Colorado Medicaid
Managed Care Program

FY 2010–2011 Site Review Report

for

Denver Health Medicaid Choice

April 2011

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

HSAG Health Services Advisory Group

3133 East Camelback Road, Suite 300 • Phoenix, AZ 85016
Phone 602.264.6382 • Fax 602.241.0757

CONTENTS

Overview of FY 2010–2011 Compliance Monitoring Activities

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

This is the third year that HSAG has performed compliance monitoring reviews of the Colorado Medicaid Managed Care Program. For the fiscal year (FY) 2010–2011 site review process, the Department requested a review of three areas of performance. HSAG developed a review strategy and monitoring tools for reviewing the three performance areas chosen. The standard areas chosen were Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, and Standard VIII—Credentialing and Recredentialing.

Various health plan administrative records were reviewed to evaluate implementation of (1) Medicaid managed care regulations related to member denials and notices of action and (2) the National Committee for Quality Assurance (NCQA) requirements related to credentialing and recredentialing. Reviewers used standardized monitoring tools to review records and to document findings.

HSAG used a sample of 20 records with an oversample of five records for the denials record review, and a sample of 10 records with an oversample of five records for the credentialing review and for the recredentialing review. Using a random sampling technique, HSAG selected the samples from all applicable health plan Medicaid denials that occurred between January 1, 2010, and September 15, 2010. HSAG used the same random sampling technique to select samples from all providers who had been credentialed and recredentialed during the same time period.

For the record reviews, the health plan received a score of *Yes* (compliant), *No* (not compliant), or *Not Applicable* for each of the elements evaluated. Compliance with federal regulations and contract requirements was evaluated through review of the three standards and review of the administrative denial, credentialing, and recredentialing files. The health plan received an overall percentage of compliance score for the standards and a separate overall percentage of compliance score for the record reviews.

This report documents results of the FY 2010–2011 site review activities for the review period—January 1, 2010, through the date of the on-site review January 13 and 14, 2011. Section 2 contains summaries of the findings, opportunities for improvement, strengths, and required actions for each standard area. Section 3 describes the extent to which the health plan was successful in completing corrective actions required as a result of the 2009–2010 site review activities. Appendices A, B, C, and D contain data collection and record review tools. Appendix E is a list of HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix F

describes the corrective action process the health plan will be required to complete and the template for this process.

Methodology

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 G contains a detailed description of HSAG's site review activities by activity outlined in the CMS final protocol.

In developing the data collection tools and in reviewing the three standards, HSAG used the **Denver Health Medicaid Choice**'s (**DHMC**'s) contract requirements and regulations specified by the BBA, with revisions issued June 14, 2002, and effective August 13, 2002. 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 **DHMC** personnel to determine compliance. Documents submitted for the desk review and during the on-site document review consisted of policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials.

The three standards chosen (Standards I, II, and VIII) for the FY 2010–2011 site reviews represent a portion of the requirements based on the Medicaid managed care contract and BBA requirements. Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, Standard IX—Subcontracts and Delegation, and Standard X—Quality Assessment and Performance Improvement will be reviewed in subsequent years.

Objective of the Site Review

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

- The MCO's/PIHP's compliance with federal regulations and contract requirements in the three areas of review.
- Strengths, opportunities for improvement, and actions required to bring the **DHMC** 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/PIHP, as assessed by the specific areas reviewed.
- Possible interventions to improve the quality of **DHMC**'s services related to the areas reviewed.
- Activities to sustain and enhance performance processes.

Summary of Results

Based on the results from the compliance monitoring tool and conclusions drawn from the review activities, HSAG assigned each element within the standards in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, *or Not Applicable.* HSAG assigned required actions to any individual element within the compliance monitoring tool receiving a score of *Partially Met* or *Not Met.* HSAG also identified opportunities for improvement with associated recommendations for enhancement for some elements, regardless of the score. Recommendations for enhancement for requirements scored as *Met* did not represent noncompliance with contract requirements or BBA regulations.

Table 1-1 presents the score for **DHMC** for each of the standards. Details of the findings for each standard follow in Appendix A. Table 1-2 presents the scores for each of the record reviews. Details of the findings for record reviews can be found in Appendices B, C, and D.

Table 1-1—Summary of Scores for the Standards

Standard #	Description of Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
I	Coverage and Authorization of Services	27	27	23	4	0	0	85%
II	Access and Availability	13	13	11	2	0	0	85%
VIII	Credentialing and Recredentialing	47	37	34	3	0	10	92%
	Totals	**87**	**77**	**68**	**9**	**0**	**10**	**88%**

Table 1-2—Summary of Scores for the Record Reviews

Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Denials	120	84	82	0	2	36	98%
Credentialing	79	68	68	0	0	11	100%
Recredentialing	79	58	58	0	0	21	100%
Totals	**278**	**210**	**208**	**0**	**2**	**68**	**99%**

2. Summary of Performance Strengths and Required Actions

for **Denver Health Medicaid Choice**

Overall Summary of Performance

For the Credentialing and Recredentialing standard, **DHMC** earned an overall percentage-of-compliance score of 92 percent, representing a clear strength for the health plan. **DHMC** earned a score of 85 percent for both the Coverage and Authorization of Services and the Access and Availability standards, representing an opportunity for continued improvement of **DHMC**'s performance.

Standard I—Coverage and Authorization of Services

Summary of Findings and Opportunities for Improvement

DHMC had documented evidence through its policies, procedures, processes, and member communications that its goal was to provide covered services in a sufficient amount, duration, or scope. Policies specified that utilization decisions were made in a fair, impartial, and consistent manner using standardized, measureable criteria and were based on medical necessity. **DHMC** policy specified, and staff members corroborated, that all actions regarding utilization review decisions would be reviewed by either the medical director or an individual with applicable expertise. The denials record review score was 98 percent, which demonstrated that the processes mirrored policy requirements. The HSAG reviewer noted that the utilization review determination policy should be reviewed and revised to correct numbering inconsistencies.

Summary of Strengths

DHMC's definition of medical necessity was consistent across policies and with the BBA definition. **DHMC**'s definitions of emergency medical condition, emergency medical services, and poststabilization services were also congruent with federal requirements. Simplified definitions for these terms were also included in the member handbook.

DHMC's care management and case management processes were integrated with utilization management (UM) processes, and staff members met routinely to discuss complex cases, provide referrals to service providers outside of the Denver Health system, and assist with level of care transitions.

Summary of Required Actions

DHMC's utilization review determination policy contained a decision grid showing that expedited service authorizations would be made within "3 working days (72 hours)." These time periods were inconsistent because three working days could represent more than 72 hours if the time period

included a weekend. The same inconsistent information was presented in the corresponding provider manual matrix. **DHMC** must ensure that policies, procedures, and manuals are consistent in their use of three working days, three calendar days, or 72 hours.

DHMC's utilization review determination policy stated that an expedited determination would be sent to the member within "two business days" of the determination decision. If a decision is made on the third working day, federal Medicaid managed care regulations do not allow two additional days to notify the member. **DHMC** must ensure that its policy states that a member must be notified of an expedited authorization decision as expeditiously as the member's health condition requires but no later than three working days after receipt of the request for service.

DHMC's utilization review determination policy stated that oral appeals shall be followed with a written appeal. This is only the case for nonexpedited appeals. Oral expedited appeal requests do not have to be followed by a written appeal. **DHMC** must ensure that its policy does not require written follow-up to oral expedited appeal requests.

DHMC's Policy RX160 stated that the notice of extension letter must include the member's right to file a grievance if he or she disagrees with the time frame extension. Section XIII of the provider manual contained a matrix that included correct extension time frames for standard and expedited authorization decisions. However, the corresponding matrix in **DHMC**'s utilization review determination policy did not contain the line detailing extension time frames. The language in the policy at (V)(1)(E-Insufficient information) did not reflect those time frames. **DHMC** must ensure that its policy includes extension time frames for standard and expedited authorization decisions and that its policies and manuals are consistent with each other.

DHMC's pharmacy policy, RX1601, included clear language specifying that no individual or entity received compensation or any other incentive to deny, limit, or discontinue medically necessary services for any member. However, the policy presented as evidence for all other nonpharmacy decisions did not address utilization incentives. **DHMC** must ensure that its policies are consistent and state that there are no incentives for denial, limitation, or discontinuation of medically necessary services for any individual involved in UM activities.

DHMC polices did not describe that **DHMC** would be financially responsible for poststabilization care services obtained within or outside its network if **DHMC** did not respond to a request for pre-approval within one hour, if it could not be contacted, or if the **DHMC** representative and the attending provider could not reach an agreement concerning the member's care. **DHMC** should ensure that its policies and claims payment processes are congruent with the Code of Federal Regulations (CFR) at 42 CFR 438.114(e).

Standard II—Access and Availability

Summary of Findings and Opportunities for Improvement

DHMC's 2009–2010 Strategic Access Plan documented the organization's efforts to make covered services available and accessible to its members. **DHMC** demonstrated that when covered services were not available or accessible in a timely fashion, services were authorized and provided out of network. **DHMC**'s 2009–2010 Network Adequacy Report demonstrated that **DHMC** considered the anticipated enrollment, expected utilization, numbers and types of providers, number of providers not accepting new patients, and geographic location when measuring the adequacy of its network.

DHMC had numerous policies and processes in place and under development to promote the delivery of services in a culturally competent manner to all members, including those with limited English skills. **DHMC**'s Readability of Member Materials policy provided procedures 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, and provider directory. **DHMC** member services had a documented process for assisting members who required member materials in an alternate format such as large print or Braille. The **DHMC** Web page could be translated into numerous other languages by clicking the *Translate* button. During the on-site interview, **DHMC** staff members reported that Denver Health staff members in clinics who passed fluency tests wore badges that signified their bilingual ability. **DHMC** had processes to provide interpreters (including sign language), translation services, and auxiliary communication devices to members at no charge. **DHMC** staff members also reported that resources were available to staff members via the internal Cultural Diversity SharePoint site, and that an annual cultural diversity Web course was required for all employees within the Denver Health system.

Summary of Strengths

DHMC, through its various quality improvement initiatives, monitored timely access to services and began implementing mechanisms to improve performance. This included analyzing information from member grievances, member satisfaction surveys, HEDIS performance measures, and appointment availability data. **DHMC** began improving scheduling processes by handling appointment requests via a centralized appointment center. Although not all **DHMC** provider sites were participating at the time of the review, **DHMC** noted that the six sites that were fully participating had decreased call abandonment rates and improved the percentage of accurately scheduled appointments. Additional physicians were hired to meet increased demand for services.

Summary of Required Actions

DHMC's grievance analysis indicated that the access and availability category had the highest percentage of grievances. These grievances related to appointment delay and wait time to get appointments. Further, member satisfaction survey data, as reported by HSAG in the 2009–2010 External Quality Review Technical Report for Colorado Medicaid, showed that adult Medicaid

members' level of satisfaction decreased on the Getting Care Quickly measure from 40.6 percent in FY 2008–2009 to 39.1 percent in FY 2009–2010. The children's rate on the measure for the same time period decreased 8.4 percentage points from 52.9 percent to 44.5 percent. DHMC must ensure that it has sufficient resources available to Medicaid members to provide adequate access to all services covered under the contract.

The Access to Care/Services for **DHMC** policy included appointment standards that met BBA requirements. The appointment standards were also presented in the member handbook and the provider manual; however, there were inconsistencies between documents. **DHMC** must ensure that its policies, procedures, manuals, and member materials provide consistent information regarding appointment standards.

Standard VII—Credentialing and Recredentialing

Summary of Findings and Opportunities for Improvement

DHMC had a well-defined process for credentialing and recredentialing both employed and contracted individual practitioners and for assessing organizational providers. **DHMC**'s policies and procedures were consistent with NCQA standards and requirements. Furthermore, HSAG found ample evidence that **DHMC** followed its policies and procedures.

Summary of Strengths

The credentialing and recredentialing record reviews demonstrated that **DHMC** implemented its policies and procedures as written. Credentialing and recredentialing files were well-organized. Primary source verification was completed as required and within the required time frames.

Summary of Required Actions

Although **DHMC**'s Assessment of Organizational Providers policy stated that a site visit and evaluation is required for all nonaccredited providers and that site visits would be conducted by **DHMC** credentialing staff, the on-site interview and review of organizational provider records indicated that Denver Health and Hospital Authority (DHHA) did not have a process, assessment criteria, or an organizational provider site visit form. **DHMC** must develop a process for conducting on-site quality assessments, when applicable. The process may include accepting a State survey in lieu of performing an on-site assessment if NCQA guidelines are followed.

The Assessment of Organizational Providers policy stated that **DHMC** would accept proof of a passing CMS or State review in lieu of a site visit; however, the policy did not clearly define **DHMC**'s assessment criteria and site visit standards to determine whether the CMS or State report met **DHMC** standards. DHHA/DHMC must develop its own criteria for organizational provider assessment for each type of organizational provider and determine if CMS or State site visits evaluate each of DHHA's site assessment standards.

While the organizational provider template agreement required the organizational provider to credential its practitioners, DHHA/DHMC did not have a process for ensuring that organizational providers did credential their own practitioners. DHHA/DHMC must develop a process for ensuring that its organizational providers credential their own practitioners.

3. Follow-up on FY 2009–2010 Corrective Action Plan

for **Denver Health Medicaid Choice**

Methodology

As a follow-up to the FY 2009–2010 site review, each MCO/PIHP was required to submit a corrective action plan (CAP) to the Department addressing all requirements for which it received a score of *Partially Met* or *Not Met*. The plan was required to describe interventions designed to achieve compliance with the specified requirements, the timelines associated with those activities, anticipated training and follow-up activities, and documents anticipated to be sent following the completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the MCO/PIHP and determined whether the MCO/PIHP successfully completed each of the required actions. HSAG and the Department continued to work with the MCO/PIHP until HSAG and the Department determined that the MCO/PIHP 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/PIHP's FY 2009–2010 site review.

Summary of FY 2009–2010 Required Actions

As a result of the FY 2009–2010 site review, **DHMC** was required to submit a CAP to address deficiencies in Standard IV—Member Rights and Protections, Standard V—Member Information, and Standard VI—Grievance System.

In Standard IV—Member Rights and Protections, **DHMC** was required to revise its member handbook to remove the statement that requires members to pay for emergency services without a referral and to ensure that its policies are congruent with 42 CFR 438.114. **DHMC** was also required to develop a mechanism to demonstrate that it requires compliance with federal and State law, including the Age Discrimination Act and the Rehabilitation Act.

For Standard V—Member Information, **DHMC** was required to develop a policy and internal protocols to document and guide the distribution of member handbooks. **DHMC** was required to clarify its policies and notify members at least once a year that they may request and receive member information upon request. **DHMC** was required to ensure that appointment standards were complete, correct, and consistent among its various documents.

DHMC was also required to revise its member handbook to clarify that State fair hearing requests must be made within 20 days of the notice of action letter, and that 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 continuation of benefits during an appeal and State fair hearing, and clarify that providers may file grievances or appeals on behalf of a member, with the member's written consent.

DHMC was required to develop a policy on advance directives that included the requirement to notify members of any changes to State law relevant to advance directives within 90 days following the change in law. **DHMC** must revise its member materials to include its advance directives policy.

DHMC had 13 required actions related to grievance system requirements. The required actions fell into three categories: incorrect interpretation or misunderstanding of federal Medicaid managed care regulations, inaccurate or inadequate implementation of requirements, or inaccurate or incomplete information to providers, members, or employees related to grievance system requirements.

Summary of Corrective Action/Document Review

DHMC submitted its CAP to HSAG in June 2010. HSAG and the Department agreed that the plan was not sufficient as written and asked **DHMC** to resubmit. **DHMC** revised its plan and resubmitted it to HSAG and the Department at the end of July 2010. HSAG and the Department determined that if **DHMC** implemented the CAP as written, it would achieve compliance. **DHMC** was advised to move forward with implementation, and it was asked to submit documentation providing evidence of having completed the required actions. **DHMC** made its final submission of documents January 21, 2011.

