Colorado Medicaid
Managed Care Program

FY 2009–2010 SITE REVIEW REPORT
for
Denver Health Medicaid Choice

May 2010

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

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HSAG HEALTH SERVICES ADVISORY GROUP

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Overview of FY 2009–2010 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 each state's quality strategy. The Colorado 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 second year that HSAG has performed compliance monitoring reviews of the MCOs. For the fiscal year (FY) 2009–2010 site review process, the Department requested a review of five areas of performance. For its review of **Denver Health Medicaid Choice** (**DHMC**), HSAG developed a review strategy consisting of five standards that had not been reviewed either by the Department or HSAG within the previous two fiscal years. The areas chosen for review were Standard III—Coordination of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VI—The Grievance System, and Standard X—Quality Assessment and Performance Improvement. Compliance with federal regulations and contract requirements was evaluated through review of the five standards. This report documents results of the FY 2009–2010 site review activities for the review period—July 1, 2009, through February 9–10, 2010 (the dates of the on-site review). Section 2 contains summaries of the findings, opportunities for improvement, strengths, and required actions for each standard area. Appendices A and B contain details of the findings.

Methodology

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

The five standards chosen for the FY 2009–2010 site reviews represent a portion of the requirements based on Medicaid managed care contract and BBA requirements. Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, and Standard IX—Subcontracts and Delegation will be reviewed in subsequent years.

The site review processes were consistent with the February 11, 2003, Centers for Medicare & Medicaid Services (CMS) final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs).* Appendix E contains a detailed description of HSAG's site review activities by activity, as 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 five areas of review.
- Strengths, opportunities for improvement, and actions required to bring the MCO into compliance with federal health care regulations in the standard areas reviewed.
- 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 to enhance some elements, regardless of the score. While HSAG provided recommendations for enhancement of MCO processes based on these identified opportunities for improvement, for requirements that may have been scored *Met*, these recommendations 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 are 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)
III	Coordination and Continuity of Care	10	9	9	0	0	1	100%
IV	Member Rights and Protections	7	7	5	2	0	0	71%

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)**
V	Member Information	28	28	21	5	2	0	75%
VI	The Grievance System	35	35	22	11	2	0	63%
X	Quality Assessment and Performance Improvement	14	14	14	0	0	0	100%
	Totals	**94**	**93**	**71**	**18**	**4**	**1**	**76%**

2. Summary of Performance Strengths and Required Actions *for* Denver Health Medicaid Choice

Overall Summary of Performance

For two of the five standards HSAG reviewed, Quality Assessment and Performance Improvement and Coordination and Continuity of Care, the MCO received an overall percentage-of-compliance score of 100 percent, representing clear strengths for **DHMC**. The scores of 71 percent and 75 percent, respectively, for Member Rights and Protections and Member Information represented opportunities for continued improvement, and the score of 63 percent for the Grievance System represented the most significant opportunity for improvement across the five standards.

Standard III—Coordination and Continuity of Care

Summary of Findings and Opportunities for Improvement

DHMC had an organizational structure that provided systemwide coordination of services to its members. It offered health care services through the network at Denver Health and Hospital Authority (DHHA), family health clinics, specialty clinics, and school-based clinics. Services not provided by **DHMC** were authorized and coordinated with the Children's Hospital and the University of Colorado Hospital. Within the medical management departments, the Care Management, Case Management, Pharmacy Case Management, and Quality Improvement departments collaborated to provide coordinated, cost-effective care for managed care members. **DHMC** established assessment protocols to identify individual member needs and special conditions requiring case management or a health coach. **DHMC** also established procedures for continuity of care or authorization of medication for new members. There was evidence that **DHMC** coordinated services with other medical and behavioral health care organizations. Policies and systems were in place to safeguard protected health information (PHI).

Summary of Strengths

The Medical Management Department's care management team and the inpatient, outpatient, and pharmacy case management teams collaborated to provide member education, improve members' ablity to follow a treatment plan, help members cope with their health problem, coordinate services with other providers, obtain medications or medical equipment, and transition between levels of care.

Summary of Required Actions

There were no corrective actions required for this standard.

Standard IV—Member Rights and Protections

Summary of Findings and Opportunities for Improvement

DHMC had a comprehensive policy regarding member rights and responsibilities and employed mechanisms to ensure that staff received member rights training upon hire and annually thereafter. **DHMC**'s policies complied with Title VI of the Civil Rights Act, the Americans with Disabilities Act, as well as other laws regarding advance directives and the confidentiality and security of PHI.

Every **DHMC** employee agreed to abide by the Integrity Program Code of Conduct and signed an annual confidentiality agreement. **DHMC** employees demonstrated consideration for PHI by requiring HSAG reviewers to sign confidentiality agreements.

Summary of Strengths

DHMC representatives described a work place culture that focused on member needs, serving members, and a code of professional conduct for employees to ensure that they treated members with dignity and respect, and with their privacy in mind.

DHMC had a program called The Denver Health Dozen that distributed reminders to improve the work place and "perfect the patient experience." The program, for example, reminded employees to: "treat each other, our patients and their families with courtesy, empathy and respect. Be a Denver Health ambassador."

Summary of Required Actions

DHMC must remove language in the member handbook stating that a member is responsible for paying for emergency care without a referral and ensure that its policies are congruent with 42 CFR 438.114.

DHMC must develop a mechanism to demonstrate that it requires compliance with federal and State laws, including the Age Discrimination Act and the Rehabilitation Act.

Standard V—Member Information

The member handbook included the required general information about the services offered by **DHMC**. The readability level was consistent with State requirements, and vital documents were available in English and Spanish. Other formats such as Braille, large print, and audiotapes were available upon request. **DHMC** made oral interpretation services for all non-English languages available free of charge.

Summary of Findings and Opportunities for Improvement

Although detailed member rights were available in policy and procedure, many rights were missing details or simplified to the point that their meaning was changed or unclear. HSAG discussed with **DHMC** the possibility of exploring with the Department the development of pamphlets written at a higher reading level. This alternative would allow member information to be presented in a more detailed and accurate manner and would be especially useful for complicated topics such as the grievance system and advance directives. **DHMC** is encouraged to clarify language in the member handbook regarding whether a member will be disenrolled or warned for physically threatening a doctor.

Summary of Strengths

DHMC consistently used readability guides in the preparation of member materials. The health plan and member services staff was focused on serving members. **DHMC** had a well-designed intranet for exchanging and posting information that was useful to member service representatives in responding to questions posed by members calling **DHMC** for information or with inquiries or complaints.

Summary of Required Actions

DHMC must develop a policy and internal protocols to document and guide the distribution of member handbooks.

DHMC must ensure appointment standards are complete, correct, and consistent within the member handbook.

Member handbook information regarding the grievance system must be clarified. State fair hearing requests must be made within 20 days of the notice of action letter, and a member need not exhaust the local appeal process before requesting a State fair hearing. The member handbook must also clarify the 10-day time frame requirement to request a continuation of benefits during an appeal and State fair hearing.

DHMC must develop an MCO policy on advance directives that includes the requirement to notify members of any changes to State law relevant to advance directives within 90 days following the change in the law.

Member materials must include the **DHMC** policy about advance directives (for example, that **DHMC** will honor all legally prepared advance directives).

The member handbook must include information regarding the rights available to providers to challenge **DHMC**'s failure to cover a service.

Standard VI—The Grievance System

Summary of Findings and Opportunities for Improvement

DHMC had a system in place that included a grievance process, an appeal process, and access to the State fair hearing process. Member and provider materials were written in a simple manner. Although the materials met the Department's readability requirements (providers received a version similar to members), members reading the materials would have difficulty obtaining a full understanding of their grievance and appeal rights.

The member handbook addressed the rules that govern representation at a State fair hearing. It would provide an additional advantage to members if **DHMC** informed members that additional important information regarding representation can be found by visiting the Colorado Official State Web Portal, www.colorado.gov/cs/Satellite/DPA-OAC/OAC/1245426030863, and clicking on the link, Guide for Non-Lawyers.

HSAG discussed with **DHMC** the possibility of exploring with the Department the development of pamphlets about the grievance system written at a higher reading level. This would allow the presentation of more detailed and accurate grievance system information.

DHMC reported only one appeal to the Department during the period of review. Given the size of the **DHMC** Medicaid membership, the identified network capacity issues, and findings from member satisfaction surveys, it is likely that potential appeals are being lost in the system. Other contributory factors could include the clarity of member and provider informational materials regarding the rights of providers to file appeals on behalf of members.

Summary of Strengths

The grievance record review demonstrated that acknowledging and resolving grievances was a strength for **DHMC**. The overall score for the record review was 97 percent.

Summary of Required Actions

DHMC must clarify in member and provider materials that a provider may, acting on behalf of a member and with the member's written consent, file a grievance or appeal, request a State fair hearing, and act as the member's authorized representative at a State fair hearing.

DHMC must develop and implement a process to ensure that oral requests to file an appeal are followed with a written, signed appeal from the member or the designated client representative (DCR).

DHMC must make clear in policy and member materials that timely filing of an appeal for termination, suspension, or reduction of previously authorized services must occur on or before the later of the following: (1) within 10 days of the postmark of the notice of action or (2) the intended effective date of the proposed action.

DHMC's policies and member materials must reflect current regulatory requirements, which specify that a member may request a State fair hearing within 20 days from the date of the notice of action.

DHMC must ensure that the appeal-by date specified in the notice of action letter reflects a time period of 20 days from the date of the letter.

DHMC must ensure that its claims process is compliant with the requirements of 42 CFR 438.114, et seq.

DHMC must ensure that its policy and practice are compliant with the requirement to advise the member of the right to file a grievance when it sends written notice of its decision to extend the time frame for an authorization decision.

DHMC must log grievances on the actual date of receipt of the grievance.

DHMC must develop and implement a process to ensure that oral requests to file an appeal are followed with a written, signed appeal from the member or the DCR.

DHMC must ensure that appeal resolution letters for appeals not resolved wholly in favor of the member include the right to request a State fair hearing and how to do so, that a State fair hearing must be requested within 20 calendar days from the date of the notice of action, the member's right to request and receive benefits while the hearing is pending and how to make the request, and that the member may be held liable for the cost of those benefits if the hearing decision upholds the plan's action.

DHMC must provide the information about the grievance system specified in 42 CFR 438.10 to all providers and subcontractors at the time they enter into a contract. This information should include: (1) the requirements and time frames for filing appeals and that verbal appeals must be followed with a written appeal; (2) that when requested by a member, benefits will continue if an appeal or request for a State fair hearing is filed within the time frames specified for filing; (3) the time frames for continued-benefit requests; (4) and the correct time frame for requesting State fair hearings (20 days).

DHMC must inform providers of their right to appeal the failure of the contractor to cover a service.

DHMC must ensure that the process to designate a client representative is not unnecessarily burdensome. Requiring a DCR to submit the equivalent of a driver's license and documentation

providing legal authority exceeds the requirements of Colorado statute, which defines a DCR as any person authorized in writing by the member or the member's legal guardian to represent his or her interests.

DHMC must evaluate its processes for recording and responding to feedback from members and providers who have been sent a notice of action. Assessment should include various contact points within the system, including providers and satellite clinics, and results should be used to identify and respond to any possible barriers to members or providers exercising the right to appeal an action.

DHMC must ensure that its internal documents and member materials clearly identify the conditions and time frames under which benefits can continue.

DHMC must ensure that its policy clearly contains the conditions under which continued or reinstated benefits will occur during the appeal or State fair hearing processes.

Standard X—Quality Assessment and Performance Improvement

Summary of Findings and Opportunities for Improvement

The Quality Improvement Impact Analysis document included findings and opportunities that **DHMC** has identified for its quality improvement activities. The Quality Improvement Program Description described all of the components of the program and detailed the purpose, scope, policy, and responsibilities. A surge in demand for services secondary to economic conditions has had a significant impact on **DHMC**'s ability to meet its quality improvement (QI) goals. Findings from satisfaction surveys and grievance data highlight this negative impact on members' ability to access services.

Summary of Strengths

DHMC had a highly functional quality assessment and performance improvement (QAPI) program. **DHMC** integrated its quality improvement activities throughout the health plan; quality improvement was a core focus of the organization. **DHMC**'s documentation demonstrated extensive analysis of utilization and assessment of the quality and appropriateness of care.

Summary of Required Actions

There were no corrective actions required for this standard.

3. Follow-up on FY 2008–2009 Corrective Action Plan
for **Denver Health Medicaid Choice**

Methodology

As a follow-up to the FY 2008–2009 site review, each MCO was required to submit a corrective action plan (CAP) to the Department addressing all components for which the MCO received a score of *Partially Met* or *Not Met*. The plan was to include interventions to achieve compliance and the timeline associated with those activities. HSAG reviewed the CAP and associated documents submitted by the MCO and determined whether the MCO successfully completed each of the required actions. HSAG and the Department continued to work with the MCO until HSAG and the Department determined that the MCO completed each of the required actions from the FY 2008–2009 compliance monitoring site review, or until the time of the on-site portion of the MCO's FY 2009–2010 site review.

Summary of 2008–2009 Required Actions

As a result of the FY 2008–2009 review, **DHMC** was required to address six components of the Coverage and Authorization of Services, Access and Availability, and Provider Participation and Program Integrity standards.

Based on HSAG's finding for Coverage and Authorization of Services, **DHMC** was required to:

- Revise applicable policies to include time frames for extending standard and expedited authorization decisions.
- Revise applicable documents to address and define poststabilization services.
- Ensure that policies, member materials, and provider materials consistently state that prior authorization is not required for urgent care services.
- Revise applicable policies and documents to address the fact that members temporarily out of the service area may receive urgently needed services.

For Access and Availability, **DHMC** was required to clearly describe any instances of noncompliance identified during secret shopper studies and require that the provider(s) submit corrective action plans to **DHMC**. HSAG suggested that **DHMC** may need to evaluate whether the secret shopper results represent capacity issues verses process issues in order to implement appropriate corrective actions.

As a result of the review for the Provider Participation and Program Integrity standard, HSAG found that **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 by the Medicaid managed care contract. **DHMC** was required to revise its policy related to fraud reporting to include the content of the report to the Department.

Summary of Corrective Action/Document Review

DHMC submitted its CAP to HSAG and the Department in May 2009. After careful review, HSAG and the Department determined that if implemented as written, the plan submitted by **DHMC** would adequately address all required actions. In September 2009, **DHMC** implemented its plan and submitted documents to HSAG and the Department that demonstrated compliance.

By October 2009, HSAG and the Department had reviewed all documentation submitted by **DHMC** and determined that **DHMC** had successfully implemented its CAP and addressed all required actions.

Summary of Continued Required Actions

DHMC successfully addressed all required actions. There were no required actions continued from FY 2008–2009.

Appendix A. Compliance Monitoring Tool
for Denver Health Medicaid Choice

The completed compliance monitoring tool follows this cover page.

Standard III—Coordination and Continuity of Care			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.208(b)(1)	1. The Contractor has a mechanism to ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member.	**Documents Submitted/Location Within Documents:** 1. Managed Care Coordination of Care Document 2. Medical Management Internal Coordination, Communication and Referral process 3. Drug Authorization Policy and Procedure CHOICE_RX1601 (pgs 4-7) 4. Utilization Management Program Description CHOICE_UMG1001 (pgs 1-13) 5. Case Management for DH Medicaid Choice CHOICE_CMG1202) (pgs 2 -4) 6. Case Management Program Description.2009.final.doc (pgs 2-4) 7. Provider Newsletter (Provider Second QTR09.pdf) 8. Member Notification.pdf 9. Post Discharge Phone Call Assessement.pdf 10. Appointment Confirmation.pdf 11. Teaching Sheet Micromedex®.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: DHMC had processes in place to ensure that members had an ongoing source of primary care appropriate to their needs. The DHMC network included Denver Health Medical Center, eight family health clinics, 12 school-based health centers, and adult and pediatric urgent care clinics, specialty clinics (obstetrics, orthopedic, etc.), and a nurse advice line. Resources in development included an outpatient surgery center and adolescent psychiatric unit. Contracted services included home health services, durable medical equipment (DME), pharmacy services and long-term skilled nursing care. Services not provided by DHMC were authorized and coordinated with Children's Hospital or University of Colorado Hospital. All new members were mailed a member handbook and provider directory. The member handbook provided information about primary care providers (PCPs), how to get information about providers, and how to choose a PCP. The handbook stated that if a member did not select a PCP, he or she would be assigned to the Denver Health family clinic closest to their address. The member handbook and provider directory each contained listings of the family health centers and school-based clinics in its network. The member handbook and provider directory stated that members could change their PCP by calling member services. The local and toll-		

Standard III—Coordination and Continuity of Care			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
	free telephone numbers for member services were printed at the bottom of every page of the member handbook. PCP responsibilities were specified in the provider manual and included coordination of all member care activities, referrals, and requests for authorization of specialty care.		
	Required Actions: None		
	2. The Contractor provides a continuum of enhanced care management designed to improve the quality of care and decrease the cost of care for the highest risk members. The Contractor uses risk stratification to make this intervention available to all members and to determine the appropriate intensity of services.	**Documents Submitted/Location Within Documents:** Not Applicable **Description of Process:**	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
	Findings: This requirement was not applicable to DHMC.		
	Required Actions: None		

Standard III—Coordination and Continuity of Care			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
DHHA Contract: II.E.4.a	3. The Contractor has written policies and procedures to ensure timely coordination of the provision of covered services to its members to promote and assure service accessibility, attention to individual needs, continuity of care, maintenance of health, and independent living.	**Documents Submitted/Location Within Documents:** 1. Managed Care Coordination of Care Document 2. Drug Authorization Policy and Procedure CHOICE_RX1601 (pgs 4-7) 3. New Member Process 4. New Member Questionnaire.pdf 5. Case Management Program Description.2009.final.doc (pgs 2-4) 6. Case Management for DH Medicaid Choice CHOICE_CMG1202 (pgs 2 – 4) 7. Care Management Program Description.2009.final.doc(pgs 2-5) 8. Special Health Care Needs CHOICE_UMG1004 (pgs 2-6) 9. Diabetes Support Group all info revised.doc 10. Health & Wellness Series poster.pdf 11. Chantix Guidelines.doc 12. Initial assessment checklist revised.doc 13. Care Management Referral doc PP (2).doc 14. UPDATED electronic referral form.doc	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: DHMC had an organizational structure and written policies and procedures to ensure coordination of services provided to its members. The medical management departments (the Care Management, Case Management, Pharmacy Case Management, and Quality Improvement departments) used both individual guidelines as well as the Managed Care Coordination of Care process, the Medical Management Internal Coordination, Communication, and Referral process, and the New Member process (new members were sent a welcoming questionnaire to identify members and children in the home, their primary language, any developmental issues of the children, home oxygen use, or any needs that a health coach could address). Other policies and processes used to ensure coordination and continuity of care and maintenance of health and independent living included the Initial Assessment Checklist, Special Health Care Needs, Care Management Referral, Transition to Home Care From Hospital, Identifying Medicaid Skilled Nursing Facility (SNF) Patients for Transition, SNF Transition Script, Home Health Referral, Community Resource Guidelines, Post Discharge Phone Call Assessment, Appointment Confirmation, Transition to Home Care From Hospital, and various teaching sheets.		
	Required Actions: None		

Standard III—Coordination and Continuity of Care			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.208(b)(2) DHHA Contract: II.E.4.a & b	4. The Contractor coordinates services furnished to the member by the Contractor with the services the member receives from any other medical or behavioral health care organization. (This element requires a policy/procedure.)	**Documents Submitted/Location Within Documents:** 1. Managed Care C Managed Care Coordination of Care (pgs 1-11) 2. Case Management CHOICE_CMG1202 3. SNF script for transition 4. Identifying Medicaid SNF Patients for Transition 5. Managed Care Transition Protocol 6. Infusion GUIDELINES 7. Home Health Referral CHOICE_UMG1014 8. Community Resources guideline.doc 9. Member Notification.pdf 10. Post Discharge Phone Call Assessement.pdf 11. Appointment Confirmation.pdf 12. Teaching Sheet Micromedex®.pdf 13. Caremark Report Sample 14. PCP Appointment Cab Scheduling Database screen shots (pg 1-2)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: There was ample evidence that DHMC coordinated the services its member received from other medical or behavioral health care organizations provided through submitted policies and processes; on-site demonstration of pharmacy, care coordination, and case management systems; and examples of coordination activities with community agencies discussed during the on-site interviews with DHMC staff members. Relevant policies and processes included the New Member process, the Managed Care Coordination of Care process, and the Medical Management Internal Coordination, Communication, and Referral process. A community resource library was maintained by the Care Management Program on a shared drive for the managed care staff. Community resource information was used to assist members in the management of a medical condition or to make a referral to assist with other psychosocial needs. A member admitted to an out-of-network facility received follow-up monitoring by a case manager who provided the member's medical record information pertinent to the current inpatient stay. Member information extracted from the electronic medical record decreased duplication of recently performed diagnostic or laboratory procedures. The member's medication history and current list of medications were also provided to the out-of-network facility. At the time of discharge, the case manager facilitated coordination of medication needs. Postdischarge assistance could be provided for follow-up appointments, medical record transition, and transportation. The Pharmacy Case Management Department identified behavioral health members who had not had a PCP visit in the previous 12 months and would make at least three attempts to contact those members via telephone or letter to encourage the scheduling of a PCP		

