal year (FY) 2008–2009 site review process, the Department requested a focused review of four areas of performance. HSAG developed a review strategy consisting of four standards for review of **Denver Health Medicaid Choice** (**DHMC**), which corresponded with the four areas identified by the Department. These were: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation. Compliance with federal regulations and contract requirements was evaluated through review of the four standards. This report documents results of the FY 2008–2009 site review activities for the review period—July 1, 2007, through June 30, 2008. Section 2 contains summaries of the findings, strengths, opportunities for improvement, and required actions for each standard. Appendix A contains details of the findings.

Methodology

In developing the data collection tools and in reviewing the four standards, HSAG used the MCO's contract requirements and regulations specified by the BBA with revisions that were issued on June 14, 2002, and effective on August 13, 2002. HSAG conducted a desk review of materials submitted prior to the on-site review activities, a document review of materials provided on-site, and interviews of key MCO personnel to determine compliance. Documents submitted for the desk review and during the on-site document review consisted of policies and procedures, staff training materials, minutes of key committee meetings, and member and provider informational materials. Details of the review of the four standards follow in Appendix A.

The four standards chosen for the FY 2008–2009 site review represent a portion of the requirements based on Medicaid managed care contract and BBA requirements. Standards III—Coordination and Continuity of Care, IV—Member Rights and Protections, V—Member Information, VI—Grievance System, VIII—Credentialing and Recredentialing, and X—Quality Assessment and Performance Improvement will be reviewed in subsequent years.

The site review processes were consistent with the February 11, 2003, Centers for Medicare & Medicaid Services final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs).* Appendix D contains a detailed description of HSAG's site review activities by activity outlined in the CMS final protocol.

Objective of the Site Review

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

- The MCO's compliance with federal regulations and contract requirements in the four areas of review.
- The quality and timeliness of, and access to, health care furnished by the MCO, as assessed by the specific areas reviewed.
- Possible interventions to improve the quality the MCO's service related to the area reviewed.
- Activities to sustain and enhance performance processes.

Summary of Results

Based on the results from the Compliance Monitoring Tool and conclusions drawn from the review activities, HSAG assigned each element within the standards in the Compliance Monitoring Tool a score of *Met, Partially Met, Not Met, or Not Applicable.* HSAG assigned required actions to any individual element within the Compliance Monitoring Tool receiving a score of *Partially Met* or *Not Met.* HSAG also identified opportunities for improvement with associated recommendations for enhancement for some elements, regardless of the score. While HSAG provided recommendations for enhancement of MCO processes based on these identified opportunities for improvement, they do not represent noncompliance with contract or BBA regulations at this time.

Table 1-1 presents the score for **DHMC** for each of the standards. Details of the findings for each standard follow in Appendix A.

Table 1-1—Summary of Scores for the Standards

Standard #	Description of Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
I	Coverage and Authorization of Services	25	25	21	4	0	0	84%
II	Access and Availability	14	14	13	0	1	0	93%
VII	Provider Participation and Program Integrity	16	16	15	1	0	0	94%
IX	Subcontracts and Delegation	8	0	0	0	0	8	N/A
	Totals	**63**	**55**	**49**	**5**	**1**	**8**	**89%**

2. Summary of Performance Strengths and Required Actions

for Denver Health Medicaid Choice

Overall Summary of Performance

DHMC received overall percentage-of-compliance scores of 94 percent and 93 percent on Provider Participation and Program Integrity, and Access and Availability standards, respectively, representing a clear strength. **DHMC** received a score of 84 percent on the Coverage and Authorization of Services, representing opportunities for continued improvement of **DHMC**'s performance. One standard, Subcontracts and Delegation, was not applicable to **DHMC** as it did not delegate any Medicaid managed care responsibilities during the review period (FY 2007–2008).

Standard I—Coverage and Authorization of Services

Summary of Findings

There was evidence that **DHMC** had systems in place to ensure that services were provided appropriately and in an amount, duration, and scope adequate to achieve their purpose. **DHMC** had care management and case management programs to evaluate for and facilitate appropriate care. In addition, **DHMC**'s policies and procedures regarding coverage and authorization of services included most of the Medicaid managed care requirements.

Policies and processes related to emergency care and payment for emergency services included most of the requirements. Members and providers were informed that no authorization is needed for emergency care, and claims payment practices related to emergency care met all of the requirements. **DHMC**'s drug formulary included each of the therapeutic drug categories listed in the Medicaid program, and **DHMC** had a process for providers to request an exception to the drug formulary.

DHMC's member handbook included a notation that **DHMC** determines the medical necessity of services, but the handbook did not define medical necessity for members. While not required, since **DHMC** addressed medical necessity in its member handbook, **DHMC** may want to consider defining medical necessity in terms easily understood at the sixth-grade reading level.

Summary of Strengths

DHMC used the online, interactive Milliman program to ensure consistent application of utilization review criteria. The Milliman program contained a variety of tools available for the utilization management (UM) manager to evaluate staff and analyze data. **DHMC**'s staff model for providing care set no limits on primary and specialty care provided through Denver Health and Hospital Authority (DHHA) staff and treatment decisions by practitioners. Utilization limits were used only for medical and ancillary services provided by non-DHHA practitioners and out-of-network providers, and were used to ensure medical necessity and appropriateness of services. In addition, **DHMC**'s utilization review processes included a review by the medical director of all adverse determinations based on medical necessity.

Summary of Required Actions

There were several areas where the policies did not completely meet Medicaid managed care requirements. The Utilization Review Determinations policy (UMG 1002) included the time frames for making standard and expedited authorization decisions; however, the policy did not include the time frames for extending authorization decisions. **DHMC** must revise applicable policies to include the time frames for extending standard and expedited authorization decisions.

DHMC had no documents that specifically addressed poststabilization services. **DHMC** must revise applicable documents to address and define poststabilization services.

While the Protocols for Authorization of Out-of-Network Referrals policy stated that emergency and urgent clinical services are exempt from the authorization process, the Utilization Review Determinations policy (UMG 1002) contained definitions of urgent care and urgent preservice reviews that indicated a requirement for authorization of urgent care services. In addition, the member handbook did not contain any direction to members about not needing prior authorization for urgent care services. **DHMC** must review all applicable policies and ensure that policies, member materials, and provider materials consistently state that prior authorization is not required for urgent care services.

The member handbook informed members that they may receive emergency services while out of the **DHMC** service area; however, the handbook did not address receiving urgent care services out of network. Policies were also silent regarding out-of-network urgent care services. **DHMC** must revise all applicable policies and documents to address the fact that members temporarily out of the service area may also receive urgently needed services.

Standard II—Access and Availability

Summary of Findings

There was evidence that **DHMC** maintained and monitored network providers, using written agreements to supplement the staff model for primary and most specialty care. **DHMC**'s network adequacy reports indicated consideration of all the required elements for developing and maintaining the network. **DHMC** communicated with members and providers regarding direct access to women's services and emergency services, how to choose a primary care provider (PCP), and how to change PCPs. There was evidence that services were available 24 hours per day, 7 days per week, if medically necessary, and that hours of operation for Medicaid members were no different than for DHHA's other lines of business. **DHMC**'s policies regarding access and availability included all of the Medicaid managed care requirements.

While there appeared to be a mechanism for members to obtain a second opinion, **DHMC** was vague when informing the PCP that it is the PCP's responsibility to arrange for these services. **DHMC** may want to consider adding language to the provider manual that clearly informs the PCP of his or her responsibilities related to second opinions.

While **DHMC**'s documents demonstrated compliance regarding notifying providers of expectations for access to care for the review period (FY 2008), **DHMC** may consider revising the standards in the provider manual to include each of the standards and ensure continued compliance.

While **DHMC** had a mechanism to track compliance with access-to-care standards, there was minimal evidence that **DHMC** took corrective action. **DHMC** may consider enhancing its process for addressing noncompliance with access standards by its clinics and develop more robust methods of responding to the data and taking corrective action.