Summary of Continued Required Actions

DHMC successfully revised all documents, clarifying inconsistencies and inaccuracies. The final submission of documents, however, occurred following the FY 2010–2011 site review process. Therefore, **DHMC** continued to implement the designated changes to its processes during FY 2010–2011.

One corrective action remained outstanding as **DHMC** continued to work with the Department to determine an appropriate method of evaluating its system for collecting and tracking grievances.

Appendix A. Compliance Monitoring Tool for Denver Health Medicaid Choice

The completed compliance monitoring tool follows this cover page.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor ensures that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. *42CFR438.210(a)(3)(i)* Contract: DHMC: II.C.1.a RMHP: II.D.1.a	◆ CHOICE_UMG1002 – Utilization Review Determinations – pgs 1-2 ◆ CHOICE_RX1601 Pharmacy - pgs 1-12 ◆ Pediatric Referral Guidelines.xls ◆ Adult Send out Guidelines.xls ◆ CHOICE_UMG1010 - Written Criteria for UM Decisions – Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: DHMC documented evidence through its policies, procedures, processes, and member communications that its goal was to provide covered services in a sufficient amount, duration, or scope. Policies described the mechanisms and criteria the plan used to make authorization decisions. Care management and case management processes were integrated with UM processes, and staff members met routinely to discuss complex cases, provide referrals to care outside of the Denver Health system, and assist with level of care transitions. The Denver Health Participating Provider Services Agreement required providers to render services in a manner that ensured availability, adequacy, responsiveness, and continuity of care to members. DHMC provided documentation of referrals to out-of-network services not available through the DHMC system.		
Required Actions: None		
2. The Contractor provides the same standard of care for all members regardless of eligibility category and makes all covered services as accessible in terms of timeliness, amount, duration, and scope to members as those services are to non-Medicaid recipients within the same area. Contract: DHMC: II.C.1.b RMHP: II.D.1.b	◆ CHOICE_UMG1002 – Utilization Review Determinations – pgs 1-11 ◆ CHOICE_RX1601 – Pharmacy pgs 1 & 5-12 ◆ CHOICE_UMG1010 - Written Criteria for UM Decisions – Entire Document ◆ MCD_PROV_MANUAL_PG_39.pdf ◆ MCD_TEMPLATE_SEC_3_2.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: DHMC's policy, UMG1002—Utilization Review Determinations Including Approvals and Actions for DHMC Members, specified that utilization decisions were made in a fair, impartial, and consistent manner using standardized, measureable criteria. The policy required that utilization determination decisions be based on medical necessity. The Denver Health Participating Provider Services Agreement required that all covered services be provided without regard to a member's participation in a publicly financed program, and that the services be equal in quality, completeness, and promptness compared to health care services rendered to other individuals not covered by the agreement. The pharmacy UM policy, RX1601, stated that the same standard of care would be provided for all members regardless of plan coverage.		
Required Actions: None		
3. The Contractor does not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42CFR438.210(a)(3)(ii)* Contract: DHMC: II.C.1.c RMHP: II.D.1.c	◆ CHOICE_UMG1002 – Utilization Review Determinations – pgs 1-2 ◆ BHO List and instructions.pdf - Pages 140 thru 145 and Page 158 ◆ CHOICE_RX1601 – Pharmacy pgs 1-8	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: During the interview, staff members described the processes they followed and the criteria they used to make impartial decisions on requests for services. The Utilization Review Determinations policy contained specific language that it did not arbitrarily deny or reduce the amount, duration, or scope of a service due to the diagnosis, type of illness, or condition of the member. The Denver Health Participating Provider Services Agreement stated that providers could not deny, place condition on, or limit services to members on the basis of any factor related to health status, medical condition, disability, claims experience, medical history, existence of an advance directive, genetic information, or evidence of insurability complications resulting from acts of domestic violence.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. If the Contractor places limits on services, it is: ◆ On the basis of criteria applied under the State plan (medical necessity). ◆ For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose. *42CFR438.210(a)(3)(iii)* Contract: DHMC: II.H.1.a RMHP: II.I.1.a	◆ SAMPLE_Milliman_Care_Guideline.pdf ◆ Urgent-Emergency Care.ppt ◆ MCD CHOICE_CLM205 Adjud of ER Non-Auth.pdf ◆ Auth Instruction 1.pdf ◆ CHOICE_RX1601 Pharmacy - pgs 1-8 ◆ CHOICE_UMG1014 – Home Health – Entire Document ◆ CHOICE UMG1101 – DME – Entire Document ◆ CHOICE_UMG1004 – Special Health Care Needs pgs 3-5 ◆ CHOICE_UMG1010 - Written Criteria for UM Decisions – pg 1	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: DHMC used nationally recognized criteria—i.e., Milliman CareEnhance guidelines—to make decisions regarding medical necessity and appropriateness of authorizations. The medical director was consulted for any instance in which no written criteria existed. Denial records reviewed on-site demonstrated that decisions were based on medical necessity and established clinical criteria.		
Required Actions: None		
5. The Contractor specifies what constitutes "medically necessary services" in a manner that: ◆ Is no more restrictive than that used in the State Medicaid program. ◆ Addresses the extent to which the Contractor is responsible for covering services related to the following: • The prevention, diagnosis, and treatment of health impairments, • The ability to achieve age-appropriate growth and development, • The ability to attain, maintain, or regain functional capacity. *42CFR438.210(a)(4)*	◆ CHOICE_UMG1014 - Home Health – Entire Document ◆ CHOICE_UMG1101 – DME – pgs 4-27 ◆ CHOICE_UMG1004 – Special Health Care Needs pgs 3-6 ◆ Milliman_Care_Guidelines_Amendment.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract: DHMC: Exhibit A2 RMHP: Exhibit A		
Findings: DHMC's medical necessity criteria, found in Policy UMG1002, were consistent with the definition of medical necessity in the Medicaid managed care contract. Medically necessary services were defined as those that would, or could reasonably be expected to, prevent, diagnose, cure, correct, reduce, or ameliorate pain and suffering or the physical, mental, cognitive, or developmental effects of an illness, injury, or disability.		
Required Actions: None		
6. The Contractor has written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42CFR438.210(b)* Contract: DHMC: II.H.1.a RMHP: II.I.1.a	◆ CHOICE_UMG1002 – Utilization Review Determinations – pgs 1-13 ◆ Auth Instruction I .pdf - Pages 62 to top of page 73. The system is set up to alert the claims processors that the submitted services possibly require an auth. The hold reason code is HDARQ. ◆ CHOICE_UMG1006 – Entire Document ◆ CHOICE_RX1601 –Pharmacy –pgs 1-12	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Documentation demonstrated that DHMC had written policies and procedures that addressed the health plan's processes for reviewing, processing, making final determinations about, and responding to provider requests for initial and continuing authorization of services. During the interview, DHMC staff members described the processes and personnel they used to address requests for initial and continuing authorization of the limited number of services subject to health plan authorization.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor's written policies and procedures include mechanisms to ensure consistent application of review criteria for authorization decisions. *42CFR438.210(b)(2)(i)* Contract: DHMC: II.H.1.b RMHP: II.I.1.b	◆ CHOICE_UMG1011 – Inter-Rater Reliability – Entire Document ◆ CHOICE_UMG1010 - Written Criteria for UM Decisions – Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: DHMC's policies documented the processes and standardized criteria used in making UM decisions. To ensure additional consistency, the health plan implemented a process for interrater reliability of its authorization decisions across reviewers. Licensed staff made or supervised all UM decisions.		
Required Actions: None		
8. The Contractor's written policies and procedures include a mechanism to consult with the requesting provider when appropriate. *42CFR438.210(b)(2)(ii)* Contract: DHMC: II.H.1.b RMHP: II.I.1.b	◆ CHOICE_UMG1002 – Utilization Review Determinations – pg 8-9 ◆ CHOICE_RX1601 Pharmacy – pgs 8 & 12 ◆ MCD_PROV_MANUAl_PG_79.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Policy UMG1002 specified that in instances in which a determination could not be made due to lack of necessary information, DHMC would contact the requesting provider for the specific details surrounding the clinical information necessary to complete the determination. Denial records reviewed on-site provided evidence that referring providers were consulted.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor's written policies and procedures include the provision that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease. *42CFR438.210(b)(3)* Contract: DHMC: II.H.1.e RMHP: II.I.1.e	◆ CHOICE_UMG1002 - Utilization Review Determinations pgs 4-5; 9 ◆ CHOICE_RX1601 Pharmacy pgs 5 & 7 ◆ CHOICE_UMG1010 - Written Criteria for UM Decisions – Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Policy UMG1002 specified that all actions regarding utilization review decisions would be reviewed by either the medical director or an individual with applicable expertise from the Denver Health panel of clinicians. During the on-site interview, staff members stated that all denials were approved by the medical director. The pharmacy UM policy described that only licensed pharmacists, nurse case managers, or expert clinical practitioners made UM decisions related to pharmacy services, and that only a health care professional with appropriate clinical expertise or the DHMC medical director could make a decision to deny or limit pharmacy services.		
Required Actions: None		
10. The Contractor's written policies and procedures include processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested (notice to the provider need not be in writing). *42CFR438.210(c)* Contract: DHMC: II.H.1.b RMHP: II.I.1.b	◆ CHOICE_UMG1002 – Utilization Review Determinations – pg 5 ◆ CHOICE_RX1601 – Pharmacy - pgs 7-8	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: Policy UMG1002 included the requirement to notify the requesting provider and to give the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope less than requested. The policy described these notification procedures for concurrent review determinations as well as for retrospective determinations. Denial records reviewed on-site provided evidence that members received written notification and that providers were notified either telephonically or electronically via fax or e-mail. The Notice of Action letter included all required content.		
Required Actions: None		
11. The Contractor's written policies and procedures include the following timeframes for making standard and expedited authorization decisions: ◆ For standard authorization decisions—10 calendar days. ◆ For expedited authorization decisions—3 days. *42CFR438.210(d)* Contract: DHMC: Exhibit I— 8.209.4.A.3.c and 8.209.6 RMHP: Exhibit B— 8.209.4.A.3.c and 8.209.6	◆ CHOICE_UMG1002– Utilization Review Determinations – pgs 5-13 ◆ CHOICE_RX1601 – Pharmacy pgs 7-11 ◆ MCD_PROV_MANUAL_PG_78.pdf	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: Policy UMG1002 included the time frame of 10 calendar days for standard authorization decisions and the time frame of three days for expedited authorization decisions. However, the policy contained a decision grid showing that expedited service authorizations would be made within "3 working days (72 hours)." These were inconsistent time periods because three working days could represent more than 72 hours if the time period included a weekend. The same inconsistent information was presented in the corresponding provider manual matrix. The policy stated that an expedited determination would be made in "no longer than 3 working days from the client's request," but also stated that a written determination would be sent to the member within "two business days" of the determination decision. If the decision was made on the third working day, federal Medicaid managed care regulations would not permit two additional days to notify the member. The policy was numbered incorrectly, leading to possible confusion. Also, the policy stated that oral appeals shall be followed by written appeals. This is only the case for nonexpedited appeals. Oral requests for an expedited appeal do not have to be followed by a written request.		
Required Actions: DHMC must ensure that policies, procedures, and manuals are consistent in their use of three working days, three calendar days, or 72 hours. DHMC must ensure that its policy states that a member must be notified of an expedited authorization decision as expeditiously as the member's health		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
condition requires but no later than three working days after receipt of the request for service, not "two business days" from the day the determination decision was made. Also, DHMC must ensure that its policy does not require written follow-up to oral requests for an expedited appeal.		
12. The Contractor's written policies and procedures include the following timeframes for possible extension of timeframes for authorization decisions: ◆ Standard authorization decisions—up to 14 calendar days. ◆ Expedited authorization decisions—up to 14 calendar days. *42CFR438.210(d)* Contract: DHMC: None RMHP: None	◆ CHOICE_UMG1002 – Utilization Review Determinations – Procedure 3 (b)(f)(i) ◆ CHOICE_RX1601 – Pharmacy - Pg 7– Procedure 7, section c(2) and c(3) ◆ MCD_PROV_MANUAL_PG_78.pdf	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: DHMC's Policy RX1601 included a clear description of the procedure to extend the time frame for authorization decisions at the above-noted citation. Section XIII of the provider manual contained a matrix that included the correct extension time frames for standard and expedited authorization decisions. However, the corresponding matrix in Policy UMG1002 did not contain the line detailing extension time frames. The language in the Utilization Review Determinations policy (UMG1002) at (V)(1)(E-Insufficient information) did not reflect these time frames. The UMG1002 policy citation was not applicable to this requirement as that section pertained to notification of an action *after* a determination decision has already been made, and did not include the time frame for extending authorization decisions.		
