Colorado Medicaid
Managed Care Program

FY 2012–2013 Site Review Report

for

Denver Health Medicaid Choice

April 2013

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

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Overview of FY 2012–2013 Compliance Monitoring Activities

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

This is the fifth year that HSAG has performed compliance monitoring reviews of the Colorado Medicaid Managed Care Program. For the fiscal year (FY) 2012–2013 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the four performance areas chosen. The standards chosen were Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement.

The health plan's administrative records were also reviewed to evaluate implementation of National Committee for Quality Assurance (NCQA) Standards and Guidelines related to credentialing and recredentialing. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of 5 records. Using a random sampling technique, HSAG selected the samples from all applicable practitioners who had been credentialed or recredentialed in the previous 36 months. For the record review, 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 was evaluated through review of the four standards. HSAG calculated a percentage of compliance score for each standard and an overall percentage of compliance score for all standards reviewed. HSAG also separately calculated an overall record review score.

This report documents results of the FY 2012–2013 site review activities for the review period—January 1, 2012, through December 31, 2012. 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 2011–2012 site review activities. Appendix A contains details of the findings for the review of the standards. Appendix B contains details of the findings for the credentialing and recredentialing record reviews. Appendix C lists HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action process the health plan will be required to complete for FY 2012–2013 and the required template for doing so.

Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the health plan's contract requirements, NCQA Credentialing and Recredentialing Standards and Guidelines, 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 health plan 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 four standards chosen for the FY 2012–2013 site reviews represent a portion of the Medicaid managed care requirements. Standards that will be reviewed in subsequent years are: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

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

Objective of the Site Review

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

- The health plan's compliance with federal regulations, NCQA Credentialing and Recredentialing Standards and Guidelines, and contract requirements in the four areas selected for review.
- Strengths, opportunities for improvement, and actions required to bring the health plan into compliance with federal health care regulations and contract requirements in the standard areas reviewed.
- The quality and timeliness of, and access to, services furnished by the health plan, as assessed by the specific areas reviewed.
- Possible interventions to improve the quality of the health plan's services related to the areas reviewed.

Summary of Results

Based on the results from the compliance monitoring tool and conclusions drawn from the review activities, HSAG assigned each requirement 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 requirement 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 **Denver Health Medicaid Choice** (**DHMC**) for each of the standards. Details of the findings for each standard follow in Appendix A—Compliance Monitoring Tool.

Table 1-1—Summary of Scores for the Standards

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
III Coordination and Continuity of Care	15	15	14	0	1	0	93%
IV Member Rights and Protections	5	5	5	0	0	0	100%
VIII Credentialing and Recredentialing	49	47	44	3	0	2	94%
X Quality Assessment and Performance Improvement	13	13	11	2	0	0	85%
Totals	**82**	**80**	**74**	**5**	**1**	**2**	**93%**

Table 1-2 presents the scores for **DHMC** for the record reviews. Details of the findings for the record reviews are in Appendix B—Record Review Tools.

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

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Credentialing Record Review	80	80	80	0	0	100%
Recredentialing Record Review	80	78	78	0	2	100%
Totals	**160**	**158**	**158**	**0**	**2**	**100%**

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

Overall Summary of Performance

DHMC is a line of business within Denver Health and Hospital Authority (DHHA). As such, **DHMC** benefitted from overall DHHA systems, processes, and service provision for members primarily from DHHA clinics located throughout the Denver metropolitan area. For the four standards reviewed by HSAG, **DHMC** earned an overall compliance score of 93 percent. **DHMC**'s strongest performance was in Standard IV—Member Rights and Protections, where it earned a score of 100 percent. **DHMC** also scored well in Standard III—Coordination and Continuity of Care and Standard VIII—Credentialing and Recredentialing, with scores of 93 percent and 94 percent, respectively. Although **DHMC**'s lowest score was 85 percent in Standard X—Quality Assessment and Performance Improvement, **DHMC** demonstrated an overall understanding of federal health care regulations, the Medicaid Managed Care Contract, and NCQA Credentialing and Recredentialing Standards and Guidelines.

Standard III—Coordination and Continuity of Care

Summary of Findings and Opportunities for Improvement

DHMC had a well-defined, comprehensive case management program that included a care support team, a utilization management team, and a complex case management team. The program description addressed care coordination of needed services with multiple providers and agencies. **DHMC** ensured that each member had an assigned primary care physician (PCP) who was responsible for the member's care coordination. PCPs of members with complex needs were assisted by the complex case manager. **DHMC** assessed each new member's health care needs and performed a comprehensive needs assessment for all members referred to the complex case management team. The comprehensive assessment was performed by appropriate health care professionals and included input from the member/family, the PCP, and medical record review. **DHMC** care coordinators shared pertinent information from the member's assessment with external providers and agencies, as allowed through the member's signed release of information and other Health Insurance Portability and Accountability Act (HIPAA) policies. **DHMC** maintained policies and procedures concerning confidentiality of protected health information (PHI) and other HIPAA security requirements in all operations. **DHMC** procedures allowed members with special health care needs to have direct access to a specialist; however, HSAG recommended that **DHMC** clarify its member and provider communications to reflect that it allows this access to members with special health care needs.

During the on-site interview, **DHMC** presented two cases to demonstrate care coordination: one 49-year-old male with multiple medical issues including gangrene and amputation of lower extremities, few home supports, transportation needs, mental health needs, and involvement with multiple providers; and one 61-year-old male with multiple medical conditions, physical mobility limitations, and transportation and financial needs, who required high doses of narcotics for chronic leg pain. Both cases were eligible for home and community-based services (HCBS) benefits. Case presentations demonstrated coordination with multiple providers and agencies, completion of a comprehensive individual needs assessment that included all of the required elements, development of an individual treatment plan based on the assessment and the member's prioritized goals, involvement of the member/family in the care plan, assignment of a PCP, and frequent updates. The case presentations also demonstrated the Altruista Guiding Care software system used to document and support case management activities. HSAG recommended that **DHMC** consider a mechanism to more clearly document the member's agreement with the treatment plan in the Guiding Care system. **DHMC** staff explained that case managers located in the DHHA specialty clinics often manage members at the highest risk levels with special health care needs. HSAG recommended that **DHMC** develop a means to coordinate with the specialty clinic case managers to ensure compliance with **DHMC** contract requirements.

DHMC provided Early Periodic Screening, Diagnosis, and Treatment (EPSDT) screenings and services to members under the age of 21. The **DHMC** Provider Manual and Member Handbook informed members and providers of the EPSDT services available through the PCP, as well as the periodicity schedule. **DHMC** provided examples of member reminders and communications used to enhance member compliance with EPSDT scheduled services. The provider manual and member

handbook also detailed all required wraparound services available to children. **DHMC** had not defined its EPSDT screening package in a formal policy.

Summary of Strengths

DHMC maintained experienced, qualified staff to perform case management and care coordination functions. In addition, organizing the utilization management, care support, and complex case management staff within one department facilitated efficiency and communications regarding care coordination for members. The availability of case management personnel in the DHHA specialty clinics enhanced the overall complex case management capabilities within the delivery system.

The Altruista Guiding Care case management software is a powerful program and resource to ensure consistent and complete documentation of complex case management. **DHMC** staff took the initiative to add customized information to the auto-generated features of the system to ensure a more individualized plan of care. Integration of the Guiding Care system with the **DHMC** health information system and the DHHA clinical information system enhanced the sharing of case management information with DHHA providers and ancillary departments. When necessary, **DHMC** obtained member-signed release of information forms to specifically allow for care coordination with external agencies and providers, including mental health providers.

Summary of Required Actions

DHMC must develop and approve a policy and procedure that outlines the EPSDT screening package and methods to ensure that screening requirements are met.