Summary of Strengths

DHMC's 2008–2009 Cultural Competency Initiative program had a variety of features that met the requirements for providing culturally competent services. **DHMC** had policies, procedures, and training in place and provided required member materials in English, Spanish, and Braille upon request. **DHMC**'s policies described the use of adaptive devices (pocket amplifiers, TTD/TTY, etc.) as well as interpreters who were on staff, in addition to use of the language line when necessary. Also, **DHMC**'s quality improvement program staff members had completed projects using HEDIS data to analyze patterns of accessing care and compare cultural patterns, and were planning to use the data in the coming FY for evaluating access to care and providing services.

Summary of Required Actions

When communicating results of secret shopper studies or other studies that indicate providers are noncompliant with standards set by **DHMC** or the Medicaid managed care contract, **DHMC** must clearly describe the noncompliance and require that the provider(s) submit corrective action plans to **DHMC**. **DHMC** may need to evaluate whether the secret shopper results represent capacity issues vs. process issues in order to implement appropriate corrective action.

Standard VII—Provider Participation and Program Integrity

Summary of Findings

Written agreements with subcontracted providers, policies, and procedures, as well as **DHMC**'s compliance program, included all of the requirements. **DHMC** had a mechanism to ensure that providers and other employees were not excluded from federal health care participation. **DHMC**'s method of communicating most of the Medicaid managed care requirements to providers was the provider manual. The provider manual included a wealth of information for both subcontracted and staff providers. **DHMC** may want to consider including a clause in both the staff and subcontracted provider agreement that binds the provider to compliance with requirements in the provider manual.

Summary of Strengths

Since **DHMC** provided the majority of services via a staff model, **DHMC**'s monitoring mechanism for subcontracted providers consisted of a review of 100 percent of cases by the UM staff to ensure the quality and appropriateness of care and compliance with documentation requirements.

Summary of Required Actions

DHMC's Fraud policy included the statement that **DHMC** will report possible instances of fraud to the Department, but did not specify the content of that report as required in the Medicaid managed care contract. **DHMC** must revise its policy related to fraud reporting to include the content of the report to the Department.

Standard IX—Subcontracts and Delegation

Summary of Findings

This standard was not applicable to **DHMC** as it did not delegate any Medicaid managed care responsibilities.

Summary of Strengths

Not applicable.

Summary of Required Actions

Not applicable.

The completed compliance monitoring tool follows this cover page.

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
42CFR438.210(a)(3) Contract: II.D.1.a Exhibit A	1. The Contractor provides or arranges for services and ensures that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. The Contractor provides care coordination, utilization management, and disease state management for members to promote the appropriate and cost-effective utilization of covered services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Per the organization chart and DHMC staff report, DHMC is the division of DHHA that administered the Medicaid administrative tasks. DHHA provided all primary care and the majority of specialty care. Ancillary services, durable medical equipment (DME), skilled nursing facility care, and a few specialty care services were provided through either subcontracted providers or out-of-network providers. DHHA providers were informed of their responsibilities regarding the provision of primary and specialty care via the Provider Service Agreement for Denver Health and Hospital Staff Physicians. The Utilization Management Program Description described the use of nationally recognized standards for utilization review management. The Utilization Review Determinations policy described the processes for authorizing services provided by subcontracted and out-of-network providers. DHMC's provider manual included a list and explanation of benefits and informed providers of their responsibilities regarding service provision and care coordination. The continuity-of-care policy described the process for continuity of care during the transition to and from DHMC or between providers and community-based programs. The member handbook described benefits and services available to members.	
	Required Actions: None	
42CFR438.210(a)(3) Contract: II.D.1.c	2. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Utilization Review Determinations policy described the use of Milliman utilization review criteria and the process for making utilization review decisions. The policy stated that denials are based on the benefit package, eligibility, and review of clinical information by the medical director. Review of examples of authorization records confirmed the process. DHMC staff reported that only services provided by subcontracted or out-of-network providers are subject to authorization. Primary care and most of specialty care provided are not prior authorized. The policy indicated, and staff confirmed, that PCPs refer to the specialty care clinics.	
	Required Actions: None	

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
42CFR438.210(a)(3) Contract: II.D.2.a	3. If the Contractor places limits on services, it is: ◆ On the basis of criteria applied under the State plan (medical necessity). ◆ For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Utilization Review Determinations policy described use of medical necessity and Milliman criteria for utilization authorization of services for the purpose of utilization control.	
	Required Actions: None	
42CFR438.210(a)(4) Contract: Exhibit A	4. The Contractor specifies what constitutes "medically necessary services" in a manner that: ◆ Is no more restrictive than that used in the State Medicaid program. ◆ Addresses the extent to which the Contractor is responsible for covering services related to the following: ▪ The prevention, diagnosis, and treatment of health impairments ▪ The ability to achieve age-appropriate growth and development ▪ The ability to attain, maintain, or regain functional capacity	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Utilization Review Determinations policy included a definition of medical necessity that was consistent with the BBA definition. The provider agreement template also included the BBA definition. During the on-site interview staff reported that staff physicians at Denver Health Hospital and clinics discuss the need for a particular treatment with members on a case-by-case basis. The member handbook informed members that Denver Health determines what is medically necessary. While not required, DHMC may consider including an easy-to-understand definition of medical necessity in the member handbook.	
	Required Actions: None	

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
42CFR438.210(b)	5. The Contractor has written policies and procedures that address the processing of requests for initial and continuing authorization of services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Utilization Review Determinations policy and the Concurrent Utilization Management policy addressed the processing of requests for initial and continuing authorization of services. In addition, the provider manual informed providers that DHMC used Milliman criteria and how to obtain a copy of the criteria.	
	Required Actions: None	
42CFR438.210(b) Contract: II.I.1.b	6. The Contractor's written policies and procedures include mechanisms to ensure consistent application of review criteria for authorization decisions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Inter-Rater Reliability (IRR) policy described training and orientation to the criteria for UM staff, rounds for discussion of difficult cases, and IRR testing. On-site demonstration of the Milliman interactive utilization computer software illustrated how the director of UM can access the system and verify staff's consistent use of the criteria.	
	Required Actions: None	
42CFR438.210(b)	7. The Contractor's written policies and procedures include the procedure to consult with the requesting provider when appropriate.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Utilization Review Determinations policy stated that the medical director and registered nurse (RN) case managers consult with either board-certified specialists or the requesting provider when the request requires additional clarity and collaboration. An on-site example of an authorization record demonstrated application of the process described in policy.	
	Required Actions: None	

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
42CFR438.210(b)(3) Contract: II.I.1.e	8. The Contractor's written policies and procedures include the provision that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Utilization Review Determinations policy stated that any decision to deny or limit services is the result of an assessment by the medical director. An on-site review of three examples demonstrated that the medical director made decisions to deny a service based on medical necessity.	
	Required Actions: None	
42CFR438.210(c) Contract: II.I.1.a	9. The Contractor's written policies and procedures include processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested (notice to the provider need not be in writing).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Utilization Review Determinations policy described electronic notification of the provider in the case of a notice of action, and written notice to the member. On-site review of the denial log and examples of denial records demonstrated that written notice was sent to members, and providers were notified.	
	Required Actions: None	
42CFR438.210(d) Contract: Exhibit I—8.209.4.A.3.c & 8.209.4.A.6	10. The Contractor's written policies and procedures include the time frames for making standard and expedited authorization decisions extending time frames, as specified in the Grievance System standard.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The Utilization Review Determinations policy (UMG 1002) included the time frames for making standard and expedited authorization decisions; however, the policy did not include the time frames for extending authorization decisions.	
	Required Actions: DHMC must revise applicable policies to include the time frames for extending standard and expedited authorization decisions.	