Required Actions: DHMC must ensure that its policy includes extension time frames for standard and expedited authorization decisions and that its policies and manuals are consistent.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor's written policies and procedures provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42CFR438.210(e)* Contract: DHMC: II.I.3.a RMHP: None	◆ CHOICE_UMG1011 – Inter-Rater Reliability – Entire Document ◆ CHOICE_RX1601 –Pharmacy - pg 5	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: DHMC's pharmacy policy, RX1601, included clear language specifying that no individual or entity received compensation or any other incentive to deny, limit, or discontinue medically necessary services for any member. Policy UMG1011 described how DHMC ensured consistency with the application of UM criteria, but that policy did not address utilization incentives. Policy UMG1002 stated at (V)(2)(I) that case management staff consisted of salaried individuals whose compensation was not structured to provide incentives to deny, limit, or discontinue medically necessary services to any member. Inasmuch as case management staff can only authorize services and only the medical director can deny services, the policy should be clarified to include the medical director's role.		
Required Actions: DHMC must ensure that its policies are consistent and state that there are no incentives for any individual involved in UM activities to deny, limit, or discontinue medically necessary services.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor defines Emergency Medical Condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: ◆ Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, ◆ Serious impairment to bodily functions, ◆ Serious dysfunction of any bodily organ or part. *42CFR438.114(a)* Contract: DHMC: I.12 RMHP: I.14	◆ MCD_PROV_MANUAL_PG40.pdf ◆ CHOICE_UMG1002 – Utilization Review Determinations – pg 2 Definition "L" ◆ CHOICE_RX1601 –Pharmacy – pg 3 Definition 8 ◆ Member Handbook – Chapter 4, heading title "Emergency Care"	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: DHMC's policies and the provider manual defined emergency medical condition congruent with the federal requirement based on the prudent layperson standard. According to this standard, an emergency medical condition exists if a prudent layperson could reasonably expect that the absence of immediate medical attention would place the health of an individual in jeopardy or result in serious impairment to bodily organs, parts, or functions. The member handbook provided a definition at the required reading level.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The Contractor defines Emergency Services as Inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title, and are needed to evaluate or stabilize an emergency medical condition. *42CFR438.114(a)* Contract: DHMC: I.13 RMHP: I.15	◆ MCD_PROV_MANUAL_PG40.pdf ◆ Member Handbook – Chapter 4, heading title "Emergency Care" ◆ CHOICE_UMG1002 – Utilization Review Determinations – pg 3 Definition "M" ◆ CHOICE_RX1601 –Pharmacy – pg 3 Definition 9	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: DHMC's policies and the provider manual defined emergency medical services as inpatient or outpatient services furnished by a provider qualified to evaluate or stabilize an emergency medical condition.		
Required Actions: None		
16. The Contractor defines Poststabilization Care as covered services, related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or provided to improve or resolve the member's condition. *42CFR438.114(a)* Contract: DHMC: II.C.4.d RMHP: II.D.4.d	◆ Member Handbook – Chapter 4, heading title "Emergency Care" ◆ MCD_PROV_MANUAL_PG41.pdf ◆ CHOICE_UMG1002– Utilization Review Determinations – pg 3 Definition "V" ◆ CHOICE_UMG1006 – Non-network Hospital Concurrent UM & OBS – Definition 4	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The provider manual and DHMC policies defined poststabilization care services consistent with the federal requirement. The member handbook included a definition that met the requirement and was at the required reading level.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. *42CFR438.114(c)(1)(i)* Contract: DHMC: II.C.4.a.4 RMHP: II.D.4.a.4	◆ Member Handbook – Chapter 4, heading title "Emergency Services" ◆ MCD CHOICE_CLM205 –Adjudication of ER non-auth ◆ Auth Instruction 1.pdf – pg 63, Procedure A) ◆ Urgent-Emergency Care.ppt ◆ MCD_PROV_MANUAL_PG40.pdf ◆ CHOICE_UMG1002 – Utilization Review Determinations – pg 3	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: DHMC policies and the on-site review of denial records provided evidence that, while subsequent out-of-network services were denied, emergency services were covered and reimbursed regardless of whether the provider was part of the DHMC network.		
Required Actions: None		
18. The Contractor does not require prior authorization for emergency or urgently needed services. *42CFR438.10(f)(6)(viii)(B)* DHMC: II.C.4.a.3 RMHP: II.D.4.a.3	◆ Member Handbook – Chapter 4, heading title "Emergency Services" ◆ CHOICE_UMG1002 – Utilization Review Determinations – pg 3 ◆ MCD_PROV_MANUAL_PG40.pdf ◆ Urgent-Emergency Care.ppt ◆ MCD CHOICE_CLM205- Adjudication of ER aon-auth ◆ Auth Instruction 1.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: DHMC policies and the on-site review of denial records provided evidence that, while subsequent services were denied, emergency services were covered and reimbursed without prior authorization. There was one inconsistency in the member handbook; however, the inconsistency was not substantial, and DHMC staff indicated that it would be remedied with the submission of the 2009–2010 corrective action plan documents.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
19. The Contractor may not deny payment for treatment obtained under either of the following circumstances: ◆ A member had an emergency medical condition, including cases in which the absence of immediate medical attention would *not* have had the following outcomes: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, • Serious impairment to bodily functions, • Serious dysfunction of any bodily organ or part. ◆ A representative of the Contractor's organization instructed the member to seek emergency services. *42CFR438.114(c)(1)(ii)* Contract: DHMC: II.C.4.a.4 RMHP: II.D.4.a.4	◆ CHOICE_UMG1002 – Utilization Review Determinations – pg 10 ◆ MCD_PROV_MANUAL_PG40.pdf ◆ MCD CHOICE_CLM205 – Adjudication of ER non-auth ◆ Auth Instruction 1.pdf ◆ Urgent-Emergency Care.ppt	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The provider manual stated that review of emergency services claims took the prudent layperson standard into consideration. Although no language was found pertaining to a reimbursement for services when a representative of the contractor's organization instructed a member to seek emergency services, it was clear through policies, the provider manual, and the on-site record review that services provided in emergency departments were covered.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
20. The Contractor does not: ◆ Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms. ◆ Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the Contractor or State agency of the member's screening and treatment within 10 days of presentation for emergency services. *42CFR438.114(d)(1)* Contract: DHMC: II.C.4.c RMHP: II.D.4.c	◆ Urgent-Emergency Care.ppt ◆ CHOICE_CLM205 – Adjudication of ER non-auth ◆ Auth Instruction 1.pdf ◆ CHOICE_UMG1006 – Concurrent UM & OBS – pgs 2-3	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Policy UMG1002 stated in the policy statement (II)(3) that it did not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the member. Retrospective review determinations were made within 10 days of receipt of a request to review the services. Policy CLM205, Adjudication Of Emergency Room Non-Authorized Inpatient Stays, stated that if the emergency provider was not contracted with DHMC, timely filing limits would not be enforced. There was evidence in the on-site record review that emergency services were reimbursed even if the notification came in several months after the service was provided.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
21. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42CFR438.114(d)(2)* Contract: DHMC: None RMHP: None	◆ MCD_PROV_MANUAL_PG40.pdf ◆ MCD_PROV_MANUAL_PG41.pdf ◆ CHOICE_UMG1002 – Utilization Review Determinations – pg 10	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Policy UMG1002 specified that DHMC covered any emergency medical service necessary to screen and stabilize its members. The policy stated that emergency and poststabilization services and urgently needed services were covered. The Adjudication of Emergency Room Non-Authorized Inpatient Stays policy (CLM205) described the DHMC process used to review any claim denied for having no authorization. The policy specified that identified instances would be corrected by the claims department. During the on-site interview, staff members reported that members were never held liable for payment of emergency or poststabilization services.		
Required Actions: None		
22. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment. *42CFR438.114(d)(3)* Contract: DHMC: II.C.4.a.5 RMHP: II.D.4.a.5	◆ CHOICE_UMG1006 – Concurrent UM & OBS – pg. 3 ◆ CHOICE_UMG1002 – Utilization Review Determinations – pg 5-6	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: DHMC's Policy UMG1006, Concurrent Utilization Management of Inpatient and Observation Stays for Medicaid Choice, detailed that DHMC allowed the attending emergency physician or provider to determine whether a member was sufficiently stabilized for transfer or discharge. If the member was deemed not stable for transfer, the policy indicated that the admission would be authorized.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: None		
23. The Contractor is financially responsible for post-stabilization care services obtained within or outside the network that are pre-approved by a plan provider or other organization representative. *42CFR438.114(e)* Contract: DHMC: II.C.4.d RMHP: II.D.4.d	◆ CHOICE_UMG1002 – Utilization Review Determinations – pg 7 ◆ CHOICE_UMG1006 – Concurrent UM & OBS –Entire Document ◆ CHOICE_CLM205 – Adjudication of ER non-auth ◆ Urgent-Emergency Care.ppt ◆ Auth Instruction 1.pdf ◆ MCD_PROV_MANUAL_PG41.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: DHMC policies provided evidence that poststabilization care services obtained within or outside the network were covered and reimbursed regardless of whether the provider was part of the DHMC network.		
Required Actions: None		
24. The Contractor is financially responsible for post-stabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition within 1 hour of a request to the organization for pre-approval of further post-stabilization care services. *42CFR438.114(e)* Contract: DHMC: II.C.4.d RMHP: II.D.4.d	◆ CHOICE_UMG1006 – Concurrent UM & OBS – Entire Document ◆ CHOICE_UMG1002 – Utilization Review Determinations – pgs 5-6 ◆ MCD_PROV_MANUAL_PG41.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: DHMC policies provided evidence that poststabilization care services were covered and reimbursed regardless of whether the provider was part of the DHMC network.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
25. The Contractor is financially responsible for post-stabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the member's stabilized condition if: ◆ The organization does not respond to a request for pre-approval within 1 hour, ◆ The organization cannot be contacted, The organization representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the organization must give the treating physician the opportunity to consult with a plan physician. *42CFR438.114(e)* Contract: DHMC: II.C.4.d RMHP: II.D.4.d	◆ CHOICE_UMG1006 – Concurrent UM & OBS – Entire Document ◆ CHOICE_UMG1002 – Utilization Review Determinations – pgs 5-6 ◆ MCD CHOICE_CLM205 – Adjudication of ER non-auth ◆ Urgent-Emergency Care.ppt ◆ Auth Instruction 1.pdf ◆ MCD_PROV_MANUAL_PG41.pdf	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: DHMC Policies UMG1006, UMG1002, and CLM205 did not describe that DHMC would be financially responsible for poststabilization care services obtained inside or outside its network if DHMC did not respond to a request for preapproval within one hour, if DHMC could not be contacted, or if the DHMC representative and the attending provider could not reach an agreement concerning a member's care.		
Required Actions: DHMC should ensure that its policies and claims payment processes are congruent with 42 CFR 438.114(e).		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
26. The Contractor must limit charges to members for post-stabilization care services to an amount no greater than what the organization would charge the member if he or she had obtained the services through the contractor. *42CFR438.114(e)* Contract: DHMC: II.C.4.d RMHP: II.D.4.d	◆ MCD_PROV_MANUAL_PG41.pdf ◆ CHOICE_UMG1002 – Utilization Review Determinations pg 5-7 ◆ CHOICE_UMG1006 – Concurrent UM & OBS – pg 3 ◆ MCD CHOICE_CLM205 – Adjudication of ER non-auth ◆ Urgent-Emergency Care.ppt ◆ Auth Instruction 1.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: DHMC policies and member materials provided evidence that poststabilization care services were covered and reimbursed regardless of whether the provider was part of the DHMC network. During the on-site interview, DHMC staff members confirmed that DHMC Medicaid members were not held financially liable for medically necessary poststabilization services.		
Required Actions: None		
27. The Contractor's financial responsibility for post-stabilization care services it has not pre-approved ends when: ◆ A plan physician with privileges at the treating hospital assumes responsibility for the member's care, ◆ A plan physician assumes responsibility for the member's care through transfer, ◆ A plan representative and the treating physician reach an agreement concerning the member's care, ◆ The member is discharged. *42CFR438.114(e)* Contract: DHMC: II.C.4.d RMHP: II.D.4.d	◆ CHOICE_UMG1006 – Concurrent UM & OBS ◆ MCD CHOICE_CLM205 – Adjudication of ER non-auth ◆ Urgent-Emergency Care.ppt ◆ Auth Instruction 1.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: DHMC policies provided evidence of when its responsibility for poststabilization care services it had not preapproved ended. Denial records included examples of instances in which the attending provider deemed the member medically stable for transfer but the member refused to transfer. In those instances a denial was issued and the provider notified. During the on-site interview staff members described that in those instances the providing hospital provided the member with a statement of financial responsibility.		
Required Actions: None		