Standard IV—Member Rights and Protections

Summary of Findings and Opportunities for Improvement

DHMC had numerous policies and procedures that appropriately addressed each of the rights at 42CFR438.100 and as described in the Colorado Medicaid Managed Care contract. **DHMC**'s member handbook informed members of their rights under the Medicaid program. **DHMC**'s provider manual listed member rights and informed providers of the expectation that providers understand the rights listed and that they treat members with respect. **DHMC** provided several policies that articulated **DHMC**'s commitment to comply with federal nondiscrimination regulations in its interactions with employees and members. The member handbook included a statement that informed members that **DHMC** will not take any action against a member because of race, color, sex, age, religion, political values, national origin, language, sexual choice, or disability. **DHMC**'s provider newsletter included an article describing how shared decision-making between providers and members can enhance the member's participation in health care and overall health. **DHMC** may want to consider including additional topic-specific member rights articles in future provider newsletters periodically.

Summary of Strengths

DHMC staff had a variety of methods for keeping the topic of member rights visible to staff and providers. Methods included periodic discussions and trainings in DHHA provider meetings and **DHMC** leadership meetings and availability of rights lists on the Web site and company portal. Staff members also reported that customer service and grievance staff members are encouraged to take the opportunity to explain member rights during member-initiated telephone calls to ensure member understanding. In addition, a reminder about member rights was published in the member newsletter at least once each year.

Summary of Required Actions

There were no required actions for this standard.

Standard VIII—Credentialing and Recredentialing

Summary of Findings and Opportunities for Improvement

DHMC had a well-defined credentialing program with policies and procedures that were consistent with NCQA's *2012 Standards and Guidelines for Health Plans*. **DHMC**'s Credentialing and Recredentialing of Practitioners policy applied to independent practitioners contracted directly with **DHMC**. The DHHA Medical Staff Bylaws applied to DHHA staff practitioners. Together, these documents provided evidence that **DHMC** and DHHA, as applicable, credentialed and recredentialed practitioners as required.

DHMC used the Colorado Healthcare Professional Credentials Application, which included all of the required elements. On-site review of credentialing committee meeting minutes, credentialing files, and recredentialing files demonstrated that **DHMC** and DHHA followed credentialing processes as described in policies. The Practitioner Office Site Quality policy was consistent with NCQA standards and included all the required elements. Organizational provider files reviewed on-site provided evidence that **DHMC** assessed organizational providers as required and documented each assessment activity in the organization-specific file. **DHMC** may want to consider documenting review of organizational provider credentialing policies and procedures directly on the **DHMC** site review form, when **DHMC** performs the site visit for nonaccredited facilities.

Summary of Strengths

DHMC's credentialing and recredentialing files were well organized and provided clear evidence that primary source verification and recredentialing activities occurred well within the prescribed time frames. Although **DHMC** is a line of business within DHHA, **DHMC** entered into an interdepartmental memorandum of understanding (MOU) with DHHA's medical staff office (MSO) to document the relationship and ensure compliance with NCQA standards for credentialing. **DHMC** performed delegation oversight and monitoring activities, as required when credentialing activities are delegated.

Summary of Required Actions

Although the Medical Staff Bylaws stated that the bylaws applied to allied health professionals (AHPs), they did not delineate processes used for the AHPs. During the on-site interview, **DHMC** and DHHA staff members explained that AHPs are credentialed using different processes and a separate credentialing committee. **DHMC** must either revise the Medical Staff Bylaws or develop policies and procedures that clearly describe the process for making credentialing and recredentialing decisions for DHHA AHPs.

The Credentialing and Recredentialing of Practitioners policy included the applicant's right to receive notification of applicant rights. The Medical Staff Bylaws did not address notification to applicants regarding their rights under the credentialing program. **DHMC** must develop or revise documents to address notification to DHHA applicants regarding notification of rights under the credentialing program.

The Medical Staff Bylaws addressed the notification to the provider that an action will be taken, the process for the hearing, and the types of actions available to DHHA; but grounds for actions did not include quality

of care reasons. **DHMC** must revise or develop documents that describe the range of actions available to DHHA for changing the conditions of a practitioner's status based on quality reasons.

Standard X—Quality Assessment and Performance Improvement

Summary of Findings and Opportunities for Improvement

The **DHMC** Quality Improvement (QI) Program Description, the QI Work Plan, and the QI Impact Analysis annual report outlined a comprehensive approach for monitoring and improving services and outcomes for **DHMC** members. The QI committee was accountable to the Board of Directors, with QI oversight responsibilities assigned to the **DHMC** Medical Management Committee (MMC). The annual QI Impact Analysis Report included summary findings, analysis, interventions, opportunities for improvement, and actions planned for the subsequent year related to each QI program component. The report, however, did not include a summary or statement of the overall impact and effectiveness of the QI program. The QI Work Plan included a comprehensive listing of the QI activities for the coming year, but it did not include measurable goals or benchmarks for performance. HSAG recommended that **DHMC** consider adding measurable goals or benchmarks to the QI Work Plan, as appropriate, and ensure that any opportunities for improvement identified in the QI Impact Analysis Report are clearly incorporated in the subsequent year's QI Work Plan.

DHMC monitored underutilization through Healthcare Effectiveness Data and Information Set (HEDIS®)[2-1] measures and overutilization through quarterly reports of routine utilization measures and cost of service reports using a dashboard format. The health plan also monitored Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[2-2] member satisfaction results, grievance trends, quality of care concerns, provider access, and results of designated performance improvement projects (PIPs). Reports also included assessment of the quality and appropriateness of care for persons with special health care needs. **DHMC** had a health care information system that collected and integrated member, provider, and encounter data to support QI initiatives. Data was verified annually for accuracy and completeness. **DHMC** developed and adopted clinical practice guidelines (CPGs). Developed in compliance with the required contract criteria, these guidelines were integrated with the DHHA system guidelines through the DHHA Practice Guidelines Committee. CPGs were available to providers through multiple channels and to members upon request. The **DHMC** policy stated that CPGs were available to the public at cost.

The **DHMC** QI program activities were integrated with the DHHA system; and QI data review and analysis was often conducted by QI subcommittees, operations management staff, or committees within the DHHA provider system. The MMC meeting minutes did not routinely document the outcomes of these review processes. The MMC meeting minutes also did not routinely include the discussion of conclusions and recommendations related to the data reported to the committee. The QI Impact Analysis Report was not reviewed by the MMC; therefore, HSAG could not substantiate that the MMC, as the designated QI oversight body, was maintaining oversight and providing direction for the comprehensive QI program. HSAG recommended that **DHMC** develop and

[2-1]HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[2-2]CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

implement mechanisms to ensure that QI monitoring activities and actions are reported back to the MMC, as outlined in the QI Program Description and other **DHMC** policies and procedures.

Summary of Strengths

DHMC had a comprehensive QI Program Description that incorporated multiple QI monitoring components. The QI Impact Analysis Report was well organized and comprehensive, and it included summarized findings, opportunities for improvement, and actions taken related to each major QI program component. Many QI activities were conducted in conjunction with the QI activities performed in the DHHA delivery system, which enhances the integration of quality of care for **DHMC** members into the overall DHHA delivery system. This integration was facilitated through the participation of staff and providers in the QI committees and efforts of both **DHMC** and DHHA staff. Staff members described the activities of the DHHA Practice Guidelines Committee and the DHHA Access Committee as examples of these efforts.

DHMC demonstrated an integrated health information system (HIS) that captures data from multiple sources, produces routine and ad-hoc reports for QI monitoring, and supports operational applications such as case management. In addition, the **DHMC** HIS had the ability to electronically access and share information with the DHHA clinical data system to support managed care programs.

Summary of Required Actions

DHMC must include a summary or statement of the overall impact and effectiveness of the QI program in the annual QI Impact Analysis Report.

DHMC must correct its policies to allow public access to CPGs at no cost. **DHMC** must also communicate to members the availability of CPGs and inform members how to access or request them.