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
42CFR438.210(e) Contract: II.I.1.a	11. The Contractor's written policies and procedures provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The UM program description indicated that UM case managers do not work under an incentive program. Staff providers were informed in the Provider Service Agreement for Denver Health and Hospital Staff Physicians.	
	Required Actions: None	
42CFR438.114(a) Contract: I.13 & II.D.4.c	12. The Contractor defines emergency medical condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: ◆ Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy ◆ Serious impairment to bodily functions ◆ Serious dysfunction of any bodily organ or part	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The BBA-compliant definition of "emergency medical condition" was included the provider manual and the provider agreement template. Emergency medical condition was also defined in the Protocols for Authorization of Out-of-Network Referrals policy. The member handbook contained an easy-to-understand definition of "emergency medical condition" that was consistent with the BBA.	
	Required Actions: None	

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
42CFR438.114(a) Contract: I.14	13. The Contractor defines emergency services as follows: ◆ Services furnished by a provider who is qualified to furnish these services under this title ◆ Services needed to evaluate or stabilize an emergency medical condition	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The BBA definition of "emergency services" was contained in the Utilization Review Determinations policy, the provider manual, and the provider agreement template.	
	Required Actions: None	
42CFR438.114 Contract: II.D.4.c	14. The Contractor does not: ◆ Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms ◆ Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the Contractor or the State agency of the member's screening and treatment within 10 days of presentation for emergency services	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Utilization Review Determinations policy stated that the prudent layperson standard is used to determine if an emergency medical condition existed. The provider manual stated that the emergency room should provide screening or treatment without PCP referral. DHMC staff reported that claims denial audits are performed to ensure that denied payments for emergency services are based on valid reasons (member not eligible, duplicate claims), and provided an example of an audit.	
	Required Actions: None	

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
42CFR438.114(a) Contract: Exhibit A	15. The Contractor defines poststabilization care as covered services, related to an emergency medical condition, that are provided after a member is stabilized in order to maintain the stabilized condition, or are provided to improve or resolve the member's condition.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: DHMC had no documents that specifically addressed poststabilization services. The section of the provider agreement template that addressed emergency services referred the reader to the BBA citation that addressed both emergency and poststabilization services. During the on-site interview, DHMC staff discussed the processes and practices of claims payment when hospitalizations or other services are as a result of emergency care, which met requirements.	
	Required Actions: DHMC must revise applicable documents to address and define "poststabilization services."	
42CFR438.114(c)(1) Contract: II.D.4.a.2 & 4	16. The Contractor covers and pays for emergency services regardless of whether the provider who furnishes the services has a contract with the Contractor. Members temporarily out of the service area may receive out-of-network emergency and urgently needed services.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The Protocols for Authorization of Out-of-Network Referrals policy indicated that emergency claims out of network (under $25,000) pay automatically. DHMC staff clarified that claims of more than $25,000 were typically claims for hospitalizations that resulted following emergency care and were paid; however, these claims were referred to utilization management for concurrent review for continued hospitalization. The member handbook informed members that they may receive emergency services while out of the DHMC service area; however, the handbook did not address urgently needed services out of network. Policies were also silent regarding urgently needed services out of network.	
	Required Actions: DHMC must revise all applicable policies and documents to address the fact that members temporarily out of the service area may receive urgently needed services.	

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
42CFR438.114(c)(1) Contract: II.D.4.a.4	17. The Contractor may not deny payment for treatment obtained under either of the following circumstances: ◆ A member had an emergency medical condition, including cases in which the absence of immediate medical attention would *not* have had the following outcomes: ▪ Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy ▪ Serious impairment to bodily functions ▪ Serious dysfunction of any bodily organ or part ◆ A representative of the Contractor's organization instructed the member to seek emergency services	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Utilization Review Determinations policy stated that the prudent layperson standard is used to determine if an emergency medical condition existed. DHMC staff reported that claims denial audits are performed to ensure that denied payments for emergency services are based on valid reasons (member not eligible, duplicate claims), and provided an example of an audit.	
	Required Actions: None	
42CFR438.114(c)(2) Contract: II.D.4.d	18. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The provider agreement template stated that the provider may not bill, charge, or seek compensation from members for any services. The member handbook informed members that they should "never pay for medical services." DHMC staff reported that when out-of-network providers bill for the first time or contact DHMC to inquire about billing (a common example is out-of-network emergency services) the Claims Processing Manual is sent to the provider. The manual stated, "Providers are explicitly prohibited from collecting payment, or attempting to collect payment through recipient for the cost or the cost remaining after payment by Medicaid for covered items or services rendered."	
	Required Actions: None	

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
42CFR438.10.f.6.viii.B Contract: II.D.4.a.3	19. The Contractor does not require prior authorization for emergency or urgently needed services.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The Utilization Review Determinations policy stated that DHMC covers any emergency service without authorization. Members were informed via the member handbook that no authorization is needed for emergency services. The provider manual stated that emergency care providers should provide screening and treatment without a PCP referral. While the Protocols for Authorization of Out-of-Network Referrals policy stated that emergency and urgent clinical services are exempt from the authorization process, the Utilization Review Determinations policy (UMG 1002) contained definitions of urgent care and urgent preservice reviews that indicated a requirement for authorization of urgent care services. In addition, the member handbook did not contain any direction to members about not needing prior authorization for urgent care services.	
	Required Actions: DHMC must review all applicable policies and ensure that policies, member materials, and provider materials consistently state that prior authorization is not required for urgent care services.	
42CFR438.114(d)(3) Contract: II.D.4.a.5	20. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: During the on-site interview, DHMC staff stated that since DHMC is a staff model MCO, all treatment decisions, including those pertaining to transfer or discharge following emergency services, are the responsibility of the treating physician as the representative of the MCO. For non-DHHA physicians, the provider agreement template contained language that informed the provider that nothing in the contract should be construed to require the provider to take any action inconsistent with his or her professional judgment concerning covered services to be rendered. Staff reported that when emergency services are provided by out-of-network providers, the medical director has a physician-to-physician call and informs the emergency services provider of his or her responsibility to determine when the member is stabilized.	
	Required Actions: None	

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
Contract: II.I.1.f	21. Utilization management activities are conducted under the auspices of a qualified clinician.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Per the organization chart and confirmed by DHMC staff report, UM staff are RNs. The Utilization Review Determinations policy stated, (confirmed on-site via review of example records) that the medical director made the final decisions for denial or limited authorizations based on medical necessity.	
	Required Actions: None	
Contract: II.D.4.f.2.a	22. If the Contractor establishes a drug formulary for all medically necessary covered drugs with its own prior authorization criteria, the Contractor includes each therapeutic drug category in the Medicaid program.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: DHMC's formulary included each of the therapeutic drug categories listed in the Medicaid program.	
	Required Actions: None	
Contract: II.D.4.f.2.b	23. The Contractor provides a covered drug if there is a medical necessity that is unmet by the Contractor's formulary product.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Drug Authorization Procedure policy stated that there is an exception process for providers and members to request a nonformulary drug. The DHMC Web site included the form to request an exception. On-site, DHMC provided an example of an authorization of a nonformulary drug.	
	Required Actions: None	

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
Contract: II.D.4.f.3	24. 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 Contractor has a process to ensure that the member signs the prescription stating that he/she is willing to pay the difference to the pharmacy.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: DHMC staff reported that MCO staff members have had discussions with network pharmacies about maintaining the signatures of members. The pharmacies, however, have indicated that they cannot maintain this record of signatures. As a result, staff reported that these requests are typically processed as out-of-formulary exception requests.	
	Required Actions: None	
Contract: II.D.4.i.3	25. The Contractor informs its home health services providers and members that home health services after 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 ensures 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 adult members.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Home Health Care Referrals policy (UMG 1014) described the process for notifying the home health provider of the need for continued services past the 60th day. Staff provided a screen shot of how the notification is documented in the UM system.	
	Required Actions: None	

Results for Coverage and Authorization of Services							
Total	Met	=	21	X	1.00	=	21
	Partially Met	=	4	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	25	**Total Score**		=	21