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	23	X	1.00	=	23
	Partially Met	=	4	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	27	**Total Score**		=	23

Total Score ÷ Total Applicable	=	85%

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor ensures that all covered services are available and accessible to members. *42CFR438.206(a)* Contract: DHMC: II.D.1.a.2 RMHP: II.E.1.a.2	◆ DHMCDChoice_StrategicAccessPlan_2010.pdf – entire document ◆ Next Available Appointments for Specialty Care at the Children.doc ◆ Pediatric Referral guidelines.xls ◆ Adult Send out Guidelines.xls ◆ PEDIATRIC SPECIALTY CLINICS IN THE KIDS CARE CLINIC.doc ◆ MS_Specialty_Appointments_Assistance_Process_2010.vsd Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: DHMC's Access to Care/Services for DHMC policy defined how DHMC monitored compliance with network adequacy. The 2009–2010 Strategic Access Plan documented DHMC's steps to make covered services available and accessible to its members. DHMC provided documentation that it tracked available appointments and had referred members to specialty and out-of-network providers, demonstrating that when covered services were not available or accessible in a timely fashion within the DHHA system, services were authorized and provided out of network.		
Required Actions: None		
2. The Contractor maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. *42CFR438.206(b)(1)* Contract: DHMC: II.D.1.a.2 RMHP: II.E.1.a.2	◆ CHOICE_PRR701 – pages 1 and 2, refer to the documentation under Policy ◆ DHMCDChoicestrategicaccessplan_final_2010.pdf - Pages 4-9, 16-18, 19, 20	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: DHHA, as a staff model HMO, monitored its own clinics and supplemented the employed provider network with contracted providers when a service was not available within the DHHA system. The Access to Care/Services for DHMC policy defined DHMC's standard for its ratio of primary care physicians (PCPs) to members, and its ratio of specialists to members, as 1:2,000. The policy also stated that the standard for the geographic radius of providers to members was 30 minutes or 30 miles. The 2009–2010 Strategic Access Plan demonstrated that DHMC maintained a ratio that was better than 1:2,000 for PCPs to members and specialists to members for FY 2009–2010. The plan also demonstrated that 98.8 percent of DHMC members were		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
within 30 miles of a Denver Health provider. Nevertheless, DHMC's grievance analysis indicated that the access and availability category had the highest percentage of grievances. These grievances related to appointment delay and wait time to get appointments. Further, member satisfaction survey data, as reported by HSAG in the 2009–2010 External Quality Review Technical Report for Colorado Medicaid, showed that adult Medicaid members' level of satisfaction decreased on the *Getting Care Quickly* measure from 40.6 percent in FY 2008–2009 to 39.1 percent in FY 2009–2010. The children's rate on the measure for the same time period decreased 8.4 percentage points from 52.9 percent to 44.5 percent. The adult measure, *Getting Needed Care*, showed an increase from 30.6 percent to 33.4 percent for the same time frame.		
Required Actions: DHMC must ensure that it has sufficient resources available to Medicaid members to provide adequate access to all services covered under the contract.		
3. In establishing and maintaining the network, the Contractor considers: ◆ The anticipated Medicaid enrollment, ◆ The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the Contractor's service area, ◆ The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services, ◆ The numbers of network providers who are not accepting new Medicaid patients, ◆ The geographic location of providers and Medicaid members, considering distance, travel time, the means of transportation ordinarily used by Medicaid members, and whether the location provides physical access for Medicaid members with disabilities. *42CFR438.206(b)(1)(i) through (v)* Contract: DHMC: II.D.1.a.3 RMHP: II.E.1.a.3	◆ Network Adequacy Report_1Q FY11.doc – entire report. This report includes the ADA Building Survey_10_15-10 1Q_FY11.xls. ◆ Strategic Network Access Report –Pages 3-7, pages 13-24 ◆ Next Available Appointments for Specialty Care at the Children.doc ◆ Pediatric Referral guidelines.xls ◆ Adult Send out Guidelines.xls ◆ PEDIATRIC SPECIALTY CLINICS IN THE KIDS CARE CLINIC.doc **Description of Process:** The Network Adequacy Report_1Q FY11.doc is a report that is created by DHMC and given to HCPF on a quarterly basis. The other listed documents further show the guidelines and methods DHMC uses to ensure network adequacy.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: DHMC's Access to Care/Services for DHMC policy stated that, when establishing and maintaining the network, DHMC would consider the anticipated enrollment, expected utilization, numbers and types of providers, number of providers not accepting new patients, and geographic location when measuring the adequacy of its network. The 2009–2010 Network Adequacy Report demonstrated that DHMC measured these indicators and identified opportunities for improvement.		
Required Actions: None		
4. The Contractor provides female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventative health care services. This is in addition to the member's designated source of primary care if that source is not a women's health care specialist. *42CFR438.206(b)(2)* Contract: DHMC: II.D.1.a.4 RMHP: II.E.1.a.4	◆ Member Handbook – Chapter 6, heading "Seeing an OB/GYN" ◆ CHOICE_PRR701 – Page 4, number 3,c ii ◆ MCD_PROV_MANUAL_PG_69.pdf **Description of Process:** In chapter 6, heading "Seeing an OB/GYN" of the Member Handbook, it is explained to Members that they may see a women's health specialist without first obtaining a prior authorization from DHMC. CHOICE_PRR701, page 4, number 3, c ii disseminates this information to DHMC staff, and MCD_PROV_MANUAL_PG_69.pdf gives this same information to DHMC providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Access to Care/Services for DHMC policy stated that women have direct access to women's health care specialists for routine and preventive health care services. This provision was also included in the member handbook and provider manual.		
Required Actions: None		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor has a mechanism to allow members to obtain a second opinion from a qualified health care professional within the network, or arranges for the member to obtain one outside the network, at no cost to the member. *42CFR438.206(b)(3)* Contract: DHMC: II.D.1.a.5 RMHP: II.E.1.a.5	◆ Member Handbook – Chapter 2, heading title "Your Rights" ◆ MCD_PROV_MANUAL_PG_67.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: DHMC's Access to Care/Services for DHMC policy included the right of members to receive a second opinion at no cost to the member. The policy added that if a qualified in-network provider was not available, members would be given a referral to obtain a second opinion from outside the network at no cost to the member. The "Your Rights and Responsibilities" section of the member handbook informed members that they have the right to "ask for a second doctor to review your case, at no cost to you." The provider manual also included the right of members to receive a second opinion and directed providers to call for a copy of DHMC's policy regarding second opinions. There was evidence in the denial records reviewed on-site that although certain services had been denied, members were receiving second opinion assessments at no cost.		
Required Actions: None		
6. If the Contractor is unable to provide necessary services to a member in-network, the Contractor must adequately and timely cover the services out of network for the member, for as long as the Contractor is unable to provide them. *42CFR438.206(b)(4)* Contract: DHMC: II.D.1.b.1 RMHP: II.E.1.b.1	◆ Member Handbook – Chapter 1, heading title "Approvals"	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The medical management standards section of the Access to Care/Services for DHMC policy stated that if necessary services were not available in network, DHMC would arrange for a referral to a practitioner with the necessary expertise and ensure that the member receives the services at no cost. The member handbook informed DHMC members that services would be covered outside of the network if and when a series of conditions had been		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
met. DHMC provided evidence during the on-site review that it provided out-of-network services when it did not have the necessary resources or could not provide them in a timely manner within its network. Examples included referrals to asthma, pediatric cardiology, and allergy/immunology providers.		
Required Actions: None		
7. The Contractor requires out-of-network providers to coordinate with the Contractor with respect to payment and ensures that the cost to the member is no greater that it would be if the services were furnished within the network. *42CFR438.206(b)(5)* Contract: DHMC: II.D.1.b.2 RMHP: II.E.1.b.2	◆ MCD_OUTSIDE_PROVIDER_GUIDELINES.pdf – highlighted language of document	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: DHMC Policy PRRR701, Access to Care/Services for DHMC, stated that DHMC would coordinate payment with out-of-network providers and ensure that the cost to its members would not be greater than if the services had been furnished in network. Tracking of out-of network referrals documented that DHMC was financially responsible for the referred, authorized services. The member handbook advised members that referrals to out-of-network providers would not result in any member financial responsibility. The Denver Health and Hospital Authority Participating Provider Services Agreement specified that providers could not balance-bill members.		
Required Actions: None		
8. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services taking into account the urgency of the need for services. The Contractor has written policies and procedures for how 24-hour availability of services will be achieved and communicates the information to participating providers and members: ◆ Emergency services are available 24 hours per day, 7 days per week.	◆ MCD_PROV_MANUAL_PG_39.pdf ◆ CHOICE_PRR701 – Pages 4-6 refer to numbers 2 through 5 ◆ Member Handbook – Chapter 4, appointment standards chart ◆ Medicaid Choice Advice Line.pdf ◆ DHMC Member Newsletter – Taliah Lauf ◆ Report on new Members who need appointments – DHMCDChoicestrategicaccessplan_final_2010.pdf –Pages 16-18 ◆ 9800_wccpostcard_eng_04_10.pdf	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
◆ The Contractor has a comprehensive plan for triage of requests for services on a 24-hour-7-day per week basis including: • Immediate medical screening exam by the primary care physician or hospital emergency room, • Access to a qualified health care practitioner via live telephone coverage either on-site, call-sharing, or answering service, • Practitioner back-ups covering all specialties. ◆ Non-urgent healthcare is scheduled within two weeks. ◆ Adult, non-symptomatic well care physical examinations are scheduled within 4 months. ◆ Urgently needed services are provided within 48 hours of notification of the primary care physician or the Contractor. *42CFR438.206(c)(1)(i)* Contract: DHMC: II.D.1.d & e RMHP: II.E.1.d & e	◆ NurseAdviceLine_AprilMayJune2010Report.pdf-	
Findings: The Access to Care/Services for DHMC policy included appointment standards that met BBA requirements. The standards were also presented in the member handbook and the provider manual; however, there were inconsistencies between documents. The standard for scheduling adult, nonsymptomatic examinations was within 40 working days in the policy and within four months in the provider manual and the December 2010 member newsletter. The standard for scheduling first trimester care was within 10 days in the policy, but within 15 days in the member handbook and provider manual. DHMC required that PCPs and specialty providers provide emergency telephone coverage 24 hours a day, seven days a week. DHMC provided all members with information about accessing the nurse advice line in the member handbook and had mailed a newsletter with a removable magnet promoting use of the nurse advice line. The member handbook specified that emergency services were available 24 hours a day, seven days a week, by going to the nearest emergency room or by dialing 9-1-1.		
Required Actions: DHMC must ensure that its policies, procedures, manuals, and member materials provide consistent information regarding appointment standards.		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor and its providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if the provider serves only Medicaid members. *42CFR438.206(c)(1)(ii)* Contract: DHMC: None RMHP: None	◆ MCD_PROV_MANUAL_PG_39.pdf ◆ CHOICE_PRR701 – Page 5, b	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Access to Care/Services for DHMC policy stated that DHMC offered hours of operation comparable to its Medicaid fee-for-service and commercial members. DHMC used primarily DHHA-staffed clinics to provide services to Medicaid members. DHHA clinics were open to members with all payor types during clinic hours.		
Required Actions: None		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor makes Services available 24 hours a day, 7 days a week, when medically necessary. *42CFR438.206(c)(1)(iii)* Contract: DHMC: II.D.1.d RMHP: II.E.1.d	◆ CHOICE_PRR701 –Page 4-bullets 6,7 ◆ Member Handbook – Chapter 4, appointment standards chart ◆ MCD_PROV_MANUAL_PG_39.pdf **Description of Process:** CHOICE_PRR701 states this requirement on page 4 under bullets 6 and 7. The Member Handbook explains this availability of services to DHMC Members in chapter 4 in the appointment standards chart. MCD_PROV_MANUAL_PG_39.pdf explains to DHMC providers the requirement that services are made available 24 hours a day 7 days a week when medically necessary.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: DHMC required that PCPs and specialty providers provide emergency telephone coverage 24 hours a day, seven days a week. The member handbook specified that emergency services were available 24 hours a day, seven days week, by going to the nearest emergency room or by dialing 9-1-1. The member handbook also stated that after normal business hours, a member could call the nurse advice line for after-hours help. Members were informed via the member handbook that they did not need prior authorization to see an urgent care doctor, even if the provider was not in the DHMC network.		
Required Actions: None		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor has mechanisms to ensure compliance by providers regarding timely access to services, and has mechanisms to monitor providers regularly to determine compliance and to take corrective action if there is failure to comply. *42CFR438.206(c)(1)(iv) through (vi)* Contract: DHMC: None RMHP: None	◆ Refer to DH_Access_2010_11_CAP.doc that includes the following documentation in the folder: 1. 2010_CHS AccessInterventions.doc –shows improvements made in the Community health Services_(CHS) during 2010 2. 2010-11 MCD CAHPS_Plan_MBR_SRV.xls Entire Document 3. FW Notes from 10.5HealthLiteracy Mtg.htm 4. FW Health Literacy Committee 119 minutes.htm 5. MC Hlth Literacy Task Force Action Plan.doc 6. Committee on Health Literacy_who we are (2).doc ◆ DHMCDChoicestrategicaccessplan_final_2010.pdf – monitoring of access refer to pages 16-18 ◆ MCD_PROV_MANUAL_PG45.pdf ◆ Next Available Appointments for Specialty Care at the Children.doc ◆ Pediatric Referral guidelines.xls ◆ Adult Send out Guidelines.xls ◆ PEDIATRIC SPECIALTY CLINICS IN THE KIDS CARE CLINIC.doc ◆ MS_Specialty_Appointments_Assistance_Process_2010.vsd Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Findings:
Through its various quality improvement initiatives, DHMC has monitored timely access to services and has begun implementing mechanisms to improve performance. This included analyzing information from member grievances, member satisfaction surveys, HEDIS performance measures, and appointment availability data. DHMC has begun improving its scheduling process by handling appointment requests through a centralized appointment center. Although not all DHMC provider sites were participating in centralized scheduling at the time of the review, the plan noted that the six sites that were fully participating had decreased call abandonment rates and improved the percentage of accurately scheduled appointments. Additional physicians were hired to meet increased demand for services.

Required Actions:
None

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner, to all members including those with limited English proficiency or reading skills including those with diverse cultural and ethnic backgrounds by: ◆ Maintaining policies to reach out to specific cultural and ethnic members for prevention, health education, and treatment for diseases prevalent in those groups, ◆ Maintaining policies to provide health care services that respect individual health care attitudes, beliefs, customs, and practices of members related to cultural affiliation, ◆ Make a reasonable effort to identify members whose cultural norms and practices may affect their access to health care. Such efforts may include inquiries conducted by the Contractor of the language proficiency of members during the Contractor's orientation calls or being served by participating providers or improving access to health care through community outreach and Contractor publications, ◆ Develop and/or provide cultural competency training programs, as needed, to the network providers and Contractor staff regarding: • health care attitudes, values, customs, and beliefs that affect access to and benefit from health care services, • the medical risks associated with the Client population's racial, ethical and socioeconomic conditions. ◆ Make available written translation of Contractor materials, including member handbook,	◆ CHOICE_MBR804 –Evaluating Member's Non-English Needs for Language Translation Services and the Readability of Member Materials; entire document ◆ CHOICE_MBR808 Readability of Member Materials; entire document ◆ CHOICE_QIM1304 Cultural and Linguistic Appropriate Services Program; entire document ◆ DHA Training Materials (rev12.22.09).pdf ; entire document ◆ DHA Staff Training Record.pdf ◆ DHA Cultural Policies.pdf; entire document • Americans with Disabilities Act • Cultural and Religious Considerations Relative to Provision of Care • Interpreter Services • Equal Employment Opportunity • Workforce Diversity ◆ Assessment of Member Demographics_2010.pdf ; entire document (including Race, Language, Gender) ◆ MCD Provider Directory May 2010.pdf – page 1; highlights to Language spoken by providers ◆ Readability_2010.xls – See "MCD" tab ◆ MCD Choice Readability log.docm ◆ StrategicAccessPlan_excerpt_2010.pdf– highlighted areas ◆ Member Handbook – pg 3 ◆ MS_Alternate_Mbr_Materials_Process_2010.vsd Entire Document **Description of Process:** MBR804, MBR808, QIM1304, and DHA Cultural Policies outlines how the organization provides health services that are responsive to members' culture and language needs.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
correspondence and newsletters. Written member information and correspondence shall be made available in languages spoken by prevalent non-English speaking member populations within the Contractor's service area. Prevalent populations shall consist of 500 or more members speaking each language, ◆ Develop policies and procedures, as needed, on how the Contractor shall respond to requests from participating providers for interpreter services by a qualified interpreter. This shall occur particularly in service areas where language may pose a barrier so that Participating Providers can: • Conduct the appropriate assessment and treatment of non-English speaking members (including Members with a communication disability), • promote accessibility and availability of covered services, at no cost to Members. ◆ Develop policies and procedures on how the Contractor shall respond to requests from members for interpretive services by a qualified interpreter or publications in alternative formats ◆ Make a reasonable effort, when appropriate, to develop and implement a strategy to recruit and retain qualified, diverse and culturally, competent clinical providers that represent the racial and ethnic communities being served, ◆ Provide access to interpretative services by a qualified interpreter for members with a hearing impairment in such a way that it shall promote accessibility and availability of covered services,	DHA Training Materials and Staff Training Records outline our cultural competency training program for all staff including providers. Assessment of Member Demographic shows we have identified prevalent member populations and assessed language needs MCD Provider Directory, Readability Log, and Strategic Access excerpt show that we have made a reasonable effort to address member needs based on the Member Demographic Assessment including language needs of providers, low literacy needs of members and available interpreter services within the organization and how to access services. Member Handbook, page 3 outlines how a member can access interpreter or other language services. MS_Alternate_Mbr_Materials_Process outlines the internal process if a member requests alternative materials including Braille and TDD.	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Develop and maintain written policies and procedures to ensure compliance with requirements of the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973, • Arrange for Covered Services to be provided through agreements with non-participating providers when the Contractor does not have the direct capacity to provide covered services in an appropriate manner, consistent with independent living, to members with disabilities, • Provide access to TDD or other equivalent methods for members with a hearing impairment in such a way that it will promote accessibility and availability of covered services, • Make member information available upon request for members with visual impairments, including, but not limited to, Braille, large print, or audiotapes. For members who cannot read, member information shall be available on audiotape. *42CFR438.206(c)(2)* Contract: DHMC: II.D.6.c RMHP: II.E.6.c		
Findings: DHMC had numerous policies and processes in place and being developed to promote the delivery of services in a culturally competent manner to all members, including those with limited English skills. Relevant policies included the Americans with Disabilities Act, Cultural and Religious Considerations Relative to Provision of Care, Interpreter Services, Equal Employment Opportunity, and Workforce Diversity. DHMC's Readability of Member Materials policy provided procedures for assessing the reading level of all member materials against the Health Literacy Advisor software.		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Vital documents were available in English and Spanish (printed on opposite sides, when applicable), including the member handbook, newsletters, and provider directory. DHMC member services had a documented process for assisting members who required member materials in an alternate format such as large print or Braille. The member handbook informed members that information was available in other formats, including Braille, large print, and audiotapes. The DHMC Web page could be translated into numerous other languages by clicking the *Translate* button. During the on-site interview, DHMC also explained that Denver Health staff members in clinics who passed fluency tests wore badges that signified their bilingual ability. DHMC provided documentation showing that it arranged for covered services to be provided through agreements with nonparticipating providers when DHMC did not have the direct capacity to provide the services in an appropriate manner. DHMC had processes to provide interpreters (including sign language), translation services, and auxiliary communication devices to members at no charge. DHMC was participating in America's Health Insurance Plans Health Literacy Task Force and the Managed Care Health Literacy Task Force. DHMC staff members also reported that resources were available to staff members via the internal Cultural Diversity SharePoint site, and that an annual cultural diversity Web course was required for all employees within the Denver Health system.		
Required Actions: None		
13. The Contactor submits to the State (in a format specified by the State) documentation to demonstrate that the Contractor: ◆ Offers an appropriate range of preventative, primary care, and specialty services that is adequate for the anticipated number of members for the services area, ◆ Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. *42CFR438.207(b)* Contract: DHMC: II.D.2.c RMHP: II.E.2.c	◆ Network Adequacy Report_1Q FY11.doc –entire report ◆ Letter from HCPF re 4th Quarter compliance report submission.pdf ◆ DHMC Response to HCPF QST SFY10.doc **Description of Process:** The Network Adequacy Report_1Q FY11.doc is a quarterly report that DHMC creates and submits to HCPF to demonstrate network adequacy. The Letter from HCPF re 4th Quarter compliance report submission.pdf is a response from HCPF to DHMC's quarterly submission of this report. The DHMC Response to HCPF QST SFY10.doc is a response from DHMC to HCPF's response.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The DHMC Network Access Strategic Report was submitted to the Department as required. The report described the processes for evaluating the adequacy of the network and addressed each of the above requirements. The document reported the number and types of PCPs (e.g., internal medicine,		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
family practice) and specialists (e.g., cardiologists), and the number of providers not accepting new patients. The report included data regarding the geographic distribution of providers and Medicaid-eligible members in the service area. During the on-site interview, staff members described strategies to provide services to the growing number of monolingual Spanish-speaking members.		
Required Actions: None		

Results for Standard II—Access and Availability							
Total	Met	=	11	X	1.00	=	11
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	13	**Total Score**		=	11