Methodology

As a follow-up to the FY 2011–2012 site review, each health plan that received one or more *Partially Met* or *Not Met* scores was required to submit a corrective action plan (CAP) to the Department addressing those requirements found not to be fully compliant. If applicable, the health plan was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the health plan and determined whether the health plan successfully completed each of the required actions. HSAG and the Department continued to work with **DHMC** until the health plan completed each of the required actions from the FY 2011–2012 compliance monitoring site review.

Summary of 2011–2012 Required Actions

DHMC achieved 100 percent compliance during the 2011–2012 site review and had no corrective actions required.

Summary of Corrective Action/Document Review

DHMC had no corrective actions required.

Summary of Continued Required Actions

DHMC had no corrective actions required.

Appendix A. Compliance Monitoring Tool for Denver Health Medicaid Choice

The completed compliance monitoring tool follows this cover page.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has written policies and procedures to ensure timely coordination of the provision of Covered Services to its members and to ensure: ◆ Service accessibility. ◆ Attention to individual needs. ◆ Continuity of care to promote maintenance of health and maximize independent living. DH Contract: II.D.4.a RMHP Contract: II.E.4.a	1. Care Coordination Overview.pdf 2. Care Coordination Visio.pdf These two documents provide a narrative and illustrative overview of the care coordination activities by DH Managed Care. 3. CM01 v.01 Case Management Program Description.pdf This document describes how the various units within the CM department function to make sure the members can access the services they need. 4. HW01 v.02 Behavioral Health & Wellness Program Description.pdf Pages 5-8 describe the role of the BHW Program in promoting the improvement/maintenance of member health and maximizing independent living. 5. MCD Choice CHP UM04 v 02 Members w SHCNs.pdf This policy details the processes for coordination of services for members with Special Health Care Needs. 6. Guideline: CHOICE_CG Authorizing Visits for Continuity of Care.pdf This provides the guidelines for authorizing care for continuity of care – especially for members new to the plan. 7. MS_New_Mbr_Welcome_Call_Flow.final.vsd This Visio illustrates the process for the New Member Welcome Call and the specific department interventions. 8. MS New Member Welcome Call Script.doc This script includes the questions asked during for the New Member Welcome Call. 9. CS01 Referral Revew.pdf This Visio illustrates how member needs are identified and referred to appropriate department for intervention.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	10. HC_CCM_CM_CS comparison chart.pdf This chart differentiates the Managed Care Resources available for member with special health care needs. 11. Medical Management Referral Form.pdf 12. LCR Electronic Referral System – Screenshots.doc These illustrate the paper and electronic forms used to refer members for intervention. 13. Managed Care Flyer.pdf 14. CM_Program Brochure.pdf 15. Health & Wellness Brochure.pdf 16. 2013 Educational Classes.pdf 17. 2013 H&W Health Ed Series.pdf 18. HW Depression flyer.pdf 19. HW Depression flyer SPA.pdf 20. TDIP flyer.pdf 21. HW Diabetes flyer.pdf 22. HW Heart flyer.pdf These brochures and flyers are used to advertise the programs which increase the likelihood that members with needs will be referred for needed services.	
Findings: The Case Management Program Description policy described the structure and responsibilities of the case management program. The program included a care support component that assists members with navigating the system, outreaches to members with identified gaps in care, conducts new member screenings, and assists members with post-discharge transition. The program included a utilization management (UM) component that ensures members receive timely authorization of services and assists with continuity of care for less complex members. The program also included a complex case management (CCM) component for members with complex medical and social needs who require a variety of resources. DHMC submitted a variety of supporting documents that outlined the details of the case management functions and provided examples of tools used to assess members' individual needs, ensure continuity of care, and facilitate referrals.		
Required Actions: None.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor's procedures are designed to address those members who may require services from multiple providers, facilities, and agencies; and require complex coordination of benefits and services and members who require ancillary, social, or other community services. The Contractor coordinates with the member's mental health providers to facilitate the delivery of mental health services, as appropriate. *42CFR438.208(b)(2)* DH Contract: II.D.4.c, II.D.4.b RMHP Contract: II.E.4.b and II.E.4.c	1. Care Coordination Documentation.pdf 2. Care Coordination Visio.pdf These two documents provide a narrative and illustrative overview of the care coordination activities by DH Managed Care. 3. CM01 v.01 Case Management Program Description.pdf Pages 4-8 discuss the CCM and UM activities related to coordination with various providers and resources. 4. HW01 v.02 Behavioral Health & Wellness Program Description.pdf Page 7, d, describes the integration of the health coaches into the community health clinics. Section #4 on pages 8-9, describes the telephonic counseling for depression and anxiety program. 6. HC_CCM_CM_CS comparison chart.pdf This chart differentiates the Managed Care Resources available for member with special health care needs. 7. DOP – Community Resources.pdf Program guidelines that outlines how to address members with multiple needs, requiring community referrals. 8. Community Resources Script.xls This questionnaire is used to document in Guiding Care™ the Community Resource Referrals made by the staff. 9. CS01 Referral Review.pdf This Visio illustrates the process used by Care Support staff to evaluate members' needs and refer members to the appropriate programs for services.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	10. CS02 Appointments.pdf This Visio illustrates the process for coordinating care including scheduling appointments. 11. CO03 Transportation.pdf Visio illustrating process for coordinating care including arranging transportation to/from appointments. 12. CS07 Post Discharge Call.pdf Visio illustrating the process for making calls to members upon discharge from hospital – often coordinating with pharmacy, home health, DME, etc. 13. Post Discharge Call Script.xls Copy of the questions (script) asked during the post-discharge call – asking questions to determine coordination needs. 14. MS_New_Mbr_Welcome_Call_Flow.final.vsd This Visio illustrates the process for the New Member Welcome Call and the specific department interventions. 15. MS New Mbr Welcome Call Script.doc This script includes the questions asked during for the New Member Welcome Call. 16. CCM Introduction Letter.doc Copy of letter sent to members new to Complex Case Management – explaining CCM role in coordinating with multiple providers.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	17. CM Program Consent.docx Consent form that is sent to members new to Complex Case Management – seeking their signature for consent to the program and for coordination of care activities. 18. DH Release of Info form.pdf DHHA form that provides consent for staff to assist in care coordination activities with multiple providers, agencies and/or services. 19. LCR Electronic Referral System – Screenshots.doc Screenshots that illustrate the electronic form used to refer members for intervention. 20. Medical Mgt Documentation form.pdf Managed Care staff use this form to document member updates. The form is then uploaded into EDM – for viewing by all Denver Health providers. 21. DH Behavioral Health Coordination Program.doc 22. Criteria to fill at DH Pharmacy.doc These documents describe the coordination efforts between the Managed Care Pharmacy Department and the members' behavioral health providers. 23. DOP – Coordination of Mental Health.pdf Program guidelines that outlines how to address members with multiple needs, requiring coordination - including mental health providers and services. 24. TDI Provider Brochure.pdf Brochure that was sent to provider – to identify members for the telephonic depression intervention.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The Case Management Program Description and the Care Coordination Overview defined Medicaid members requiring care coordination as those members who require services from multiple providers, including mental health, ancillary, social, or other community services. The program delineated how individuals with special health care needs are identified, individual needs assessed, and a treatment plan implemented. The Behavioral Health and Wellness Program Description stated that behavioral health coaches facilitate the integration of behavioral and physical health needs either telephonically or on-site in Denver Health and Hospital Authority (DHHA) primary care. DHMC submitted documents that addressed procedures related to various case management program functions. The Community Resources procedure outlined the process for the coordination of services with external community service providers and agencies. The Coordination of Mental Health procedures addressed assessment of members' mental health needs and facilitating access to needed mental health services. The procedure stated that a member-signed release of information, specific to mental health information, was required for care coordination with mental health providers. During the on-site interview, staff presented two cases demonstrating care coordination: one 49-year-old male with multiple medical issues including gangrene and amputation of lower extremities, few home supports, transportation needs, mental health needs, and involvement with multiple providers; and one 61-year-old male with multiple medical conditions, physical mobility limitations, and transportation and financial needs, who was taking high doses of narcotics for chronic leg pain. Both cases were eligible for home and community-based services (HCBS) benefits. The care coordination presentations and treatment records demonstrated coordination of care and benefits, by CCM staff, with multiple medical providers; with ancillary, community, and social services agencies; and with mental health facilities.		