Total Score ÷ Total Applicable	=	84%

Standard II—Access and Availability		
References	**Requirement**	**Score**
42CFR438.206(b)(1) Contract: II.E.1.a .2	1. The Contractor maintains and monitors a network of providers that is supported by written agreements and is sufficient to provide adequate access to covered services. The Contractor considers Essential Community Providers and other providers when establishing the network. The Contractor ensures a provider-to-member caseload ratio as follows: ◆ 1:2000 primary care physician to member ratio. ◆ 1:2000 physician specialist to member ratio. ◆ OB/GYN, gerontologists, and internal medicine physicians may be counted as either PCP or specialists, but not both.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Network Access Strategic Report 2007/2008 demonstrated that DHMC monitors its network of providers for availability of appointments, access to care, and caseload ratio. DHMC is a division of DHHA and provides a staff model of service provision for primary care and specialty care, except for rare circumstances in which the required specialty care is not available within the DHHA hospital and clinic system. Home health services and ancillary care (including DME) is provided by a network of providers supported by written agreements. DHMC staff provided examples of signed agreements with a hospital, a DME company, and a home health agency. The fourth quarter network adequacy report showed a PCP-to-member ratio of approximately 1:400 and a specialist-to-member ratio of 1:151. DHMC staff reported that DHHA and its community-based clinics are federally qualified health centers (FQHCs) and, therefore, are essential community providers.	
	Required Actions: None	

Standard II—Access and Availability		
References	**Requirement**	**Score**
42CFR438.206(b)(1) Contract: II.E.1.a.3	2. In establishing and maintaining the network, the Contractor considers: ◆ The anticipated Medicaid enrollment. ◆ The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the Contractor's service area. ◆ The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services. ◆ The numbers of network providers who are not accepting new Medicaid patients. ◆ The geographic location of providers and Medicaid members, and whether the location provides physical access for Medicaid members with disabilities.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Network Access Strategic Report 2007/2008 demonstrated that DHMC evaluated its network based on current and expected Medicaid enrollment, expected utilization, type of providers in the network, and geographic locations of members, DHHA clinics, and facilities. DHMC staff reported that providers at DHHA clinics are required to accept new patients at all times.	
	Required Actions: None	
42CFR438.206(b)(2) Contract: II.E.1.a.4	3. The Contractor provides female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health care specialist.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Access to Care/Services policy (PRR 701) stated that DHMC members have direct access to women's health care specialists in addition to their PCP if the members' PCP is not a women's health care specialist. Members were informed of this via the member handbook. The provider manual has women's health preventive medicine on the list of benefits.	
	Required Actions: None	

Standard II—Access and Availability		
References	**Requirement**	**Score**
42CFR438.6(m) Contract: II.E.3.a	4. The Contractor allows, to the extent possible and appropriate, each member to choose his or her primary care physician.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Access to Care/Services policy stated that members may choose their PCP. The provider manual informed providers that members may choose their PCP. The member handbook directed members to choose a PCP and informed members how to change their PCP.	
	Required Actions: None	
42CFR438.206(b)(3) Contract: II.E.1.a.5	5. The Contractor has a mechanism to allow members to obtain a second opinion from an appropriate qualified health care professional within the network, or arranges for the member to obtain one outside the network, at no cost to the member.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Access to Care/Services policy stated that members may obtain a second opinion from a provider in or out of the network, but the policy did not specifically describe the mechanism. DHMC staff reported that the UM system had the capability to track any second opinions that were received by out-of-network providers, but the system could not track second opinions received within the DHHA system. Staff reported that the UM system showed that no second opinions were obtained during the review period from outside the DHHA system, but that staff were unable to determine how many were obtained within the DHHA system. The right to work with a PCP to arrange for a second opinion, at no cost, is on the list of rights contained in the member handbook and in the provider manual. The list of member rights (in the member handbook and the provider manual) indicated that the mechanism to arrange for a second opinion was the responsibility of the PCP. While there appeared to be a mechanism for members to obtain a second opinion, the responsibility of the PCP to arrange for the services was vague in terms of informing the PCP. DHMC may want add language to the provider manual (or other appropriate document) that informs the PCP of his or her responsibilities related to second opinions.	
	Required Actions: None	

Standard II—Access and Availability		
References	**Requirement**	**Score**
42CFR438.206(b)(4) Contract: II.E.1.b	6. If the Contractor is unable to provide necessary services to a member in-network, the Contractor must adequately and timely cover the services out-of-network for the member, for as long as the Contractor is unable to provide them.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Protocols for Authorization of Out-of-Network Referrals policy addressed out-of-network referrals. DHMC used the Milliman criteria (as described in Standard I) for authorizations (for all out-of-network services). Staff provided examples of services authorized out of network.	
	Required Actions: None	
42CFR438.206(b)(5) Contract: II.E.1.b	7. The Contractor requires out-of-network providers to coordinate with the Contractor with respect to payment and ensures that the cost to the member is no greater than it would be if the services were furnished within the network.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: DHMC staff reported that when services were provided by an out-of-network provider, the director of provider relations sent the provider a copy of the Claims Processing Manual, which explained billing DHMC for services provided and that the provider must not collect or attempt to collect payment from members in addition to the Medicaid payment.	
	Required Actions: None	
42CFR438.206(c)(1) Contract: II.D.1.b	8. The Contractor and its providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if the provider serves only Medicaid members.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: DHMC staff reported that all DHHA clinics served all lines of business served by DHHA and that there were no discriminatory scheduling practices.	
	Required Actions: None	

Standard II—Access and Availability		
References	**Requirement**	**Score**
42CFR438.206(c)(1) Contract: II.E.1.d	9. The Contractor makes services available 24 hours a day, 7 days a week, when medically necessary, and has written policies and procedures for how this will be achieved.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: DHHA had urgent care clinics and in-network hospital facilities for emergency care. In addition, the provider manual informed providers of the 24-hour nurse advice line, and the PCPs'/specialty care providers' responsibility to provide 24-hour on-call coverage. The Access to Care/Services policy described the mechanisms for providing services 24 hours a day, 7 days a week, as medically necessary.	
	Required Actions: None	
42CFR438.206(c)(1) Contract: II.E.1.d	10. The Contractor has mechanisms to ensure compliance by providers regarding timely access to services, and to take corrective action if there is failure to comply. The Contractor communicates the access standards to providers and has routine monitoring mechanisms to ensure that participating providers comply with access policies and procedures.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The provider manual informed providers of the access standards, except for the standard for adult nonurgent health care (symptomatic) provided within two weeks. The provider newsletter for the third and fourth quarter of 2008 informed providers of the access standards, including the adult nonurgent standard. While this demonstrated compliance for the review period (FY 2008), DHMC may consider adding the standard to the provider manual to ensure continued compliance. The revised member handbook informed members of the standards for access to care. The Medical Management Committee (MMC) meeting minutes indicated that the committee monitored and tracked member complaints regarding access to care. The Secret Shopper results for 2007 and 2008 provided a comprehensive analysis of secret shopper calls by quarter and by clinic, as well as a comparison of results between the two years. While DHMC had a mechanism to track compliance with access-to-care standards, there was minimal evidence that DHMC took corrective action. DHMC may consider enhancing its process for addressing noncompliance with access standards by its clinics and develop more robust methods of responding to the data and taking corrective action.	
	Required Actions: None	