Total Score ÷ Total Applicable	=	85%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. NCQA CR1	◆ #1 Directs: CHOICE_CRE1501 ◆ #2 DHH: CHOICE_CRE1501 Attachment B DHH MS Bylaws.pdf (Article XVII, page 34-) ◆ #3 CHOICE_CRE1501 Attachment D **Description of Process:** #1 describes the process for selection, credentialing and recredentialing of outside network contracted providers; #2 is the DHH Medical Staff Bylaws, which within that document is the description for credentialing, recredentialing and selection of DHH physicians, and physician assistants who are staff or affiliated with DHHA; #3 describes the process for selection, credentialing and recredentialing of other DHH Allied Health Professionals who are staff or are affiliated with DHHA.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: During the on-site interview, DHMC staff members described DHMC's credentialing processes and its processes for service provision to Medicaid managed care members. DHMC was the Medicaid line of business within DHHA. DHHA was a staff model HMO and provided the majority of services to DHMC members. DHMC contracted directly with very few independent practitioners (about 35 at the time of the site review). DHMC's Credentialing and Recredentialing of Practitioners policy applied to DHMC-contracted practitioners. Attachment B (Medical Staff Bylaws, Rules and Regulations, Fair Hearing Plan, and Appointment Procedures), and Attachment D to the policy (Credentialing and Recredentialing for Allied Health Professionals) applied to DHHA staff practitioners. Together these documents provided evidence that DHMC had a well-defined credentialing and recredentialing process for DHHA's employed practitioners as well as for practitioners contracted directly for DHMC service provision. The policy and attachments were consistent with NCQA's *2010 Standards and Guidelines for Health Plans*.		
Required Actions: None		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners to credential and recredential. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. (Examples include MDs, Dentists, Chiropractors, Osteopaths, Podiatrists). *42CFR438.214(a)* NCQA CR1—Element A1 Contract: DHMC: II.F.1.b & c RMHP: II.G.1.b & c	◆ #1 CHOICE_CRE1501 (Purpose & Scope) ◆ #2 DHH: CHOICE_CRE1501 Attachment B, Section 2 and Article II (Purpose) ◆ #3 CHOICE_CRE1501 Attachment D (II Policy) **Description of Process:** These same P&P's as outlined, explicitly state the providers who are credentialing and recredentialed by either Managed Care for direct independent providers and DHHA for DHHA providers	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy specified that the policy applies to all practitioners contracted with DHMC, including medical doctors (MDs); doctors of osteopathic medicine (DO), podiatry (DPM), and optometry (OD); licensed, doctoral-level psychologists (PsyD, PhD); masters-level clinical social workers who are State-certified or licensed; as well as allied health professionals. Attachments B and D to the policy (applicable to DHHA-employed practitioners) specified the types of practitioners to be credentialed. The policy and attachments defined allied health professionals as licensed professionals who are permitted to practice independently under State law (nurse practitioners [NPs], physician assistants [PAs], certified nurse midwives [CNMs], clinical nurse specialists [CNSs], and certified registered nurse anesthetists [CRNAs]). Attachment D to the Credentialing and Recredentialing of Practitioners policy, titled Credentialing and Recredentialing for Allied Health Professionals, specifically addressed the process for credentialing and recredentialing allied health professionals.		
Required Actions: None		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
2.B. The verification sources used. NCQA CR1—Element A2	◆ #1 CHOICE_CRE1501(Procedures #4 & Attachment G) ◆ #2 DHH: CHOICE_CRE1501 Attachment B (Article XVII, page 37) ◆ #3 CHOICE_CRE1501 Attachment D (III Procedure) **Description of Process:** # 1 & #2 states that only PSV's and other sources acceptable to NCQA, JC & CMS will be used for verification purposes as outlined. #3 is a list of acceptable sources.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy (applicable to contracted practitioners) identified the primary sources for verification of licenses, license sanctions, U.S. Drug Enforcement Administration (DEA) certification, malpractice claims history, and Medicare/Medicaid sanctions. Attachment G to the policy (Sources of Primary Source Verification for Practitioner Credentials) clearly delineated acceptable sources for obtaining primary source verification for board certification, education, and training. Attachments B and D (applicable to DHHA practitioners) described primary sources for verification of each required element.		
Required Actions: None		
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	◆ #1 CHOICE_CRE1501 ◆ #2 DHH: CHOICE_CRE1501 Attachment B (Article XVII, page 35) ◆ #3 CHOICE_CRE1501 Attachment D **Description of Process:** The criteria for credentialing and recredentialing is clearly outlined in #1 (Procedures) for outside network providers and #2 & #3 for DHHA providers	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy included the conditions and requirements practitioners must comply with for participation in the DHMC network. Attachment B to the policy listed the general and basic qualifications (e.g., licensure and federal health care eligibility, clinical knowledge, communication skills, and professionalism) that must be met before an application would be accepted for review.		
Required Actions: None		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	◆ #1 CHOICE_CRE1501 (Procedures #10 & 11) ◆ #2 DHH: CHOICE_CRE1501 Attachment B (Article XVII, Section 4-5 ◆ #3 CHOICE_CRE1501 Attachment D (page 4) **Description of Process:** DHMC has a well defined process for making credentialing and recredentialing decisions as outlined in #1 (Procedures 10 & 11) for network providers; #2 sections 4 & 5 for DHHA physicians and PA's ; and #3 p 4 for DHHA AHP's.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy and Attachment B clearly delineated the process for making credentialing and recredentialing decisions for physicians and similar medical staff. Attachment D, Credentialing and Recredentialing for Allied Health Professionals, clearly defined the procedures for making credentialing and recredentialing decisions for allied health professionals employed by DHHA. The policy also clearly delineated the process for making credentialing and recredentialing decisions for allied health professionals contracted by DHMC.		
Required Actions: None		
2.E. The process for managing credentialing/recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	◆ #1 CHOICE_CRE1501 (Procedures #3 & #5) ◆ #2 DHH: CHOICE_CRE1501 Attachment B (Article XVII, Section 12, page 48) ◆ #3 CHOICE_CRE1501 Attachment D (page 7) **Description of Process:** Credentialing files are handled in a very strict and confidential manner as described in #1 for network providers and #2 & 3 for DHHA providers	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The process described in the Credentialing and Recredentialing of Practitioners policy and Attachment B for determining which credentialing files met the required criteria was based on NCQA credentialing criteria. The policy and the attachment defined clean files, which can be presented to the medical director for approval, and defined red-flagged files, which must be presented to the committee for discussion and recommendations regarding action to be taken. During the on-site interview, DHMC and DHHA credentialing staff indicated that even files approved by the DHHA chief medical officer were typically presented to the committee, while DHMC files approved by the DHMC medical director were typically not presented to the committee, but were available to the committee for review, if requested.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
Required Actions: None		
2.F. The process for delegating credentialing or recredentialing (if applicable). NCQA CR1—Element A6	◆ NA	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Findings: DHMC did not delegate credentialing or recredentialing of its practitioners.		
Required Actions: None		
2.G. The process for ensuring that credentialing and recredentialing are conducted in a non-discriminatory manner, (i.e., must describe the steps the Contractor takes to ensure that it does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes). NCQA CR1—Element A7	◆ #1 CHOICE_CRE1501 (Policy, 1st paragraph, & Procedures #10) ◆ #2 DHH: CHOICE_CRE1501 Attachment B (Article XVII, Section 2, page 34) ◆ #3 CHOICE_CRE1501 Attachment D (II Policy) **Description of Process:** The statement of non-discrimination in regards to credentialing and recredentialing, and the process to ensure compliance is fully described in the above: #1 for network providers, #2&3 for DHHA providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy, Attachment B, and Attachment D specifically stated that the granting of privileges would be made without regard to race, sex, national origin, color, religion, age, military status, sexual orientation, marital status, or the types of procedures or patients in which the practitioner specializes. The policy and attachments described the credentialing process as designed to ensure that decisions are made based on standardized criteria, which precludes discriminatory decision making. During the on-site interview, DHMC and DHHA credentialing staff confirmed that credentialing and recredentialing decisions were based on the criteria. On-site review of committee minutes confirmed the nondiscriminatory process of decision making		
Required Actions: None		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
2.H. The process for notifying practitioners if information obtained during the Contractor's credentialing/recredentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A8	◆ #1 CHOICE_CRE1501 (#9) ◆ #2 DHH: CHOICE_CRE1501 Attachment B (Article XVII, Section 13, page 48) ◆ #3 CHOICE_CRE1501 Attachment D (page 2) **Description of Process:** The process for notifying practitioners when application information varies from what is obtained otherwise, and how this is handled is described in #1 for network providers & #2&3 for DHHA providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy, Attachment B, and Attachment D all included the provision to notify providers, either in writing or by telephone call, if the information obtained during the credentialing process varied substantially from the information they provided to DHMC.		
Required Actions: None		
2.I. The process for ensuring that practitioners are notified of the credentialing/recredentialing decision within 60 calendar days of the committee's decision. NCQA CR1—Element A9	◆ CHOICE_CRE1501 (#11, bullet 3) ◆ DHH: CHOICE_CRE1501 Attachment B (Article XVII, Section 4 #G, 1st paragraph) ◆ CHOICE_CRE1501 Attachment D (page 4) **Description of Process:** DHMC clearly states that it notifies both its network and DHHA providers of its credentialing and recredentialing decisions within 60 days as outlined in the above P&Ps and attachments.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy stated that applicants will be notified in writing within 60 calendar days of the decision. Attachments B and D indicated notification within 30 days. The on-site review demonstrated that applicants were notified within one week of the decision with a letter, often dated the same day.		
Required Actions: None		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
2.J. The medical director or other designated physician's direct responsibility and participation in the credentialing/recredentialing program. NCQA CR1—Element A10	◆ #1 CHOICE_CRE1501 (#11, bullet 1) ◆ #2 DHH: CHOICE_CRE1501 Attachment B (Article XVII, Section 4 #E-G, & Section 5) ◆ #3 CHOICE_CRE1501 Attachment D (page 4 & 6) **Description of Process:** #1 describes what role the Medical Director plays in credentialing and recredentialing of network providers, #2&3 describes the voting process and who is responsible for what piece of the credentialing decisions for all DHHA providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy and Attachments B and D described the roles of the chief medical officer (for DHHA) and the medical director (for DHMC) regarding clean and red-flagged files and participation in the credentialing committees. Attachment D stated that the designated medical director appointed members of the Allied Health Professionals (AHP) Credentialing Committee and chaired the committee.		
Required Actions: None		
2.K. The process for ensuring the confidentiality of all information obtained in the credentialing/ recredentialing process, except as otherwise provided by law. NCQA CR1—Element A11	◆ #1 CHOICE_CRE1501 (#15) ◆ #2 DHH: CHOICE_CRE1501 Attachment B (Article XVII, Section 12) ◆ #3 CHOICE_CRE1501 Attachment D (page 7) **Description of Process:** All information obtained in the process of credentialing and recredentialing is confidential as described in #1 for network providers and #2&# for DHHA providers	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The DHMC Credentialing and Recredentialing of Practitioners policy stated that DHMC will maintain and respect the confidentiality of all discussions, records, and files; that files would be kept in a locked cabinet; and that committee members would be required to sign a confidentiality statement (Attachment F). Attachment B and Attachment D stated that all files would be kept under strict security and designated which staff members would be allowed access to credentialing and recredentialing files.		
Required Actions: None		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
2.L. The process for ensuring that listings in provider directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty. NCQA CR1—Element A12	◆ #1 CHOICE_CRE1501 (#16) **Description of Process:** The information contained in the DHMC providers directories comes from the credentialing database and is imputed by the credentialing coordinator as described in #1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy stated that, in order to ensure that information in all directories (print and online) is consistent with the information obtained during the credentialing process, all published information would come directly from the credentialing database. During the on-site interview, DHMC staff reported that the online directly was refreshed with current credentialing/recredentialing data monthly and that the contractor for sending the member information also received the updated information electronically each month.		
Required Actions: None		
2.M. The right of practitioners to review information submitted to support their credentialing/ recredentialing application. NCQA CR1—Element B1	◆ #1 CHOICE_CRE1501 (Procedures, #9) ◆ #2 DHH: CHOICE_CRE1501 Attachment B (Article XVII, Section 13) ◆ #3 CHOICE_CRE1501 Attachment D (page 7) **Description of Process:** All practitioners credentialed, both DHHA and network have the right to review information being used for credentialing purposes except that which is peer protected, as described in #1 for network & #2&3 for DHHA.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy, Attachment B, and Attachment D all included the right of practitioners to review credentialing information and to check the status of their application.		
Required Actions: None		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
2.N. The right of practitioners to correct erroneous information. NCQA CR1—Element B2	◆ #1 CHOICE)CREW1501 (Procedures #9) ◆ #2 DHH: CHOICE_CRE1501 Attachment B (Article XVII, Section 13) ◆ #3 CHOICE_CRE1501 Attachment D (page 7) **Description of Process:** Practitioners have the right to correct erroneous information as described in #1 for network providers and #2&3 for DHHA providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy, Attachment B, and Attachment D all specified the right of practitioners to correct erroneous information and included the process practitioners may use to correct any erroneous information.		
Required Actions: None		
2.O. The right of practitioners, upon request, to receive the status of their credentialing or recredentialing application. NCQA CR1—Element B3	◆ #1 CHOICE_CRE1501 (Procedures, #9) ◆ #2 DHH: CHOICE_CRE1501 Attachment B (Article XVII, Section 13) ◆ #3 CHOICE_CRE1501 Attachment D (page 7) **Description of Process:** All practitioners credentialed and recredentialed for DHMC have the right to receive timely notification of the status of their application as outlined in #1 for network providers and #2&3 for DHHA providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy, Attachment B, and Attachment D all included the right of practitioners to check the status of their credentialing or recredentialing application.		
Required Actions: None		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
2.P. The right of the applicant to receive notification of their rights under the credentialing program. NCQA CR1—Element B4	◆ #1 CHOICE_CRE1501 (Attachment A, Schedule A#9, & DHMC Provider Manual) ◆ #2 DHH: CHOICE_CRE1501 Attachment B (Article XVII, Section 15, page 49) ◆ #3 CHOICE_CRE1501 Attachment D (page 5) ◆ #4 MCD_PROV_MANUAL_PG_46.pdf-Ron Aguilar **Description of Process:** Applicants rights are provided to them via several documents; #1 & #4 describes the process for all DHMC directly contracted providers; #2 & # 3 describes the process for all DHHA providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Schedule A of the Colorado Healthcare Professional Credentials Application (the Colorado universal application) requires that providers attest to having had the opportunity, "to review the medical staff bylaws, rules, regulations and policies of the entity…." Attachment B to the Credentialing and Recredentialing of Practitioners policy (the medical staff bylaws) included practitioner rights. The policy stated that providers are informed of their rights via the provider manual, which is sent by the contracts department. The credentialing and recredentialing section of the provider manual included the provider relations department telephone number that practitioners may call to request a copy of credentialing and recredentialing policies and procedures.		
Required Actions: None		
2.Q. How the Contractor accomplishes ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles including: ◆ Collecting and reviewing Medicare and Medicaid sanctions, ◆ Collecting and reviewing sanctions or limitations on licensure, ◆ Collecting and reviewing complaints, ◆ Collecting and reviewing information from identified adverse events, ◆ Implementing appropriate interventions when it	◆ #1 CHOICE_CRE1501 (Procedures #13) ◆ #2 DHH: CHOICE_CRE1501 Attachment B (Article XVII, Section 15, page 49) ◆ #3 MCD_PROV_MANUAL_PG_44_45.pdf **Description of Process:** Each bullet required in 2.Q is contained in the ongoing monitoring process of both DHMC network providers and DHHA providers. The way this is accomplished and what sources are used for monitoring are described in #1 & #3 for direct contracted providers, and #2 for DHHA providers. DHMC has oversight of monitoring efforts on the part of DHHA.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
identified instances of poor quality related to the above. NCQA CR9—Element A		

Findings:

The Credentialing and Recredentialing of Practitioners policy stated that the credentialing department conducts monthly searches of state licensing boards (for all licensed health care professionals), the Office of Inspector General (OIG), and the Medicare Opt Out Report. The policy also stated that member complaints related to practitioners are received and forwarded to the quality improvement department and managed care grievance coordinators to be logged and tracked. These complaints are also forwarded to the credentialing department to be included in the provider file and reviewed during the recredentialing process. The policy stated that any DHMC practitioner identified as requiring actions is presented to the medical director and an ad hoc committee is appointed to investigate the matter. Attachment B also listed the mechanisms used for ongoing monitoring of credentialed practitioners. Section IX of Attachment B included details of the circumstances under which a DHHA provider would be subject to a corrective action, the process for implementing and monitoring a corrective action, and the types of corrective actions. DHMC's policy regarding practitioner hearings and appeals (CRE1504) delineated the process used by DHMC to collect and review information in response to a quality-of-care concern. This policy also described the process of implementing corrective actions, when necessary. On-site review of monthly printouts from the OIG list of excluded entities and the Colorado Department of Regulatory Agencies (DORA) demonstrated ongoing monitoring for sanctions. Review of credentialing committee minutes demonstrated review of possible quality-of-care complaints. During the on-site interview, DHMC staff reported that there had been one example of interventions imposed (on a physician's assistant) related to quality of care during the review period.