Standard III—Coordination and Continuity of Care			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
	appointment, provide transportation as applicable, and coordinate their medication needs. Once an appointment was kept, the pharmacy coordinator also facilitated the exchange of medical records and health information from DHMC to the behavioral health organization. The DHMC Quality Improvement Department was conducting a performance improvement project (PIP) with the goal to study ways to increase coordination of care between the physical and behavioral health providers treating Medicaid members over the age of 21 with a serious mental illness (SMI) diagnosis. Additional coordination and collaboration processes were identified that occurred for members who were dually eligible (Medicare-Medicaid), members who had standing orders to receive care out of network (e.g., Children's Hospital or University of Colorado Hospital), members transitioning in or out of skilled nursing facilities, members receiving home health care, or members receiving services in specialty clinics such as newborn intensive care follow-up.		
	Required Actions: None		
42CFR438.208(b)(4) DHHA Contract: II.E.4.a	5. The Contractor ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E (HIPAA), to the extent that they are applicable (This element requires a policy/procedure.)	**Documents Submitted/Location Within Documents:** 1. Confidentiality, Privacy and Security of Medicaid Choice Member Information HIP901 Policy and Procedure 2. Subcontracting Services for Denver Health CHOICE_CTS301 Policy and Procedure 3. 2010 Mandatory Training – Office of Integrity doc. 4. Integrity Program Code of Conduct (pgs 8 and 20)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: DHMC had implemented policies and processes to ensure that each member's privacy is protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164, Subparts A and E (the Health Insurance Portability and Accountability Act of 1996 [HIPAA]). Written policies and procedures were in place that addressed the security of member information, including the Confidentiality, Privacy and Security of Medicaid Choice Member Information policy and procedure and the Integrity Program Code of Conduct. DHMC provided evidence that it conducted annual mandatory training that included the requirements regarding PHI, such as rules regarding passwords, accessing information, storage, transmission, and encryption. DHMC documented that it monitored subcontractors for compliance with PHI requirements for medical records and data reporting. DHMC employees signed agreements to abide by the Integrity Program Code of Conduct, which provided guidelines associated with confidential information and health care regulatory compliance. DHMC used an e-mail system, Safemail, that provided a secure communication system for transmission of confidential member information.		
	Required Actions: None		

Standard III—Coordination and Continuity of Care			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.208(c)(2) DHHA Contract: II.E.5.b	6. The Contractor implements mechanisms to assess each Medicaid member, identified by the State to the Contractor as having special health care needs, in order to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals.	**Documents Submitted/Location Within Documents:** 1. Drug Authorization Policy and Procedure DHMP_RX1601 (pgs. 5-8) 2. Pharmacy PAR Workflow (pgs. 1-3) 3. Pharmacy PAR Database Screen Shots (pgs. 1-2) 4. Pharmacy PAR Database Psych Screen Shots (pgs. 1-2) 5. Care Management Referral doc-PP.doc 6. Care Management Program Description.2009.final.doc 7. Care Management Flyer 8. Initial assessment checklist 9. Utilization Management Program Description UMG1001 (pgs. 1-4) 10. Case Management for Managed Care Members CHOICE_CMG1202 (pgs 1-3) 11. Special Health Care Needs and Disabilities CHOICE_UMG1004 (pgs 1-4) 12. Managed Care Coordination of Care document revised.doc (pgs 5-9) 13. Special Needs Letter-2.doc 14. Helpful contacts for SNP members 15. Medical Management Internal Coordination, Communication and Referral process	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: DHMC sought to identify members with special health care needs (SHCN) through a variety of methods. All new members were mailed a new member questionnaire to identify any medical or developmental issues, home oxygen use, symptoms of depression, or other member needs. Care management staff and/or pharmacy case managers would follow up with the member regarding identified needs. Members could also self-refer for care management or be referred by inpatient or outpatient providers, social workers, or nurses.		

Standard III—Coordination and Continuity of Care			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
	Pharmacy case management identified members through the prior-authorization request (PAR) process. When members were identified with certain behavioral health diagnoses, complex medication regimens, serious health conditions, or involvement with multiple providers, the SHCN field of the PAR database was flagged. Members were then referred to care management health coaches and/or other medical management departments (e.g., case management) on a case-by-case basis. As members with SHCN were identified, care management health coaches were assigned to provide ongoing education about disease processes, connection to community resources, and/or assistance with psychosocial issues. Outpatient case managers and referral coordinators assisted with level-of-care transitions. They coordinated care for members who might require services such as home care, SNF, DME, or infusion services. The care plan, medication list, and hospital summary would be provided to a receiving facility as applicable. Outpatient case managers collaborated with social workers, utilization nurses, rehabilitation services, and physicians to ensure coordination of benefits and a safe discharge. Inpatient case managers provided care coordination for members admitted to out-of-network hospitals. Discharge planning began early in the admission when members were contacted to provide current contact information for follow-up. As appropriate, long-term care services, disease or condition education, outpatient case management, pharmacy case management, and health coaching services were coordinated through the processes described in the policy, the Care Management Referral process and the Medical Management Internal Coordination, Communications, and Referral process. The policy, Members with Special Health Care Needs and/or Disabilities, stated that there was an authorization system in place to allow a PCP to provide a standing referral for members with SHCN to see a specialist appropriate to treat the member's condition. The policy specified that all members with SHCN must have timely access to a comprehensive evaluation, subspecialty consultation and care, and rehabilitative services provided by professionals with appropriate subspecialty training.		
	Required Actions: None		

Standard III—Coordination and Continuity of Care			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
DHHA Contract: II.E.4.c	7. The Contractor has an effective care coordination system that includes: ◆ Capacity to provide individual needs assessment to identify special health care needs ◆ Procedures designed to address those members who may require services from multiple providers, facilities, or agencies and require complex coordination of benefits and services, and members who require ancillary services, including social services and other community resources ◆ A strategy to ensure that all members and/or authorized family members or guardians are involved in treatment planning and consent to medical treatment ◆ Procedures and criteria for making referrals and coordinating care by specialists, subspecialists and community-based organizations that will promote continuity as well as cost-effectiveness of care. ◆ Procedures to provide continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services that include, but are not limited to, care coordination staff trained to evaluate and handle individual case transition, care planning, assessment of equipment, and evaluating adequacy of participating providers ◆ Informing the member that he or she may continue to receive services from his or her	**Documents Submitted/Location Within Documents:** 1. Drug Authorization Policy and Procedure CHOICE_RX1601 (pgs. 5-8) 2. Managed Care Coordination of Care Document (pgs 5-12) 3. Case Management for Managed Care Members CMG1202 Policy and Procedure (pgs 1-3) 4. Special Health Care Needs and Disabilities UMG1004 Policy and Procedure (pgs 1-6) 5. Transition to Home Care from Hospital-Monitoring Progress.pdf 6. UPDATED electronic referral form.doc 7. Initial assessment checklist .doc 8. Medical Management Internal Coordination, Communication and Referral process 9. MCD Choice Care Management Program Description 10. Care Management Referral process 11. New Member Process 12. New Member Questionnaire.pdf 13. Community Resource Guidelines 14. Care Management Transition of Care 15. Care Plan.pdf 16. Post Discharge Phone Call Assessment	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
	provider for 60 calendar days from the date of enrollment ◆ Informing the member that he or she may continue to receive ancillary services for 75 calendar days from the date of enrollment ◆ Informing a member that is in her second or third trimester of pregnancy that she may continue to receive services from her provider until the completion of post-partum care		
	Findings: DHMC had the ability to provide an individual needs assessment to identify special health care needs. The Care Management Program used the new member questionnaire; individual initial assessments; referrals from members, providers, and ancillary staff; and lab data to identify members requiring additional services or multiple providers. Following an assessment that identified a member's needs and goals, care management health coaches collaborated with the member and treatment team to ensure timely coordination of care. There were procedures designed to address the needs of members who required services from multiple providers, facilities, or agencies, and who required complex coordination of benefits and services. There were also procedures to address the needs of members who required ancillary services, including social services and other community resources. See the findings for Element 6. The SHCN policy specified a strategy to ensure that all members and/or authorized family members or guardians are involved in treatment planning and consent to medical treatment. The policy specified that an individual treatment plan would be developed as necessary based on the needs assessment, the establishment of treatment objectives, treatment follow-up, and monitoring outcomes, as well as a process to ensure that treatment plans are revised as necessary. The policy required that the member or family agree on an individual treatment plan, and that the treatment plan include input from the multidisciplinary team. DHMC had polices and processes for making referrals and coordinating care by specialists, subspecialists, and community-based organizations to promote continuity of care. See the findings in Elements 1, 3, and 4. Additionally, pharmacy nurse case managers had a process to review each PAR request, taking into consideration the member's age, medical condition, appropriateness of medication, dosing guidelines, potential drug interactions, history of medication adherence, current medications, and cost effectiveness. Questions or needs identified from the new member questionnaires triggered a member contact from a pharmacy nurse case manager. The pharmacy nurse case manager could facilitate authorization of nonformulary, transition-of-care medication overrides for up to a 60-day supply. Additionally, the pharmacy nurse case manager could provide general information about benefits, transportation, and the availability of local pharmacies. At this contact from the pharmacy nurse case manager, members would be invited to the next new member orientation and given the Pharmacy Department telephone number for future questions.		

<table>
<tr><th colspan="4">Standard III—Coordination and Continuity of Care</th></tr>
<tr><th>References</th><th>Requirement</th><th>Evidence Submitted by the Health Plan</th><th>Score</th></tr>
<tr><td rowspan="2"></td><td colspan="3">Continuity-of-care information was provided via the member handbook as follows: “If you are a new member with special needs, we can help you. If your non-Denver Health doctor agrees, you can keep seeing this doctor for up to 60 days after you join Denver Health. You may also keep your home health or DME provider for up to 75 days after you join Denver Health. Your DME provider must agree to work with Denver Health. If you are a new member and are more than three months pregnant, you may be able to keep seeing your current doctor. You may keep your current doctor until your baby is born.”</td></tr>
<tr><td colspan="3">Required Actions:
None</td></tr>
<tr><td rowspan="3">42CFR438.208(b)(3)

DHHA Contract: II.E.5.a</td><td>8. The Contractor shares with other health care organizations serving the member with special health care needs, the results of its identification and assessment of that member’s needs, to prevent duplication of those activities.</td><td>Documents Submitted/Location Within Documents:
1. Managed Care Coordination of Care Document (pgs 5-12)
2. Managed Care Records Release</td><td>☒ Met
☐ Partially Met
☐ Not Met
☐ Not Applicable</td></tr>
<tr><td colspan="3">Findings:
Services not available in the DHMC network were authorized and coordinated with Children’s Hospital or University of Colorado Hospital. Examples of DHMC sharing information with other health care organizations serving the member with SHCN were provided through on-site demonstration of pharmacy, care coordination, and case management systems. DHMC provided printouts of care management and case management member files that documented HIPAA-compliant care coordination and service provision. Members admitted to out-of-network facilities received follow-up monitoring by case managers who provided the member’s medical record information pertinent to the current inpatient stay. Member information extracted from the electronic medical record decreased duplication of recently performed diagnostic or laboratory procedures. The member’s medication history and current list of medications were also provided to the out-of-network facility. At the time of discharge, the case manager facilitated coordination of medication needs. Postdischarge assistance could be provided for follow-up appointments, medical record transition, and transportation. Behavioral health coordination for member care was facilitated by the pharmacy referral coordinator, who encouraged patients to be compliant with their medications and make and keep appointments with their PCP. The coordinator submitted a medical records release form to Denver Health Medical Records to facilitate the exchange of medical records and health information from Denver Health to the behavioral health organization.</td></tr>
<tr><td colspan="3">Required Actions:
None</td></tr>
</table>

Standard III—Coordination and Continuity of Care			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.208(c)(3) DHHA Contract: II.E.4.c	9. The Contractor has procedures for developing treatment plans for members with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring. The treatment plan must be designed to accommodate the specific cultural and linguistic needs of the Contractor's member and include: ◆ Treatment objectives, treatment follow-up ◆ Monitoring of outcomes ◆ The process for ensuring that treatment plans are revised as necessary	**Documents Submitted/Location Within Documents:** 1. Care Management Program Description.2009.final.doc (pgs 1-6) Initial assessment checklist .doc	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: Members with SHCN were identified through direct referrals from care practitioners—including PCPs, nurses, social workers, behavioral health practitioners, utilization management (UM) case management, internal programs, and member self-referral—and through administrative claims and pharmacy data. The initial assessment checklist used to assess members addressed language, support systems, identification of PCP and any specialty providers, diagnoses, vital signs, medications, activities of daily living (ADLs), mental health issues, advance directive information, psychosocial concerns, and resources needed (e.g., DME). The form included a section to identify and monitor goals established with the member or family (i.e., the date activity toward a goal began, the date it was completed, and the status). Inpatient services developed care plans for members with SHCN. Plans were reviewed at the time of inpatient discharge with the member or guardian. Ongoing issues were followed by inpatient services for up to 30 days. If the member needed long-term health coaching, then a referral would be made to the care management area. The Care Management Program goals for each member were determined by the member. DHMC provided copies of several member treatment plans and summaries, which provided evidence that the plans accommodated members' specific needs and included the treatment objective, follow-up treatment activities, monitoring, and treatment plan revisions as the members' status changed.		
	Required Actions: None		

Standard III—Coordination and Continuity of Care			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.208(c)(4) DHHA Contract: II.E.4.c	10. For members with special health care needs, the Contractor has a mechanism in place to allow members to directly access a specialist, as appropriate to the member's condition and identified needs.	**Documents Submitted/Location Within Documents:** 1. Special Health Care Needs and Disabilities UMG1004 Policy and Procedure CHOICE_UMG1004 (pgs 2-5)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: DHMC had a mechanism to allow members direct access to a specialist. A PCP could request a standing referral from UM. During the on-site interview, staff described that this occurred frequently and authorizations could span a length of time suitable for the condition. The member handbook stated that a member needed a referral from his or her PCP to see a specialist such as a heart doctor or a cancer doctor. "Your doctor will ask for a referral from DHMC. If you will be seeing a specialist often, ask your PCP for a standing referral. This will let you see your specialist without getting a referral every time you go for a visit. Health care services are covered outside of the DHMC network if the type of care is not provided within the network; and you get a referral from your PCP, and the referral is approved ahead of time by DHMC."		
	Required Actions: None		

Results for Coordination and Continuity of Care							
Total	Met	=	9	X	1.00	=	9
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	0
Total Applicable		=	9	**Total Score**		=	9

Total Score ÷ Total Applicable	=	100%

Standard IV—Member Rights and Protections			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.100(a)(1) DHHA Contract: II.F.1.a & c	1. The Contractor has written policies regarding member rights.	**Documents Submitted/Location Within Documents:** 1. DH_MCDChoice_MBR_Rights_Tng.09.ppt 2. AdvancemedicalDirectivesCPRstatus0409Final.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: DHMC's policy, Member Rights and Responsibilities (member rights policy) included a comprehensive listing of member rights and responsibilities as specified in 42 CFR 438.100. DHMC had several other policies that referred to or referenced member rights, including Advance Directives/Cardiopulmonary Resuscitation/CPR Status (advance directives policy), Cultural and Linguistic Appropriate Services Program, and Confidentiality, Privacy, and Security of DHHA and Medicaid Choice Member Information. The director of member services had developed a synopsis of written member rights and responsibilities policies that had been presented to member services staff. A copy of the presentation was posted on the DHMC intranet, which was available to member services representatives for reference.		
	Required Actions: None		
42CFR 438.100(a)(2)	2. The Contractor ensures that its staff and affiliated providers take member rights into account when furnishing services to members.	**Documents Submitted/Location Within Documents:** 1. DH_MCDChoice_MBR_Rights_Tng.09.ppt	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: DHMC required employees to receive member rights training upon hire and annually thereafter. DHMC presented evidence of online mandatory training sessions (through a Web-based in-service) for employees covering a variety of topics, including the code of conduct and confidentiality. DHMC also prepared supervisor and manager "tips" for day-to-day use that included references to rights and responsibilities. All Denver Health employees carried a credit card-sized copy of "The Denver Health Dozen" with their identification badges that included written "reminders" about improving the work place and "perfecting the patient experience," such as: "Treat each other, our patients and their families with courtesy, empathy and respect. Be a Denver Health ambassador." Denver Health also provided "Star Awards" to DHMC and clinic employees and providers who went above and beyond to provide quality service or innovations that benefitted members, employees, or the health system as a whole. Member rights and responsibilities, as documented in the second quarter 2009 Provider Newsletter, were at a higher reading level than they were in the member handbook. Because DHMC was not required to print information for providers at a sixth-grade reading level, providers received more complete information about member rights and responsibilities than members did.		

Standard IV—Member Rights and Protections			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
	Required Actions: None		
42CFR438.100(b)(2) & (3) DHHA Contract: II.F.1.a	3. The Contractor's policies and procedures include procedures for ensuring that members are treated in a manner that is consistent with the following rights: ◆ Receive information in accordance with information requirements (42CFR438.10) ◆ Be treated with respect and with due consideration for his or her dignity and privacy ◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand ◆ Participate in decisions regarding his or her healthcare, including the right to refuse treatment ◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation ◆ To obtain family planning services directly from any Provider duly licensed or certified to provide such services without a referral ◆ Request and receive a copy of his or her medical records and request that they be amended or corrected ◆ Be furnished health care services in accordance with requirements for access	**Documents Submitted/Location Within Documents:** 1. Cultural and Linguistic Appropriate Services Program Policy and Procedure QIM1304 - demonstrates that we address Cultural and Linguistic Appropriate Services and train staff. 2. QI Program Description includes Cultural Competency - refer to pg 6, number 6. 3. Denver Health has specific Policies that apply to all employees and address cultural awareness: a. American with Disabilities Act 4-144 b. Cultural and Religious Considerations Relative to Provision of Care 4-141 c. Equal Opportunity Employment 2-100 d. Workforce Diversity 4-108 4. The following documents are related to the training of DH employees: a. New Employee Orientation (NEO) Policy and Procedure b. NEO Cultural Awareness (CA) Outline c. Email explaining the new training implemented the first week of January 2010 d. Management Class for Cultural Awareness - training outline and booklet is attached. 5. AdvancemedicalDirectivesCPRstatus0409Final.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
	and quality of services (42CFR438.206 and 42CFR438.210) ◆ To exercise his or her rights without any adverse effect on the way he or she is treated by the Contractor or its providers ◆ To receive information about advance directives as specified in 42CFR438.10		
	Findings: DHMC provided numerous documents that outlined procedures for ensuring a member's right to receive information as specified in 42 CFR 438.10. HSAG found evidence that this requirement was met through review of the following documents: DHMC's member rights policy, the advance directives policy, the Medicaid Choice Member Handbook (member handbook), the Cultural and Linguistic Appropriate Services Program policy and procedure, the Americans with Disabilities Act, the Cultural and Religious Considerations Relative to Provision of Care policy, the Equal Opportunity Employment policy, the Workforce Diversity policy, and the Quality Improvement Program Description.		
	Required Actions: None		
DHHA Contract: II.F.1.b Volume 8: 8.205.2	4. The Contractor has written requirements for member participation and the responsibilities of members in receiving covered services, which includes: ◆ Select a primary care physician from those physicians available in the Contractor's organization ◆ Obtain a referral from his/her PCP for specialty care (if required) ◆ Follow all requirements of the Medicaid managed care program as described in the Contractor's member handbook ◆ Follow the Contractor's procedures for complaints and grievances	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook 2. CHOICE_MBR805	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
	◆ Request any change of PCP from the Contractor ◆ Pay for any health care provided, except for emergency services, when health care services are sought and received without a referral from his or her PCP in the Contractor's organization. – This does not apply when the service is a covered service that is not covered by the Contractor ◆ Pay for any services received which are not Medicaid covered services ◆ Notify the Contractor of any third party insurance, including Medicare		
	Findings: All of the above-listed requirements were stated in the member rights policy. The member handbook also listed member responsibilities. Although DHMC had written requirements for member participation and the responsibilities of members in receiving covered services, there was an incorrect reference regarding a member's responsibility to pay for emergency or urgent care. The member handbook stated that a member was responsible for "paying for the care you get if you do not get a referral for emergency or urgent care." Federal regulations (42 CFR 438.114) prohibit managed care organizations from denying payment for emergency services or billing members for emergency care that meets the prudent layperson standard.		
	Required Actions: DHMC must remove language in the member handbook stating that a member is responsible for paying for emergency care without a referral and ensure that its policies are congruent with 42 CFR 438.114.		