Standard II—Access and Availability		
References	**Requirement**	**Score**
42CFR438.206(c)(1) Contract: II.E.1.d.& e	11. The Contractor must meet, and require its providers (including use of corrective action when needed) to meet, the following standards for timely access to care: ◆ The Contractor has a comprehensive plan for triage of requests for services on a 24-hours-a-day, 7-days-a-week basis, including: ▪ Immediate medical screening exam by the PCP or hospital emergency room. ▪ Access to a qualified health care practitioner via live telephone coverage either on-site, call-sharing, or answering service. ▪ Practitioner backups covering all specialties. ◆ Scheduling and waiting times: The Contractor has 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. ◆ Non-urgent care is scheduled within 2 weeks. ◆ Adult, non-symptomatic well care physical examinations scheduled within 4 months ◆ Urgently needed services provided within 48 hours of notification of the physician or Contractor.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
	Findings: The Access to Care/Services policy and the Network Access Strategic Report described DHMC's standards, which met requirements. Providers were informed in the provider manual, with revision in the third and fourth quarter provider newsletter. The secret shopper reports for 2007 and 2008 indicated that for calendar year 2007, the percentage of calls meeting the appointment standards (overall) was 76 percent. In 2008 the percentage of calls meeting the appointment standards was 57 percent. DHMC's goal for meeting appointment standards was a benchmark of 90 percent. DHMC provided e-mail communication dated January 23–27, 2009, that demonstrated discussion of the secret shopper results. DHMC staff also reported that secret shopper results are discussed in MMC meetings. Meeting minutes did demonstrate discussion of secret shopper results; however, none of the documents provided demonstrated discussion strong enough to be considered corrective actions. The e-mail communication in January did indicate that process changes were being considered; however, there was no evidence of action taken from 2007 to 2008, when secret shopper results decreased and remained low.	
	Required Actions: When communicating results of secret shopper studies or other studies that indicate providers are noncompliant with standards set by DHMC or the Medicaid managed care contract, DHMC must clearly describe the noncompliance and require that the provider(s) submit corrective action plans to DHMC.	

Standard II—Access and Availability		
References	**Requirement**	**Score**
42CFR438.206(c)(2) Contract: II.E.6.c	12. The Contractor participates in the Department's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. In addition to requirements for interpretation and written materials found at 42CFR438.10, the Contractor implements the following requirements: ◆ Establishes and maintains the following policies related to: ▪ Reaching out to specific cultural and ethnic members for prevention, health education, and treatment for diseases prevalent in those groups. ▪ Providing health care services that respect individual health care attitudes, beliefs, customs and practices of members related to cultural affiliation. ▪ How the Contractor shall respond to requests from participating providers for interpreter services by a qualified interpreter. ▪ How the Contractor shall respond to requests from members for interpretive services by a qualified interpreter or publications in alternative formats. ▪ Ensuring compliance with requirements of the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973. ◆ Makes a reasonable effort to identify members whose cultural norms and practices may affect their access to health care ◆ Develops and/or provides cultural competency training programs, as needed, to the network providers and Contractor staff regarding: ▪ Health care attitudes, values, customs, and beliefs that affect access to and benefit from health care services. ▪ The medical risks associated with the client population's racial, ethnic, and socioeconomic conditions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Cultural and Linguistic Appropriate Services Program policy and the 2008–2009 Cultural Competency Initiative program description described the processes for gathering language and cultural information about members and providers to appropriately match members with providers. The Interpreter and Translation Services and Auxiliary Communication Devices policy described the processes for providing interpreters and auxiliary communication aides (e.g., TTD/TTY, pocket sound amplifiers, the language line) to assist members with linguistic needs. The member handbook informed members that the handbook is available in large print, Braille, audiotapes, and Spanish, including a statement in Spanish that the handbook is available in Spanish. The handbook also	

Standard II—Access and Availability		
References	**Requirement**	**Score**
	informed members of the TTD/TTY number. An Outpatient Encounter Record blank form and a screen shot of the case management system included mechanisms to document linguistic, hearing, vision, and learning needs. The Summary of Health Disparities Surveillance Data report demonstrated the completion of a quality improvement study that used HEDIS data to determine future, targeted projects for development of culture-specific disease management written materials. Denver Health submitted two PowerPoint presentations on cultural diversity. The accelerated training curriculum was very comprehensive. DHMC staff reported that one PowerPoint presentation is used for Web-based training for DHHA staff. In addition, DHMC staff provided evidence of implementation of the newly-developed accelerated training with the managed care (DHMC) staff and reported that next steps involved implementing the new training for providers and clinic staff over the next fiscal year.	
	Required Actions: None	
42CFR438.207(b) Contract: II.E.2.c & d	13. The Contactor submits a network adequacy report (assurances of adequate capacity) that uses geographic access standards, provider network standards (travel of 30 minutes or 30 miles), and population demographics, and that provides documentation that the Contractor: ◆ Has the capacity to serve the expected enrollment in its service area. ◆ Provides an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of members for the service area. ◆ Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The DHMC quarterly reports and annual strategic report included all requirements.	
	Required Actions: None	

Standard II—Access and Availability		
References	**Requirement**	**Score**
42CFR438.207(c) Contract: II.E.2.c	14. The network adequacy report was submitted as required: ◆ At the time the Contractor entered into a contract with the State ◆ At any time there has been a significant change in the Contractor's operations that would affect adequate capacity and services: ▪ Change in the services, benefits or geographic service area ▪ Enrollment of a new population ◆ Quarterly	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: DHMC staff provided e-mail evidence that network adequacy reports were submitted quarterly during FY 2008, as required.	
	Required Actions: None	

Results for Access and Availability							
Total	Met	=	13	X	1.00	=	13
	Partially Met	=	0	X	.00	=	0
	Not Met	=	1	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	14	**Total Score**		=	13

Total Score ÷ Total Applicable	=	93%

Standard VII—Provider Participation and Program Integrity		
References	**Requirement**	**Score**
42CFR438.230(b)(2) Contract: II.H.2	1. The Contractor has a written agreement with each subcontractor (subcontracted provider).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: DHMC had a provider agreement template. DHMC staff reported that subcontracted providers are used for ancillary services and some specialty services that are not available within the DHHA system. On-site, staff provided examples of executed agreements with a DME company, a hospital, and a specialty services practitioner. Staff reported that tracking to ensure that each provider has a contract is accomplished during the authorization process since any services provided by subcontracted providers require authorization (except emergency services).	
	Required Actions: None	
42CFR438.102(a) Contract: II.E.3.c	2. The Contractor does not prohibit, or otherwise restrict health care professionals acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient for the following: ◆ The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered ◆ Any information the member needs in order to decide among all relevant treatment options ◆ The risks, benefits, and consequences of treatment or non-treatment ◆ The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The provider manual contained a list of member rights, which included the right to discuss a member's health status and treatment options, and to refuse treatment. This was the same list of rights that appeared in the member handbook.	
	Required Actions: None	

Standard VII—Provider Participation and Program Integrity		
References	**Requirement**	**Score**
42CFR438.12(a)(1) 42CFR438.214(c) Contract: II.G.11	3. The Contractor does not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification, and does not discriminate against particular providers who serve high-risk populations or specialize in conditions that require costly treatment. (A policy is required.)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Provider Selection and Retention policy (CTS 302) included a statement of nondiscrimination based on the high-risk population that a provider serves or a provider's specialty. The Credentialing and Recredentialing of Practitioners policy (CRE 1501) stated that the criteria used for credentialing practitioners are National Commission for Quality Assurance (NCQA) standards that are applied consistently to all applicants. Review of credentialing committee meeting minutes confirmed the process described in the policy.	
	Required Actions: None	
42CFR438.12(a)(1) Contract: II.G.11	4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: DHMC staff provided a template letter, which included a section to specify the reason for the decision not to include providers in the network.	
	Required Actions: None	

Standard VII—Provider Participation and Program Integrity		
References	**Requirement**	**Score**
42CFR438.214(d) Contract: II.G.5.c.2	5. The Contractor does not employ or contract with providers excluded for participation in federal healthcare programs under either Section 1128 or 1128 A of the Social Security Act. (A policy is required, and there must be a provision in provider subcontracts.)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Credentialing and Recredentialing of Practitioners policy described the process for verifying that practitioners (both subcontracted and employed) have not been excluded from federal health care participation. The policy stated that the National Practitioner Data Bank (NPDB) and the Office of Inspector General (OIG) Web sites are used for initial credentialing, and that the OIG Web site is checked monthly to ensure that practitioners do not appear on the list of excluded individuals and entities. DHMC staff provided screen shots of the OIG Web site to demonstrate the process used.	
	Required Actions: None	
42CFR438.608 Contract: II.G.5.c.1	6. The Contractor may not knowingly have a director, partner officer, employee, subcontractor, or owner (owning 5 percent or more of the entity) who is debarred, suspended or otherwise excluded from participating in procurement or nonprocurement activities under federal acquisition regulation or Executive Order 12549.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The OIG Sanction List policy (Office of Integrity Policy 17) described the process for reviewing the OIG Web site semiannually to ensure that active DHHA (nonpractitioner) employees are not on the list of excluded individuals and entities. The process was confirmed during the on-site interview.	
	Required Actions: None	