Required Actions:

None

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
2.R. The range of actions available to the Contractor if the provider does not meet the Contractor's standards of quality. NCQA CR10—Element A1	◆ #1 CHOICE_CRE1504 ◆ #2 DHH: CHOICE_CRE1501 Attachment B (Article XVIII, page 50-) ◆ #3 CHOICE_CRE1501 Attachment D (VI Appeals Process) ◆ #4 MCD_TEMPLATE_SEC_3_9.pdf **Description of Process:** DHMC has actions available to it if a provider does not meet the DHMC standards, these are described in #1 & #4 for directly contracted providers, and #2 & #3 for DHHA providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DHMC's policy regarding practitioner hearings and appeals (CRE1504) and Article IX of Attachment B to the Credentialing and Recredentialing policy listed a range of actions that might be taken by DHMC/DHHA if a provider does not meet DMHC's/DHHA's standards of quality. These actions included a letter of admonition, probation, clinical supervision, and reduction, suspension, or revocation of clinical privileges.		
Required Actions: None		
2.S. If the Contractor has taken action against a practitioner for quality reasons, the Contractor reports the action to the appropriate authorities. NCQA CR10—Element A2	◆ #1 CHOICE_CRE1504 (#14 &#15) ◆ #2 DHH: CHOICE_CRE1501 Attachment B (Article XVIII, #I, page 56) ◆ #3 CHOICE_CRE1501 Attachment D (IX Reporting Requirements) **Description of Process:** Whenever an action is taken against a provider due to quality reasons, the action is reportable according to JC, NCQA, CMS and State requirements. This process is outlined in #1 for network providers and #2&3 for DHHA providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DHMC's policy regarding practitioner hearings and appeals (CRE1504) and Attachments B and D to the Credentialing and Recredentialing of Practitioners policy stated that DHMC/DHHA would report any actions taken and deemed reportable under applicable Colorado State law, the National Health Care Improvement Act, and the National Practitioner Data Bank (NPDB).		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
Required Actions: None		
2.T. A well defined appeal process for instances in which the Contractor chooses to alter the conditions of a practitioner's participation based on issues of quality of care or service. NCQA CR10—Element A3	◆ #1 CHOICE_CRE1504 (Appeals Process, page 5-6) ◆ #2 DHH: CHOICE_CRE1501 Attachment B (Article XVIII, #H) **Description of Process:** DHMC has the right to alter a provider's conditions of participation if it deems necessary, based on quality issues. Whenever DHMC chooses to exercise this right, the provider has an appeal process which is well described in #1 for directly contracted providers and #2 for DHHA providers	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DHMC/DHHA had a well-defined appeal process for practitioners who receive notice of an adverse recommendation that will result in revocation of staff membership or reduction or suspension of clinical privileges. Also, the appeal process was for a practitioner who "has been found to be lacking in qualifications, has provided substandard or inappropriate patient care, or has exhibited inappropriate professional conduct." This appeal process was delineated in the medical staff bylaws (Attachment B to the Credentialing and Recredentialing policy) and DHMC's policy regarding practitioner hearings and appeals (CRE1504).		
Required Actions: None		
2.U. Making the appeal process known to practitioners. NCQA CR10—Element A4	◆ #1 DHMC Provider Manual ◆ #2 DHH: CHOICE_CRE1501 Attachment B (Article XVIII, B#2 ◆ #3 MCD_PROV-MANUAL_PG_46.pdf – Ron Aguilar **Description of Process:** The appeal process is made know to DHMC providers through various sources. This is defined in #1 & #3 for directly contracted providers and #2 for DHHA providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The fair hearing plan, as outlined in Attachment B, stated that a practitioner is notified of his or her right to appeal an adverse recommendation or decision in the Notice of Adverse Action letter. During the on-site interview, DHMC and DHHA credentialing staff reported that there were no adverse determinations during the review period.		
Required Actions: None		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
3. The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing and recredentialing decisions. The committee includes representation from a range of participating practitioners. NCQA CR2—Element A	◆ #1 CHOICE_CRE1501 (Procedure #10) ◆ #2 DHH: CHOICE_CRE1501 Attachment B (Article XVII, Section 2 #1) ◆ #3 CHOICE_CRE1501 Attachment D (page 4) **Description of Process:** DHMC utilizes a peer review process by a designated credentialing committee made up according to JC, NCQA, and CMS standards. This is described in #1 for network providers and #2 & 3 for DHHA providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy stated that the Credentialing Subcommittee (of the Medical Staff Executive Committee) will be comprised of a range of participating practitioners. Attachment B specified that the Medical Staff Executive Committee (the committee responsible for credentialing DHHA practitioners) is comprised of members from the following specialties: medicine, community medicine, family practice, emergency medicine, dentistry and oral surgery, psychiatry, anesthesiology, obstetrics/gynecology, orthopedics, pathology, pediatrics, and radiology. Attachment D specified that the AHP Credentialing Committee would be comprised of nurse practitioners, clinical nurse specialists, certified nurse midwives, nurse anesthetists, clinical psychologists, licensed clinical social workers, and either a physician assistant or child health associate. On-site review of committee minutes confirmed committee representation from a range of participating providers.		
Required Actions: None		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
4. The Contractor provides evidence of the following: ◆ Credentialing committee review of credentials for practitioners who do not meet established thresholds, ◆ Medical director or equally qualified individual review and approval of clean files. NCQA CR2—Element B	◆ #1 Independent Directs: Denver Health Managed Care Credentialing Subcommittee meeting minutes (& Practitioner Red files when applicable) (will review on site) ◆ #2 CHOICE_CRE1501 (#11, bullet 1) ◆ #3 DHH: CHOICE_CRE1501 Attachment B (Article XVII, (page 40) ◆ #4 CHOICE_CRE1501 Attachment D (page 4) ◆ #5 DHH Practitioners: DHH meeting minutes for Physicians and Allied Health (will review on site) **Description of Process:** DHMC follows JC, NCQA & CMS standards regarding credentialing providers who do not meet established thresholds (red flag) as described in #2 for network providers and #3 & 4 for DHHA providers. There is evidence of the appointed Committee's review of and participation in the decision of red flagged applicants in the meeting minutes of #1 for network and #5 for DHHA.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: On-site review of Medical Staff Executive Committee meeting minutes confirmed committee review of both clean and red-flagged credentialing files.		
Required Actions: None		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
5. The Contractor conducts timely verification (at credentialing) of information, using primary sources, to ensure that practitioners have the legal authority and relevant training and experience to provide quality care. Verification is within the prescribed time limits and includes: ◆ A current, valid license to practice (time limit 180 days), ◆ A valid DEA or CDS certificate, if applicable (must be in effect at the time of the credentialing decision), ◆ Education and training (time limit none) , including board certification (time limit 180 days), if applicable, ◆ Work history (time limit 365 days), ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (time limit 180 days). NCQA CR3—Elements A and B	◆ #1 CHOICE_CRE1501 (Procedures #5) ◆ #2 DHH: CHOICE_CRE1501 Attachment B (Article XVII, Section 4 #C) ◆ #3 CHOICE_CRE1501 Attachment D **Description of Process:** DHMC uses the Colorado Credentialing Application for credentialing and recredentialing of all DHMC practitioners. Each of the bullets of #5 are addressed in this application, each is verified appropriately, within the 180 day time limit, using acceptable JC, NCQA, and CMS sources accordingly. This process is described in #1 for network providers, and in #2 & 3 for DHHA providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy, Attachment B, and Attachment D included the required time frames for primary source verification of each piece of documentation. On-site record review of credentialing records confirmed that all primary source verification was completed within the prescribed time frames for the records reviewed.		
Required Actions: None		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
6. Practitioners complete an application for network participation (at initial credentialing and recredentialing) that includes a current and signed attestation and addresses the following: ◆ Reasons for inability to perform the essential functions of the position, with or without accommodation, ◆ Lack of present illegal drug use, ◆ History of loss of license and felony convictions, ◆ History of loss or limitation of privileges or disciplinary actions, ◆ Current malpractice insurance coverage (minimums= physician—.5mil per incident/1.5mil in aggregate per year; facility—.5milper incident/3mil in aggregate per year), ◆ The correctness and completeness of the application. NCQA CR4—Element A NCQA CR7—Element C Contract: DHMC: II.F.2.a & b RMHP: II.G.2 a & b	◆ #1 CHOICE_CRE1501 (Procedures#6) ◆ #2 CHOICE_CRE1501 Attachment A ◆ #3 DHH: CHOICE_CRE1501 Attachment B (Article XVII, Section 4 #A & #B) ◆ #4 CHOICE_CRE1501 Attachment D (page 2) **Description of Process:** DHMC uses the Colorado Credentialing Application for credentialing and recredentialing of all DHMC practitioners (see #2). Each of the bullets of Standard VIII, #6 are addressed in this application. The applicant is required to attest to its correctness and completeness; this is verified within the 180 day time limit. This process is described in #1 for network providers, and in #3 & 4 for DHHA providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Schedule A of the Colorado Healthcare Professional Credentials Application (the application used by DHHA for staff provider applicants as well as for DHMC contracted providers) included all required elements as part of the attestation. On-site review of credentialing and recredentialing records confirmed use of this application.		
Required Actions: None		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
7. The Contractor receives information on practitioner sanctions before making a credentialing decision (Verification time limit—180 days) , including: ◆ State sanctions, restrictions on licensure or limitations on scope of practice, ◆ Medicare and Medicaid sanctions. NCQA CR5—Element A	◆ #1 CHOICE_CRE1501 (Procedures #4 & #5) ◆ #2 DHH: CHOICE_CRE1501 Attachment B (Article XVII, Section 4 #C ◆ #3 CHOICE_CRE1501 Attachment D (I Procedure) **Description of Process:** DHMC verifies each bullet of # 7 within the 180 day time limit according to JC, NCQA & CMS standards. The process for this is described in #1 for network providers and #2 & 3 for DHHA providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The credentialing application required all applicants to disclose all sanctions, restrictions on licensure, or limitations on scope of practice. The Credentialing and Recredentialing of Practitioners policy and Attachment B stated that verification would be completed prior to the credentialing decision and within 180 days of the application date via the NPDB, the State practice boards, or the malpractice carrier. The policy and Attachment B also included the procedure for searching OIG for Medicare/Medicaid sanctions. The on-site review of credentialing records confirmed that all primary source verification was completed within the prescribed time frames and prior to the credentialing decision.		
Required Actions: None		
8. The Contractor has a process to ensure that the offices of all practitioners meet its office-site standards. The organization sets performance standards and thresholds for: ◆ Office site criteria: • Physical accessibility, • Physical appearance, • Adequacy of waiting and examining room space, • Availability of appointments. ◆ Medical/treatment record criteria: • Secure/confidential filing system, • Legible file markers, • Records can be easily located. NCQA CR6—Element A	◆ #1 CHOICE_CRE1502 ◆ #2 MCD_PROV_MANUAL_PG_39.pdf **Description of Process:** DHMC has set office site quality thresholds, and has a process to ensure the offices of all practitioners meet these thresholds according to NCQA requirements. This process and description of actions if needed are defined in #1.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
Findings: The Practitioner Office Site Quality policy stated that DHMC will perform a site visit to any practitioner's office that "exceeds the acceptable threshold for complaints related to physical accessibility, physical appearance, adequacy of the waiting and exam room space, and adequacy of medical record keeping." The policy went on to specify that DHMC would conduct a site visit within 60 days of an initial complaint related to physical accessibility, physical appearance, adequacy of waiting and exam room space, or adequacy of treatment record-keeping. On subsequent visits, DHMC would assess only the specific performance standard that pertained to the complaint. The Site Visit Evaluation Form (Attachment A to the Practitioner Office Site Quality policy) included the required elements. During the on-site interview, DHMC staff members reported that there had been no site visits performed during the review period. Review of the grievance reports submitted to the Department indicated that there were no grievances related to office site quality during the review period.		
Required Actions: None		
9. The Contractor implements appropriate interventions by: ◆ Conducting site visits of offices about which it has received member complaints, ◆ Instituting actions to improve offices that do not meet thresholds, ◆ Evaluating effectiveness of the actions at least every six months, until deficient offices meet the thresholds, ◆ Continually monitoring member complaints for all practitioner sites and performing a site visit within 60 days of determining its complaint threshold was met, ◆ Documenting follow-up visits for offices that had subsequent deficiencies. NCQA CR6—Element B	◆ #1 CHOICE_CRE 1502 ◆ #2 MCD_PROV_MANUAL_PG_39.pdf **Description of Process:** Each bullet of #9 is addressed and how the process works is fully described in #1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Office Site Quality policy was consistent with NCQA standards and included all the required elements.		
Required Actions: None		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
10. The Contractor formally recredentials its practitioners (at least every 36 months) through information verified from primary sources. The information is within the prescribed time limits and includes: ◆ A current, valid license to practice, ◆ A valid DEA or CDS certificate, ◆ Board certification, ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner, ◆ State sanctions, restrictions on licensure, or limitations on scope of practice, ◆ Medicare and Medicaid sanctions. NCQA CR7—Elements A, B, and D NCQA CR8— Element A	◆ #1 CHOICE_CRE1501 (Procedures #12) ◆ #2 DHH: CHOICE_CRE1501 Attachment B (Article XVII, Section 5) ◆ #3 CHOICE_CRE1501 Attachment D (IV Procedure for Recredentialing) **Description of Process**: DHMC has a formal recredentialing process as required by JC, NCQA, and CMS standards. Each bullet in #10 is addressed and appropriately verified according to these standards. DHHA follows JC requirements with a 24 month recredentialing cycle as described in #2 & 3, network providers are recredentialed on the NCQA cycle of every 36 months as described in #1.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DHMC's Credentialing and Recredentialing of Practitioners policy required all practitioners to be recredentialed every three years. Attachments B and D stated that reappointment (recredentialing) occurred every two years. The recredentialing process, as stated in the policy and Attachments B and D, included verification of a current license, a valid DEA or Controlled Dangerous Substance (CDS) certificate, board certification, and a history of liability claims within the required time frames. The policy also stated that provider complaints, quality-of-care concerns, site quality issues, and reports from Managed Care Provider Relations would be reviewed and considered when determining the status of an application. On-site review of recredentialing records confirmed that all providers reviewed were recredentialed within two years of the previous credentialing date (all were DHHA providers) and that primary source verification was completed within the prescribe time frames. During the on-site interview, DHMC staff confirmed that DHMC-contracted providers were recredentialed every three years, per the policy.		
Required Actions: None		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
11. The Contractor has written policies and procedures for the initial and ongoing assessment of (organizational) providers with which it contracts, which include: 11.A. The Contractor confirms that the provider is in good standing with state and federal regulatory bodies. NCQA CR11—Element A1	◆ #1 CHOICE_CRE1503 (Policy & Procedures #3) ◆ MCD_PROV_MANUAL_PG_44_45.pdf ◆ CHOICE_CRE1503 (Policy) **Description of Process:** DHMC has a well defined process for credentialing and recredentialing of organizational providers as described in #1. This process includes verification of 11A & 11B as stated	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DHMC's Assessment of Organizational Providers policy included the procedure for confirming that organizational providers are in good standing with state and federal regulatory bodies as part of its initial assessment and ongoing monitoring. On-site review of three organizational provider files confirmed that DHHA staff obtained copies of state licenses for the organizational providers and queried the OIG Web site for sanction information.		
Required Actions: None		
11.B. The Contractor confirms whether the provider has been reviewed and approved by an accrediting body. NCQA CR11—Element A2	◆ #1 CHOICE_CRE1503 (Policy) ◆ #2 Organizational Providers Tracking Sheet ◆ #3 MCD_PROV_MANUAL_PG_44_45.pdf **Description of Process:** This is done according to description and process defined in #1; evidenced in #2 or Organizational Providers Credentialing files on site.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Assessment of Organizational Providers policy stated that DHMC would confirm whether organizational providers had been approved by an accrediting body as part of DHMC's initial assessment and ongoing monitoring. The Organizational Provider Tracking spreadsheet and on-site review of organizational provider files demonstrated that DHHA confirmed whether the organization had been accredited.		
Required Actions: None		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
11.C. The Contractor conducts an on-site quality assessment if the provider is not accredited. NCQA CR11—Element A3	◆ #1 CHOICE_CRE1503 (Procedures #4) ◆ #2 Organizational Providers Tracking Sheet **Description of Process:** DHMC has a clear process for this as stated in #1, Procedures #4: "A site visit and evaluation is required for non-accredited providers. Site visits will be conducted by DHMC credentialing staff. Passing a CMS or state review is acceptable in lieu of a site visit. To verify this, DHMC requires a copy of the report or letter from CMS showing the provider passed inspection." This can be documented by reviewing the organizational provider's credentialing files on site or the #2 Organizational Provider Tracking Sheet.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Although DHMC's Assessment of Organizational Providers policy stated that a site visit and evaluation is required for all nonaccredited providers and that site visits would be conducted by DHMC credentialing staff, the on-site interview and review of organizational provider records indicated that DHHA did not have a process, assessment criteria, or an organizational provider site visit form.		
Required Actions: DHMC must develop a process for conducting on-site quality assessments, when applicable. The process may include accepting a State survey in lieu of performing an on-site assessment if NCQA guidelines are followed.		
11.D. The Contractor confirms at least every three years, that the organizational provider continues to be in good standing with state and federal regulatory bodies, and if applicable, is reviewed and approved by an accrediting body. The Contractor conducts a site visit every three years if the organizational provider is not reviewed and approved by an accrediting body. NCQA CR11—Element A4	◆ #1 CHOICE_CRE1503 (Procedures #10) ◆ #2 Organizational Providers Tracking Sheet ◆ MCD_PROV_MANUAL_PG_44_45.pdf **Description of Process:** The same process as initial credentialing is repeated for recredentialing as documented in #1 and #2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
Findings: The Assessment of Organizational Providers policy stated that DHMC would confirm that organizational providers meet all required standards every three years. The Organizational Provider Tracking spreadsheet demonstrated that organizational providers were assessed every three years.		
Required Actions: None		
12. The Contractor has a selection process and assessment criteria for each type of nonaccredited organizational provider with which the Contractor contracts. NCQA CR11—Element A	◆ #1 CHOICE_CRE1503 (Procedures #4) **Description of Process:** DHMC has a clear process for the assessment criteria as stated in #1: "A site visit and evaluation is required for non-accredited providers. Site visits will be conducted by DHMC credentialing staff. Passing a CMS or state review is acceptable in lieu of a site visit. To verify this, DHMC requires a copy of the report or letter from CMS showing the provider passed inspection." This can be documented by reviewing the organizational provider's credentialing files on site or the #2 Organizational Provider Tracking Sheet.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Assessment of Organizational Providers policy stated that DHMC would accept proof of a passing CMS or state review in lieu of a site visit; however, the policy did not clearly define its assessment criteria and site visit standards to determine whether the CMS or State report met DHHA standards.		
Required Actions: DHHA/DHMC must develop its own criteria for organizational provider assessment for each type of organizational provider and determine if CMS or State site visits evaluate each of DHHA's assessment and site visit standards.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
13. Site visits for nonaccredited facilities include a process for ensuring that the provider credentials its practitioners. NCQA CR11—Element A	◆ CHOICE_CRE1503 (Procedure #4)	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: While the organizational provider template agreement required the organizational provider to credential its practitioners, DHHA/DHMC did not have a process for ensuring that organizational providers did credential their own practitioners.		
Required Actions: DHHA/DHMC must develop a process for ensuring that its organizational providers credential their own practitioners.		
14. The Contractor's organizational provider assessment policies and process includes at least: ◆ Hospitals, ◆ Home Health Agencies, ◆ Skilled Nursing Facilities, ◆ Free Standing Surgical Centers. NCQA CR11—Element B	◆ #1CHOICE_CRE1503 (Scope) **Description of Process:** This is clearly stated in #1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DHMC's Assessment of Organizational Providers policy required assessment of hospitals, home health agencies, skilled nursing facilities, freestanding surgical centers, nursing homes, and behavioral health facilities providing mental health or substance abuse services in an inpatient, residential, or ambulatory setting.		
Required Actions: None		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
15. The Contractor has documentation that organizational providers have been assessed. NCQA CR11—Element D	◆ Organizational Providers Tracking.xls ◆ Organizational Providers Credentialing Files on site	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DHMC submitted a spreadsheet that demonstrated it had tracked the assessment of organizational providers. On-site review of organizational provider records also confirmed DHMC's documentation of organizational provider assessment.		
Required Actions: None		
16. If the Contractor delegates any NCQA-Required credentialing activities, there is evidence of oversight of the delegated activities. NCQA CR12	◆ NA	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Findings: DHMC did not delegate any NCQA-required credentialing activities during the review period.		
Required Actions: None		
17. The Contractor has a written delegation document with the delegate that: ◆ Is mutually agreed upon, ◆ Describes the responsibilities of the Contractor and the delegated entity, ◆ Describes the delegated activities, ◆ Requires at least semiannual reporting by the delegated entity to the Contractor, ◆ Describes the process by which the Contractor evaluates the delegated entity's performance, ◆ Describes the remedies available to the Contractor	◆ NA	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
(including revocation of the contract) if the delegate does not fulfill its obligations. NCQA CR12—Element A		
Findings: DHMC did not delegate any NCQA-required credentialing activities during the review period.		
Required Actions: None		
18. If the delegation arrangement includes the use of PHI by the delegate, the delegation document also includes: ◆ A list of allowed use of PH, ◆ A description of delegate safeguards to protect the information from inappropriate use or further disclosure, ◆ A stipulation that the delegate will ensure that subdelegates have similar safeguards, ◆ A stipulation that the delegate will provide members with access to their PHI, ◆ A stipulation that the delegate will inform the Contractor if inappropriate uses of the information occur, ◆ A stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends. NCQA CR12—Element B	◆ NA	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Findings: DHMC did not delegate any NCQA-required credentialing activities during the review period.		
Required Actions: None		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
19. The Contractor retains the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision making. This right is reflected in the delegation document. NCQA CR12—Element C	◆ NA	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Findings: DHMC did not delegate any NCQA-required credentialing activities during the review period.		
Required Actions: None		
20. For delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity before the delegation document was signed. NCQA CR12—Element D	◆ NA	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Findings: DHMC did not delegate any NCQA-required credentialing activities during the review period.		
Required Actions: None		
21. For delegation agreements in effect 12 months or longer, the Contractor audits credentialing files against NCQA standards for each year that the delegation has been in effect. NCQA CR12—Element E	◆ NA	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Findings: DHMC did not delegate any NCQA-required credentialing activities during the review period.		
Required Actions: None		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
22. For delegation agreements in effect for more than 12 months, the Contractor performs an annual substantive evaluation of delegated activities against NCQA standards and organization expectations. NCQA CR12—Element F	◆ NA	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Findings: DHMC did not delegate any NCQA-required credentialing activities during the review period.		
Required Actions: None		
23. For delegation arrangements in effect 12 months or longer, the Contractor evaluates regular reports (at least semiannually). NCQA CR12—Element G	◆ NA	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Findings: DHMC did not delegate any NCQA-required credentialing activities during the review period.		
Required Actions: None		
24. For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past two years the Contractor has identified and followed up on opportunities for improvement, if applicable. NCQA CR12—Element H	◆ NA	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Findings: DHMC did not delegate any NCQA-required credentialing activities during the review period.		
Required Actions: None		