Standard IV—Member Rights and Protections

References	Requirement	Evidence Submitted by the Health Plan	Score
42CFR438.100(d) DHHA Contract: VI.Q	5. Contractor complies with any other federal and State laws that pertain to member rights including Title VI of the Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act, and Titles II and III of the Americans with Disabilities Act and other laws regarding privacy and confidentiality.	**Documents Submitted/Location Within Documents:** 1. American with Disabilities Act 4-144 2. Cultural and Religious Considerations Relative to Provision of Care 4-141 3. Equal Opportunity Employment 2-100 4. Workforce Diversity 4-108	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: DHMC submitted a policy indicating compliance with the Americans with Disabilities Act. It had a policy regarding cultural and religious consideration, and policy statements on workforce diversity and equal opportunity employment. No policies were provided regarding the Age Discrimination Acts of 1967 and 1975 or the Rehabilitation Act.		
	Required Actions: DHMC must develop a mechanism to demonstrate that it requires compliance with federal and State laws including the Age Discrimination Acts of 1967 and 1975 and the Rehabilitation Act.		
42CFR438.224 DHHA Contract: II.F.3.c	6. The Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable.	**Documents Submitted/Location Within Documents:** 1. Confidentiality, Privacy and Security of Medicaid Choice Member Information HIP901 Policy and Procedure 2. Subcontracting Services for Denver Health CHOICE_CTS301 Policy and Procedure 3. 2010 Mandatory Training – Office of Integrity doc. 4. Integrity Program Code of Conduct (pgs 8 and 20)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: DHMC's 2010 Mandatory Training plan; the Confidentiality, Privacy, and Security of Medicaid Choice Member Information policy; and the Subcontracting Services for Denver Health Choice policy demonstrated DHMC's processes to protect the confidentiality of records and materials containing PHI in accordance with the contract. DHMC's Integrity Program Code of Conduct outlined DHMC staff requirements for confidentiality and ethical conduct. All Denver Health employees were required to complete annual training on information, privacy, and security. DHMC presented evidence of the relevant online training modules. Every DHMC employee also agreed to abide by the Integrity Program Code of Conduct and signed an annual confidentiality agreement. DHMC employees		

Standard IV—Member Rights and Protections			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
	demonstrated consideration for PHI by requiring HSAG reviewers to sign confidentiality agreements. DHMC also monitored subcontracted providers for compliance with medical records, data reporting, and other items considered PHI.		
	Required Actions: None		
DHHA Contract: II.F.1.d.6	7. The Contractor shall provide a copy of the policies on member rights and responsibilities to all participating providers and ensure that participating providers are aware of information being provided to members.	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Provider Manual 2. CHOICE_MBR805	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Medicaid Choice Provider Manual (provider manual) and the member rights policy were made available to both internal and external providers via Denver Health's internal and external Web sites. Section IX of the provider manual contained a detailed listing of member rights and responsibilities that mirrored information contained in DHMC's member rights and responsibilities policy.		
	Required Actions: None		

Results for Member Rights and Protections							
Total	Met	=	5	X	1.00	=	5
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	7	**Total Score**		=	5

Total Score ÷ Total Applicable	=	71%

Standard V—Member Information			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.10(f)(3) DHHA Contract: II.F.1.d.1 & Exhibit D	1. The Contractor provides all members, including new members, a member handbook that includes general information about services offered by the Contractor and complete statements concerning member rights and responsibilities, within a reasonable time after the Contractor is notified of the enrollment.	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook pg 12 and 13	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The member handbook included general information about the services that were offered by DHMC. The member handbook was available on the member portal of the DHMC Web site, with a revision date of January 10, 2010. DHMC staff reported that new members received member handbooks by the tenth of each month from its mailing vendor, DW Mail, LLC. DHMC representatives reported that State membership files were downloaded with daily and weekly changes in membership that allowed DHMC to determine which members were to receive handbooks. The enrollment information was transmitted to the mailing vendor, which was responsible for printing the handbooks and mailing them to members with the new member questionnaire. Although DHMC provided a copy of a contract with DW Mail, the contract termination date was March 1, 2007, and no valid extensions were provided. In addition, services performed by the mailing vendor (Attachment A) were not included with the requested document. DHMC presented no policy or internal member services procedure or protocol that verified internal requirements for sending member handbooks to new members. DHMC also provided no internal protocols for coordination of member address information with DHMC's mailing vendor to send member handbooks in a timely manner.		
	Required Actions: DHMC must develop a policy and internal protocols to document and guide the distribution of member handbooks.		

Standard V—Member Information			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
DHHA Contract: II.F.1.d.3	2. The member handbook includes a clear statement that enrollment in the Contractor's plan is voluntary, and information about how to request disenrollment.	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook pg 8	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The member handbook contained a statement that enrollment in DHMC was voluntary. The handbook also contained appropriate information for enrollment and disenrollment from the plan. Members were notified of circumstances in which they would be disenrolled from the plan, such as noncompliance with following rules, continued no-shows to appointments, or acting in a way that kept doctors from helping a member or kept another member from getting care they needed. During the on-site review, reviewers suggested a revision to the language regarding involuntary disenrollment from the DHMC (page 8). The review team found that the statement, "If you physically threaten a doctor or other staff or some other member you will get a verbal warning and will be disenrolled right away," was contradictory. A verbal warning implies that the member would not be disenrolled right away.		
	Required Actions: None		

Standard V—Member Information			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.10(b)(1)&(3) 42CFR438.10(d) DHHA Contract: II.F.1.d.2 & II.E.6.c.9.d	3. The Contractor provides all enrollment notices, informational materials (handbooks, newsletters, directories), and instructional materials (health education, grievance system notices) in a manner and format that may be easily understood (to the extent possible, at 6th grade level). ◆ In the prevalent non-English language ◆ In alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency ◆ Alternative formats include, but are not limited to Braille, large print, or audiotapes	**Documents Submitted/Location Within Documents:** 1. HHBirthdaytext012009.pdf 2. Postpartumletter123008.pdf 3. Medicaid Choice Member Handbook 4. CHOICE_MBR808 Readability of Member Materials 5. MC_Alternate_MBR_Materials_Call_Flow_2009.VSD	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: DHMC's Readability of Member Materials policy provided procedures and parameters for assessing the reading level of all member materials against the Health Literacy Advisor® software. Vital documents were available in English and Spanish (printed on opposite sides when applicable), including the member handbook, newsletters, provider directory, enrollment notices, and grievance and appeal action notices. DHMC member services had a documented process for assisting members who required member materials in an alternate format such as large print, Braille, etc. The member handbook documented that member information was available to members in other formats, including Braille, large print, and audiotapes. DHMC representatives reported that there had been no demand for Braille or audiotape versions. DHMC presented a contact between Denver Health and Hospital Authority and Braille Works International, Inc., that outlined an agreement for Braille Works to provide conversions of member materials into large print, Braille, or audiotape on an as-needed basis.		
	Required Actions: None		

Standard V—Member Information			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.10(c)(4)&(5) DHHA Contract: II.F.1.d.2	4. The Contractor makes oral interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and how to access those services.	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook pg. 3 and 15 2. P-2 100-Interpreter Services P-2_100 Rev Jan 09	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: DHMC referenced the availability of interpreter services or teletype/telecommunications device for the deaf (TTY/TDD) services in the member handbook. In the section on making appointments, the member handbook stated that if members needed an interpreter or TTY/TDD services when they saw their doctor, members were to let the provider know at the time they made an appointment. DHMC provided a copy of TTY/TDD call experience from July 2009 until the review date. The Interpreter and Translation Services and Auxiliary Communication Devices policy stated that DHMC had interpreters and translation services available upon request by a patient, authorized decision-maker, or staff member through Denver Health Medical Interpreters, the Denver Health Spanish Line, and Language Line Services. DHMC presented a valid contract for Language Line Services. Provisions for sign language were provided though American Sign Language interpreters as necessary. According the policy, DHMC registration clerks documented primary language in the member's record and other communication needs at initial registration and enrollment with DHMC. The director of member services stated that several member services representatives were multilingual and many were Spanish-speaking. The member handbook stated that member services representatives were there to help members, and members could call if they had a concern, complaint, or needed interpretation services. The member handbook also stated that members could let their doctors know if they needed an interpreter when they made their appointments. The member handbook stated that written materials were translated into Spanish and could be available in Braille or large print or on audiotapes.		
	Required Actions: None		

Standard V—Member Information			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.10(c)(5) DHHA Contract: II.E.6.c.5	5. The Contractor notifies members that written information is available for prevalent non-English languages and how to access the materials.	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook pg. 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: DHMC's member handbook notified members of the availability of written materials in Spanish and how to access the materials. Members were instructed to call the member services department to request the materials in the appropriate language. The handbook stated that if a member needed assistance, he or she should call the telephone number for the member services department or the TTY/TDD number.		
	Required Actions: None		
42CFR438.10(d)(2) DHHA Contract: II.E.6.c.9.d	6. The Contractor notifies members that written information is available in alternative formats and how to access the materials.	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook pg. 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: DHMC notified members in the member handbook that written information was available in alternative formats and how to access the materials. DHMC translated the member handbook and other member materials into Spanish. Members were to call member services to request this information. The member handbook was printed with Spanish and English versions together (inverted back-to-back). DHMC staff members noted that although written material was available in alternative formats, they could not recall a denial letter ever being requested in Spanish. Words in Spanish at the top of a template letter of notification to members of a provider's disenrollment told members to call the case management number referenced if they needed to speak with someone in Spanish.		
	Required Actions: None		

Standard V—Member Information			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.10(f) DHHA Contract: Exhibit D	7. The member handbook includes: ◆ Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers, including identification of providers who are not accepting new patients (at a minimum includes information on PCPs, specialists and hospitals) (or how to obtain such information) ◆ Any restrictions on freedom of choice among network providers	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: DHMC's member handbook encouraged members to call the member services department if they wanted information about providers. The member handbook provided a general listing (names, addresses, and telephone numbers of Denver Health clinics and hospital and urgent care clinics, including a map with locations). There was no specific information about provider names, locations, or languages spoken by each office listed in the member handbook. The provider directory was mailed to members upon enrollment. It could also be accessed from the DHMC Web site at http://www.dhmedicaidchoice.com. The provider directory contained a list of available clinics and physicians, and included information on primary care clinics and the physicians affiliated with those clinics, school-based clinics, specialists, and hospitals, as well as pharmacy providers (located within the clinics). DHMC staff reported that members were instructed in new member telephone calls and in the new member materials to call DHMC for assistance in choosing a provider. Members were free to choose their PCP from among available providers, and these were listed in the provider directory.		
	Required Actions: None		

Standard V—Member Information			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.10(f) DHHA Contract: Exhibit D	8. The member handbook includes member rights as specified in 42CFR438.100.	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook pg 12	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The member handbook included the required member rights. Reviewers discussed with DHMC the possibility of exploring with the Department the development of pamphlets written at a higher reading level so that member information could be presented in a more meaningful format. This would be especially useful for complicated topics such as grievances, appeals, State fair hearings, and advance directives.		
	Required Actions: None		

Standard V—Member Information			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.10(f)(2) DHHA Contract: II.F.1.d.8	9. The Contractor notifies all members (at least once a year) of their right to request and obtain the required information (42CFR438.10), upon request.	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook pg 3 and 23	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: Members were notified in the member handbook that they had the right to a new member handbook and all the information within the handbook every year. Because a new member handbook was not necessarily sent to members annually, and no members received a standard letter or formal notification that they had the right to request the information in the handbook, members were not notified annually of their right to request member information. Reviewers discussed with DHMC that this could be accomplished by including a statement in a member newsletter about the availability of information upon request.		
	Required Actions: DHMC must implement a system to notify members at least once a year of their right to request and obtain information as required by 42 CFR 438.10.		
42CFR438.10(f)(4) DHHA Contract: II.F.1.d.8	10. The Contractor gives written notice of any significant change in information, to members at least 30 days before the intended effective date of the change.	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook pg 10	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The member handbook notified members that written notification would be sent to them if any change occurs in benefits, doctor or expert (specialist), or if they are denied benefits for any reason. DHMC provided a template letter used to notify members that their PCP had left the network.		
	Required Actions: None		

Standard V—Member Information			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.10(f)(5) DHHA Contract: II.G.9.b	11. The Contractor makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice, to each member who received his or her primary care from, or was seen by, the terminated provider. The notice shall: ◆ Describe how services provided by the participating provider will be replaced ◆ Inform the member of disenrollment procedures	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook pg 10	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The member handbook informed members that they would be notified of changes related to their provider. Member template letters were in place to notify members; however, the template letter indicated that the provider had already left the network. The member was instructed to choose another PCP within 30 days. There was an instruction at the bottom of the notification letter that told members to call member services to change their PCP or for help with disenrollment.		
	Required Actions: None		

<table>
<tr><th colspan="4">Standard V—Member Information</th></tr>
<tr><th>References</th><th>Requirement</th><th>Evidence Submitted by the Health Plan</th><th>Score</th></tr>
<tr><td rowspan="3">42CFR438.10(f)(6)

DHHA Contract: Exhibit D</td><td>12. The member handbook includes:
◆ The amount duration and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled
◆ Procedures for obtaining benefits including authorization requirements
◆ The extent to which and how members may obtain benefits, including family planning services from out-of-network providers and EPSDT services (if applicable)
◆ How and where to access any benefits available under the State plan but not covered under the Medicaid managed care contract, including any cost sharing and how transportation is provided
◆ Excluded or non-covered services</td><td>Documents Submitted/Location Within Documents:
1. MCD_Benefit_Inquiries_Call_Flow_2009.VSD
2. Medicaid Choice Member Handbook</td><td>☒ Met
☐ Partially Met
☐ Not Met
☐ Not Applicable</td></tr>
<tr><td colspan="3">Findings:
The member handbook contained information regarding the duration and scope of benefits available under the contract, and information could be found throughout the member handbook regarding the extent to which and how members could obtain benefits. The member handbook told members how to obtain benefits covered under the State plan but not covered by DHMC, and included a list of excluded or noncovered services. The DHMC member services department had a process in place for answering specific questions regarding benefits and how to obtain services.</td></tr>
<tr><td colspan="3">Required Actions:
None</td></tr>
</table>

Standard V—Member Information			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
DHHA Contract: Exhibit D	13. Maximum number of days between the appointment request and the actual visit with the appropriate provider, as follows: ◆ Urgent care within forty-eight (48) hours. ◆ Non-urgent care and EPSDT screens (if applicable) within two (2) weeks. ◆ Adult non-symptomatic well care physical examinations within four (4) months.	**Documents Submitted/Location Within Documents:** 1. Access to Care CHOICE_PRR701 Policy and Procedure - page 4, number 7 demonstrates that we have primary and specialty care appointment standards. 2. Total PCPVsits_Adult_Peds_09_revisedNov.doc demonstrates that we monitor appointments for adults and children through Lifelink. Note that we started this in April of 2009 because QI staff had to be trained and given access to Lifelink to obtain the reports. 3. SummaryCAHPSComparativeDataData2009_revised_Dec.doc - demonstrates that we compare the CAHPS data and have noted statistically sig. decreases from 2008 to 2009 in the categories of Getting Needed Care and Getting Care Quickly for adults. 4. The following documents: a. 2009 CAHPS Overview-Plan Comparison, and b. 2009 CAHPS-Top Priorities Demonstrate show how we compare to the other Colorado Medicaid plans and the top priorities note the categories that we need to look at for opportunities for improvement. All of the opportunities for improvement relate to access and availability for urgent care, routine care, needed care, and specialty care. 5. The presentation:2PAppt.Process for New Primary Care Pts Feb2009.ppt - demonstrates how a designated group of DH staff and consultants from Managed Care when through a planning event to improve appointment making for new DH members. This presentation documents that our demand for appointments exceeds capacity. This process is addressing the issue and developing a plan for action.	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable

Standard V—Member Information			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
		6. Visio flowchart for Routine and Specialty Appt Flow 9_8_09.pdf 7. Medicaid Choice Member Handbook pg 14	
	Findings: DHMC's member handbook contained most of the required access standards to care. The member handbook provided conflicting information about appointment standards for pediatric well-care exams within Section 4, *How to Get Care,* and Section 7 *Children's Health Care*. Section 4 did not contain the standard for adult access to urgent care services.		
	Required Actions: DHMC must ensure appointment standards are complete, correct, and consistent within the member handbook.		

Standard V—Member Information			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.10(f)(6) DHHA Contract: Exhibit D	14. The member handbook includes the extent to which and how after hours and emergency coverage are provided, including: ◆ What constitutes an emergency medical condition, emergency services, and post-stabilization services with reference to the definitions in 42CFR438.114(a) ◆ The fact that prior-authorization is not required for emergency services ◆ The process and procedures for obtaining emergency and post-stabilization services, including the use of the 911-telephone system or its local equivalent ◆ The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services ◆ The fact that the member has the right to use any hospital or other setting for emergency care ◆ The process and procedures for obtaining urgently needed services	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook pg 14	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The member handbook defined what constituted an emergency medical condition, emergency services, and poststabilization services, with a reference to the definitions in 42 CFR 438.114(a).		

Standard V—Member Information			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
	The handbook stated that prior authorization was not required for emergency services or poststabilization services. The process and procedures for obtaining emergency and poststabilization services, including the use of the 911 telephone system, was described. The member handbook and provider directory listed the locations where emergency and poststabilization services were provided. This information was also available on the DHMC Web site. The member handbook informed members that they could use the nearest emergency room or hospital for emergency care. Members requiring urgent care services were advised to go to the nearest urgent care center and instructed to call their PCP or the Denver Health nurse line for advice. Members were notified that they would receive a doctor visit within 48 hours for an urgent need. Urgent care services were listed as available seven days a week from 7:30 a.m. to 9:30 p.m.		
	Required Actions: None		
42CFR438.10 DHHA Contract: Exhibit D	15. The member handbook includes policies on referral for specialty care and other services not provided by the member's PCP.	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook pg 9	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: DHMC provided information in the member handbook on referral for specialty care and other services not provided by the member's PCP. Specialty visits required a referral from a PCP. Other types of services required no referral, including routine eye exams at a DHMC provider, obstetric and gynecological services for annual exams or pregnancy care, and family planning services.		
	Required Actions: None		

Standard V—Member Information			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
DHHA Contract: Exhibit D	16. The member handbook includes: ◆ Enrollment and disenrollment procedures ◆ How to change primary care physicians	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook pg 8	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: Enrollment and disenrollment procedures and how to change a PCP were presented in the member handbook. PCP assignment was described, and information provided that if members did not choose a PCP they would be assigned to a clinic. The member handbook stated that if members wanted to change their PCP, they could call DHMC member services for assistance.		
	Required Actions: None		
42CFR438.10(g)(1) DHHA Contract: Exhibit D	17. The member handbook information regarding the grievance, appeal, and fair hearing procedures have been approved by HCPF and include: ◆ The right to file grievances (and includes a complaint/grievance form) ◆ The right to file appeals ◆ The right to a State fair hearing	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook pg 24, 25, and 26	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The right to file grievances, the right to file appeals, and the right to a State fair hearing were described in the member handbook. A member grievance form, an appeal form, and a designation of personal representative form were included at the back of the member handbook.		
	Required Actions: None		

Standard V—Member Information			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.10(g)(1) DHHA Contract: Exhibit D	18. The member handbook information regarding the grievance, appeal, and fair hearing procedures include: ◆ The requirements and timeframes for filing grievances and appeals ◆ The method for obtaining a State fair hearing ◆ The rules that govern representation at the State fair hearing	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook pg 24, 25, and 26	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: Members were informed via the member handbook that they had 20 days to file a grievance. The member handbook specified that members would receive an acknowledgment letter within 2 working days, and that the grievance would be resolved and a letter sent to the member within 15 working days of receipt of the grievance. The handbook stated that if more time was needed, DHMC would send a letter to the member to add 14 calendar days to the time frame for resolving the grievance. The member handbook stated that if the member was not happy with DHMC's resolution of the grievance, the member could go directly to the State of Colorado. The Department's address and Medicaid customer service telephone numbers (local and toll-free) were provided. The member handbook included the 20-day filing time frame for appeals and addressed the 10-day filing time frame for termination, reduction, or suspension of services by stating, "To appeal services that have been approved before, you have 10 days from the mailing of the notice of action or until the date the notice of action will take effect to file an appeal." HSAG discussed with DHMC staff members on-site that, while not incorrect, "services that have been approved before," could be misconstrued as any service previously approved, including those for which there was not a current authorization. Within the *When You File an Appeal* section, the member handbook stated, "You must tell us you are going to appeal within 20 days of an action, first appeal or second appeal." A second appeal is not a component of the Medicaid appeal process. Members were informed about time frames for resolution of expedited appeals (3 working days if accepted, 10 days if not expedited). The time frame for the appeal acknowledgment letter was specified (2 working days for standard appeals or 3 working days to resolution if an expedited appeal).		