Standard VII—Provider Participation and Program Integrity		
References	**Requirement**	**Score**
42CFR438.106 Contract: V.U	7. The Contractor provides that Medicaid members are not held liable for: ◆ The Contractor's debts in the event of the Contractor's or subcontractor's insolvency. ◆ Covered services provided to the member for which the State does not pay the Contractor. ◆ Covered services provided to the member for which the State or the Contractor does not pay the health care provider who provides the services under a contractual, referral, or other arrangement. ◆ Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Both the provider agreement templates and the provider manual included language to notify subcontracted providers that members may not be held liable in any of the above situations. The director of provider relations reported that out-of-network providers are given a provider manual.	
	Required Actions: None	
42CFR438.102(b) Contract: II.F.1.d.8.g	8. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: ◆ To the State. ◆ To the member before and during enrollment. ◆ To members within 90 days after adopting the policy with respect to any particular service (consistent with the format provisions in 42CFR438.10). (The Contractor need not furnish information on how and where to access the service.)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Cultural and Religious Considerations Relative to Provision of Care principles and practices described the procedure for specific providers/employees to be excluded from providing certain types of care based on their beliefs. During the on-site interview staff confirmed that DHHA does not have moral or religious objections to any services, and that if certain providers do decline to provide services they are required to follow the policy. The member would then be assigned to another provider to receive the services.	
	Required Actions: None	

Standard VII—Provider Participation and Program Integrity		
References	**Requirement**	**Score**
42CFR438.608 Contract: II.G.5.a	9. The Contractor must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse and include: ◆ Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and State standards. ◆ The designation of a compliance officer and a compliance committee 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. ◆ Enforcement of standards through well-publicized disciplinary guidelines. ◆ Provision for internal monitoring and auditing. ◆ Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the Medicaid managed care contract requirements.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Integrity Program Booklet included the standards of conduct and several patient-oriented examples. The standards of conduct and the Denver Health Integrity Office Charter, as well as the Employee Education About False Claims Recovery policy (4-145) and the Anti Fraud policy (ADM 104), articulated DHHA's commitment to comply with all applicable federal and State standards related to fraud. Minutes of the compliance committee demonstrated that DHHA's compliance officer (the compliance auditor) was chair of the compliance committee, which met almost every month during FY 2008. The organizational chart demonstrated the compliance auditor's reporting relationship to DHMC's executive director. DHMC staff reported that Web-based training (which included standards of conduct and reporting responsibilities) was provided at date of hire and annually to all employees. Staff also reported that completion of compliance training is linked to employees' annual performance reviews. The Managed Care Claims Testing Procedure described the process for the office of Program Integrity to audit claims quarterly for accuracy. In addition, the report of the 2007–2008 Medicaid Choice Claims Audit provided findings of an audit that evaluated claims and encounters for accuracy of coding, payment, and medical record documentation in support of the claims or encounters.	
	Required Actions: None	

Standard VII—Provider Participation and Program Integrity		
References	**Requirement**	**Score**
Contract: II.G.5.b	10. The Contractor reports possible instances of fraud to the Department within 10 business days of receipt of information. The referrals will include: ◆ Specific background information. ◆ The name of the provider. ◆ Description of how the Contractor became knowledgeable about the occurrence.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The Office of Integrity Investigations policy stated that possible instances of fraud are reported to the Department; however, the policy did not include the content of the report. DHMC staff reported that there had been no instances investigated during FY 2008.	
	Required Actions: DHMC must revise its policy related to fraud reporting to include the content of the report to the Department.	
Contract: II.G 9.a	11. The Contractor notifies 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 60 calendar days prior to termination of the services unless the termination is based upon quality or performance issues. The notice will include a description of how the Contractor will replace the provision of covered services at issue.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Subcontracting Services (CTS 301) policy stated that termination of any provider agreements that would cause delivery of services to be inadequate will be reported to the Department. DHMC staff reported that all PCPs and the majority of specialty service providers are employees of DHHA; therefore, it is not likely that the termination of provider agreements would affect DHHA's ability to provide adequate access to services.	
	Required Actions: None	

Standard VII—Provider Participation and Program Integrity		
References	**Requirement**	**Score**
42CFR438.240(b)(4) Contract: II.G.12	12. The Contractor monitors covered services rendered by subcontract providers for quality, appropriateness, and patient outcomes.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: DHMC staff reported that all services provided outside of the DHHA system are subject to prior authorization and, therefore, are monitored through the utilization management and authorization processes. Review of medical management committee meeting minutes demonstrated review of utilization data and monitoring of covered services for quality, appropriateness, and patient outcomes. Staff also reported that the concurrent review process evaluated appropriateness of care on a case-by-case basis.	
	Required Actions: None	
Contract: II.G.12 & II.F.3.b	13. The Contractor monitors subcontract providers for compliance with requirements for medical records, data reporting, and other applicable provisions of the Medicaid managed care contract. The Contractor also monitors for any requirements the Contractor imposes. Minimum medical record requirements include: ◆ Medical chart ◆ Prescription files ◆ Documentation sufficient to disclose the quality, quantity, appropriateness, and timeliness of services All records must be legible.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: DHMC provided examples of authorization records, which showed that subcontracted providers submit medical record documentation during the authorization process, to demonstrate compliance with documentation requirements and the quality, appropriateness, and timeliness of care.	
	Required Actions: None	

Standard VII—Provider Participation and Program Integrity		
References	**Requirement**	**Score**
42CFR438.230(a)(3) Contract: II.H.3	14. The Contractor has implemented written procedures for monitoring subcontracted providers' performance on an ongoing basis. The Contractor subjects subcontracted providers to formal review on a schedule consistent with industry standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Utilization Review Determinations, Home Health Care Referrals, and Concurrent Utilization Management policies described the processes for monitoring subcontracted providers. Review of examples of authorization records and medical management committee meeting minutes demonstrated implementation of those policies.	
	Required Actions: None	
42CFR438.230(a)(4) Contract: II.H.4	15. If the Contractor identifies deficiencies or areas for improvement, the Contractor and the subcontractor take corrective actions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Review of an authorization record demonstrated the process of UM staff working with the provider to obtain additional information needed for authorization or reauthorization.	
	Required Actions: None	

Standard VII—Provider Participation and Program Integrity		
References	**Requirement**	**Score**
Contract: II.I.1.c	16. At the time an agreement is executed with a participating provider, the Contractor provides information to the provider about how the Contractor's UM program functions and is used to determine medical necessary. The information includes: ◆ Appropriate points of contact with the program. ◆ Contact persons or numbers for information or questions. ◆ Information about how to initiate appeals related to UM decisions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The provider manual informed providers that Milliman Criteria for specific diagnoses are available and how to obtain a copy. The introductory section of the provider manual included contact names and numbers for the UM department and member services. Also, the provider manual explained that utilization decisions may be appealed and who to contact to make an appeal.	
	Required Actions: None	

Results for Provider Participation and Program Integrity							
Total	Met	=	15	X	1.00	=	15
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	16	**Total Score**		=	15