Required Actions: None.		
3. The Contractor has a mechanism to ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating covered services furnished to the member. If a Member does not select a primary care physician (PCP), the Contractor assigns the member to a PCP or a primary care facility and notifies the member, by telephone or in writing, of his/her facility's or PCP's name, location, and office telephone number. *42CFR438.208(b)(1)* DH Contract: II.D.3.b RMHP Contract: II.E.3.b	1. 2012-2013_Member Services_MCD-CHP_New_Member_Survey_&_Follow_up_Prrocess_2012.vsd This document demonstrates the process Member Services utilizes to contact new members and provide them information regarding selecting or changing their PCP. 2. GV03 v.02_PCP Assignment.pdf Describes plan's policies related to PCP assignment.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The PCP Assignment policy and the Member Services Welcome Call flow diagram described the process for a member to select, change, or be assigned to a PCP by the member services (MS) department, as well as communication of PCP assignment through the member identification card. The policy stated that the PCP is responsible for the member's routine care and for coordinating covered services. The DHMC Provider Manual informed providers of the process for PCP assignment, the responsibility of the PCP to actively manage coordination of care with other providers, and the availability of case management services to coordinate care for members with complex health care needs. The on-site care coordination case presentations demonstrated that members had an assigned PCP and a complex case manager responsible for coordination of services.		
Required Actions: None.		
4. The Contractor implements procedures to provide individual needs assessment after enrollment and at any other necessary time, including the screening for special health care needs (e.g., mental health, high risk health problems, functional problems, language or comprehension barriers, and other complex health problems). The assessment mechanisms must use appropriate health care professionals. *42CFR438.208(c)(2)* DH Contract: II.D.4.c.1 RMHP Contract: II.E.4.c.1	1. Care Coordination Overview.pdf This document provides a narrative and illustrative overview of the care coordination activities by DH Managed Care. 2. CM01 v.01 Case Management Program Description.pdf Pages 3-7 describe multiple processes by Care Support, Complex Case Management and Utilization Management for identifying and assessing members with special health care needs. 3. HW01 v.02 Behavioral Health & Wellness Program Description.pdf Pages 2-4 list the qualifications of the program staff and Page 7, section c. details the assessments used to identify member needs. 4. MCD Choice CHP UM04 v 02 Members w SHCNs.pdf Pages 2-3 of this policy detail some of the procedures used to assess the individual needs of members. 5. Policy CCM04 v.01 CCM Member Referral Process 6. Policy CCM03 v.01 CCM Member Identification Process These two policies describe the processes by which members are assessed and identified as appropriate for Complex Case	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Management. 7. CCM01 Case Identification.pdf Visio illustrates the process used to identify members with special health care needs. 8. CCM06 CCM Process.pdf Visio illustrates the CCM program elements including assessment of individual needs, identification of barriers and other special health care needs. 8. MS New Mbr Welcome Call Flow.vsd This Visio illustrates the process for the New Member Welcome Call and the specific department interventions. 9. MS New Mbr Call Script.doc This script includes the questions asked during for the New Member Welcome Call. 10. CCM Initial Comprehensive Assessment.xls 11. Health Coaching Initial Comprehensive Assessment.xls These initial assessments for Complex Case Management and Health Coaching are comprehensive – including medical and behavioral health, social issues, support systems, cultural/linguistic preferences, etc. 12. DH Behavioral Health Coordination Program.doc This document describes the process of pharmacist review and monitoring for members with behavioral health medications. 13. 2012-2013_Member Services_MCD-CHP_New_Member_Survey_&_Follow_up_Prrocess_2012.vsd This document demonstrates the process Member Services utilizes	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	to contact new members and provide them information regarding selecting or changing their PCP.	
Findings: The Case Management Program Description stated that the care support staff conducted an initial survey with new Medicaid members to identify members with special health care needs and that the CCM process used a comprehensive assessment of the member's individual needs, including input from the member, member's family/caregiver, the PCP, and medical record review. The CCM Comprehensive Assessment, discussed during the on-site presentation of care coordination cases, confirmed assessment of all of the elements outlined in the requirement. The CCM Case Identification diagram illustrated that members can be identified for CCM through health information system (HIS) utilization reports, provider or member referral, or new member health risk assessments (HRAs). DHMC staff submitted additional documents that outlined specific procedures related to member assessments and member identification for CCM. During the on-site interview, staff confirmed that CCM assessments are performed by appropriate health care professionals (i.e., licensed nurses or social workers). During the on-site interview, staff explained that DHHA case managers are embedded in several DHHA specialty clinics and provide the case management for many of the DHMC high-risk members with special health care needs.		
Required Actions: None.		
5. The Contractor shares with other health care organizations serving the member with special health care needs, the results of its identification and assessment of that member's needs, to prevent duplication of those activities. *42CFR438.208(b)(3)* DH Contract: II.D.5.a RMHP Contract: II.E.5.a	1. Care Coordination Documentation.pdf 2. Care Coordination Visio.pdf These two documents provide a narrative and illustrative overview of the care coordination activities by DH Managed Care. 3. CM01 v.01 Case Management Program Description.pdf This document describes how the various units within the CM department function to make sure the members can access the services they need. 4. DOP – Pediatric Referrals to Children's Hospital CO.pdf This document outlines the process used by Managed Care referral coordinators – to facilitate sharing of relevant medical records between Denver Health and Children's Hospital Colorado. 5. Medical Mgt Documentation Form.pdf Managed Care staff use this form to document member updates. The form is then uploaded into EDM – for viewing by all Denver Health providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	6. DH Release of Information Form.pdf DHHA form that provides consent for staff to assist in care coordination activities with multiple providers, agencies and/or services. 7. DH Behavioral Health Coordination Program.doc This document describes the coordination efforts between the Managed Care Pharmacy Department and the members' behavioral health providers.	
Findings: The Pediatric Referrals to Children's Hospital policy described the procedure for exchanging the assessment of member needs and clinical information between Children's Hospital and DHHA. During the on-site interview, staff stated that the CCM assessment and treatment plan and the member's DHHA medical record are accessible within the DHHA HIS. Staff stated that a release of information is obtained from members to allow complex case managers to disclose member information that is pertinent to a particular agency's services.		
Required Actions: None.		
6. The Contractor implements procedures to develop an individual treatment plan as necessary. *42CFR438.208(c)(3)* DH Contract: II.D.4.c.1 RMHP Contract: II.E.4.c.1	1. CM01 v.01 Case Management Program Description.pdf Pages 5-6 outline the CCM process, including Care Plan Development and Implementation. 2. HW01 v.02 Behavioral Health & Wellness Program Description.pdf Pages 7-8 describe the process used by the Health Coaches to develop treatment plans with their members. 3. CCM06 CCM process.pdf Visio illustrates the CCM program elements including assessment of individual needs, identification of barriers and other special health care needs. 4. Care Plan Process Training.pdf Training presented to staff about using Guiding Care™ to create and update individualized care plans.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	5. Care Plan Examples.doc Screenshot examples from Guiding Care™ of individual treatment/care plans. 6. SMAP_ENG.pdf 7. SMAP_SPA.pdf Tool used to improve members self-management skills and involvement in treatment planning activities.	
Findings: The Case Management Program Description stated that case managers work with the member/family to develop an individualized patient-centered plan of care that includes goals, interventions, and regular progress notes. The Behavioral Health and Wellness Program Description defined the processes for health coaches to assist members with a self-management care plan. The Care Plan Process training document outlined the process for documenting and updating the member care plan in the Guiding Care case management system. DHMC submitted examples of care plans. During the on-site interview, staff stated that the care plan assessment results would auto-generate goals and interventions in the Guiding Care system, or case managers could customize goals and interventions as appropriate. The care coordination case presentations demonstrated the development and implementation of individualized care coordination plans based on the member assessment that included prioritized goals, interventions, time frames for completion, and case manager progress notes with frequent follow-up.		
Required Actions: None.		