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	34	X	1.00	=	34
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	10	X	NA	=	NA
Total Applicable		=	37	**Total Score**		=	34

Total Score ÷ Total Applicable	=	92%

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

The completed grievance record review tool follows this cover page.

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2010–2011 Denials Record Review Tool
for Denver Health Medicaid Choice

Review Period:	January 1, 2010–January 13, 2011
Date of Review:	January 13, 2011
Reviewer:	Diane Somerville
Participating Plan Staff Member:	Janice Tucker

1	2	3	4	5	6	7	8	9	10	11	12
		Complete if Standard/Expedited Authorization Decision				Complete for Termination, Suspension, or Reduction of Previously Authorized Services		Complete for All Denials			
File #	Member ID	Date of Initial Request	Date Notice of Action Sent	Number of Days for Decision and Notice	Notice Sent w/in Time Frame? (S = 10 C days after request; E = 3 W days after request)	Date Notice Sent	Notice Sent w/in Time Frame? (At least 10 days prior to change in service)	Notice Includes Required Content?	Decision Made by Qualified Clinician?	Requesting Physician Consulted? (if applicable)	Reason Valid?
1	******	3/24/10	4/1/10	8	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
2	******	8/19/10	8/20/10	1	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
3	******	7/2/10	7/12/10	10	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
4	******	9/22/10	9/22/10	0	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐
Comments:											
5	******	1/5/10	1/7/10	2	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
6	******	7/12/10	7/12/10	0	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐
Comments:											
7	******	1/13/10	1/13/10	0	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
8	******	9/22/10	9/22/10	0	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
9	******	2/8/10	2/9/10	1	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
10	******	2/8/10	2/23/10	15	Y ☐ N ☒ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments: Fifteen days exceeded the required time frame.											

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2010–2011 Denials Record Review Tool
for Denver Health Medicaid Choice

1	2	3	4	5	6	7	8	9	10	11	12
		Complete if Standard/Expedited Authorization Decision				Complete for Termination, Suspension, or Reduction of Previously Authorized Services		Complete for All Denials			
File #	Member ID	Date of Initial Request	Date Notice of Action Sent	Number of Days for Decision and Notice	Notice Sent w/in Time Frame? (S = 10 C days after request; E = 3 W days after request)	Date Notice Sent	Notice Sent w/in Time Frame? (At least 10 days prior to change in service)	Notice Includes Required Content?	Decision Made by Qualified Clinician?	Requesting Physician Consulted? (if applicable)	Reason Valid?
11	******	9/13/10	9/13/10	0	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
12	******	3/26/10	4/5/10	10	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
13	******	9/16/10	9/16/10	0	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐
Comments:											
14	******	5/25/10	5/28/10	3	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
15	******	3/15/10	3/15/10	0	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
16	******	6/3/10	6/14/10	11	Y ☐ N ☒ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments: This notice was sent in 11 days, which exceeded the required time frame of 10 calendar days.											
17	******	6/9/10	6/10/10	1	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐
Comments:											
18	******	8/17/10	8/25/10	8	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
19	******	10/26/10	11/5/10	10	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
20	******	6/15/10	6/16/10	1	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2010–2011 Denials Record Review Tool
for Denver Health Medicaid Choice

1	2	3	4	5	6	7	8	9	10	11	12
		Complete if Standard/Expedited Authorization Decision				Complete for Termination, Suspension, or Reduction of Previously Authorized Services		Complete for All Denials			
File #	Member ID	Date of Initial Request	Date Notice of Action Sent	Number of Days for Decision and Notice	Notice Sent w/in Time Frame? (S = 10 C days after request; E = 3 W days after request)	Date Notice Sent	Notice Sent w/in Time Frame? (At least 10 days prior to change in service)	Notice Includes Required Content?	Decision Made by Qualified Clinician?	Requesting Physician Consulted? (if applicable)	Reason Valid?
21	******				Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐
Comments: There were no oversample cases needed to obtain a review sample of 20 cases.											
22	******				Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐
Comments:											
23	******				Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐
Comments:											
24	******				Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐
Comments:											
25	******				Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐
Comments:											
# Applicable Elements					20		0	20	20	4	20
# Compliant Elements					18		0	20	20	4	20
Percent Compliant					90%			100%	100%	100%	100%

Total # Applicable Elements	**84**
Total # Compliant Elements	**82**
Total Percent Compliant	**98%**

The completed grievance record review tool follows this cover page.

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix C. Colorado Department of Health Care Policy & Financing
FY 2010–2011 Credentialing Record Review Tool
for Denver Health Medicaid Choice

Review Period:	January 1, 2010–September 30, 2010
Date of Review:	January 13, 2011
Reviewer:	Barbara McConnell
Participating Plan Staff Member:	Sharry DiQuinzio

Sample	1		2		3		4		5		6		7		8		9		10	
Provider ID#	RMR		ABH		JRG		MKR		JRK		ANW		JSE		TML		SDT		SAW	
Provider Type (e.g., MD, PhD, NP, PA)	MD		MD		PhD		DDS		MD		MD		MD		MD		MD		PA	
Application Date	12/22/09		2/5/10		2/19/10		2/25/10		4/8/10		3/3/10		3/23/10		3/31/10		5/20/10		5/20/10	
Specialty	Gastero		Internal M.		Psychologist		Dentist		Rheumat		Opthalm		Pediatrics		Pediatrics		Radiology		Phys. Asst.	
Credentialing Date (Committee/Medical Director Approval Date)	1/28/10		2/5/10		4/15/10		4/22/10		5/27/10		5/27/10		6/17/10		6/17/10		6/17/10		7/19/10	
Item	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Initial Credentialing Verification: The contractor, using primary sources, verifies that the following are present:																				
♦ A current, valid license to practice (with verification that no state sanctions exist)	X		X		X		X		X		X		X		X		X		X	
♦ A valid DEA or CDS certificate (if applicable)	X		X		N/A		X		X		X		X		X		X		N/A	
♦ Credentials (i.e., education and training, including board certification if the practitioner stated on the application that he or she was board certified)	X		X		X		X		X		X		X		X		X		X	
♦ Work history	X		X		X		X		X		X		X		X		X		X	
♦ Current malpractice insurance in the required amount (with a history of professional liability claims)	N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A	
♦ Verification that the provider has not been excluded from federal health care participation	X		X		X		X		X		X		X		X		X		X	
♦ Signed application and attestation	X		X		X		X		X		X		X		X		X		X	
♦ Provider credentialing was completed within verification time limits (see specific verification element—180/365 days)	X		X		X		X		X		X		X		X		X		X	
Applicable Elements	**7**		**7**		**6**		**7**		**7**		**7**		**7**		**7**		**7**		**6**	
Point Score	**7**		**7**		**6**		**7**		**7**		**7**		**7**		**7**		**7**		**6**	
Percentage Score	**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**	

Appendix C. Colorado Department of Health Care Policy & Financing
FY 2010–2011 Credentialing Record Review Tool
for Denver Health Medicaid Choice

Oversample	1		2		3		4		5											
Provider ID#	MPD		JMK		VM		WEJ		MRE											
Provider Type (e.g., MD, PhD, NP, PA)	MD		MD		LCSW		MD		MD											
Application Date																				
Specialty																				
Credentialing Date (Committee/Medical Director Approval Date)																				
Item	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**										
Initial Credentialing Verification: The contractor, using primary sources, verifies that the following are present:																				
♦ A current, valid license to practice (with verification that no state sanctions exist)																				
♦ A valid DEA or CDS certificate (if applicable)																				
♦ Credentials (i.e., education and training, including board certification if the practitioner stated on the application that he or she was board certified)																				
♦ Work history																				
♦ Current malpractice insurance (with a history of professional liability claims)																				
♦ Verification that the provider has not been excluded from federal health care participation																				
♦ Signed application and attestation																				
♦ Provider credentialing was completed within verification time limits (see specific verification element—180/365 days)																				
Applicable Elements																				
Point Score																				
Percentage Score																				
Total Record Review Score									**Total Applicable: 68**				**Total Point Score: 68**				**Total Percentage: 100%**			

Notes: No oversample records were required to obtain a review of 10 credentialing records. Proof of malpractice insurance was not applicable as all providers reviewed were DHHA providers. As a staff model HMO, DHHA provides for malpractice insurance for its staff practitioners.

Appendix D. Recredentialing Record Review Tool for Denver Health Medicaid Choice

The completed grievance record review tool follows this cover page.