Standard V—Member Information			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
	The member handbook stated within the *When You File an Appeal* section, "If you ask for a State fair hearing you must do so within 30 days of an action or appeal." Within the *State Fair Hearing* section it stated, "You should send the request within 30 calendar days from the date of the notice of action." Both statements were incorrect. DHMC staff members stated during the on-site interview that they had recently revised the member handbook to reflect a change in Colorado regulations that now allows Medicaid recipients receiving services via the fee-for-service program to file a State fair hearing request within 30 days of the notice of action letter. However, a similar change has not yet been made for managed care programs. The current requirement for managed care is that a State fair hearing request must be filed within 20 days. The member handbook contained a section, *Three Step Process*, which provided information inconsistent with Medicaid requirements, i.e., "If you are not happy let us know within 30 days after you received a notice of action and DHMC will have a panel review our decision." The member handbook addressed the rules that govern representation at a State fair hearing by stating that members could represent themselves "or use a provider, legal counsel, a relative, a friend, or other spokesman at the hearing." It would be advantageous to members if DHMC informed members that additional important information regarding representation can be found by visiting the Colorado Official State Web Portal at www.colorado.gov/cs/Satellite/DPA-OAC/OAC/1245426030863 and clicking on the link Guide for Non-Lawyers. The member handbook did not specify that a member need not exhaust the local appeal process before requesting a State fair hearing.		
	Required Actions: DHMC must provide members with information that State fair hearing requests must be made within 20 days of a notice of action letter. DHMC must clarify in the member handbook that a member need not exhaust the local appeal process before requesting a State fair hearing.		

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<tr><th colspan="4">Standard V—Member Information</th></tr>
<tr><th>References</th><th>Requirement</th><th>Evidence Submitted by the Health Plan</th><th>Score</th></tr>
<tr><td rowspan="3">42CFR438.10(g)(1)

DHHA Contract: Exhibit D</td><td>19. The member handbook information regarding the grievance, appeal, and fair hearing procedures include:
◆ The availability of assistance filing a grievance, an appeal, or requesting a State fair hearing
◆ The toll free numbers the member may use to file a grievance or an appeal by phone</td><td>Documents Submitted/Location Within Documents:
1. Medicaid Choice Member Handbook</td><td>☒ Met
☐ Partially Met
☐ Not Met
☐ Not Applicable</td></tr>
<tr><td colspan="3">Findings:
DHMC’s member handbook provided information regarding the availability of assistance in filing grievances or appeals or requests for a State fair hearing. Each section that described grievances, appeals, and State fair hearing filings described the availability of assistance in filing and listed the local and toll-free numbers for members services, fax numbers to send a written grievance or appeal, and the telephone number for the grievance and appeal coordinator, the TTY/TDD, the Medicaid ombudsman, DHMC Medical Management (if members wanted to examine their case files, medical records, etc.), and the Office of the Administrative Courts.</td></tr>
<tr><td colspan="3">Required Actions:
None</td></tr>
</table>

Standard V—Member Information			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.10(g)(1) DHHA Contract: Exhibit D	20. The member handbook information regarding the grievance, appeal, and fair hearing procedures include: ◆ The fact that, when requested by the member, benefits will continue if the appeal or request for State fair hearing is filed within the timeframes specified for filing ◆ The fact that, if benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal is pending, if the final decision is adverse to the member	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook pg 25	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The member handbook stated within the *How to File an Appeal* section that "to appeal for services that have been approved before, you have 10 days from the mailing of the notice of action or until the date the notice of action will take effect to file an appeal." That phrasing (to appeal for services) does not make clear that to request that currently authorized services be continued, an appeal must be filed within 10 days or by the date the notice takes effect. The member handbook section, *What is a Notice of Action,* stated, "you have the right to keep receiving services that have been approved while the appeal is being decided or if you are requesting a State fair hearing." It also stated, "If the final decision is to deny the services, you might have to pay for the approved services you received while a final decision is pending." The information provided for members about requesting a continuation of benefits during an appeal or a request for a State fair hearing was unclear. Instead of being presented in the same place, the information was scattered in different sections and, overall, did not allow a member or his or her DCR to discern the member's right to request a continuation of services, the required time frame for filing, or the member's potential fiscal responsibility.		
	Required Actions: DHMC must provide clear and cohesive information regarding the member's right to request a continuation of benefits during an appeal and State fair hearing, the time frames for filing, and the fact that if benefits are continued, the member may be required to pay the cost of services if the final decision is adverse to the member.		

Standard V—Member Information			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.10(g)(1) DHHA Contract: Exhibit D	21. The member handbook information regarding the grievance, appeal, and fair hearing procedures include appeal rights available to providers to challenge the failure of the Contractor to cover a service.	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook pg 24, 25, and 26	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
	Findings: The member handbook information regarding the grievance, appeal, and fair hearing procedures provided no information regarding appeal rights available to providers to challenge the failure of the contractor to cover a service.		
	Required Actions: DHMC must include in the member handbook information about the grievance, appeal, and State fair hearing procedures available to providers.		
42CFR438.10(g)(2) DHHA Contract: Exhibit D	22. The member handbook information regarding advance directives for adult members includes: ◆ The member's right to formulate advance directives ◆ The member's rights under the State law to make decisions regarding medical care including the right to accept or refuse medical or surgical treatment ◆ The fact that complaints concerning noncompliance with the advance directive requirements may be filed with the appropriate State agency ◆ The Contractor's policies regarding implementation of advance directives, which must include a	**Documents Submitted/Location Within Documents:** 1. Medicaid Member Handbook pg 11 and 12 2. P-1.506-AdvanceMedicalDirectivesCPR Status0409FINAL.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
	clear statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience ◆ The Contractor's policies regarding Advance Directives must also include: ◆ If the Contractor cannot implement an advance directive as a matter of conscience, the difference between institution-wide conscientious objections and those raised by individual physicians ◆ Identification of the State legal authority permitting such objection ◆ Description of the range of medical conditions or procedures affected by the conscientious objection ◆ Provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and unable to receive information ◆ Provisions for providing advance directive information to the incapacitated member once he or she is no longer incapacitated		

Standard V—Member Information			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
	◆ Procedures for documenting in a prominent part of the member's medical record whether the member has executed an advance directive ◆ The provision that the decision to provide care to a member is not conditioned on whether the member has executed an advance directive, and that members are not discriminated against based on whether they have executed an advance directive ◆ Provisions for ensuring compliance with State laws regarding advance directives ◆ Provisions for informing members of changes in State laws regarding advance directives no later than 90 days following the changes in the law ◆ Provisions for the education of staff concerning its policies and procedures on advance directives ◆ Provisions for community education regarding advance directives that includes: ▪ What constitutes an advance directive ▪ Emphasis that an advance directive is designed to enhance an incapacitated		

Standard V—Member Information			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
	individual's control over medical treatment ▪ Description of applicable state law concerning advance directives		
	Findings: DHMC's member handbook documented the member's right to formulate an advance directive and the member's right under State law to make decisions regarding medical care, including the right to accept or refuse medical or surgical treatment, which was described simplistically as the right "to say no to care from any doctor." The member handbook referred the member to his or her PCP for more information on advance directives. The handbook stated that complaints concerning the implementation of advance directives should be directed to the Colorado Department of Public Health and Environment, and a telephone number was provided. The handbook did not include the DHMC polices regarding implementation of advance directives. (For example, a health plan with a religious affiliation might have a policy that it would not implement an advance directive under certain specified conditions, while another health plan might have a policy to honor any correctly drafted advance directive.) The member handbook stated that a member's doctor would notify the member in writing if he or she could not implement the member's advance directive, The next sentence stated that a member would get "facts on what your rights are, Denver Health's policy about advance directives and how you may get in touch with the Colorado Department of Public Health and Environment and tell them that your advance medical directive was not followed." This statement implies that a member would only get facts on their rights and the DHMC policy about advance directives in the event that a doctor refused to follow the member's advance directive. DHMC provided the advance directives policy, which stated that if a patient's attending physician could not comply with the terms of the advance directive on the basis of conscience, the attending physician would transfer the care of the member to another physician who was willing to comply with the terms of the advance directive. The provider was required to give the member a written statement of the limitation. The policy also stated that all the informational material would be given to members again at the time of admission or presentation to an ambulatory care center or community health service facility, and that Denver Health assisted members in executing advance directives when requested. The State legal authority permitting conscientious objection was stated in the policy (Colorado Medical Practice Act—CRS 12-36-117). The policy also contained provisions for providing information regarding advance directives to the member's family or surrogate if the member was incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and was unable to receive information. The policy also contained provisions for providing advance directive information to an incapacitated member once he or she was no longer incapacitated. The policy		

Standard V—Member Information			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
	indicated that advance directives were a permanent part of the member's medical record and that the admissions office would document that the information on advance directives/CPR directives was given. In the event that an advance medical directive was changed or revoked, the policy had a detailed procedure for medical, facility, or physician staff to follow in correctly documenting the revised or revoked directive as a part of the medical record. Staff was to scan information into the electronic file, or in the case of a paper record, staff was to use a special place in the member's chart with an advance directive tab. The policy contained a statement that a member was not required to have an advance directive, and the existence or lack of an advance directive would not determine the member's access to care, treatment, and services. The policy and procedure was prepared using the provisions for State laws regarding advance directives. The policy stated that Denver Health provided staff and community education by placing written information regarding advance directives in inpatient and outpatient settings and at provider locations. While the Denver Health advance directives policy included most of the required content, it was written to meet the requirements of an inpatient facility and, therefore, did not include the requirement to inform managed care *members* of changes in State laws regarding advance directives within 90 days following the changes in the law.		
	Required Actions: DHMC must draft a similar policy that includes all the required elements that are currently in place, but is revised slightly to reflect the requirements for advance directives from a managed care perspective. For example, the policy should include advance directive requirements for level-of-care transitions such as those for SNF placements. DHMC must include the requirement to notify members of any changes to State law relevant to advance directives within 90 days following the change in the law. DHMC must include in the member handbook a statement of its policies regarding implementation of advance directives, including a clear statement of any limitations.		

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<tr><th colspan="4">Standard V—Member Information</th></tr>
<tr><th>References</th><th>Requirement</th><th>Evidence Submitted by the Health Plan</th><th>Score</th></tr>
<tr><td rowspan="3">42CFR438.10(g)(3)

DHHA Contract: Exhibit D</td><td>23. The member handbook includes a description of information that is available upon request, which are at a minimum:
◆ Information on the structure and operation of the Contractor
◆ Physician incentive plans</td><td>Documents Submitted/Location Within Documents:
1. Medicaid Choice Member Handbook pg 12 and 13</td><td>☒ Met
☐ Partially Met
☐ Not Met
☐ Not Applicable</td></tr>
<tr><td colspan="3">Findings:
The member handbook directed members to information about the structure and operation of the contractor, stating: “Call us if you want to know about how Denver Health is set up and how it works.” The member handbook also directed members to call for information about physician incentive plans, stating that members had the right to “ask for facts about our doctor incentive plan.”</td></tr>
<tr><td colspan="3">Required Actions:
None</td></tr>
<tr><td rowspan="3">DHHA Contract: Exhibit D</td><td>24. The member handbook includes information regarding member participation on the contractor’s consumer advisory committee, and notification of right to attend meetings of the committee. Such information includes the telephone number.</td><td>Documents Submitted/Location Within Documents:
1. Medicaid Choice Member Handbook
2. CHOICE_MBR806 Consumer Advisory Committee</td><td>☒ Met
☐ Partially Met
☐ Not Met
☐ Not Applicable</td></tr>
<tr><td colspan="3">Findings:
The member handbook included information on the Consumer Advisory Committee. Members were informed of their right to “join” the Consumer Advisory Committee.</td></tr>
<tr><td colspan="3">Required Actions:
None</td></tr>
</table>

Standard V—Member Information			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
DHHA Contract: Exhibit D	25. Information concerning a member's responsibility for providing the Contractor with written notice after filing a claim or action against a third party responsible for illness or injury to the member and for following and protocols of a liable third party payor prior to receiving non-emergency services.	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook pg 10 and 11	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The member handbook section, *How Your Plan Works*, described what a member should do in the case of a member's claim against a third party responsible for injury or illness to the member, and included the information members were to provide to DHMC, e.g., names of liable parties, the liable parties' insurance company, and the names of lawyers representing the member in the case. Information was provided in the member handbook about requirements for members to follow the protocols of a third-party payor prior to receiving nonemergency services.		
	Required Actions: None		

Standard V—Member Information

References	Requirement	Evidence Submitted by the Health Plan	Score
42CFR438.10(i)(3) DHHA Contract: Exhibit D	26. Member information describes information that must be furnished annually and upon request includes: ◆ The Contractor's service area ◆ Benefits covered under the contract ◆ Cost sharing, if any ◆ To the extent available quality and performance indicators, including member satisfaction data	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The service area information was found in the section, *When Are You Not Able To Be A DHMC Member*. Benefits covered under the contract were described throughout the member handbook. Cost-sharing information was included, and members were notified that they could get information about the DHMC quality program by contacting member services.		
	Required Actions: None		
DHHA Contract: II.F.1.d.7	27. The Contractor does not knowingly provide untrue or misleading information regarding the Contractor's plan or Medicaid eligibility to members.	**Documents Submitted/Location Within Documents:** 1. Integrity Program Code of Conduct	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: All DHHA employees were required to attend a training on the Integrity Program Code of Conduct on an annual basis. DHMC presented evidence that Internet modules were included as a component of mandatory training for employees. DHMC provided statements in its Integrity Program Code of Conduct indicating that DHMC would not provide untrue or misleading information regarding its plan or Medicaid eligibility to members. The DHMC Integrity Program Code of Conduct documented guiding principles for conducting business within the organization and included being honest and ethical, requiring employees to: 1) respect each other, 2) protect the privacy of patient information, 3) be honest with other businesses, and 4) obey the law.		
	Required Actions: None		

Standard V—Member Information			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
DHHA Contract: II.I.1.c	28. At the time of enrollment, the Contractor provides information to the member (in the appropriate formats) about how the Contractor's UM program functions and is used to determine medical necessity. 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	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: Information about utilization management was found in the member handbook. The member services local and toll-free telephone numbers were printed on the bottom of every page, and program information and contact numbers were provided for care management, utilization management, the grievance coordinator, the medical staff office, and the Medicaid ombudsman. Information about how to initiate appeals related to UM decisions was found in Sections 12 and 13, *Grievances* and *Appeals*.		
	Required Actions: None		

Results for Member Information							
Total	Met	=	21	X	1.00	=	21
	Partially Met	=	5	X	.00	=	0
	Not Met	=	2	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	28	**Total Score**		=	21

Total Score ÷ Total Applicable	=	75%

Standard VI—Grievance System			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.402(a) DHHA Contract: Exhibit I— 8.209.1	1. The Contractor has a system in place that includes a **grievance** process, an **appeal** process, and access to the **State fair hearing** process.	**Documents Submitted/Location Within Documents:** 1. Choice_MBR803.doc 2. Choice_UMG1002 3. Medicaid Choice Member Handbook (pgs 24 – 29) 4. MCD_Prov_Manual_Appeals.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The DHMC Grievance Process policy (grievance policy) described the DHMC grievance process. The Utilization Review (UR) Determinations Including Approvals and Actions policy (UR determinations policy) described the appeal process and member access to the State fair hearing process. The provider manual described DHMC's member grievance and appeal process and access to the State fair hearing process. The member handbook informed members of the grievance and appeal process and access to the State fair hearing process.		
	Required Actions: None		
42CFR438.400(b) DHHA Contract: Exhibit I— 8.209.2	2. The Contractor defines Action as: ◆ The denial or limited authorization of a requested service, including the type or level of service ◆ The reduction, suspension, or termination of a previously authorized service ◆ The denial, in whole, or in part, of payment for a service ◆ The failure to provide services in a timely manner ◆ The failure to act within the timeframes for resolution of grievances and appeals ◆ For a resident of a rural area with only one MCO, the denial of a	**Documents Submitted/Location Within Documents:** 1. Choice_UMG1002 2. Medicaid Choice Member Handbook (pgs 24 – 29) 3. MCD_Prov_Manual_Appeals.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance System			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
	Medicaid member's request to exercise his or her rights to obtain services outside of the network (as specified in 42CFR438.52(b)(2)(ii)		
	Findings: The UR determinations policy included the definition of an action and contained the following provisions: ◆ The denial or limited authorization of a requested service, including the type or level of service ◆ The reduction, suspension, or termination of a previously authorized service. ◆ The denial, in whole or in part, of payment for a service. ◆ The failure to provide services in a timely manner. ◆ The failure to act within the time frames provided in the Code of Colorado Regulations (CCR) at 10 CCR 2505-10, Section 8.209. For failure to act within the time frames for resolution of grievances and appeals, the policy stated, "failure to act within the timeframes as set forth for Managed Care Organization." ◆ The last bullet of the requirement pertaining to members living in rural areas with only one MCO was not applicable to DHMC.		
	Required Actions: None		
42CFR438.400(b) DHHA Contract: Exhibit I—8.209.2	3. The Contractor defines Appeal as a request for review of an Action.	**Documents Submitted/Location Within Documents:** 1. Choice_UMG1002 2. MCD_Prov_Manual_Appeals.pdf 3. Member Handbook (pgs 24 – 29)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: Both the UR determinations and grievance policy stated that an appeal is a request to review an action. The member handbook stated that an appeal is a request to review a decision DHMC made about a medical treatment or services. The member handbook definition of an appeal is consistent with the BBA definition.		
	Required Actions: None		

Standard VI—Grievance System

References	Requirement	Evidence Submitted by the Health Plan	Score
42CFR438.400(b) DHHA Contract: Exhibit I—8.209.2	4. The Contractor defines Grievance as an expression of dissatisfaction about any matter other than an Action.	**Documents Submitted/Location Within Documents:** 1. Choice_MBR803.doc 2. MCD_Prov_Manual_Appeals.pdf 3. Member Handbook (pgs 24 – 29)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The grievance policy defined a grievance as an oral or written expression of dissatisfaction about any matter other than an action. The member handbook stated that, "a grievance is when you are not happy with something DHMC does." The member handbook included examples of possible subjects of grievances.		
	Required Actions: None		
42CFR438.402(b)(1) DHHA Contract: Exhibit I—8.209.1	5. The Contractor has provisions for who may file: ◆ A member may file a grievance, a PIHP-level appeal, and may request a State fair hearing ◆ A provider may file a grievance on behalf of a member (the State permits the provider to act as the member's authorized representative) ◆ A provider, acting on behalf of the member and with the member's written consent may file an appeal. ◆ A provider may request a State fair hearing on behalf of a member (the State permits the provider to act as the member's authorized representative)	**Documents Submitted/Location Within Documents:** 1. Choice_UMG1002 (pg 12-13 Section A.) 2. Medicaid Choice Member Handbook (pgs 24 – 29) 3. MCD_Prov_Manual_Appeals.pdf 4. Choice_MBR803.doc	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The grievance policy stated that DHMC would accept a grievance from a member or a member's DCR. The definition of a DCR in the policy was congruent with the definition in 10 CCR 2505-10, § 8.209: "any person, including a treating health care professional,		

Standard VI—Grievance System			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
	authorized in writing by the member or the member's legal guardian to represent the member's interests related to a grievance or appeal about health care benefits and services." The UR determinations policy (the policy that addressed appeals and the State fair hearing process) defined DCR more expansively as any person, including a treating health care professional, a family member, spouse, legal guardian, foster parent, or other interested party authorized in writing by the member to represent his or her concern in a complaint or appeal about health care benefits and services. The member handbook stated that members may file or use DCRs when filing grievances or appeals or requesting a State fair hearing. The member handbook, however, did not inform the member that a provider could file a grievance or appeal on behalf of a member. The member handbook section, *Using a Designated Client Representative (DCR),* stated that a member could choose "someone" to be in charge of their medical care. It stated that a DCR "looks after your interests when you have a complaint." It stated that there was a DCR form in the back of the handbook. The Designation of Personal Representative form in the back of the handbook specified that the member's identification card and drivers' license or their equivalent for both the client and the designated personal representative, as well as any available documentation providing legal authority, were required to be submitted for both the member and the designated personal representative. This appeared to exceed the requirement for written authorization and may represent a barrier to provider participation. Providers were given no more information about the ability to file a grievance or appeal or request a State fair hearing on a member's behalf, as information in the provider manual was composed of excerpts from the member handbook.		
	Required Actions: DHMC must clarify in member and provider materials that a provider may, acting on behalf of a member and with the member's written consent, file a grievance or appeal, request a State fair hearing, and act as the member's authorized representative at a State fair hearing. DHMC must ensure that the process to designate a client representative is not unnecessarily burdensome. Requiring a DCR to submit the equivalent of a driver's license and documentation providing legal authority exceeds the requirements of Colorado statute, which defines a DCR as any person authorized in writing by the member or the member's legal guardian to represent his or her interests.		