7. The Contractor's procedures for individual needs assessment and treatment planning are designed to: ◆ Accommodate the specific cultural and linguistic needs of the members. ◆ Allow members with special health care needs direct access to a specialist as appropriate to the member's conditions and needs. *42CFR438.208(c)(3)(iii)* DH Contract: II.D.4.c.1 RMHP Contract:II.E.4.c.1	1. CM01 v.01 Case Management Program Description.pdf Pages 5-6 outline the CCM process, including Care Plan Development and Implementation. 2. HW01 v.02 Behavioral Health & Wellness Program Description.pdf Page 5 includes discussion of staff training, including cultural competency 3. MCD Choice CHP UM04 v 02 Members w SHCNs.pdf Page 4 of this policy describes the Case Management process, to include individual needs assessment and treatment planning.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	4. Policy P-2.100 Interpreter and Translation Services and Auxiliary Communication Devices 10-12-12.pdf DHHA policy for use of interpreter and/or translation services. 5. LLS-Training Reference Guide.pdf 6. Quick Reference Guide_DHHA.pdf Reference tools for staff when utilizing interpretation services for members. 7. Language Proficiency Testing_visio 8. Language Proficiency Test Info.pdf 9. Language Proficiency Test FAQs.pdf 10. Sample LLS Proficiency Test.pdf 11. Language Proficiency_Test Taking Tips.pdf These documents show Managed Care's process to ensure staffs are adequately equipped to accommodate special linguistic needs of members. 12. CCM Initial Comprehensive Assessment.xls (Q5 and Q10) 13. Health Coaching Initial Comprehensive assessment.xls (Q5 and Q9) Questions in the initial assessments for these programs include evaluation of cultural and linguistic needs, preferences or limitations.	
Findings: The Case Management Program Description and assessment documents submitted by DHMC addressed the member's cultural and linguistic needs. DHMC also submitted evidence of programs and procedures that assist staff in addressing the language proficiency needs of members. The Coordination and Continuity of Care for Members with Special Health Care Needs and/or Disabilities policy stated that the PCP may provide a standing referral to a specialist appropriate to the member's needs. The policy also stated that if necessary specialty care is not available in the DHMC network, staff would arrange for the member to see an out-of-network provider. The Compliance with Requirements of the Americans with Disabilities Act and Rehabilitation Act policy addressed the provision of special services to accommodate the needs of members with disabilities. The DHMC Member Handbook		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
communicated that members with special needs could continue care with existing providers for a period of time when transitioning into or out of the Plan. The Member Handbook also stated that members must have a PCP referral to see a specialist. During the on-site interview, staff stated that the PCP referral is intended to facilitate the transfer of necessary information between providers, and that no authorization is required for in-network referrals. Staff also stated that after initial referral by the PCP, a member may re-access the specialist without a new referral. HSAG recommended that DHMC review the member handbook and the provider manual to determine the clarity and consistency of communications that members with special health care needs may have direct access to a specialist, or clearly describe DHMC's process for standing referrals.		
Required Actions: None.		
8. The Contractor ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that they are applicable. In all other operations as well, the Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42CFR438.208(b)(4)* *42CFR438.224* DH Contract: II.D.4.a, II.E.3.c RMHP Contract: II.E.4.a, II.F.3.c	1. HIP01 v.04_Confidentiality, Privacy, and Security of Member Information.pdf Demonstrates that each member's privacy is protected and that individually identifiable health information is used and disclosed in accordance with the privacy requirements in 45CFR parts 160 and 164, subparts A and E. 2. CHOICE_CTS301.pdf 3. DH Code of Conduct 2011.pdf (pgs. 8 & 20) 4. New Employee Orientation - HIPAA Compliance.ppt	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Confidentiality, Privacy, and Security of Member Information policy stated that all providers, employees, vendors, and subcontractors are required to maintain confidentiality of member information; and they may only disclose information for treatment, payment, and operations associated with administering patient care, including care management. The policy stated that DHMC would obtain appropriate member authorization for other uses or disclosures, and described multiple circumstances in which member authorization is and is not required for disclosure of member information. DHMC required employees to sign a confidentiality agreement and included confidentiality requirements in provider contracts. The policy outlined the process of documenting and tracking disclosures of protected health information (PHI) through the compliance department; and it described the administrative,		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
physical, and technical safeguards to protect PHI. DHMC submitted information related to employee communications and training related to member confidentiality, PHI, and HIPAA privacy requirements. The Community Resources and Coordination of Mental Health procedure included a requirement to obtain a member release of information to share PHI or mental health information for coordination of services.		
Required Actions: None.		
9. The Contractor's procedures include a strategy to ensure that all members and/or authorized family members are involved in treatment planning and consent to medical treatment. DH Contract: II.D.4.c.3 RMHP Contract:II.E.c.3	1. CM01 v.01 Case Management Program Description.pdf Pages 5-6 discuss inclusion of authorized family members/caregivers in the CCM process. 2. DOP – Community Resources.pdf Program procedure that outlines how member and/or family/caregiver involvement in the coordination and referral for community resources. 3. DOP – Coordination of Mental Health.pdf Pages 2-3 discuss ways in which the members and/or family members are involved in the mental health referral/coordination process. 4. CCM Initial Comprehensive Assessment.xls (Q7-Q9) 5. Health Coaching Initial Comprehensive Assessment.xls (Q7-Q9) Initial assessment of member health status, including specific question about family, caregiver and/or support system involvement. 6. CM Program Consent.docx Letter sent to members to obtain consent for CM services.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Case Management Program Description stated that member involvement in complex case management is voluntary and requires written member consent. It also stated that complex case managers include the member and/or family and caregivers in the development of the member care plan, self-management goals, and interventions. The case management assessment documents identified family/caregivers who the member would like to be		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
involved in the treatment plan. The care coordination case presentations demonstrated that the care coordination plan included a checkmark to designate the individual goals that the member has designated as high-priority goals. Care plan progress notes also documented frequent contact with the members. HSAG recommended that DHMC explore a mechanism to more clearly document the member's/family's agreement with the treatment plan in the Guiding Care case management system.		
Required Actions: None.		
10. The Contractor: ◆ Instructs its participating providers on how to refer a member for wraparound services. ◆ Advises participating providers of EPSDT support services that are available through local public health departments. ◆ Informs the provider of the availability of the following wraparound services: • Auditory services (children)—HMO covered services include screening, medically necessary ear exams, and audiological testing. Wraparound benefits include hearing aids, auditory training, audiological assessment, and hearing evaluation. • Dental services (children)—comprehensive dental assessment, care, and treatment (age 1 or before). • Drug/Alcohol treatment for pregnant women—assessment and treatment (Special Connections Program administered by the Alcohol/Drug Abuse Division, Department of Human Services. Specified treatment centers only). • Extraordinary Home Health Services—expanded EPSDT benefit includes any combination of necessary home health services that exceed the maximum allowable per day; and services that must, for medical reasons, be provided at	Please see Medicaid Choice Provider Manual MCD_PROV_MANUAL_PG69.pdf MCD_PROV_MANUAL_PG76.pdf MCD_PROV_MANUAL_PG82.pdf MCD_PROV_MANUAL_PG91-94pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
locations other than the child's place of residence. • HCBS services—case management, home modification, electronic monitoring, personal care, and non-medical transportation. • Hospice services—client may continue to receive care not related to the terminal illness from the HMO. • Hospital back-up level of care as set forth in 10 CCR 2505-10, Section 8.470. • Inpatient substance abuse rehabilitation DRG 936 (Valley View). • Intestinal transplants (excluding immunosuppressive medications, which are a covered HMO benefit) covered alone or with other simultaneous organ transplants (e.g., liver); coordinated by the Department and HMO case manager (provided only at three out-of-state facilities: University of Pittsburgh, Jackson Memorial, and Mt. Sinai). • Non-emergency transportation to medical appointments—covered services (through the client's county of residence). • Private duty nursing (nursing services only). • Skilled nursing facility services (skilled nursing and rehabilitation services) if client meets level of care certification. DH Contract: II.D.4.g RMHP Contract: II.C.4.i		
Findings: The Medicaid Choice Provider Manual defined wraparound services, listed the wraparound services available to Medicaid members as outlined in the requirement, and instructed the provider on how to contact the State Medicaid Customer Service department to obtain details. The provider manual		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
described the role of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Outreach Coordinator (located at the local health department) to assist members seeking wraparound services.		
Required Actions: None.		