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix D. Colorado Department of Health Care Policy & Financing
FY 2010–2011 Recredentialing Record Review Tool
for Denver Health Medicaid Choice

Review Period:	January 1, 2010—September 30, 2010
Date of Review:	January 13, 2010
Reviewer:	Barbara McConnell
Participating Plan Staff Member:	Sharry DiQuinzio

Sample	1		2		3		4		5		6		7		8		9		10	
Provider ID#	JSG		SKM		BJF		MLW		SRC		PHB		MML		YEB		JC		CEU	
Provider Type (e.g., MD, PhD, NP, PA)	MD		RN		MD		MD		MD		MD		MD		MD		PA		MD	
Application Date/Attestation Date	INITIAL		12/31/09		11/30/09		2/9/10		1/6/10		INITIAL		2/3/10		INITIAL		INITIAL		4/22/10	
Specialty			Nurse Pract.		Urology		Pathology		Internal M.				Emergency						Family Pr.	
Last Credentialing/Recredentialing Date			4/17/08		3/27/08		4/24/08		4/24/08				5/22/08						7/24/08	
Recredentialing Date (Committee/Medical Director Approval Date)			2/18/10		2/25/10		3/25/10		3/25/10				4/22/10						6/17/10	
Item	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Recredentialing Verification: The contractor, using primary sources, verifies that the following are present:																				
♦ A current, valid license to practice (with verification that no state sanctions exist)			X		X		X		X				X						X	
♦ A valid DEA or CDS certificate (if applicable)			N/A		X		X		X				X						X	
♦ Credentials (i.e., verified board certification only if the practitioner stated on the recredentialing application that there was new board certification since the last credentialing/recredentialing date)			N/A		N/A		N/A		N/A				N/A						N/A	
♦ Current malpractice insurance in the required amount			N/A		N/A		N/A		N/A				N/A						N/A	
♦ Verification that the provider has not been excluded from federal health care participation			X		X		X		X				X						X	
♦ Signed application and attestation			X		X		X		X				X						X	
♦ Provider recredentialing was completed within verification time limits (see specific verification element—180/365 days)			X		X		X		X				X						X	
♦ Recredentialing was completed within 36 months of the last credentialing/ recredentialing date			X		X		X		X				X						X	
Applicable Elements			**5**		**6**		**6**		**6**				**6**						**6**	
Point Score			**5**		**6**		**6**		**6**				**6**						**6**	
Percentage Score			**100%**		**100%**		**100%**		**100%**				**100%**						**100%**	

Appendix D. Colorado Department of Health Care Policy & Financing
FY 2010–2011 Recredentialing Record Review Tool
for Denver Health Medicaid Choice

Oversample	1		2		3		4		5											
Provider ID#	JRS		RGN		WRB		SL													
Provider Type (e.g., MD, PhD, NP, PA)	MD		PA		MD		CNM													
Application Date/Attestation Date	4/22/10		6/6/10		6/4/10		6/2/10													
Specialty	Dermatology		Phys. Asst.		Gastro.		Midwife													
Last Credentialing/Recredentialing Date	4/28/08		9/18/08		9/25/08		9/18/08													
Recredentialing Date (Committee/Medical Director Approval Date)	7/22/10		8/16/10		8/26/10		8/26/10													
Item	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**										
Recredentialing Verification: The contractor, using primary sources, verifies that the following are present:																				
♦ A current, valid license to practice (with verification that no state sanctions exist)	X		X		X		X													
♦ A valid DEA or CDS certificate (if applicable)	X		X		X		N/A													
♦ Credentials (i.e., verified board certification only if the practitioner stated on the recredentialing application that there was new board certification since the last credentialing/recredentialing date)	N/A		N/A		N/A		N/A													
♦ Current malpractice insurance in the required amount	N/A		N/A		N/A		N/A													
♦ Verification that the provider has not been excluded from federal health care participation	X		X		X		X													
♦ Signed application and attestation	X		X		X		X													
♦ Provider recredentialing was completed within verification time limits (see specific verification element—180/365 days)	X		X		X		X													
♦ Recredentialing was completed within 36 months of the last credentialing/ recredentialing date	X		X		X		X													
Applicable Elements	**6**		**6**		**6**		**5**													
Point Score	**6**		**6**		**6**		**5**													
Percentage Score	**100%**		**100%**		**100%**		**100%**													
Total Record Review Score									**Total Applicable: 58**				**Total Point Score: 58**				**Total Percentage: 100%**			

Notes: Proof of malpractice insurance was not applicable as all providers reviewed were DHHA providers. As a staff model HMO, DHHA provides for malpractice insurance for its staff practitioners. It was determined that four records in the sample were initial credentialing records rather than recredentialing records. These records were replaced by four oversample records to obtain a review of 10 recredentialing records.

Appendix E. Site Review Participants for Denver Health Medicaid Choice

Table E-1 lists the participants in the FY 2010–2011 site review of **DHMC**.

Table E-1—HSAG Reviewers and MCO/PIHP Participants	
HSAG Review Team	**Title**
Barbara McConnell, MBA, OTR	Project Director
Diane Somerville, MSW	Director, State & Corporate Services
Denver Health Medicaid Choice Participants	**Title**
Ronald Jay Aguilar	Director, Contracts
David Brody	Medical Director
Sharry DiQuinzio	Credentialing Coordinator
Leann Donovan	Chief Executive Officer
Nettie Finn	Inpatient Supervisor
Rich French	Member Services
Laurie Goss	Director, Marketing and Commercial Product Lines
Aygul Gumerova	Compliance Program Analyst
Craig Gurule	Government Products Manager
Karl F. Haught, Jr.	Director, Compliance
Beth Henchel	Medicare Program Manager
Taliah Lauf	Government Products Specialist
Chryss MacGowan	Pharmacy Manager
Deb Markson	Director, HMO Information Systems
Mary Pinkney	Director, Quality Improvement
Clint Randolph	Director, Finance
Sandra Taylor	Manager, Medical Staff Services
Janice Tucker	Outpatient Case Manager/Utilization Management
Pat Williams	Claims Manager
Department Observers	**Title**
Valerie Baker-Easly	Contract Manager
Kimberly deBruynKops	Quality/Compliance Specialist
Maggie Reyes-Leczinski	Quality/Compliance Specialist

Appendix F. Corrective Action Plan Process for FY 2010–2011 for Denver Health Medicaid Choice

DHMC is required to submit a CAP to the Department 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 and complete the attached CAP template. 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/PIHP must submit documents based on the approved timeline.

Table F-1—Corrective Action Plan Process

Step 1	**Corrective action plans are submitted**
	Each MCO/PIHP 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/PIHP will submit the CAP using the template provided. 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 describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training and follow-up activities, and documents to be sent following the completion of the planned interventions.
Step 2	**Prior approval for timelines exceeding 30 days**
	If the MCO/PIHP 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**
	Following review of the CAP, the Department will notify the MCO/PIHP via e-mail whether: ◆ The plan has been approved and the MCO/PIHP should proceed with the interventions as outlined in the plan. ◆ Some or all of the elements of the plan must be revised and resubmitted.
Step 4	**Documentation substantiating implementation**
	Once the MCO/PIHP has received Department approval of the plan, the MCO/PIHP should implement all the planned interventions and submit evidence of such implementation to HSAG via e-mail or the FTP site, with an e-mail notification regarding the posting. The Department should be copied on any communication regarding CAPs.
Step 5	**Progress reports may be required**
	For any planned interventions requiring an extended implementation date, the Department may, based on the nature and seriousness of the noncompliance, require the MCO/PIHP to submit regular reports to the Department detailing progress made on one or more open elements of the CAP.

Table F-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/PIHP as to whether: (1) the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements or (2) the MCO/PIHP must submit additional documentation. The Department will inform each MCO/PIHP in writing when the documentation substantiating implementation of all Department-approved corrective actions is deemed sufficient to bring the MCO/PIHP into full compliance with all the applicable contract requirements.

The template for the CAP follows.

Table F-2—FY 2010–2011 Corrective Action Plan *for* Denver Health Medicaid Choice					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
I. Coverage and Authorization of Services 11. The Contractor's written policies and procedures include the following timeframes for making standard and expedited authorization decisions: ◆ For standard authorization decisions—10 calendar days. ◆ For expedited authorization decisions—3 days.	Policy UMG1002 contained a decision grid showing that expedited service authorizations would be made within "3 working days (72 hours)." The same inconsistent information was presented in the corresponding provider manual matrix. The policy stated that an expedited determination would be made in "no longer than 3 working days from the client's request," but also stated that a written determination would be sent to the member within "two business days" of the determination decision. If the decision was made on the third working day, federal Medicaid managed care regulations would not permit two additional days to notify the member. The policy was numbered				

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	incorrectly, leading to possible confusion. Also, the policy stated that oral appeals shall be followed by written appeals. This is only the case for nonexpedited appeals. Oral requests for an expedited appeal do not have to be followed by a written request. DHMC must ensure that policies, procedures, and manuals are consistent in their use of three working days, three calendar days, or 72 hours. DHMC must ensure that its policy states that a member must be notified of an expedited authorization decision as expeditiously as the member's health condition requires but no later than three working days after receipt of the request for service, not "two business days" from the day the determination decision was made. Also, DHMC must ensure that				

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	its policy does not require written follow-up to oral requests for an expedited appeal.				
12. The Contractor's written policies and procedures include the following timeframes for possible extension of timeframes for authorization decisions: ◆ Standard authorization decisions—up to 14 calendar days. ◆ Expedited authorization decisions—up to 14 calendar days.	Section XIII of the provider manual contained a matrix that included the correct extension time frames for standard and expedited authorization decisions. However, the corresponding matrix in Policy UMG1002 did not contain the line detailing extension time frames. The language in the Utilization Review Determinations policy (UMG1002) at (V)(1)(E-Insufficient information) did not reflect these time frames. DHMC must ensure that its policy includes extension time frames for standard and expedited authorization decisions and that its policies and manuals are consistent.				

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13. The Contractor's written policies and procedures provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member.	Policy UMG1011 described how DHMC ensured consistency with the application of UM criteria, but that policy did not address utilization incentives. DHMC must ensure that its policies are consistent and state that there are no incentives for any individual involved in UM activities to deny, limit, or discontinue medically necessary services.				
25. The Contractor is financially responsible for post-stabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the member's stabilized condition if: ◆ The organization does not respond to a request	DHMC Policies UMG1006, UMG1002, and CLM205 did not describe that DHMC would be financially responsible for poststabilization care services obtained inside or outside its network if DHMC did not respond to a request for preapproval within one hour, if DHMC could not be contacted, or if the				

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Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
for pre-approval within 1 hour, ◆ The organization cannot be contacted, The organization representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the organization must give the treating physician the opportunity to consult with a plan physician.	DHMC representative and the attending provider could not reach an agreement concerning a member's care. DHMC should ensure that its policies and claims payment processes are congruent with 42 CFR 438.114(e).				
II. Access and Availability 2. The Contractor maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract.	DHMC's grievance analysis indicated that the access and availability category had the highest percentage of grievances. These grievances related to appointment delay and wait time to get appointments. Further, member satisfaction survey data, as reported				

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	by HSAG in the 2009–2010 External Quality Review Technical Report for Colorado Medicaid, showed that adult Medicaid members' level of satisfaction decreased on the *Getting Care Quickly* measure from 40.6 percent in FY 2008–2009 to 39.1 percent in FY 2009–2010. The children's rate on the measure for the same time period decreased 8.4 percentage points from 52.9 percent to 44.5 percent. The adult measure, *Getting Needed Care*, showed an increase from 30.6 percent to 33.4 percent for the same time frame. DHMC must ensure that it has sufficient resources available to Medicaid members to provide adequate access to all services covered under the contract.				

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Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
8. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services taking into account the urgency of the need for services. The Contractor has written policies and procedures for how 24-hour availability of services will be achieved and communicates the information to participating providers and members: ◆ Emergency services are available 24 hours per day, 7 days per week. ◆ The Contractor has a comprehensive plan for triage of requests for services on a 24-hour-7-day per week basis including: • Immediate medical screening exam by the primary care physician or hospital emergency room, • Access to a qualified health	The Access to Care/Services for DHMC policy included appointment standards that met BBA requirements. The standards were also presented in the member handbook and the provider manual; however, there were inconsistencies between documents. The standard for scheduling adult, nonsymptomatic examinations was within 40 working days in the policy and within four months in the provider manual and the December 2010 member newsletter. The standard for scheduling first trimester care was within 10 days in the policy, but within 15 days in the member handbook and provider manual. DHMC must ensure that its policies, procedures, manuals, and member				

Table F-2—FY 2010–2011 Corrective Action Plan *for* Denver Health Medicaid Choice					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
care practitioner via live telephone coverage either on-site, call-sharing, or answering service, • Practitioner back-ups covering all specialties. ◆ Non-urgent healthcare is scheduled within two weeks. ◆ Adult, non-symptomatic well care physical examinations are scheduled within 4 months. ◆ Urgently needed services are provided within 48 hours of notification of the primary care physician or the Contractor.	materials provide consistent information regarding appointment				
VIII. Credentialing and Recredentialing 11.C. The Contractor conducts an on-site quality assessment if the provider is not accredited.	Although DHMC's Assessment of Organizational Providers policy stated that a site visit and evaluation is required for all nonaccredited providers and that site visits would be conducted by DHMC				

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	credentialing staff, the on-site interview and review of organizational provider records indicated that DHHA did not have a process, assessment criteria, or an organizational provider site visit form. DHMC must develop a process for conducting on-site quality assessments, when applicable. The process may include accepting a State survey in lieu of performing an on-site assessment if NCQA guidelines are followed.				
12. The Contractor has a selection process and assessment criteria for each type of nonaccredited organizational provider with which the Contractor contracts.	The Assessment of Organizational Providers policy stated that DHMC would accept proof of a passing CMS or state review in lieu of a site visit; however, the policy did not clearly define its assessment criteria and site visit standards to determine whether the CMS or State report met				

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Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
	DHHA standards. DHHA/DHMC must develop its own criteria for organizational provider assessment for each type of organizational provider and determine if CMS or State site visits evaluate each of DHHA's assessment and site visit standards.				
13. Site visits for nonaccredited facilities include a process for ensuring that the provider credentials its practitioners.	While the organizational provider template agreement required the organizational provider to credential its practitioners, DHHA/DHMC did not have a process for ensuring that organizational providers did credential their own practitioners. DHHA/DHMC must develop a process for ensuring that its organizational providers credential their own practitioners.				

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

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

Table G-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 and a meeting at the Department to determine the content of the review. ◆ HSAG coordinated with the Department and the health plans to set the date of the review. ◆ HSAG coordinated with the Department to determine timelines for the Department's review and approval of the tool and report template and other review activities. ◆ HSAG staff attended Medical Quality Improvement Committee (MQUIC) meetings and discussed the FY 2010–2011 compliance monitoring review process as needed. ◆ HSAG assigned staff to the review team. ◆ Prior to the review, HSAG representatives also responded to questions from **DHMC** via telephone contact or e-mails related to federal managed care regulations, contract requirements, the request for documentation, and the site review process to ensure that **DHMC** was prepared for the compliance monitoring review.
Activity 2:	**Obtained Background Information From the Department**
	◆ HSAG used the BBA Medicaid managed care regulations and the **DHMC**'s Medicaid managed care contract with the Department to develop HSAG's monitoring tool, desk audit request, on-site agenda, record review tool, 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 **DHMC** in writing of the desk audit request via delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk audit request included instructions for organizing and preparing the documents related to the review of the three standards. Thirty days prior to the review, **DHMC** provided documentation for the desk audit, as requested. ◆ Documents submitted for the desk review and during the on-site document review consisted of the completed desk audit form, the compliance monitoring tool with **DHMC**'s section completed, 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 G-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 **DHMC**'s key staff members to obtain a complete picture of **DHMC**'s compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of **DHMC**'s performance.
Activity 5:	**Collected Accessory Information**
	◆ During the on-site portion of the review, HSAG collected and reviewed additional documents as needed. (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 or were requested as a result of the pre-on-site document review.) ◆ HSAG reviewed additional documents requested as a result of the on-site interviews.
Activity 6:	**Analyzed and Compiled Findings**
	◆ Following the on-site portion of the review, HSAG met with MCO/PIHP staff to provide an overview of preliminary findings. ◆ HSAG used the FY 2010–2011 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 required of the MCO/PIHP to achieve full compliance with Medicaid managed care regulations.
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 2010–2011 Site Review Report. ◆ HSAG submitted the site review report to the Department for review and comment. ◆ HSAG incorporated the Department's comments. ◆ HSAG distributed a second draft report to the MCO/PIHP for review and comment. ◆ HSAG coordinated with the Department to incorporate the MCO's/PIHP's comments and finalized the report. ◆ HSAG distributed the final report to the MCO/PIHP and the Department.