<table>
<tr><th colspan="4">Standard VI—Grievance System</th></tr>
<tr><th>References</th><th>Requirement</th><th>Evidence Submitted by the Health Plan</th><th>Score</th></tr>
<tr><td rowspan="3">42CFR438.402(b)(3)

DHHA Contract:
Exhibit I—
8.209.5.D</td><td>6. The member may file a grievance orally or in writing.</td><td>Documents Submitted/Location Within Documents:
1. Medicaid Choice Member Handbook (pgs 24 – 29)
2. MCD_Prov_Manual_Appeals.pdf
3. Choice_MBR803.doc</td><td>☒ Met
☐ Partially Met
☐ Not Met
☐ Not Applicable</td></tr>
<tr><td colspan="3">Findings:
The grievance policy stated the definition of a grievance as “an oral or written expression of dissatisfaction.” The first procedure of the policy specified that members or their DCR may express dissatisfaction about any matter other than an action through the grievance process either verbally or in writing. The member handbook directed members to call or write to file grievances and provided the telephone number and address for members to use. The member handbook also included a form that members may use to file a grievance.</td></tr>
<tr><td colspan="3">Required Actions:
None</td></tr>
<tr><td rowspan="3">42CFR438.402(b)(2)

DHHA Contract:
Exhibit I—
8.209.5.A</td><td>7. The member has 20 calendar days from the date of the incident to file a grievance.</td><td>Documents Submitted/Location Within Documents:
1. Medicaid Choice Member Handbook (pgs 24 – 29)
2. MCD_Prov_Manual_Appeals.pdf
3. Choice_MBR803.doc</td><td>☒ Met
☐ Partially Met
☐ Not Met
☐ Not Applicable</td></tr>
<tr><td colspan="3">Findings:
The grievance policy stated that DHMC will accept grievances within 20 days of the date of the incident. Members were informed via the member handbook that they have 20 days to file. The grievance policy included a template letter for use when the grievance is filed more than 20 days following the incident.</td></tr>
<tr><td colspan="3">Required Actions:
None</td></tr>
</table>

Standard VI—Grievance System			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.402(b)(3) DHHA Contract: Exhibit I—8.209.4.F	8. The member may file an appeal either orally or in writing, and must follow the oral request with a written request (unless the request is for expedited resolution).	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook (pgs 24 – 29) 2. MCD_Prov_Manual_Appeals.pdf 3. Choice_UMG1002.doc	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
	Findings: The UR determinations policy stated that DHMC accepted appeals orally or in writing, but did not address requiring that oral requests be followed by written requests. The member handbook informed members of how to call or write to file an appeal and included a form that members may use for filing an appeal. The member handbook did not inform members that oral requests must be followed by written requests.		
	Required Actions: DHMC must develop and implement a process to ensure that oral requests to file an appeal are followed by a written, signed appeal from the member or the DCR.		
42CFR438.402(b)(2) and 42CFR 438.420(a) DHHA Contract: Exhibit I—8.209.4.B	9. An appeal may be filed: ◆ For termination, suspension, or reduction of previously authorized services, timely filing is defined as the later of the following: ▪ Within ten days of the Contractor mailing the notice of action, or ▪ The intended effective date of the proposed action ◆ For all other actions, 20 calendar days from the date of the notice of proposed action.	**Documents Submitted/Location Within Documents:** 1. CHOICE_UMG1002 pg 18 number 15 2. Medicaid Choice Member Handbook (pgs 24 – 29) 3. CD_Prov_Manual_Appeals.pdf	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The UR determinations policy included the 20-day filing time frame for appeals, but did not address the 10-day filing time frame for appeals by members requesting continuation of previously authorized services that have been terminated, suspended, or reduced. The member handbook stated, “To appeal services that have been approved before, you have 10 days from the mailing of the notice of action or until the date the notice of action will take effect to file an appeal.”		

Standard VI—Grievance System			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
	Required Actions: DHMC must make clear in policy and member materials that timely filing of an appeal for the termination, suspension, or reduction of previously authorized services must occur on or before the later of the following: (1) within 10 days of the postmark of the notice of action or (2) the intended effective date of the proposed action.		
42CFR438.402(b)(2) DHHA Contract: Exhibit I—8.209.4.N	10. A member need not exhaust the Contractor's appeal process before requesting a State fair hearing. The member may request the State fair hearing 20 days from the date of the notice of action.	**Documents Submitted/Location Within Documents:** 1. CHOICE_UMG1002 pg . 19 Section D 2. Medicaid Choice Member Handbook (pgs 24 – 29) 3. CD_Prov_Manual_Appeals.pdf	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
	Findings: The UR determinations policy stated that members need not exhaust the DHMC appeal process before requesting a State fair hearing and that members had 30 days to request a State fair hearing. The member handbook stated 20 days, then later on the same page stated 30 days as the time frame for requesting a State fair hearing. DHMC stated during the on-site interview that it had recently revised its materials to reflect the 30-day time frame. Recent regulatory changes in Colorado extended the time frame to request a State fair hearing from 20 to 30 days for Medicaid beneficiaries in the fee-for-services programs. Although a similar change is anticipated for Medicaid managed care populations, the current regulation is 20 days.		
	Required Actions: DHMC's policies and member materials must reflect current regulatory requirements, which specify that a member may request a State fair hearing within 20 days from the date of the notice of action.		

Standard VI—Grievance System			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.404(a) DHHA Contract: Exhibit I—8.209.4.A.1	11. Notices of action must meet the language and format requirements of 42CFR438.10 and ensure ease of understanding.	**Documents Submitted/Location Within Documents:** 1. Choice_MBR803.doc 2. CHOICE_UMG1002	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The UR determinations policy stated that written notice of each UR determination (whether an action or an authorization) was available in English and the prevalent non-English languages spoken by members of DHMC. The policy included a notice of action template letter. Fifteen examples of denial letters were provided during the on-site review and were written in manner that was easy to understand. The first paragraph of the template letter included a statement in Spanish that if the information was required in Spanish, the member should call DHMC. The telephone number provided was to member services, which was staffed with individuals who were fluent in numerous languages. While there were no examples of notice of action letters written in Spanish, a letter included in the grievance sample was written entirely in Spanish.		
	Required Actions: None		
42CFR438.404(b) DHHA Contract: Exhibit I—8.209.4.A.2	12. Notices of action must contain: ◆ The action the Contractor has taken or intends to take ◆ The reasons for the action ◆ The member's (and provider's on behalf of the member) right to file an appeal and how to do so ◆ The member's right to request a State fair hearing and how to do so ◆ The circumstances under which expedited resolution is available and how to request it ◆ The member's right to have benefits continue pending resolution of the appeal and how to request that	**Documents Submitted/Location Within Documents:** 1. Choice UMG_1002 pgs 12-14 Pg. 21 Section V	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance System			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
	◆ The circumstances under which the member may have to pay for the costs of services if continued benefits are requested		
	Findings: The UR determinations policy included a list of required content for "member notifications of UR Determinations." The list included all of the required content. The notice of action template letter attached to the policy included a prompt for including all of the required content. The letters, in addition to including information on how to file an appeal (e.g., fill out the appeal form in the member handbook, call member services, call the Ombudsman), also specified the date by which an appeal must be filed. Of the 14 notice of action letters selected for review (more were provided), 6 specified an appeal-by date of 20 days from the notice, 3 specified a date that exceeded 20 days, 4 specified a date that was fewer than 20 days, and 1 did not have a date inserted. One letter provided on-site notified the member that the first day of an emergency admission at a non-network hospital had been denied, and information regarding filing a grievance (not an appeal) was provided to the member. The member was provided information that DHMC would not reimburse the first day of an emergency admission because the providing hospital had not notified DHMC in a timely manner. Attached documentation indicated that the providing hospital was given a verbal and faxed denial. Per 42 CFR 438.114f(d)(ii), a managed care organization cannot refuse to cover emergency services based on the emergency room provider or hospital not notifying the enrollee's MCO of the enrollee's treatment within 10 calendar days of presentation for emergency services.		
	Required Actions: DHMC must ensure that the appeal-by date it specifies in the notice of action letter represents 20 days from the date of the letter. While outside the purview of this review, DHMC must ensure that its claims process is compliant with the requirements of 42 CFR 438.114, et seq.		

Standard VI—Grievance System			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.404(c) DHHA Contract: Exhibit I—8.209.4.A.3	13. The notice of action must be mailed within the following timeframes: ◆ For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least 10 days before the date of action (unless extenuating circumstances exist – found in Exhibit I) ◆ For denial of payment, at the time of any action affecting the claim ◆ For standard service authorization decisions that deny or limit service, within 10 calendar days ◆ For service authorization decisions not reached within ten calendar days, on the date the timeframes expire ◆ For expedited service authorization decisions, within 3 days	**Documents Submitted/Location Within Documents:** 1. CHOICE_UMG1002	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The UR determinations policy included each of the required time frames for notification and the extenuating circumstances that may exist to shorten the notice requirement for termination, suspension, or reduction of previously authorized services. The only time frame stated in the member handbook was 10 days before the date of the action consistent with the termination, suspension, or reduction of previously authorized services. A variety of notice of action letters were reviewed and were mailed within applicable time frames.		
	Required Actions: None		

Standard VI—Grievance System			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.404(c) DHHA Contract: Exhibit I—8.209.4.A.4	14. If the Contractor extends the timeframe for authorization decisions, (see Standard I), it provides the member: ◆ Written notice of the reason for the decision to extend the timeframe ◆ The right to file a grievance if the member disagrees with the decision ◆ Issuance of its decision (and carries out the decision) as expeditiously as the member's health condition requires and no later than the date the extension expires	**Documents Submitted/Location Within Documents:** 1. CHOICE_UMG1002 pg 15. C	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable e
	Findings: The UR determinations policy included the provision that if DHMC extends the time frame for authorization decisions, it will give the member written notice of the reason the decision is being delayed; however, the policy indicated that DHMC would notify the member of appeal rights if the member disagrees with the decision to extend the time frame. Per 42 CFR 438.404 (c)(4)(i), the member should be notified of his or her right file a grievance, not an appeal. The policy also included the provision that DHMC will issue its decision (and carry out the decision) as expeditiously as the member's health condition requires and no later than the date the extension expires.		
	Required Actions: DHMC must ensure that its policy and practice are compliant with the requirement to advise the member of the right to file a grievance when it sends written notice of its decision to extend the time frame for an authorization decision.		

Standard VI—Grievance System			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.406(a) DHHA Contract: Exhibit I—8.209.4.C	15. In handling grievances and appeals, the Contractor must give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.	**Documents Submitted/Location Within Documents:** 1. Choice_MBR803.doc 2. Choice_UMG1002.doc 3. Medicaid Choice Member Handbook (pgs 24 – 29) 4. MCD_Prov_Manual_Appeals.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The UR determinations policy stated that DHMC gives members reasonable assistance in completing any forms required by DHMC, putting oral requests for a State fair hearing into writing and taking other procedural steps, including providing interpreter services and toll-free numbers with adequate TTY/TDD capability. The grievance policy stated that DHHA (parent company to DHMC) provides services to facilitate members' and DCRs' effective use of the grievance process, including qualified interpreters for persons with communication disabilities or differences and non-English-speaking clients. The member handbook offered assistance from DHMC to file a grievance or an appeal and provided the telephone number for the Medicaid ombudsman, as well. Additionally, the member services area was staffed with individuals who were multilingual.		
	Required Actions: None		

Standard VI—Grievance System			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.406(a) DHHA Contract: Exhibit I—8.209.5.B	16. The Contractor acknowledges each grievance in writing within two working days of receipt.	**Documents Submitted/Location Within Documents:** 1. Choice_MBR803.doc	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The grievance policy stated that if a grievance cannot be resolved within two business days, DHMC would send a written acknowledgment of each grievance within two business days from receipt. The member handbook informed members that DHMC would send a letter within two working days to let the member know that DHMC received the grievance. The grievance policy included a template of a grievance acknowledgment letter. All grievances in the record review sample were either acknowledged or resolved within two days. However, the DHMC policy specified that grievances received after 3 p.m. were logged as received on the next day. This would result in incorrect grievance dates being notated on those grievances and potentially result in an acknowledgment not being sent until the third day from the actual filing of the grievance.		
	Required Actions: DHMC must log grievances on the actual date of receipt.		
42CFR438.406(a) DHHA Contract: Exhibit I—8.209.4.D	17. The Contractor acknowledges each appeal in writing within 2 working days of receipt, unless expedited resolution is requested.	**Documents Submitted/Location Within Documents:** 1. Chocie_UMG1002.doc (pgs 16 – 18) 2. Medicaid Choice Member Handbook (pgs 24 – 29) 3. CD_Prov_Manual_Appeals.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The UR determinations policy stated that DHMC sends the member written acknowledgment of each appeal within two working days of receipt unless the member or DCR requests an expedited resolution. The member handbook informed members that DHMC must tell the member within two working days that the appeal was received. DHMC reported one appeal during the review period. DHMC responded to the appeal within two working days of receipt. Appeals were logged on the date of receipt.		
	Required Actions: None		

Standard VI—Grievance System			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.406(a) DHHA Contract: Exhibit I—8.209.5.C	18. The Contractor ensures that the individuals who make decisions on grievances are individuals who: ◆ Were not involved in any previous level of review or decision-making ◆ If deciding a grievance regarding the denial of expedited resolution of an appeal, or a grievance that involves clinical issues, has the appropriate clinical expertise in treating the member's condition or disease.	**Documents Submitted/Location Within Documents:** 1. Choice_MBR803.doc 2. Medicaid Choice Member Handbook (pgs 24 – 29) 3. CD_Prov_Manual_Appeals.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The grievance policy stated that individuals who made decisions on grievances were not involved in any previous level of review or decision making and had the appropriate clinical expertise in treating the member's condition or disease if they were deciding a grievance that involved clinical issues. One record reviewed indicated that the individual who responded to the grievance was not part of the original decision or involved in the review process. This element was not applicable on the other records in the sample.		
	Required Actions: None		

Standard VI—Grievance System			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.406(a) DHHA Contract: Exhibit I—8.209.4.E	19. The Contractor ensures that the individuals who make decisions on appeals are individuals who: ◆ Were not involved in any previous level of review or decision-making ◆ If deciding an appeal of a denial based on medical necessity, or involves any clinical issues, has the appropriate clinical expertise in treating the member's condition or disease	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook (pgs 24 – 29) 2. CD_Prov_Manual_Appeals.pdf 3. Choice_UMG1002 (pg 17)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The UR determinations policy stated that individuals who made decisions on appeals were not involved in any previous level of review or decision making and had the appropriate clinical expertise in treating the member's condition or disease if they were deciding any of the following: an appeal of a denial that was based on lack of medical necessity, an appeal regarding a denial of an expedited resolution of an appeal, or an appeal that involved a clinical issue. During the on-site interview staff members described that a panel of experts was available to the plan, and documentation reviewed with the sample notice of action letters documented that other individuals were called upon in this process.		
	Required Actions: None		

Standard VI—Grievance System			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.406(b) DHHA Contract: Exhibit I—8.209.4.G—I	20. The Contractor's appeal process must provide: ◆ That oral inquiries seeking to appeal an action, are treated as appeals (to establish the earliest possible filing date) and must be confirmed in writing, unless the member or the provider requests expedited resolution ◆ The member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The Contractor must inform the member of the limited time available for this in the case of expedited resolution) ◆ The member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents considered during the appeals process ◆ That included, as parties to the appeal, are ▪ The member and his or her representative; or ▪ The legal representative of a deceased member's estate	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook (pgs 24 – 29) 2. CD_Prov_Manual_Appeals.pdf 3. Choice_UMG1002 (pg 17)	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: ◆ None of the DHMC materials submitted for review addressed that oral inquiries must be followed by written requests for an appeal or the use of the date of the oral inquiry as the filing date.		

Standard VI—Grievance System			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
	◆ The UR determinations policy stated that DHMC provides the member reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing, and that DHMC informs the member of the limited time available in the case of expedited resolution. Staff members stated that there had been no requests during the review period for an expedited resolution. ◆ The member handbook did not inform members that they or their DCR have the opportunity to present evidence or allegations of fact or law, or address the shortened time frame for this. However, the notice of action letter specified that a member or DCR had the chance to examine the denial case file before and during the appeal process. It stated that the case file included medical records and any other papers and records considered during the appeal process that were not considered confidential under State and federal law. The UR determinations policy stated that DHMC provided the member and the DCR the opportunity before and during the appeal process to examine the member's case file with a physician present, including medical records and any other documents and records considered during the appeal process. The member handbook stated, "the appeal case file includes medical records and any other documents and records considered during the appeal process that are not considered confidential under state and federal law." Staff members clarified that this limitation pertained to certain psychiatric and substance abuse records. ◆ The UR determinations policy stated that DHMC included as parties to the appeal the member and his or her DCR or the legal representative of a deceased member's estate.		
	Required Actions: DHMC must develop and implement a process to ensure that oral requests to file an appeal continue to be accepted to establish the earliest possible filing date and are followed with a written, signed appeal from the member or the DCR.		
42CFR438.408(b)&(d) DHHA Contract: Exhibit I— 8.209.5.D.1 & 8.209.5.F	21. The Contractor must dispose of each grievance and provide notice of the disposition in writing, as expeditiously as the member's health condition requires, not to exceed 15 working days from the day the Contractor receives the grievance.	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook (pgs 24 – 29) 2. CD_Prov_Manual_Appeals.pdf 3. Choice_MBR803	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The grievance policy stated that grievances are resolved as expeditiously as possible, not to exceed 15 business days from receipt of the grievance. The member handbook informed members that they would receive DHMC's ruling on a grievance within 15 working days. The grievance policy included as an attachment a template resolution letter. All grievance records reviewed were resolved within 15 working days; the range was from 0 days to 12 days. See the related required action for Element 16.		
	Required Actions: None		

Standard VI—Grievance System			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.408(b)&(d) DHHA Contract: Exhibit I—8.209.4.J	22. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires: ◆ For standard resolution of appeals, 10 working days from the day the Contractor receives the appeal ◆ For expedited resolution of an appeal and notice to affected parties, 3 working days after the Contractor receives the appeal	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook (pgs 24 – 29) 2. CD_Prov_Manual_Appeals.pdf 3. Choice_UMG1002 (pg. 18)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The UR determinations policy included the correct time frame for resolution of standard appeals and expedited appeals. The one appeal during the review period was resolved within two working days.		
	Required Actions: None		

Standard VI—Grievance System			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.408(c) DHHA Contract: Exhibit I—8.209.4.K & 80209.5.E	23. The Contractor may extend the timeframes for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: ◆ The member requests the extension, or ◆ The Contractor shows that there is need for additional information and how the delay is in the member's interest	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook (pgs 24 – 29) 2. CD_Prov_Manual_Appeals.pdf 3. Choice_UMG1002 4. Chcoice_MBR803.doc	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The grievance policy stated that the resolution time frame of a grievance could be increased by up to 14 calendars days if the member requested the extension or DHMC showed a need for additional information and the delay was in the member's best interest. The member handbook (in the grievances section) stated, "If you ask for more days or DHMC believes that more facts are needed to make a ruling, DHMC may add 14 calendar days." The UR determinations policy included the provision that DHMC may extend the time frame for resolution of appeals by up to 14 calendar days if the member requests the extension or DHMC shows that there is a need for additional information and the delay is in the member's best interest. The member handbook (in the appeals section) stated that the member or DHMC may extend the time DHMC has to reach a decision to 14 days. That wording essentially limits the extension to a 4-day extension. The section of the appeal policy dealing with expedited appeals did not clarify that extensions of up to 14 additional calendar days applied to both standard and expedited appeals. While the requirement is essentially met, HSAG would encourage DHMC to provide clarification in both the internal documents and member materials.		
	Required Actions: None		