11. The Contractor informs all members aged 20 and under that EPSDT services are available. Information must effectively inform those individuals who are blind or deaf, or who cannot read or understand the English language and must include: ◆ The benefits of preventive health care. ◆ That services provided under the EPSDT program are without cost to the individual. ◆ The services available under the EPSDT program and where and how to obtain those services, which include: • Auditory devices (children)—HMO covered services include screening, medically necessary ear exams, and audiological testing. Wraparound benefits include hearing aids, auditory training, audiological assessment, and hearing evaluation. • Dental services (children)—comprehensive dental assessment, care, and treatment (age 1 or before). • Drug/Alcohol treatment for pregnant women—assessment and treatment (Special Connections Program administered by the Alcohol/Drug Abuse Division, Department of Human Services. Specified treatment centers only). • Extraordinary Home Health Services—expanded EPSDT benefit includes any combination of necessary home health services that exceed the maximum allowable per day; and services that	1. 1100 Medicaid HB_2012-13 ENG.pdf 2. 1100 Medicaid HB_2012-13 SPA.pdf These two documents (found in the common documents folder) demonstrate that DHMC informs all members about the EPSDT benefits available to them. 3. QI Well child visit flyer. V3.pdf 4. QI Well child visit teen v1.pdf 5. QI SBHC flyer v6.pdf [#3-5 are mailing reminders of what services are available to the members]	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
must, for medical reasons, be provided at locations other than the child's place of residence. • HCBS services—case management: home modification, electronic monitoring, personal care, and non-medical transportation. • Hospice services—client may continue to receive care not related to the terminal illness from the HMO. • Hospital back-up level of care as set forth in 10 CCR 2505-10, Section 8.470. • Inpatient substance abuse rehabilitation DRG 936 (Valley View). • Intestinal transplants (excluding immunosuppressive medications, which are a covered HMO benefit) covered alone or with other simultaneous organ transplants (e.g., liver); coordinated by the Department and HMO case manager (provided only at three out-of-state facilities: University of Pittsburgh, Jackson Memorial, and Mt. Sinai). • Non-emergency transportation to medical appointments—covered services (through the client's county of residence). • Private duty nursing (nursing services only). • Skilled nursing facility services (skilled nursing and rehabilitation services) if client meets level of care certification. *42CFR441.56(a)(1)—(3)* DH Contract: II.E.6.e RMHP Contract: II.D.6.e		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The DHMC Member Handbook stated that EPSDT services are available at no cost through the member's PCP and listed the periodic examination schedule, as well as the schedule of immunizations. The handbook detailed the EPSDT wraparound service benefits and instructed members to contact the county health department EPSDT coordinator for details. DHMC submitted several samples of communications and reminders sent to members regarding the recommended frequency and composition of well-child visits. These communications emphasized the importance of regular visits and immunizations to maintain the health of the child. The member handbook was printed in Spanish and English and informed members that all information is available in other languages, Braille, large print, and audiotapes.		
Required Actions: None.		
12. The Contractor provides referral assistance for treatment that is not covered by the plan, but found to be needed as a result of conditions disclosed during screening and diagnosis. *42CFR441.61(a)* DH Contract: II.D.4.g RMHP Contract: II.C.4.i	1. CM01 v.01 Case Management Program Description.pdf Pages 4 and 7 discuss activities of the CCM and UM staff to refer members for treatment that is not covered by the plan. 2. DOP – Community Resources.pdf Program procedure outlining how to assist member's with identified needs that are not covered by the plan but found to be needed. 3. Wraparound Benefit reference guide.pdf Reference guide for staff regarding how to assist with referrals for treatment that are considered a wraparound benefit.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Case Management Program Description stated that either the UM team (less-complex cases) or CCM team (more complex cases) assist the member with referrals to community resources, including wraparound services. The Care Support staff also educates members regarding wraparound benefits or benefits available through other government or community resources. The Wraparound Benefits Reference Guide provided detailed instructions for case manager referrals regarding each of the specific wraparound services. The Community Resources procedure and electronic Community Resource Repository defined the mechanisms for case managers to assist members with referrals to ancillary, social, or community services.		
Required Actions: None.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor provides to members regularly scheduled examinations and evaluations of general physical and mental health, growth, and development, and nutritional status of infants, children, and youth. Screenings must include: ◆ Comprehensive health and developmental history. ◆ Comprehensive, unclothed physical examination. ◆ Appropriate vision testing. ◆ Appropriate hearing testing. ◆ Appropriate laboratory testing. ◆ Dental screening services furnished by direct referral to a dentist for children beginning at 1 year of age. ◆ If it is determined at the time of screening that immunization is needed, and appropriate, then immunizations must be provided at the time of treatment. *42CFR441.56(a)(4)(b)—(c)* DH Contract II.E.6.e RMHP Contract II.D.6.e	Medicaid for moms card.web.pdf – comprehensive incentive program to encourage moms-to-be to stay on top of all their checkups for their babies health and developmental history QI SBHC flyer v6.pdf – reminder for children in our school based clinics to obtain a yearly check up QI Well child visit flyer. V3.pdf QI Well child visit teen v1.pdf [both #3-4 are reminders sent to members that go over age brackets from birth to 20 years of age and what appropriate visit should be done such as prevention, immunization, hearing, vision, labs, physical examination and diet]	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The DHMC Provider Manual informed providers of the need to perform EPSDT screenings for all Medicaid children and specified the types and schedule of screenings, including all of the elements in the requirement. The DHMC member handbook informed members of the need to obtain EPSDT screenings through the member's PCP and provided the periodic schedule of examinations and immunizations. The School-Based Health Care flyer informed members that children may receive primary care and screening services through designated school-based clinics. DHMC submitted several examples of communications and reminders sent to members concerning the frequency and composition of well-child visits. During the on-site interview, staff stated that providers access the State's Immunization Registry and provide any needed immunizations during each member PCP visit.		
Required Actions: None.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor has implemented the State's periodicity schedule for screening services and specifies screening services applicable at each stage of the member's life, beginning with neonatal examination, up to the age at which an individual is no longer eligible for EPSDT services. (The Contractor must demonstrate outreach efforts based on established periodicity schedules) *42CFR441.58* DH Contract II.E.6.e RMHP Contract II.D.6.e	QI Well child visit flyer. V3.pdf QI Well child visit teen v1.pdf [both #1-2are reminders sent to members that go over age brackets from birth to 20 years of age and what appropriate visit should be done such as prevention, immunization, hearing, vision, labs, physical examination and diet] Medicaid HB_2012-13 ENG.pdf, pg. 15 Medicaid HB_2012-13 SPA.pdf, pg. 15 (found in the common documents folder) These documents demonstrate that State's periodicity schedule for screenings is expressed to members.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The DHMC Provider Manual and the DHMC Member Handbook included the description of EPSDT services available through the PCP, including the periodicity schedule for screenings, exams, and immunizations. The provider manual also instructed PCPs to schedule the next appointment for EPSDT services at the time of each patient visit. DHMC submitted examples of communications and reminders for members regarding the schedule and composition of EPSDT services. Staff stated that well-child flyers are mailed to members quarterly, and the annual exam reminder card is sent to members on the child's birthday. During the on-site interview, staff stated that State Immunization Registry and DHHA information system reports track needed EPSDT services and are used by DHHA providers, staff, and school-based clinics to track needed services and assist with determining who needs outreach and reminders sent. Staff emphasized the importance of the school-based clinics in the provision of well-child exams. In addition, DHMC had an EPSDT committee that reviewed the periodicity schedules and EPSDT services provided, and determined initiatives to ensure the provision of EPSDT services.		
Required Actions: None.		
15. The Contractor maintains policies describing its screening package and the methods used to assure that screening requirements are met. *42CFR441.56(d)* DH Contract II.E.6.e RMHP Contract II.D.6.e	1. QI well child teen v1.pdf QI well child visit flyer v3.pdf HH Happy Bday 2012 v1.pdf HH Happy Bday Span 2012 v1.pdf Demonstrates: how to contact and obtain an appointment and the services/preventive services offered per age/ announced on annual birthday reminder cards. The well child flyers are mailed out quarterly to members and the birthday cards	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	annually. 2. QI SBHC flyer v6.pdf Demonstrates: what services are offered, hours of operation, and there is no cost sharing to the member. This is sent out to members in the Fall, Spring, and Summer. 3. QI Back to school DHMC v1.pdf Demonstrates: incentive program for children to receive their yearly check-ups, how to make an appointment to see their doctor, how to contact Member Services, TTY/TDD services for the hearing impaired and hours of operation.	
Findings: Staff submitted evidence of many tools and communications related to EPSDT screening requirements. During the on-site interview, staff stated that the Quality Improvement (QI) Department screens tracking reports of the status of EPSDT screenings for members at least quarterly. Staff stated that the EPSDT screening requirements and monitoring methods were not outlined in a formal DHMC policy.		
Required Actions: DHMC must develop and approve a policy and procedure that outlines the EPSDT screening package and methods to ensure that screening requirements are met.		