Total Score ÷ Total Applicable	=	94%

Standard IX—Subcontracts and Delegation		
References	**Requirement**	**Score**
42CFR438.230(a)(1) Contract: II.H.1	1. The Contractor oversees, and is accountable for any functions and responsibilities that it delegates to any subcontractor.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
	Findings: DHMC does not delegate any Medicaid managed care responsibilities.	
	Required Actions: None	
42CFR438.230(b)(1) Contract: II.H.1	2. Before any delegation, the Contractor evaluates a prospective subcontractor's ability to perform the activities to be delegated.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
	Findings: DHMC does not delegate any Medicaid managed care responsibilities.	
	Required Actions: None	
42CFR438.230(b)(2) Contract: II.H.2 NCQA CR 12—Element D	3. There is a written agreement with each delegate.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
	Findings: DHMC does not delegate any Medicaid managed care responsibilities.	
	Required Actions: None	

Standard IX—Subcontracts and Delegation		
References	**Requirement**	**Score**
42CFR438.230(b)(2) Contract: II.H.2 NCQA CR12— Element A Element B Element C	4. The written delegation agreement: ◆ Specifies the activities and reporting responsibilities delegated to the subcontractor. ◆ Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. For delegation of credentialing only, the agreement: ◆ Is mutually agreed upon. ◆ Describes the responsibilities of the Contractor and the delegated entity. ◆ Describes the delegated activities. ◆ Requires at least semiannual reporting to the Contractor. ◆ Describes the process by which the Contractor evaluates the delegated entity's performance. ◆ Describes the remedies available to the Contractor if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement. ◆ Includes a list of allowed uses of PHI. ◆ Includes a description of delegate safeguards to protect the information (PHI) from inappropriate uses. ◆ Includes a stipulation that the delegate will ensure that subdelegates have similar safeguards. ◆ Includes a stipulation that the delegate will provide individuals with access to their PHI. ◆ Includes a stipulation that the delegate will inform the Contractor if inappropriate use of the information (PHI) occur. ◆ Includes a stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends. ◆ Includes a stipulation that the Contractor has the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision-making.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
	Findings: DHMC does not delegate any Medicaid managed care responsibilities.	
	Required Actions: None	

Standard IX—Subcontracts and Delegation		
References	**Requirement**	**Score**
42CFR438.230(b)(3) Contract: II.H.3	5. The Contractor implements written procedures for monitoring the subcontractor's (delegates and providers) performance on an ongoing basis. The Contractor subjects subcontractors to a formal review according to a periodic schedule established by the State, consistent with industry standards or state MCO laws and regulations.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
	Findings: DHMC does not delegate any Medicaid managed care responsibilities. See Standard VII for evidence of monitoring subcontracted providers.	
	Required Actions: None	
42CFR438.230(b)(4) Contract: II.H.4	6. If the Contractor identifies deficiencies or areas for improvement in the subcontractor's performance, the Contractor and the subcontractor take corrective action.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
	Findings: DHMC does not delegate any Medicaid managed care responsibilities. See Standard VII for evidence of monitoring subcontracted providers.	
	Required Actions: None	
45CFR Part 164	7. The Contractor ensures that any subcontractors agree to implement reasonable and appropriate safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of protected health information (PHI), including electronic information. Those safeguards include: ◆ Not using or disclosing PHI except as required by the contract. ◆ Using appropriate safeguards (physical security, security of electronic records, appropriate use of releases of information) to protect PHI. ◆ Implementing reasonable and appropriate policies and procedures related to the use, disclosure, and protection of PHI. ◆ Making PHI available in accordance with 45CFR164.524. ◆ Using business associate agreements with business associates of the subcontractor. ◆ Not using or disclosing the information for employment-related actions or decisions.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard IX—Subcontracts and Delegation		
References	**Requirement**	**Score**
	◆ Reporting to the health plan any use or disclosure of PHI that it becomes aware of that is inconsistent with the uses or disclosures provided for by the contract. ◆ Restricting access to and use of PHI to employees or classes of employees for which the information is required related to payment of, or performance of, health care operations. ◆ Providing an effective mechanism for resolving any noncompliance by employees. ◆ If feasible, returning or destroying all PHI received from the health plan and retaining no copies when such information is no longer needed for the purpose for which disclosure was made.	
	Findings: DHMC does not delegate any Medicaid managed care responsibilities.	
	Required Actions: None	
45CFR Part 164	8. The Contractor ensures that any subcontractors have implemented and complied with each requirement (see Requirement 7) with respect to use, disclosure, and protection of PHI.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
	Findings: DHMC does not delegate any Medicaid managed care responsibilities.	
	Required Actions: None	

Results for Subcontracts and Delegation							
Total	Met	=	0	X	1.00	=	0
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	8	X	NA	=	0
Total Applicable		=	0	**Total Score**		=	N/A

Total Score ÷ Total Applicable	=	N/A

Appendix B. Site Review Participants for Denver Health Medicaid Choice

Table B-1 lists the participants in the FY 2008–2009 site review of **DHMC**.

Table B-1—HSAG Reviewers and MCO Participants	
HSAG Review Team	**Title**
Barbara McConnell, MBA, OTR	Project Director
DHMC Participants	**Title**
Mary Pinkney	Director of Quality Improvement
Craig Gurule	Government Projects Manager
Richard French	Director of Member Services
Janice Tucker	Director of Utilization Management
Nettie Finn	Lead Case Manager
Laurie Goss	Director of Marketing
Ron Aguilar	Director of Contracts and Provider Relations
Scott Hoye	Senior Assistant General Counsel
Dan Schirmer	Compliance Auditor
Deb Markson	Director, Health Maintenance Organization Information Systems
LeAnn Donovan	Executive Director of Managed Care
Shary DiQuinzio	Public Relations/Credentialing Coordinator
David Brody	Medical Director
Beth Henchel	Medicare Product Manager
Department Observers	**Title**
Beverly Hirsekorn	Manager—Health Outcomes and Quality Management
Gloria Johnson	Contract Manager

Appendix C. Corrective Action Plan Process for FY 2008–2009 for Denver Health Medicaid Choice

DHMC is required to submit to the Department a corrective action plan (CAP) for all elements within each standard scored as *Partially Met* or *Not Met*. The CAP must be submitted within 30 days of receipt of the final report. For each element that requires correction, the health plan should identify the planned interventions to achieve compliance with the requirement(s) and the timeline for completion. Supporting documents should not be submitted and will not be considered until the plan has been approved by the Department. Following Department approval, the MCO must submit documents per the timeline that was approved.

Table C-1—Corrective Action Plan Process

Step 1	**Corrective action plans are submitted**
	Each MCO will submit a CAP to the Department within 30 calendar days of receipt of the final external quality review site review report via e-mail or the file transfer protocol (FTP) site with an e-mail notification regarding the posting. The Department should be copied on any communication regarding CAPs. For each of the elements receiving a score of *Partially Met* or *Not Met*, the CAP must address the planned intervention(s) to complete the required actions and the timeline(s) for the intervention(s).
Step 2	**Prior approval for timelines exceeding 30 days**
	If the MCO is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.
Step 3	**Department approval**
	The Department will notify the MCO via e-mail whether: ◆ The plan has been approved and the MCO should proceed with the interventions as outlined in the plan, or ◆ Some or all of the elements of the plan must be revised and resubmitted.
Step 4	**Documentation substantiating implementation**
	Once the MCO has received Department approval of the plan, the MCO should implement all the planned interventions and submit evidence of such intervention to HSAG via e-mail or the FTP site with an e-mail notification regarding the posting. The Department should be copied on any communication regarding CAPs.
Step 5	**Progress reports may be required**
	For any planned interventions requiring an extended implementation date, the Department may, based on the nature and seriousness of the noncompliance, require the MCO to submit regular reports to the Department detailing progress made on one or more open elements in the CAP.

Table C-1—Corrective Action Plan Process	
Step 6	**Documentation substantiating implementation of the plans is reviewed and approved**
	Following a review of the CAP and all supporting documentation, the Department will inform the MCO as to whether: (1) the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements or (2) the MCO must submit additional documentation. The Department will inform each MCO in writing when the documentation substantiating implementation of all Department-approved corrective actions is deemed sufficient to bring the MCO into full compliance with all the applicable contract requirements.