<table>
<tr><th colspan="4">Standard VI—Grievance System</th></tr>
<tr><th>References</th><th>Requirement</th><th>Evidence Submitted by the Health Plan</th><th>Score</th></tr>
<tr><td rowspan="3">42CFR438.408(c)(2)

DHHA Contract:
Exhibit I—
8.209.4.K &
80209.5.E</td><td>24. If the Contractor extends the timeframes, it must—for any extension not requested by the member—give the member written notice of the reason for the delay.</td><td>Documents Submitted/Location Within Documents:
1. Medicaid Choice Member Handbook (pgs 24 – 29)
2. CD_Prov_Manual_Appeals.pdf
3. Choice_UMG1002
4. Chcoice_MBR803.doc</td><td>☒ Met
☐ Partially Met
☐ Not Met
☐ Not Applicable</td></tr>
<tr><td colspan="3">Findings:
The grievance policy and the UR determinations policy (for appeals) stated that if DHMC extended the time frame for resolution of a grievance or an appeal, it would provide the member with written prior notice of the reason for the delay. The grievance section of the member handbook informed members that DHMC would send a letter to inform them of the reason the extra time was needed. The appeals section of the member handbook stated that DHMC had to have a good reason for the delay and had to tell the member the reason.</td></tr>
<tr><td colspan="3">Required Actions:
None</td></tr>
<tr><td rowspan="3">42CFR438.408(d)

DHHA Contract:
Exhibit I—
8.209.4.L</td><td>25. For notice of an expedited resolution of an appeal, the Contractor must also make reasonable efforts to provide oral notice of resolution.</td><td>Documents Submitted/Location Within Documents:
1. Medicaid Choice Member Handbook (pgs 24 – 29)
2. CD_Prov_Manual_Appeals.pdf
3. Choice_UMG1002</td><td>☒ Met
☐ Partially Met
☐ Not Met
☐ Not Applicable</td></tr>
<tr><td colspan="3">Findings:
The UR determinations policy stated that for notices of an expedited resolution, DHMC also makes reasonable efforts to provide oral notice. The one appeal during the review period was not requested to be resolved as an expedited appeal.</td></tr>
<tr><td colspan="3">Required Actions:
None</td></tr>
</table>

Standard VI—Grievance System			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.408(e) DHHA Contract: Exhibit I—8.209.4.M	26. The written notice of appeal resolution must include: ◆ The results of the resolution process and the date it was completed ◆ For appeals not resolved wholly in favor of the member ▪ The right to request a State fair hearing, and how to do so ▪ The right to request that benefits continue while the hearing is pending, and how to make the request ▪ That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's action	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook (pgs 24 – 29) 2. CD_Prov_Manual_Appeals.pdf 3. Choice_UMG1002	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The UR determinations policy stated only that the resolution letter includes the results of the disposition/resolution and the date it was completed. The policy did not include State fair hearing rights or information pertaining to continuation of benefits. The appeal resolution letter reviewed did provide the member with information on how to request a State fair hearing. It did not contain information about continuation of benefits because that was not applicable. However, the letter incorrectly stated that a State fair hearing could be requested within 20 days of the date of "the notice of second request action." A State fair hearing must be requested within 20 days of the original notice of action letter, not the resolution letter date.		
	Required Actions: DHMC must ensure that appeal resolution letters for appeals not resolved wholly in favor of the member include the member's right to request a State fair hearing and how to do so, that a State fair hearing must be requested within 20 calendar days from the date of the notice of action, the member's right to request and receive benefits while the hearing is pending and how to make the request, and that the member may be held liable for the cost of those benefits if the hearing decision upholds the plan's action.		

Standard VI—Grievance System			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.410 DHHA Contract: Exhibit I—8.209.4.P—R	27. The Contractor has an expedited review process for appeals, when the Contractor determines, or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to regain maximum function. The Contractor's expedited review process includes: ◆ The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal ◆ If the Contractor denies a request for expedited resolution of an appeal, it must ▪ Transfer the appeal to the timeframe for standard resolution, and ▪ Make reasonable efforts to give the member prompt oral notice of the denial and follow-up within two calendar days	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook (pgs 24 – 29) 2. CD_Prov_Manual_Appeals.pdf 3. Choice_UMG1002	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The UR determinations policy stated that DHMC has an expedited review process for appeals when DHMC determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to maintain or regain maximum function. The policy also included the provisions that: ◆ Punitive action is not taken against a provider who requests an expedited resolution or who supports a member's appeal. ◆ If DHMC denies a request for expedited resolution, it shall transfer the appeal to the time frame for standard resolution, make reasonable effort to give the member prompt verbal notice of the denial, and send written notice of the denial of an expedited resolution within two calendar days. The member handbook informed members about DHMC's expedited review process for appeals.		

Standard VI—Grievance System			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
	Required Actions: None		
42CFR438.414 DHHA Contract: Exhibit I— 8.209.3.B	28. The Contractor must provide the information about the grievance system specified in 42CFR438.10 to all providers and subcontractors at the time they enter into a contract. The information includes: ◆ The right to file grievances ◆ The right to file appeals ◆ The right to a State fair hearing ◆ The requirements and timeframes for filing grievances and appeals ◆ The method for obtaining a State fair hearing ◆ The rules that govern representation at the State fair hearing ◆ The availability of assistance filing a grievance, an appeal, or requesting a State fair hearing ◆ The toll free numbers the member may use to file a grievance or an appeal by phone ◆ The fact that, when requested by the member, benefits will continue if the appeal or request for State fair hearing is filed within the timeframes specified for filing ◆ The fact that, if benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook (pgs 24 – 29) 2. CD_Prov_Manual_Appeals.pdf 3. Choice_UMG1002 4. Chcoice_MRB803	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance System			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
	appeal is pending, if the final decision is adverse to the member ◆ Appeal rights available to providers to challenge the failure of the Contractor to cover a service		

Findings:

DHMC provided information to providers via the provider manual. Information in the provider manual regarding member grievances and appeals was excerpted from the member handbook and, therefore, was provided in a very simplistic format. The excerpted material addressed the requirements as follows:

- The right to file grievances.
- The right to file appeals.
- The right to a State fair hearing.
- The requirements and time frames for filing grievances and appeals.
- Partial information about appeals. The material listed the overall 20-day requirement but not the 10-day requirement for terminations, reductions, etc. It listed the 10-day prior notice requirement, but included nothing about the member's time frame for filing within that time. It did not state that appeals filed orally must be followed by a written appeal.
- Partial information about the method for obtaining a State fair hearing. The material stated that a State fair hearing could be requested within 30 calendar days from the date of the notice of action. Current regulations are that members of managed care plans have 20 days from the date of the notice of action.
- The rules that govern representation at a State fair hearing.
- The availability of assistance filing a grievance or an appeal, or requesting a State fair hearing.
- The toll-free numbers the member may use to file a grievance or an appeal by telephone.
- The fact that, when requested by a member, benefits will continue if the appeal or request for a State fair hearing is filed within the time frames specified for filing. The information, however, was listed under required content for a notice of action and did not state that the member must request that the benefits continue or anything about the time frames.
- The fact that if benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal is pending if the final decision is adverse to the member.
- Appeal rights available to providers to challenge the failure of the contractor to cover a service. The material stated that a DCR may file an appeal, but it did not clarify that a provider may be a DCR. It referenced the DCR section of the member handbook and the DCR form in the provider manual (which was actually a Designation of Personal Representative form). Neither clarified that a provider could be a DCR.

Standard VI—Grievance System			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
	Required Actions: DHMC must provide the information about the grievance system specified in 42 CFR 438.10 to all providers and subcontractors at the time they enter into a contract, including: ◆ Information about the requirements and time frames for filing appeals and that verbal appeals must be followed by a written appeal. ◆ Information that when requested by a member, benefits will continue if an appeal or request for a State fair hearing is filed within the time frames specified for filing. The time frames for continued benefit requests should be identified. ◆ The correct time frame for requesting State fair hearings (20 days) should be specified. ◆ The appeal rights available to providers to challenge the failure of the contractor to cover a service.		
42CFR438.416 DHHA Contract: Exhibit I— 8.209.3.C	29. The Contractor maintains records of all grievances, and submits quarterly reports to the Department.	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook (pgs 24 – 29) 2. CD_Prov_Manual_Appeals.pdf 3. Choice_MRB803	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: Evidence that grievances were tracked was provided through screen prints of electronic records of grievances, copies of acknowledgment and resolution letters sent for grievances selected for the record review, and quarterly grievance and appeals reports submitted to the Department (for two quarters of the review period: July 1, 2009–September 30, 2009, and October 1, 2009–December 31, 2009).		
	Required Actions: None		

Standard VI—Grievance System			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.416 DHHA Contract: Exhibit I—8.209.3.C	30. The Contractor maintains records of all appeals, and submits quarterly reports to the Department.	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook (pgs 24 – 29) 2. CD_Prov_Manual_Appeals.pdf 3. Choice_UMG1002	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: DHMC reported only one appeal to the Department during the period of review. Given the size of the DHMC Medicaid membership, the identified network capacity issues, and findings from member satisfaction surveys, it is likely that potential appeals are being lost in the system. Other contributory factors could include the clarity of member and provider informational materials regarding the right of providers to file appeals on behalf of members.		
	Required Actions: DHMC must evaluate its processes for recording and responding to feedback from members and providers who have been sent a notice of action. Assessment should include various contact points within the system, including providers and satellite clinics, and results should be used to identify and respond to any possible barriers to members or providers exercising the right to appeal an action.		

Standard VI—Grievance System			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.420(b) DHHA Contract: Exhibit I—8.209.2 & 8.209.4.S	31. The Contractor continues the member benefits if ◆ The member or the provider files timely—defined as on or before the later of the following: ▪ Within ten days of the Contractor mailing the notice of action ▪ The intended effective date of the proposed action ◆ The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment ◆ The services were ordered by an authorized provider ◆ The original period covered by the original authorization has not expired ◆ The member requests extension of benefits	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook (pgs 24 – 29) 2. CD_Prov_Manual_Appeals.pdf 3. Choice_UMG1002	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The UR determinations policy stated that if members want their services to continue, they can call DHMC medical management and request continuation of services. The policy included the conditions that apply; however, the policy stated that members must file an appeal "in time," without specifying how much time members have to file.		
	Required Actions: DHMC must ensure that its internal documents and member materials clearly identify the conditions and time frames under which continuation of benefits can occur.		

Standard VI—Grievance System			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.420(c) DHHA Contract: Exhibit I—8.209.4.T	32. If the Contractor continues or reinstates the benefits while the appeal is pending, the benefits must be continued until one of the following occurs: ◆ The member withdraws the appeal ◆ Ten days pass after the Contractor mails the notice providing the resolution of the appeal against the member, unless the member (within the 10-day timeframe) has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached ◆ A State fair hearing office issues a hearing decision adverse to the member ◆ The time period or service limits of a previously authorized service has been met	**Documents Submitted/Location Within Documents:** 1. Medicaid Choice Member Handbook (pgs 24 – 29) 2. CD_Prov_Manual_Appeals.pdf 3. Choice_UMG1002 (pgs 18-20)	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The UR determinations policy included the conditions, stating how long services would continue. Information in the appeals section, however, was not presented clearly, with the second half of the requirement placed far away from the first half. Additionally, the policy did not include the second half of the second bullet above at Appeals-C-15, "…unless the member (within the 10-day timeframe) has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached."		
	Required Actions: DHMC must ensure that its policy clearly contains the conditions under which continued or reinstated benefits will occur during the appeal or State fair hearing processes.		

Standard VI—Grievance System			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.420(d) DHHA Contract: Exhibit I—8.209.4.U	33. If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's action, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this rule.	**Documents Submitted/Location Within Documents:** 1. Choice_UMG1002 pg 15 Section 4 2. Medicaid Choice Member Handbook (pgs 24 – 29) 3. CD_Prov_Manual_Appeals.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The UR determinations policy stated that "if the final resolution of the appeal upholds the DHMC action, DHMC may recover the cost of services furnished to the member while the appeal is pending to the extent that the services were furnished solely because of the requirements of this rule."		
	Required Actions: None		
42CFR438.424 DHHA Contract: Exhibit I—8.209.4.V	34. If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires.	**Documents Submitted/Location Within Documents:** 1. Choice_UMG1002 (Pg 18 Section 15) 2. Medicaid Choice Member Handbook (pgs 24 – 29) 3. CD_Prov_Manual_Appeals.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The UR determinations policy included the provision that if a State fair hearing officer reverses a DHMC decision to deny or limit services, DHMC authorizes or provides the disputed services promptly and as expeditiously as the member's health condition requires.		
	Required Actions: None		

Standard VI—Grievance System			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.424 DHHA Contract: Exhibit I—8.209.4.W	35. If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending, the Contractor must pay for those services.	**Documents Submitted/Location Within Documents:** 1. Choice_UMG1002 (Pg 18 Section 15) 2. Medicaid Choice Member Handbook (pgs 24 – 29) 3. CD_Prov_Manual_Appeals.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The UR determinations policy included the provision that if a State fair hearing officer reverses a DHMC decision to deny authorization of services and the member received the services while the appeal was pending, DHMC must pay for those services.		
	Required Actions: None		

Results for Grievance System							
Total	Met	=	22	X	1.00	=	22
	Partially Met	=	11	X	.00	=	0
	Not Met	=	2	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	35	**Total Score**		=	22

Total Score ÷ Total Applicable	=	63%

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.240(a) DHHA Contract: II.J.1 & II.J.2.i	1. The Contractor has an internal Quality Assessment and Performance Improvement (QAPI) Program. The Contractor has a QAPI plan that: ◆ Delineates current and future QAPI activities ◆ Integrates findings and opportunities for improvement indentified from focused studies, HEDIS measurements, enrollee satisfaction surveys, and other monitoring and quality activities	**Documents Submitted/Location Within Documents:** 1. DH MCD Choice Program Description QIM1301- demonstrates that we have a QAPI Program. On pgs1-3, there is documentation of the purpose, scope, policy, and the responsibility of the QI Program. The remaining pgs describe in more detail all of the components of the QI Program. 2. DH MCD Choice QI Impact Analysis-pgs 9-24 and 26-31 demonstrate current and future QAPI activities. The entire report demonstrates how we integrate findings and opportunities for improvement identified from focused studies, HEDIS measurements, enrollee satisfaction surveys, and other monitoring and quality activities. 3. DH 2010 QI Work Plan - demonstrates future QI activities	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The DHMC QAPI program was described and evaluated in the Medicaid Quality Improvement Program Description and the DHMC Quality Improvement Impact Analysis. The QAPI plan contained documentation of the purpose, goals and objectives, scope, policy, authority, and responsibility of the QI program, as well as a description of the organizational structure and staff roles in the medical management department. The scope of QI activities documented in the program description included: adequacy and availability of service (network access, timeliness, service responsiveness), member satisfaction, health management, clinical guidelines, continuity of care through case management and care management, cultural and linguistic competency, quality of clinical care, patient safety issues, preventive health/health promotion, medical record documentation, case management, utilization management, provider satisfaction with DHMC services, credentialing and delegated credentialing, and quality-of-care issues. The DHMP/Medicaid Choice Board of Directors maintained overall responsibility and authority for the QI program. The QI Impact Analysis document described how the organization assessed current and future QAPI activities and integrated findings and opportunities for improvement identified from focused studies, Healthcare Effectiveness Data and Information Set (HEDIS) measurements, enrollee satisfaction surveys, and other monitoring and quality activities. DHMC presented detailed notes, meeting documentation and attendance rosters, work plans, summaries, and reports that documented a functioning QAPI program that included input from all health plan functional areas.		
	Required Actions: None		

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.240(b)(3) DHHA Contract: II.J.2.e	2. The Contractor's QAPI program includes mechanisms to detect both underutilization and overutilization of services.	**Documents Submitted/Location Within Documents:** 1. EPSDT Interventions July 2008-June 2009 - demonstrates our outreach activities to our EPSDT members to increase screening rates. 2. 2009 MCD Choice HEDIS report - demonstrates that we track results from year to year to detect underutilization and overutilization. 3. MCD 2009 HEDIS Summary of results - demonstrates that we compare to the previous year and evaluate any statistically significant change and to detect under and over utilization. 4. Network Adequacy report FY09Q4 - demonstrates that we monitor utilization refer to pg 1. 5. EPSDT Committee minutes - demonstrate discussions about our underutilization and interventions to improve screenings-refer to 09Jul21, 09Apr21, and 09Feb17 minutes. 6. ACQI Peds Preventive Minutes - demonstrate collaborative effort to address underutilization within the DH system. Refer to minutes 021209,040109, and 060309. 7. Adult Outreach 200912 - demonstrates how we address underutilization. 8. DH Medicaid Choice Collaborative Activities - demonstrate that we partner within Denver Health to prevent duplication of efforts and to improve preventive screenings and chronic care. 9. QI 2010Annual Work Plan Final.xls - shows that the Medical Director and QI Director in Managed Care participate in this committee and identify the QI activities that we will focus on within the Denver Health system to improve preventive and chronic care.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
	Findings: DHMC documentation demonstrated analysis of over- and underutilization across multiple programs, incorporation of findings from analyses into QI and summary reports, and development of internal CAPs and program improvement activity. The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Interventions Report (FY 2008–2009) demonstrated the plan's outreach activity to parents of EPSDT members to increase screening rates. The 2009 HEDIS report showed tracking of results from year to year to detect underutilization and overutilization. The 2009 HEDIS summary of results report demonstrated that DHMC used annual comparisons and evaluated statistically significant changes to detect under- and overutilization. DHMC performed a quarterly analysis of network adequacy by measuring several utilization standards for inpatient services such as discharge days, inpatient days, and timeliness and adequacy of pharmacy precertification decisions. The Network Adequacy report (fourth quarter 2009) demonstrated that DHMC monitored utilization and compared results to prior-year findings. Minutes from the DHMC EPSDT Committee from January, April, and July 2009 documented discussions about underutilization of EPSDT services and interventions to improve screenings. The work plan identified that DHMC would focus on improvements in preventive and chronic care. DHMC had a policy regarding interrater reliability within utilization management, which documented processes for detecting the consistency of application of clinical decision criteria in utilization management decisions.		
	Required Actions: None		

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.240(e)(2) DHHA Contract: II.J.2.h	3. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program (at least annually). The process includes a review of: ◆ The techniques used by the Contractor to improve performance ◆ The outcome of each performance improvement project ◆ The overall impact and effectiveness of the QAPI program	**Documents Submitted/Location Within Documents:** 1. DH MCD Choice QI Impact Analysis - demonstrates techniques used to improve performance by identifying barriers (refer to page 12-Eye Cameras, and evaluating the impact of interventions refer to pg 15 Interventions 08/09). 2. Technique used by DH MCD Choice: MCD 2009 HEDIS Summary of Results-we conduct chi stat to determine statistically significant change, especially negative trends. 3. Techniques used by DH MCD Choice: Collaborative Activities within DH to improve performance. Participate on the Preventive Cancer Screening Mtgs-see Cancer Screening SC Minutes1109(2) for evidence of implementing standard work in the clinics and having a registry to capture data. 4. DH MCD Choice QI Impact Analysis-demonstrates the outcome of each QAPI activities as well as the impact and effectiveness of the QAPI program. Refer to the entire document for evidence of compliance. 5. DHMC.COOFY2009_10_MCO_PIP_Val_CoordCareresubmit_12-10_09 demonstrates how we follow the CMS Protocol requirements.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: DHMC provided Board of Directors meeting minutes that documented review and approval of the annual QAPI plan. DHMC presented its written plan for analyzing the effectiveness of its QAPI program. The QI Impact Analysis demonstrated techniques used to improve performance by identifying barriers and evaluating the impact of interventions. The document provided a summary and outcome assessment of each QI activity as well as the impact and effectiveness of the QAPI program. The QI work plan contained components related to internal evaluation of the program as well as tracking of initiatives and interventions. In addition to a general, detailed work plan, detailed work plans were provided for outpatient case management, inpatient management, and pharmacy management.		
	Required Actions: None		