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	14	X	1.00	=	14
	Partially Met	=	0	X	.00	=	0
	Not Met	=	1	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	15	**Total Score**		=	14

Total Score ÷ Total Applicable	=	93%

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has written policies and procedures regarding member rights. *42CFR438.100(a)(1)* DH Contract: II.E.1.a RMHP Contract: II.F.1.a	1. GV02 v.04_Member Rights and Responsibilities.pdf – Outlines DHMC policies and procedures regarding member rights. 2. CHOICE_UMG1008.pdf Outlines DHMC policies and procedures regarding member rights to Advance Directives.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Member Rights and Responsibilities policy included each of the rights at 42CFR438.100 and as described in the Colorado Medicaid Managed Care contract. DHMC also had topic-specific policies that addressed specific member rights such as grievances and appeals, advance directives, and providing culturally and linguistically appropriate services.		
Required Actions: None.		
2. The Contractor ensures that its staff and affiliated network providers take member rights into account when furnishing services to members. *42CFR 438.100(a)(2)* DH Contract: None. RMHP Contract: None.	1. GV02 v.04_Member Rights and Responsibilities.pdf Demonstrates that DHMC has policies and procedures in place regarding member rights that staff and affiliated network providers must follow when providing services to members.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The member handbook informed members of their rights under the Medicaid program. The DHMC Provider Manual (distributed via DHHA's intranet for DHHA providers and mailed to independently contracted providers) listed member rights and informed providers of the expectation that providers understand the rights listed and that they treat members of the DHMC health plan with respect. The May 25, 2012, Provider Newsletter (distributed via the intranet for DHHA providers and mailed to independently contracted providers) included an article titled, "Shared Decision Making" that described the benefits of including members in treatment decisions. DHMC may want to consider including additional topic-specific member rights articles in provider newsletters periodically. During the on-site interview, DHMC staff described methods of keeping the topic of member rights visible to staff and providers. Methods included periodic discussions and trainings in DHHA provider meetings and DHMC leadership meetings and availability of rights' lists on the Web site and company portal. Staff members also reported that customer service and grievance staff members are encouraged to take the opportunity to explain member rights during member-initiated telephone calls to ensure member understanding.		
Required Actions: None.		

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's policies and procedures ensure that each member is treated by staff and affiliated network providers in a manner consistent with the following specified rights: ◆ Receive information in accordance with information requirements (42CFR438.10). ◆ Be treated with respect and with due consideration for his or her dignity and privacy. ◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. ◆ Participate in decisions regarding his or her health care, including the right to refuse treatment. ◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. ◆ Obtain family planning services directly from any provider duly licensed or certified to provide such services without a referral. ◆ Request and receive a copy of his or her medical records and request that they be amended or corrected. ◆ Be furnished health care services in accordance with requirements for access and quality of services (42CFR438.206 and 42CFR438.210). *42CFR438.100(b)(2) and (3)* DH Contract: II.E.1.a RMHP Contract:II.F.1.a	1. DHMC Member Handbook ENG.pdf – (found in the common documents folder) Demonstrates that members receive information in accordance with information requirements. 2. GV02 v.04_Member Rights and Responsibilities.pdf – Outlines DHMC policies and procedures which ensure that each member is treated with respect, receives information about treatment options and alternatives, participates in his or her health care, is free from any restraint or seclusion, can obtain family planning services without a referral, and can request a copy of his or her medical records. 3. QI SBHC flyer v6.pdf - Is furnished health care services in accordance with requirements for access and quality of services for children within 5 miles of Denver Health School based systems. Demonstrates that we address Cultural and Linguistic Appropriate Services and train staff. 4. CHOICE_QIM1305l.pdf Demonstrates that we address Cultural and Linguistic Appropriate Services and train staff. 5.MCD_QI01 v.04_Quality Improvement Program Description.pdf (page 6 under heading #5 titled Cultural and Linguistic Competency) 6. Denver Health has specific Policies that apply to all employees and address cultural awareness: a. American with Disabilities Act 4-144	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	b. Cultural and Religious Considerations Relative to Provision of Care 4-141 c. Equal Opportunity Employment 2-100 d. Workforce Diversity 4-108 7. CHOICE_UMG1008.pdf Outlines DHMC policies and procedures regarding member rights to Advance Directives.	
Findings: DHMC staff members reported that routine and most specialty services (unless not available within the DHHA system) are provided to DHMC members by the staff providers and DHHA clinics. The Member Rights and Responsibilities policy included each of the member rights. The list of member rights was published in the Medicaid Choice Summer 2012 Member Newsletter. The provider manual included each of the member rights. The May 25, 2012, Provider Newsletter contained an article about shared decision making in providing medical care. Several policies described processes to ensure cultural awareness and linguistically appropriate services. During the on-site interview, DHMC staff members reported that DHMC member rights staff members provide presentations regarding member rights and related processes during DHHA staff orientation. Staff stated that patient advocate staff are trained regarding DHMC member rights and grievance and appeals processes and will refer members to the managed care staff to follow up on any member concerns expressed to DHHA staff members. Staff also stated that grievance staff members review member grievances to determine if there are trends or patterns that indicate member rights have been violated.		
Required Actions: None.		
4. The Contractor ensures that each member is free to exercise his or her rights and that exercising those rights does not adversely affect the way the Contractor or its providers treat the member. *42CFR438.100(c)* DH Contract: II.E.1.a.7 RMHP Contract: II.F.1.a.7	1. DHMC Member Handbook, pg. 10 – (found in the common documents folder) Demonstrates that DHMC notifies each member of their rights and that practicing these rights will not result in adverse treatment from Contractor or providers. 2. Choice Matters Newsletter 6_12_Eng.pdf pgs. 8-9 – Demonstrates that DHMC notifies the member that exercising his or her rights will not adversely affect the way the Contractor or providers treat them. 3. GV02 v.04_Member Rights and Responsibilities.pdf (part VI.A.x) Demonstrates that plan has policies in place that ensure that its	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	members are free to exercise their rights without any adverse effect in the way they are treated.	
Findings: The members' right to freely exercise rights without fear of retaliation is on the lists of rights found in the Member Rights and Responsibilities policy, the member handbook, the Summer 2012 member newsletter, and the provider manual. The Grievances section of the member handbook informed members that they will not lose Medicaid benefits because of filing a grievance. DHMC staff reported that member rights are listed in the member newsletter at least once per year and that the newsletter is a quarterly publication distributed via U.S. mail.		
Required Actions: None.		
5. Contractor complies with any other federal and State laws that pertain to member rights including Title VI of the Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act, and titles II and III of the Americans with Disabilities Act. *42CFR438.100(d)* DH Contract: IV.W RMHP Contract: VI.X	1. Americans With Disabilities Act (ADA) 4-144.pdf 2. Cultural and Religious Considerations Relative to Provision of Care 4-141.pdf 3. EqualEmploymentOpportunity2-100.pdf 4. Workforce Diversity 4-108.pdf 5. InternalDiscriminationInvestigationProcess4-109.pdf 6. CHOICE_MBR801 Compliance with Requirements of the American Disabilities Act of 1990 and Section 504 of the Rehabilitation A.PDF 7. SexualHarassmentNonDiscrimination4-106.pdf Demonstrates that Denver health complies to non-discriminatory procedures. 8. CHOICE_ADM101.pdf Demonstrates that the plan has policies in place that mandate compliance with Federal and State laws	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DHMC provided several policies that articulated DHMC's commitment to compliance with federal nondiscrimination regulations in its interactions with employees and members. The member handbook included a statement that informs members that DHMC will not take any action against a member because of race, color, sex, age, religion, political values, national origin, language, sexual choice, or disability. The Medicaid Choice Compliance with Federal and State Laws policy described the processes to ensure compliance with federal and State Laws, including nondiscrimination laws.		
Required Actions: None.		