The template for the CAP follows.

Table C-2—FY 2008–2009 Corrective Action Plan *for* DHMC				
Standard	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents to be Submitted as Evidence of Completion**
I. Coverage and Authorization of Services 10. The Contractor's written policies and procedures include the time frames for making standard and expedited authorization decisions extending time frames, as specified in the Grievance System standard. The Utilization Review Determinations policy (UMG 1002) included the time frames for making standard and expedited authorization decisions; however, the policy did not include the time frames for extending authorization decisions.	DHMC must revise applicable policies to include the time frames for extending standard and expedited authorization decisions.			
15. The Contractor defines poststabilization care as covered services, related to an emergency medical condition, that are provided after a member is stabilized in order to maintain the stabilized condition, or are provided to improve or resolve the member's condition.	DHMC must revise applicable documents to address and define "poststabilization services."			

Table C-2—FY 2008–2009 Corrective Action Plan *for* DHMC				
Standard	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents to be Submitted as Evidence of Completion**
DHMC had no documents that specifically addressed poststabilization services.				
16. The Contractor covers and pays for emergency services regardless of whether the provider who furnishes the services has a contract with the Contractor. Members temporarily out of the service area may receive out-of-network emergency and urgently needed services. The member handbook informed members that they may receive emergency services while out of the DHMC service area; however, the handbook did not address urgently needed services out of network. Policies were also silent regarding urgently needed services out of network.	DHMC must revise all applicable policies and documents to address the fact that members temporarily out of the service area may receive urgently needed services.			

Table C-2—FY 2008–2009 Corrective Action Plan *for* DHMC				
Standard	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents to be Submitted as Evidence of Completion**
19. The Contractor does not require prior authorization for emergency or urgently needed services. While the Protocols for Authorization of Out-of-Network Referrals policy stated that emergency and urgent clinical services are exempt from the authorization process, the Utilization Review Determinations policy (UMG 1002) contained definitions of urgent care and urgent preservice reviews that indicated a requirement for authorization of urgent care services. In addition, the member handbook did not contain any direction to members about not needing prior authorization for urgent care services.	DHMC must review all applicable policies and ensure that policies, member materials, and provider materials consistently state that prior authorization is not required for urgent care services.			

Table C-2—FY 2008–2009 Corrective Action Plan *for* DHMC				
Standard	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents to be Submitted as Evidence of Completion**
II. Access and Availability 11. The Contractor must meet, and require its providers (including use of corrective action when needed) to meet, the following standards for timely access to care: ◆ The Contractor has a comprehensive plan for triage of requests for services on a 24-hours-a-day, 7-days-a-week basis, including: ▪ Immediate medical screening exam by the PCP or hospital emergency room. ▪ Access to a qualified health care practitioner via live telephone coverage either on-site, call-sharing, or answering service. ▪ Practitioner backups covering all specialties. ◆ Scheduling and waiting	When communicating results of secret shopper studies or other studies that indicate providers are noncompliant with standards set by DHMC or the Medicaid managed care contract, DHMC must clearly describe the noncompliance and require that the provider(s) submit corrective action plans to DHMC.			

Table C-2—FY 2008–2009 Corrective Action Plan *for* DHMC				
Standard	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents to be Submitted as Evidence of Completion**
times: The Contractor has 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. ◆ Non-urgent care is scheduled within 2 weeks. ◆ Adult, non-symptomatic well care physical examinations scheduled within 4 months ◆ Urgently needed services provided within 48 hours of notification of the physician or Contractor.				

Table C-2—FY 2008–2009 Corrective Action Plan *for* DHMC				
Standard	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents to be Submitted as Evidence of Completion**
Meeting minutes did demonstrate discussion of secret shopper results; however, none of the documents provided demonstrated discussion strong enough to be considered corrective actions. The e-mail communication in January did indicate that process changes were being considered; however, there was no evidence of action taken from 2007 to 2008, when secret shopper results decreased and remained low.				

Table C-2—FY 2008–2009 Corrective Action Plan *for* DHMC				
Standard	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents to be Submitted as Evidence of Completion**
VII. Provider Participation and Program Integrity 10. The Contractor reports possible instances of fraud to the Department within 10 business days of receipt of information. The referrals will include: ◆ Specific background information. ◆ The name of the provider. ◆ Description of how the Contractor became knowledgeable about the occurrence. The Office of Integrity Investigations policy stated that possible instances of fraud are reported to the Department; however, the policy did not include the content of the report.	DHMC must revise its policy related to fraud reporting to include the content of the report to the Department.			

Appendix D. Compliance Monitoring Review Activities for Denver Health Medicaid Choice

The following table describes the activities performed throughout the compliance monitoring process. The activities listed below are consistent with CMS' final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)*, February 11, 2003.

Table D-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG…
Activity 1:	**Planned for Monitoring Activities**
	Before the compliance monitoring review: ◆ HSAG and the Department held teleconferences to determine the content of the review. ◆ HSAG coordinated with the Department and the MCO to set the date of the review. ◆ HSAG coordinated with the Department to determine timelines for the Department's review and approval of the tool and report template and other review activities. ◆ HSAG staff provided an orientation on October 3, 2008, for the MCO and the Department to preview the FY 2008–2009 compliance monitoring review process and to allow the MCO to ask questions about the process. HSAG reviewed the processes related to the request for information, CMS' protocol for monitoring compliance, the components of the review, and the schedule of review activities. ◆ HSAG assigned staff to the review team. ◆ Prior to the review, HSAG representatives responded to questions from the MCO related to the process and federal managed care regulations to ensure that the MCO was prepared for the compliance monitoring review. HSAG maintained contact with the MCO as needed throughout the process and provided information to the MCO's key management staff members about review activities. Through this telephone and/or e-mail contact, HSAG responded to the MCO's questions about the request for documentation for the desk audit and about the on-site review process.
Activity 2:	**Obtained Background Information From the Department**
	◆ HSAG used the MCO's contract, dated April 14, 2005, to develop HSAG's monitoring tool, desk audit request, on-site agenda, and report template. ◆ HSAG submitted each of the above documents to the Department for its review and approval.
Activity 3:	**Reviewed Documents**
	◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the MCO in writing of the desk audit request and sent a documentation request form and an on-site agenda. The MCO had 30 days to provide all documentation for the desk audit. The desk audit request included instructions for organizing and preparing the documents related to the review of the four standards. ◆ Documents requested included applicable policies and procedures, minutes of key MCO committee or other group meetings, reports, logs, and other documentation. ◆ The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.

Table D-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG…**
Activity 4:	**Conducted Interviews**
	◆ During the on-site portion of the review, HSAG met with the MCO's key staff members to obtain a complete picture of the MCO's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the MCO's performance.
Activity 5:	**Collected Accessory Information**
	◆ During the on-site portion of the review, HSAG collected additional documents. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were of a confidential or proprietary nature.) ◆ HSAG requested and reviewed additional documents needed that HSAG identified during its desk audit. ◆ HSAG requested and reviewed additional documents needed that HSAG identified during the on-site interviews.
Activity 6:	**Analyzed and Compiled Findings**
	◆ Following the on-site portion of the review, HSAG met with MCO staff to provide an overview of preliminary findings of the review. ◆ HSAG used the FY 2008–2009 Site Review Report to compile the findings and incorporate information from the pre-on-site and on-site review activities. ◆ HSAG analyzed the findings and assigned scores. ◆ HSAG determined opportunities for improvement based on the review findings. ◆ HSAG determined actions to be required of the MCO to achieve full compliance with Medicaid managed care regulations.
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 2008–2009 Site Review Report. ◆ HSAG submitted the site review report to the Department for review and comment. ◆ HSAG coordinated with the Department to incorporate the Department's comments. ◆ HSAG distributed a second draft report to the MCO for review and comment. ◆ HSAG coordinated with the Department to incorporate the MCO's comments and finalize the report. ◆ HSAG distributed the final report to the MCO and the Department.