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.236(b) DHHA Contract: II.J.2.a.2	4. The Contractor's QAPI program addresses practice guidelines. The Contractor adopts practice guidelines that meet the following requirements: ◆ Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field ◆ Consider the needs of the Contractor's members ◆ Are adopted in consultation with contracting health care professionals ◆ Are reviewed/updated annually	**Documents Submitted/Location Within Documents:** 1. DH MCD Choice QI Impact Analysis-demonstrates that we have practice guidelines on pg 8. 2. Clinical practice Guideline Policy and Procedure - demonstrates that we meet the requirements: - Documentation on pages 3-4 shows that guidelines are based on valid and reliable clinical evidence. - Documentation on page 3 shows how we consider the needs of our members - Documentation on page 2 under Procedures shows that we review/update annually. 3. Diabetes Standards of Care is an example of a clinical practice guideline with evidence of referencing the ADA Diabetes Guideline and ADA Summary of Review for 2009. 4. Master Guidelines demonstrates that we have clinical and preventive that address special needs.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: DHMC's QI program description outlined the requirements for the development of clinical practice guidelines and stated that the guidelines were reviewed and approved annually by the Medical Management Committee. DHMC's policy, Clinical Practice Guidelines and Preventive Care Guidelines, outlined the detailed processes, procedure, and structure for the development of practice guidelines. The policy also contained an overview that described the purpose and intended focus of the clinical and preventive guidelines in relation to the members served in DHMC. The DHMC QI Impact Analysis stated that the guidelines were recommendations for practitioners and were not intended to set legal standards of care. DHMC maintained a list of physician consultants who were available for participation in practice guideline review committees. Clinical guideline work sheets were presented that guided the completion of requirements for review and approval of a practice guideline. Practice guidelines were developed and available in a variety of relevant areas, including care of well newborns, diabetes, asthma, pediatric care, prenatal care, and other areas. These clinical and preventive care guidelines were available on the Denver Health provider portal Web site. The QI Impact Analysis stated that planned activities for 2009–2010 included development of a SHCN guideline specific to the pediatric population. The DHMC medical director participated in the Colorado Clinical Guideline Collaborative.		
	Required Actions: None		

<table>
<tr><th colspan="4">Standard X—Quality Assessment and Performance Improvement</th></tr>
<tr><th>References</th><th>Requirement</th><th>Evidence Submitted by the Health Plan</th><th>Score</th></tr>
<tr><td rowspan="3">DHHA Contract:
II.J.2.a.1</td><td>5. The Contractor has practice guidelines for:
◆ Perinatal, prenatal, and postpartum care for women
◆ Conditions related to persons with a disability or special health care needs
◆ Well Child Care</td><td>Documents Submitted/Location Within Documents:
1. Clinical Practice and Preventive Care Guidelines Policy and Procedure - pg 1 demonstrates guidelines for Perinatal, prenatal, and postpartum care for women and well child care.
2. Clinical Practice and Preventive Care Guidelines Policy and Procedure demonstrates conditions related to special health care needs on pg 1 –the specific purposes of Clinical Practice Guidelines</td><td>☒ Met
☐ Partially Met
☐ Not Met
☐ Not Applicable</td></tr>
<tr><td colspan="3">Findings:
Practice guidelines were divided into categories of preventive care guidelines and clinical guidelines. The policy stated that the preventive and clinical care guidelines applied to all members, including members with disabilities. The following guidelines were available to DHMC providers: care of the well newborn; EPSDT/well-child/adolescent evaluation and management criteria; pediatric/adolescent immunizations; prenatal, postpartum, and perinatal care for women; screening mammography; prostate cancer screening; colorectal cancer screening; smoking cessation; adult immunization; child/adult asthma management; diabetes management; management of hypertension; preventive drug management of congestive heart failure; management of high-risk newborns after discharge; authorizing visits for Medicaid choice enrollees for continuity and coordination of care; treatment of depression in primary care; and ambulatory management for follow up of behavioral health admissions. The QI Impact Analysis indicated that DHMC would be working with the Community Health Services (CHS) pediatric director to create a special health care needs guideline as a planned activity for 2009/2010. The QAPI work plan for 2010 indicated the development of a special health care needs guideline as a work plan item.</td></tr>
<tr><td colspan="3">Required Actions:
None</td></tr>
</table>

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.236(c) DHHA Contract: II.J.2.a.3	6. The Contractor disseminates the guidelines to all affected providers, and upon request, to members and potential members at no cost. The guidelines are available to non-members, including the public, at cost.	**Documents Submitted/Location Within Documents:** 1. Clinical Practice and Preventive Care Guidelines Policy and Procedure - pgs 1-2 under Policy 2. Print screen of the internal website for Providers that demonstrates that we have made guidelines available to our providers. Refer to documentGuidelines4providerscreen.bpm	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: DHMC policy stated that the medical director determined who would receive the guidelines, and there were various options for disseminating guidelines. Dissemination methods included the provider newsletter, provider-targeted mailings as appropriate, hand delivery during site visits, and incorporation in the provider manual. In addition to providing guidelines to individuals upon request, the clinical and practice guidelines were available on the DHMC Web site in an accessible PDF format.		
	Required Actions: None		
42CFR438.236(d) DHHA Contract: II.J.2.a.4	7. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the practice guidelines.	**Documents Submitted/Location Within Documents:** 1. Clinical Practice and Preventive Care Guidelines Policy and Procedure -pg 4-number 8 under C.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: DHMC's preventive care guidelines policy and procedure contained steps in the review process for reviewing member benefits to ensure that all components of the guideline were consistent with covered benefits and that the utilization and clinical management standards for member care were supported in the guidelines. DHMC presented a clinical practice development guideline work sheet that contained an element stating that utilization standards and member and provider education were consistent with the guidelines. Member education about smoking cessation and immunizations in a recent member newsletter was consistent with the respective clinical/preventive care guideline.		
	Required Actions: None		

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.240(b) DHHA Contract: II.J.2.b-d & f	8. The QAPI Program includes the following basic elements: ◆ Performance improvement projects ◆ The submission of performance measurement data ◆ Member satisfaction ◆ Investigation of quality of care concerns	**Documents Submitted/Location Within Documents:** 1. Refer to the MCD Choice QI Impact Analysis-pgs 24 for performance improvement projects, pgs 9-23 for performance measurement data, pgs 28-30 for the CAHPS data, and pg 31 for quality of care concerns. 2. Quality of Care Concerns Policy and Procedure QIM1303 -demonstrates that we have a process for investigating quality of care concerns.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The DHMC QI Program Description included performance improvement projects (PIPs), submission of performance measurement data, member satisfaction surveys, and the results of quality-of-care concern investigations. DHMC audited medical records using a standardized tool to evaluate critical elements related to the quality of care provided. The DHMC policy, Medical Records Standards and Audits, provided policy, procedure, criteria, audit standards, permissible delegation activities, and guidelines for medical record review. DHMC analyzed member grievances for potential quality-of-care concerns. Quality-of-care concerns were tracked, trended, and reported quarterly to the Medical Management Committee.		
	Required Actions: None		

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
DHHA Contract: II.J.2.d.1	9. The Contractor's QAPI program includes mechanisms to monitor members' perceptions of accessibility and adequacy of services through the use of: ◆ Member satisfaction surveys ◆ Anecdotal information ◆ Grievance and appeal data ◆ Enrollment and disenrollment data	**Documents Submitted/Location Within Documents:** 1. The DH MCD Choice Network Access Strategic Report - demonstrates the use of Member satisfaction surveys on pgs 20-21 2. The DH MCD Choice Network Access Strategic Report - demonstrates the use of grievance and appeal data on pgs 8-9 3. The DH MCD Choice Network Access Strategic Report - demonstrates the use of enrollment and disenrollment data on pgs 9-11. 4. The DH Medicaid Choice QI Impact Analysis - demonstrates the use of Member satisfaction surveys on pgs 29-30 5. The DH Medicaid Choice QI Impact Analysis - demonstrates the use of grievance and appeal data on pgs 30-32	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: DHMC monitored members' perceptions of accessibility and adequacy of services through member satisfaction surveys, grievance information, and enrollment and disenrollment information in the QI Impact Analysis. DHMC presented a detailed network analysis strategic report that incorporated analysis of survey data; anecdotal information from case and care managers, member services, ombudsmen, and other persons; as well as a detailed analysis of enrollment and disenrollment at DHMC. DHMC provided documentation of anecdotal evidence arising from quality-of-care concerns that resulted in the development of process improvements.		
	Required Actions: None		

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
DHHA Contract: II.J.2.d.3	10. The Contractor develops a corrective action plan when members report statistically significant levels of dissatisfaction, when a pattern of complaint is detected, or when a serious complaint is reported.	**Documents Submitted/Location Within Documents:** 1. BOD_QI_Report_Oct15_09.ppt - demonstrates that we have identified issues with access and availability based on the comparison of 2008 to 2009 CAHPS and HEDIS scores. 2. The Powerpoint: 2P Appt Process Feb 2009 - demonstrates that the access and availability has been identified as a Denver Health system issue, and a process was developed to facilitate new member appointment making. 3. MCDProcessImprovementProjects2009.xls **-** demonstrates that in the course of reviewing 3 separate grievances identified as potential quality of care concerns we discovered opportunities for process improvements and have developed or implemented corrective action plans. 4. The Executive Staff presentation by LeAnn Donovan, Executive Director for Managed Care on December 8, 2009 - demonstrates that the senior leadership is made aware of the access and availability problems-refer to pgs 1-23. In addition, the Medical Director of (CHS) Community Health Services presented a business plan for hiring more practitioners to expand capacity-refer to pgs 24-31. 5. CAP_CHS_Access_09.doc - demonstrated that we develop a correction action plan for a pattern of complaint. The CHS Medical Director has described the actions that will be taken to address access issues with the DH system in this CAP.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: DHMC documented several internal CAPs developed and implemented subsequent to identification of concerns or opportunities for improvement, such as the development of process improvements as a result of grievance reviews, and centralized appointment scheduling for new members. A presentation prepared for the Board of Directors by the medical director demonstrated that DHMC had identified issues with access and availability and was working toward resolution by increasing physician resources.		
	Required Actions: None		

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
DHHA Contract: II.J.2.d.4	11. The Contractor's QAPI program includes a mechanism to assess the quality and appropriateness of care for persons with special health care needs.	**Documents Submitted/Location Within Documents:** 1. Coordination of Care Policy and Procedure (Pharmacy section pgs. 10-11) 2. Medical Record Review 2009_summary.doc - demonstrates how we review the quality and appropriateness of the 10 critical elements. 3. The Quality Improvement Department demonstrates how we collect, analyze, integrate, and report on the quality and appropriateness of care for persons with special health care needs in the following reports: a. 2008HCPFDisparitiesSurveillance b. HCPF Race Surveillance_Apr09, and c. CBPRaceSurveillance_2009_10 - demonstrates how we utilize several data sources to analyze for disparities and then report the data. 4. Medical Record Documentation policy QIM 1306 - demonstrates that we have standards and a process to review for 10 critical elements	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: DHMC presented documentation that it assessed the quality and appropriateness of health care for persons with SHCN, including the Coordination of Care policy and procedure and findings of the Medical Record Review 2009. The medical record review of quality and appropriateness care included 10 critical elements. The Quality Improvement Department presented documentation of analysis of several data sources to analyze for disparities and report the data. For example, the QI staff analyzed HEDIS diabetes and hypertension measures for disparities in care and developed targeted interventions. The work plan for 2010 included a section regarding special needs, including methods to monitor the cultural competency of service delivery, as well as the evaluation of health disparities.		
	Required Actions: None		

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.242(a) DHHA Contract: II.J.2.k.1	12. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data that is used to support administration of the Contractor's Program.	**Documents Submitted/Location Within Documents:** The Xcelys Claims Based Processing System, Case and Care Management Screens, as well as the Pharmacy PAR Screens, Caremark RX Navigator and data warehouse Reports will be available during the on-site review.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: DHMC produced a wide variety of health data and management reports to support its operation. Reviewers observed operation of the Xcelys Claims Based Processing System, eligibility and enrollment data, case and care management screens, grievance management, and member screens during the on-site review. DHMC representatives reported that the QI department also used data from the Denver Health data warehouse to supplement HEDIS data. The QI department accessed Denver Health registry data for various interventions and for HEDIS. The pharmacy case management team used Caremark Client Online Services to access real-time pharmacy claims data and view all paid and rejected claims for members. DHMC tracked members who received continuity-of-care system overrides, prior-authorization request approvals, adverse determinations (denials), and withdrawn requests in the pharmacy database. The database was used to generate turnaround time, notification, and internal audit reports.		
	Required Actions: None		
42CFR438.242(a) DHHA Contract: II.J.2.k.1	13. The Contractor's health information system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.	**Documents Submitted/Location Within Documents:** Final Template MCD Grievance Appeal Report 09 Effective 7-1-2009.xls	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: DHMC's health information system provided information on utilization, grievances and appeals, and voluntary disenrollment. The quality improvement impact analysis and network analysis demonstrated use of health plan data for reporting and decision making. Reviewers had an on-site demonstration of the Xcelys customer management information system and observed staff compiling information and reports using patient eligibility and enrollment data and prior-authorization information. Grievance and appeal data was documented within the department's eligibility and customer management system (Xcelys), and quarterly reports were generated and provided to the Department detailing grievance and appeal information.		
	Required Actions: None		

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the Health Plan**	**Score**
42CFR438.242(b) DHHA Contract: II.J.2.k.2	14. The Contractor collects data on member and provider characteristics and on services furnished to members.	**Documents Submitted/Location Within Documents:** 1. 1100Mcd CH Prov Dir copy for Web-the 2009 Provider Directory 2. 2008-2009 Strategic Access Plan-pgs 23-24	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: DHMC collected and summarized data on member and provider characteristics and on services provided to members. The provider directory summarized data about providers and their characteristics, including languages spoken, specialties, and other characteristics. DHMC also collected HEDIS data for reporting on a variety of member characteristics and services received. The network adequacy strategic report was prepared with the QI Impact Analysis report to assess how Denver Health maintained a health care network sufficient in size and composition to ensure access to all covered benefits for all members and the methods for monitoring and reporting network adequacy and provider characteristics. DHMC adopted and published network adequacy standards that established time frames for appointment availability, distances to reach practitioners, and appropriate practitioner-to-member ratios, among other variables. The standards were guidelines for measurement of adequacy of services for members, developed to determine specific areas of concern or adverse trends. Quality improvement activities were developed based on areas of concerns and problems identified in the survey process.		
	Required Actions: None		

Results for Quality Assessment and Performance Improvement							
Total	Met	=	14	X	1.00	=	14
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	14	**Total Score**		=	14

Total Score ÷ Total Applicable	=	100%

Appendix B. Grievance Record Review Tool
for Denver Health Medicaid Choice

The completed grievance record review tool follows this cover page.

Plan Name:	Denver Health Medicaid Choice
Review Period:	July 1, 2009–December 15, 2009
Date of Review:	February 9, 2010, and February 10, 2010
Reviewer:	Diane Somerville
Participating Plan Staff Member:	Reviewed off-site

1	2	3	4	5	6	7	8	9	10	11
File #	**Case ID #**	**Date Grievance Received**	**Date of Acknowledg-ment Letter**	**Acknowledg-ment Sent in 2 W-days?***	**Date of Written Notice of Disposition**	**# of Days to Notice**	**Resolved and Notice Sent in 15 W-days?***	**Not Involved in Previous Level of Review**	**Appropriate Level of Expertise?**	**Resolution Letter Includes Required Content**
1	******	07/01/2009	07/02/2009	Y ☒ N ☐ N/A ☐	07/2/2009	1	Y ☒ N ☐ N/A ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐
Comments: Appointment availability.										
2	******	07/13/2009	07/15/2009	Y ☒ N ☐ N/A ☐	07/29/2009	12	Y ☒ N ☐ N/A ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐
Comments: Rudeness.										
3	******	07/21/2009	07/21/2009	Y ☒ N ☐ N/A ☐	07/21/2009	0	Y ☒ N ☐ N/A ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐
Comments: Date of service eligibility.										
4	******	7/23/2009	07/23/2009	Y ☒ N ☐ N/A ☐	07/23/2009	0	Y ☒ N ☐ N/A ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐
Comments: Appointment availability.										
5	******	07/24/2009	07/24/2009	Y ☒ N ☐ N/A ☐	07/24/2009	0	Y ☒ N ☐ N/A ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐
Comments: Appointment issue.										
6	******	07/27/2009	07/27/2009	Y ☒ N ☐ N/A ☐	07/29/2009	2	Y ☒ N ☐ N/A ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐
Comments: Appointment availability.										
7	******	07/30/2009	N/A	Y ☐ N ☐ N/A ☒	N/A	N/A	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒
Comments: Record not available.										
8	******	08/17/2009	08/18/2009	Y ☒ N ☐ N/A ☐	09/1/2009	10	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments: Diagnosis issue.										
9	******	08/19/2009	08/19/2009	Y ☒ N ☐ N/A ☐	08/19/2009	0	Y ☒ N ☐ N/A ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐
Comments: Appointment availability.										
10	******	08/20/2009	08/21/2009	Y ☒ N ☐ N/A ☐	09/03/2009	9	Y ☒ N ☐ N/A ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐
Comments: Appointment availability.										

1 File #	2 Case ID #	3 Date Grievance Received	4 Date of Acknowledg-ment Letter	5 Acknowledg-ment Sent in 2 W-days?*	6 Date of Written Notice of Disposition	7 # of Days to Notice	8 Resolved and Notice Sent in 15 W-days?*	9 Not Involved in Previous Level of Review	10 Appropriate Level of Expertise?	11 Resolution Letter Includes Required Content
11	******	08/21/2009	08/25/2009	Y ☒ N ☐ N/A ☐	08/25/2009	2	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☒ N/A ☐
Comments: Coordination of care. Resolution letter did not identify resolution.										
12	******	09/09/2009	N/A	Y ☐ N ☐ N/A ☒	N/A	N/A	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒
Comments:										
13	******	09/15/2009	N/A	Y ☐ N ☐ N/A ☒	N/A	N/A	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒
Comments:										
14	******	09/18/2009	N/A	Y ☐ N ☐ N/A ☒	N/A	N/A	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒
Comments:										
15	******	09/23/2009	N/A	Y ☐ N ☐ N/A ☒	N/A	N/A	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒
Comments:										
# Applicable Elements				10			10	2	2	10
# Compliant Elements				10			10	2	2	9
Percent Compliant				100%			100%	100%	100%	90%

# Applicable Elements	**34**
# Compliant Elements	**33**
Percent Compliant	**97%**

*W-days = Working days

Appendix C. Site Review Participants
for Denver Health Medicaid Choice

Table C-1 lists the participants in the FY 2009–2010 site review of **DHMC**.

Table C-1—HSAG Reviewers and MCO Participants	
HSAG Review Team	**Title**
Diane Somerville, MSW	Director, State & Corporate Services
Tanie Sherman, BSN, RN, MBA	External Quality Reviewer
DHMC Participants	**Title**
Leann Donovan	Executive Director
David Brody, MD	Medical Director
Karl F. Haught, Jr.	Director of Compliance
Mary M. Pinkney	Director, Quality Improvement
Deb Markson	Director, Information Systems
Richard French	Director, Member Services
Chryss MacGowan	Pharmacy Manager
Scott Hoye	Assistant General Counsel
Ronald Jay Aguilar	Director, Provider Relations/Contracts
Nicole Powell	Manager, Enrollment
Laurie Goss	Director, Managed Care Marketing
Craig Gurule	State Government Products Manager
Erika Fernandez	Government Product Specialist
Janice Tucker	Supervisor, Outpatient Case Management
Daniella Brown	Supervisor, Care Management
Jan Tucker	Supervisor/Outpatient RN Case Manager
Carola Webb	Supervisor/Grievance Coordinator
Nettie Finn	Supervisor, Inpatient Services
Nancy McDonald	Pharmacy RN Case Manager
Kelli Martin	Customer Service Representative
Aygul Gumerova	Complaints Coordinator
Sharry DiQuinzio	Credentialing Coordinator
Department Observers	**Title**
Maggie Reyes	Quality Improvement

Appendix D. Corrective Action Plan Process for FY 2009–2010

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 CAP has been approved by the Department. Following Department approval, the MCO must submit documents per the timeline that was approved.

Table D-1—Corrective Action Plan Process

Step 1	**Corrective action plans are submitted**
	Each MCO will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final external quality review site review report via e-mail or through the file transfer protocol (FTP) site, with an e-mail notification regarding the FTP posting. The MCO will submit the CAP using the template that follows. 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 interventions to HSAG via e-mail or through the FTP site, with an e-mail notification regarding the FTP 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 require that, based on the nature and seriousness of the noncompliance, the MCO submit regular reports to the Department detailing progress made on one or more open elements in the CAP.

Table D-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 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 that substantiates 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 D-2—FY 2009–2010 Corrective Action Plan *for* DHMC					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring/Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
IV. Member Rights and Protections 4. The Contractor has written requirements for member participation and the responsibilities of members in receiving covered services, which includes: ◆ Select a primary care physician from those physicians available in the Contractor's organization ◆ Obtain a referral from his/her PCP for specialty care (if required) ◆ Follow all requirements of the Medicaid managed care program as described in the Contractor's member handbook ◆ Follow the Contractor's procedures for complaints and grievances	The member handbook stated that a member was responsible for "paying for the care you get if you do not get a referral for emergency or urgent care." DHMC must remove language in the member handbook stating that a member is responsible for paying for emergency care without a referral and ensure that its policies are congruent with 42 CFR 438.114.				

Table D-2—FY 2009–2010 Corrective Action Plan *for* DHMC					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring/Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
◆ Request any change of PCP from the Contractor ◆ Pay for any health care provided, except for emergency services, when health care services are sought and received without a referral from his or her PCP in the Contractor's organization. – This does not apply when the service is a covered service that is not covered by the Contractor ◆ Pay for any services received which are not Medicaid covered services ◆ Notify the Contractor of any third party insurance, including Medicare					

Table D-2—FY 2009–2010 Corrective Action Plan *for* DHMC					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring/Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
IV.5. Contractor complies with any other federal and State laws that pertain to member rights including Title VI of the Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act, and Titles II and III of the Americans with Disabilities Act and other laws regarding privacy and confidentiality.	No policies were provided regarding the Age Discrimination Acts of 1967 and 1975 or the Rehabilitation Act. DHMC must develop a mechanism to demonstrate that it requires compliance with federal and State laws including the Age Discrimination Acts of 1967 and 1975 and the Rehabilitation Act.				
V. Member Information 1. The Contractor provides all members, including new members, a member handbook that includes general information about services offered by the Contractor and complete statements concerning member rights and responsibilities, within a reasonable time after the Contractor is notified of the enrollment	Although DHMC provided a copy of a contract with DW Mail, the contract termination date was March 1, 2007, and no valid extensions were provided. In addition, services performed by the mailing vendor (Attachment A) were not included with the requested document. DHMC presented no policy or internal member services procedure or protocol that verified internal requirements for sending				

Table D-2—FY 2009–2010 Corrective Action Plan *for* DHMC					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring/Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
	member handbooks to new members. DHMC also provided no internal protocols for coordination of member address information with DHMC's mailing vendor to send member handbooks in a timely manner. DHMC should develop a policy and internal protocols to document and guide the distribution of member handbooks.				
V.9. The Contractor notifies all members (at least once a year) of their right to request and obtain the required information (42CFR438.10), upon request.	Members were notified in the member handbook that they had the right to a new member handbook and all the information within the handbook every year. Because a new member handbook was not necessarily sent to members annually, and no members received a standard letter or formal notification that they had the right to request the information in the handbook, members were not notified annually of				

Table D-2—FY 2009–2010 Corrective Action Plan *for* DHMC					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring/Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
	their right to request member information. DHMC must implement a system to notify members at least once a year of their right to request and obtain information as required by 42 CFR 438.10.				
V.13. Maximum number of days between the appointment request and the actual visit with the appropriate provider, as follows: ◆ Urgent care within forty-eight (48) hours. ◆ Non-urgent care and EPSDT screens (if applicable) within two (2) weeks. ◆ Adult non-symptomatic well care physical examinations within four (4) months.	The member handbook provided conflicting information about appointment standards for pediatric well-care exams within Section 4, *How to Get Care,* and Section 7 *Children's Health Care*. Section 4 did not contain the standard for adult access to urgent care services. DHMC must ensure appointment standards are complete, correct, and consistent within the member handbook.				

Table D-2—FY 2009–2010 Corrective Action Plan *for* DHMC					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring/Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
V.18. The member handbook information regarding the grievance, appeal, and fair hearing procedures include: ◆ The requirements and timeframes for filing grievances and appeals ◆ The method for obtaining a State fair hearing ◆ The rules that govern representation at the State fair hearing	The member handbook stated within the *When You File an Appeal* section, "If you ask for a State fair hearing you must do so within 30 days of an action or appeal." Within the *State Fair Hearing* section it stated, "You should send the request within 30 calendar days from the date of the notice of action." DHMC must provide members with information that State fair hearing requests must be made within 20 days of a notice of action letter. Also, the member handbook did not specify that a member need not exhaust the local appeal process before requesting a State fair hearing. DHMC must clarify in the member handbook that a member need not exhaust the local appeal process before requesting a State fair hearing.				

Table D-2—FY 2009–2010 Corrective Action Plan *for* DHMC					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring/Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
V. 20. The member handbook information regarding the grievance, appeal, and fair hearing procedures include: ◆ The fact that, when requested by the member, benefits will continue if the appeal or request for State fair hearing is filed within the timeframes specified for filing ◆ The fact that, if benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal is pending, if the final decision is adverse to the member	The language in the member handbook (to appeal for services) does not make clear that to request that currently authorized services be continued, an appeal must be filed within 10 days or by the date the notice takes effect. The information provided for members about requesting a continuation of benefits during an appeal or a request for a State fair hearing was unclear. Instead of being presented in the same place, the information was scattered in different sections and, overall, did not allow a member or his or her DCR to discern the member's right to request a continuation of services, the required time frame for filing, or the member's potential fiscal responsibility. DHMC must provide clear and cohesive information regarding the				

Table D-2—FY 2009–2010 Corrective Action Plan *for* DHMC					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring/Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
	member's right to request a continuation of benefits during an appeal and State fair hearing, the time frames for filing, and the fact that if benefits are continued, the member may be required to pay the cost of services if the final decision is adverse to the member.				
V.21. The member handbook information regarding the grievance, appeal, and fair hearing procedures include appeal rights available to providers to challenge the failure of the Contractor to cover a service	The member handbook information regarding the grievance, appeal, and fair hearing procedures provided no information regarding appeal rights available to providers to challenge the failure of the contractor to cover a service. DHMC must include in the member handbook information about the grievance, appeal, and State fair hearing procedures available to providers.				

Table D-2—FY 2009–2010 Corrective Action Plan *for* DHMC					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring/Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
V.22. The member handbook information regarding advance directives for adult members includes: ◆ The member's right to formulate advance directives ◆ The member's rights under the State law to make decisions regarding medical care including the right to accept or refuse medical or surgical treatment ◆ The fact that complaints concerning noncompliance with the advance directive requirements may be filed with the appropriate State agency ◆ The Contractor's policies regarding implementation of advance directives,	DHMC should draft a similar policy that includes all the required elements that are currently in place, but is revised slightly to reflect the requirements for advance directives from a managed care perspective. For example, the policy should include advance directive requirements for level-of-care transitions such as those for SNF placements. DHMC must include the requirement to notify members of any changes to State law relevant to advance directives within 90 days following the change in the law. DHMC must include in the member handbook a statement of its policies regarding implementation of advance directives, including a clear statement of any limitations.				

Table D-2—FY 2009–2010 Corrective Action Plan *for* DHMC					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring/Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
which must include a clear statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience ◆ The Contractor's policies regarding Advance Directives must also include: ◆ If the Contractor cannot implement an advance directive as a matter of conscience, the difference between institution-wide conscientious objections and those raised by individual physicians ◆ Identification of the State legal authority permitting such objection ◆ Description of the range of medical conditions or					

Table D-2—FY 2009–2010 Corrective Action Plan *for* DHMC					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring/Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
procedures affected by the conscientious objection ◆ Provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and unable to receive information ◆ Provisions for providing advance directive information to the incapacitated member once he or she is no longer incapacitated ◆ Procedures for documenting in a prominent part of the member's medical					

Table D-2—FY 2009–2010 Corrective Action Plan *for* DHMC					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring/Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
record whether the member has executed an advance directive ◆ The provision that the decision to provide care to a member is not conditioned on whether the member has executed an advance directive, and that members are not discriminated against based on whether they have executed an advance directive ◆ Provisions for ensuring compliance with State laws regarding advance directives ◆ Provisions for informing members of changes in State laws regarding advance directives no later than 90 days following the					

Table D-2—FY 2009–2010 Corrective Action Plan *for* DHMC					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring/Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
changes in the law ◆ Provisions for the education of staff concerning its policies and procedures on advance directives ◆ Provisions for community education regarding advance directives that includes: ▪ What constitutes an advance directive ▪ Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment ▪ Description of applicable state law concerning advance directives					

Table D-2—FY 2009–2010 Corrective Action Plan *for* DHMC					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring/Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
VI. The Grievance System 5. The Contractor has provisions for who may file: ◆ A member may file a grievance, a PIHP-level appeal, and may request a State fair hearing ◆ A provider may file a grievance on behalf of a member (the State permits the provider to act as the member's authorized representative) ◆ A provider, acting on behalf of the member and with the member's written consent may file an appeal. ◆ A provider may request a State fair hearing on behalf of a member (the State permits the provider to act as the	Neither the member handbook nor the provider manual clarified that a provider could file a grievance or appeal or request a State fair hearing, or act as the member's authorized representative at a State fair hearing. DHMC must clarify in member and provider materials that a provider may, acting on behalf of a member and with the member's written consent, file a grievance or appeal, request a State fair hearing, and act as the member's authorized representative at a State fair hearing.				

Table D-2—FY 2009–2010 Corrective Action Plan *for* DHMC					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring/Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
member's authorized representative)					
VI.8. The member may file an appeal either orally or in writing, and must follow the oral request with a written request (unless the request is for expedited resolution).	The UR determinations policy stated that DHMC accepted appeals orally or in writing, but did not address requiring that oral requests be followed by written requests. DHMC must develop and implement a process to ensure that oral requests to file an appeal are followed by a written, signed appeal from the member or the DCR.				
VI.9. An appeal may be filed: ◆ For termination, suspension, or reduction of previously authorized services, timely filing is defined as the later of the following: ▪ Within ten days of the Contractor mailing the notice of action,	The UR determinations policy did not address the 10-day filing time frame for appeals by members requesting continuation of previously authorized services that have been terminated, suspended, or reduced. The member handbook stated, "To appeal services that have been approved before, you have 10 days from the mailing of the notice of				

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Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring/Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
or ▪ The intended effective date of the proposed action ◆ For all other actions, 20 calendar days from the date of the notice of proposed action.	action or until the date the notice of action will take effect to file an appeal." DHMC must make clear in policy and member materials that timely filing of an appeal for the termination, suspension, or reduction of previously authorized services must occur on or before the later of the following: (1) within 10 days of the postmark of the notice of action or (2) the intended effective date of the proposed action.				
VI.10. A member need not exhaust the Contractor's appeal process before requesting a State fair hearing. The member may request the State fair hearing 20 days from the date of the notice of action.	The UR determinations policy stated that members need not exhaust the DHMC appeal process before requesting a State fair hearing and that members had 30 days to request a State fair hearing. The member handbook stated 20 days, then later on the same page stated 30 days as the time frame for requesting a State fair hearing. DHMC's policies and member materials must				

Table D-2—FY 2009–2010 Corrective Action Plan *for* DHMC					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring/Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
	reflect current regulatory requirements, which specify that a member may request a State fair hearing within 20 days from the date of the notice of action.				
VI.12. Notices of action must contain: ◆ The action the Contractor has taken or intends to take ◆ The reasons for the action ◆ The member's (and provider's on behalf of the member) right to file an appeal and how to do so ◆ The member's right to request a State fair hearing and how to do so ◆ The circumstances under which expedited resolution is available and how to request it ◆ The member's right to have benefits continue pending	Of the 14 notice of action letters selected for review, 6 specified an appeal-by date of 20 days from the notice, 3 specified a date that exceeded 20 days, 4 specified a date that was fewer than 20 days, and 1 did not have a date inserted. DHMC must ensure that the appeal-by date it specifies in the notice of action letter represents 20 days from the date of the letter.				

Table D-2—FY 2009–2010 Corrective Action Plan *for* DHMC					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring/Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
resolution of the appeal and how to request that ◆ The circumstances under which the member may have to pay for the costs of services if continued benefits are requested					
VI.14. If the Contractor extends the timeframe for authorization decisions, (see Standard I), it provides the member: ◆ Written notice of the reason for the decision to extend the timeframe ◆ The right to file a grievance if the member disagrees with the decision ◆ Issuance of its decision (and carries out the decision) as expeditiously as the member's health condition requires	The UR determinations policy included the provision that if DHMC extends the time frame for authorization decisions, it will give the member written notice of the reason the decision is being delayed; however, the policy indicated that DHMC would notify the member of appeal rights if the member disagrees with the decision to extend the time frame. Per 42 CFR 438.404 (c)(4)(i), the member should be notified of his or her right file a grievance, not an appeal. DHMC must ensure that its				

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Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring/Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
and no later than the date the extension expires	policy and practice are compliant with the requirement to advise the member of the right to file a grievance when it sends written notice of its decision to extend the time frame for an authorization decision.				
VI.16. The Contractor acknowledges each grievance in writing within two working days of receipt.	The DHMC grievance policy specified that grievances received after 3 p.m. were logged as received on the next day. DHMC must log grievances on the actual date of receipt.				
VI.20. The Contractor's appeal process must provide: ◆ That oral inquiries seeking to appeal an action, are treated as appeals (to establish the earliest possible filing date) and must be confirmed in writing, unless the member or the provider requests expedited resolution	None of the DHMC materials submitted for review addressed that oral inquiries must be followed by written requests for an appeal or the use of the date of the oral inquiry as the filing date. DHMC must develop and implement a process to ensure that oral requests to file an appeal continue to be accepted to establish the earliest possible filing date and are				

Table D-2—FY 2009–2010 Corrective Action Plan *for* DHMC					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring/Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
◆ The member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The Contractor must inform the member of the limited time available for this in the case of expedited resolution) ◆ The member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents considered during the appeals process ◆ That included, as parties to the appeal, are ▪ The member and	followed with a written, signed appeal from the member or the DCR.				

Table D-2—FY 2009–2010 Corrective Action Plan *for* DHMC					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring/Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
his or her representative; or ▪ The legal representative of a deceased member's estate					
VI.26. The written notice of appeal resolution must include: ◆ The results of the resolution process and the date it was completed ◆ For appeals not resolved wholly in favor of the member ▪ The right to request a State fair hearing, and how to do so ▪ The right to request that benefits continue while the hearing is pending, and how to make the request	The UR determinations policy stated only that the resolution letter includes the results of the disposition/resolution and the date it was completed. The policy did not include State fair hearing rights or information pertaining to continuation of benefits. The appeal resolution letter reviewed did provide the member with information on how to request a State fair hearing. It did not contain information about continuation of benefits because that was not applicable. However, the letter incorrectly stated that a State fair hearing could be requested within 20 days of the date of "the notice of second request action." A				

Table D-2—FY 2009–2010 Corrective Action Plan *for* DHMC					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring/Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
▪ That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's action	State fair hearing must be requested within 20 days of the original notice of action letter, not the resolution letter date. DHMC must ensure that appeal resolution letters for appeals not resolved wholly in favor of the member include the member's right to request a State fair hearing and how to do so, that a State fair hearing must be requested within 20 calendar days from the date of the notice of action, the member's right to request and receive benefits while the hearing is pending and how to make the request, and that the member may be held liable for the cost of those benefits if the hearing decision upholds the plan's action.				

Table D-2—FY 2009–2010 Corrective Action Plan *for* DHMC					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring/Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
VI.28. The Contractor must provide the information about the grievance system specified in 42CFR438.10 to all providers and subcontractors at the time they enter into a contract. The information includes: ◆ The right to file grievances ◆ The right to file appeals ◆ The right to a State fair hearing ◆ The requirements and timeframes for filing grievances and appeals ◆ The method for obtaining a State fair hearing ◆ The rules that govern representation at the State fair hearing ◆ The availability of assistance filing a	DHMC should provide the information about the grievance system specified in 42 CFR 438.10 to all providers and subcontractors at the time they enter into a contract, including: ◆ Information about the requirements and time frames for filing appeals and that verbal appeals must be followed by a written appeal. ◆ Information that when requested by a member, benefits will continue if an appeal or request for a State fair hearing is filed within the time frames specified for filing. The time frames for continued benefit requests should be identified. ◆ The correct time frame for requesting State fair hearings (20 days) should be specified.				

Table D-2—FY 2009–2010 Corrective Action Plan *for* DHMC					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring/Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
grievance, an appeal, or requesting a State fair hearing ◆ The toll free numbers the member may use to file a grievance or an appeal by phone ◆ The fact that, when requested by the member, benefits will continue if the appeal or request for State fair hearing is filed within the timeframes specified for filing ◆ The fact that, if benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal is pending, if the final decision is adverse to the member	◆ The appeal rights available to providers to challenge the failure of the contractor to cover a service.				

Table D-2—FY 2009–2010 Corrective Action Plan *for* DHMC					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring/Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
◆ Appeal rights available to providers to challenge the failure of the Contractor to cover a service					
VI.30. The Contractor maintains records of all appeals, and submits quarterly reports to the Department.	DHMC reported only one appeal to the Department during the period of review. Given the size of the DHMC Medicaid membership, the identified network capacity issues, and findings from member satisfaction surveys, it is likely that potential appeals are being lost in the system. Other contributory factors could include the clarity of member and provider informational materials regarding the right of providers to file appeals on behalf of members. DHMC should evaluate its processes for recording and responding to feedback from members and providers who have been sent a notice of action. Assessment should include				

Table D-2—FY 2009–2010 Corrective Action Plan *for* DHMC					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring/Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
	various contact points within the system, including providers and satellite clinics, and results should be used to identify and respond to any possible barriers to members or providers exercising the right to appeal an action.				
VI.31. The Contractor continues the member benefits if ◆ The member or the provider files timely—defined as on or before the later of the following: ▪ Within ten days of the Contractor mailing the notice of action ▪ The intended effective date of the proposed action ◆ The appeal involves the termination, suspension, or reduction of a previously	The UR determinations policy stated that if members want their services to continue, they can call DHMC medical management and request continuation of services. The policy included the conditions that apply; however, the policy stated that members must file an appeal "in time," without specifying how much time members have to file. DHMC must ensure that its internal documents and member materials clearly identify the conditions and time frames under which continuation of benefits can occur.				

Table D-2—FY 2009–2010 Corrective Action Plan *for* DHMC					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring/Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
authorized course of treatment ◆ The services were ordered by an authorized provider ◆ The original period covered by the original authorization has not expired ◆ The member requests extension of benefits					
VI.32. If the Contractor continues or reinstates the benefits while the appeal is pending, the benefits must be continued until one of the following occurs: ◆ The member withdraws the appeal ◆ Ten days pass after the Contractor mails the notice providing the resolution of the appeal against the member, unless the member (within the	The UR determinations policy included the conditions, stating how long services would continue. Information in the appeals section, however, was not presented clearly, with the second half of the requirement placed far away from the first half. Additionally, the policy did not include the second half of the second bullet above at Appeals-C-15, "…unless the member (within the 10-day timeframe) has requested a State fair				

Table D-2—FY 2009–2010 Corrective Action Plan *for* DHMC

Standard and Requirement	Required Actions	Planned Intervention and Person(s)/Committee(s) Responsible	Date Completion Anticipated	Training Required/Monitoring/Follow-up Planned	Documents to be Submitted as Evidence of Completion
10-day timeframe) has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached ◆ A State fair hearing office issues a hearing decision adverse to the member ◆ The time period or service limits of a previously authorized service has been met	hearing with continuation of benefits until a State fair hearing decision is reached." DHMC should ensure that its policy clearly contains the conditions under which continued or reinstated benefits will occur during the appeal or State fair hearing processes.				

Appendix E. Compliance Monitoring Review Activities

for Denver Health Medicaid Choice

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

Table E-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG completed the following activities:**
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 for other review activities. ◆ HSAG staff members provided an orientation on October 1, 2009, for the MCO and the Department to preview the FY 2009–2010 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 members 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 BBA and the MCO's contract and addendums 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 five standards. ◆ Documents submitted for the desk review and during the on-site document review consisted of policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. ◆ 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 E-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG completed the following activities:**
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 it needed and had identified during its desk audit. ◆ HSAG requested and reviewed additional documents it needed and had 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 members to provide an overview of preliminary findings of the review. ◆ HSAG used the FY 2009–2010 Site Review Report Template 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 2009–2010 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.