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

Total Score ÷ Total Applicable	=	100%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as 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 CRE01 v. 03 Credentialing and Recredentialing of Practitioners.pdf- #2 CRE01 v 03ATT B DHH MS Bylaws.pdf Article XVIII, Section 3, B, Section 4, E & F, pages 37-44. #1 describes the formal process DHMC uses for credentialing and recredentialing of independent direct network practitioners #2 DHH Medical Staff Bylaws, (Article XVIII Section 3 #B & Section 4 #E & F) describes the DHHA process for credentialing, recredentialing and selection of DHHA practitioners who are credentialed.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: During the on-site interview, DHMC staff members described DHMC's credentialing processes and organizational and management structure. DHMC is a line of business within DHHA. DHHA clinics 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 independent practitioners contracted with DHMC. The DHHA Medical Staff Bylaws, Rules and Regulations, Fair Hearing Plan, and Appointment Procedures (the Medical Staff Bylaws), 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 with DHMC. The policy and the Medical Staff Bylaws were consistent with NCQA's *2012 Standards and Guidelines for Health Plans*.		
Required Actions: None.		
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 non-physician practitioners who have an independent relationship with the Contractor. (Examples include doctors of medicine [MDs],	#1 CRE01 v. 03_Credentialing and Recredentialing of Practitioners.pdf (see page 1 SCOPE) #2 CRE01 V. 03_ATT B DHH MS Bylaws.pdf Article IV, Section 1, (physician), Article VII, Section 2 Organization of the Medical Staff: letter e (for non-physician). Page 19 #1 DHMC requires credentialing of the following types of providers: 1. Medical Doctor (MD) 2. Doctor of Osteopathy (DO) 3. Doctor of Podiatric Medicine (DPM)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
doctors of osteopathy [DOs], and podiatrists.) *42CFR438.214(a)* NCQA CR1—Element A1	4. Doctor of Optometry (OD) 5. Oral Surgeons who are Dentists providing care under medical benefits 6. Non-physician practitioners who are licensed or certified by the state, have an independent relationship with the organization, and provide care under the organization's medical benefits. 7. Allied Health Professionals (AHP) who are licensed by the state and permitted to practice independently under state law: Nurse Practitioners (NP), Physician Assistants (PA), Certified Nurse Midwives (CNM), Certified Registered Nurse Anesthetists (CRNA). 8. Master's level clinical social workers who are state licensed #2 CRE01 V. 03_ATT B DHH MS Bylaws, Article XVIII, Medical Staff Appointment Procedures: Credentialing , Section 2 POLICY (for physicians); Article VII. Section 2 Organization of the Medical Staff: Page 19. Describes who DHHA is required to credential: 1. Scope describes types of independent direct practitioners credentialed by Managed Care. 2. Article IV describes types of practitioners who are credentialed for DHHA –both physician and non-physician. 3. Article XVIII: describes types of practitioners who are credentialed for DHHA –both physician and non-physician.	
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), doctors of podiatric medicine (DPM), and doctors of optometry (OD); and non-physician practitioners such as masters-level clinical social workers who are state-certified or licensed, and allied health professionals (AHPs). The policy defined AHPs as licensed professionals who are permitted to practice independently under State law (i.e., nurse practitioners [NPs], physician assistants [PAs], certified nurse midwives [CNMs], clinical nurse specialists [CNSs], and certified registered nurse anesthetists [CRNAs]). The Medical Staff Bylaws (applicable to DHHA staff practitioners) addressed credentialing and recredentialing of physician and non-physician practitioners employed by DHHA.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.B. The verification sources used. NCQA CR1—Element A2	#1 CRE01 v. 03 Credentialing and Recredentialing of Practitioners.pdf (#VI Procedures-page 3 & Attachment F) #2: CRE01 V. 03_ATT B DHH MS Bylaws.pdf Article XVIII Medical Staff Appointment Procedures: Section 4. Element and Verification Source, see pages 40-41 # 1 & #2 lists resources used by DHMP & DHHA for verification purposes; these are NCQA & JC approved resources	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Attachment F to 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. The Medical Staff Bylaws (applicable to DHHA practitioners) also described primary sources used for verification of each required element.		
Required Actions: None.		
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	#1 CRE01 v. 03 Credentialing and Recredentialing of Practitioners.pdf (Pages 3-10) under VI-Procedures #2 CRE01 V. 03_ATT B DHH MS Bylaws.pdf Article XVIII Section 3, B; see page 38 The criteria for credentialing and recredentialing is clearly outlined in #1 (Procedures) for independent network providers and #2 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 contracted network. The Medical Staff Bylaws listed the general and basic qualifications (e.g., licensure and federal health care eligibility, clinical knowledge, communication skills, and professionalism) as well as conditions and requirements for appointment to a specific DHHA staff position.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	#1 CRE01 v. 03 Credentialing and Recredentialing of Practitioners page.pdf 5 #E-I #2 CRE01 V. 03_ATT B DHH MS By-Laws.pdf Article XVIII Section 4 # E, F, & G Pages 42-44 #1 DHMC has a well-defined process for making credentialing and recredentialing decisions as outlined in CRE01 P&P under Credentialing Committee and Role of Medical Director #2 describes the process for DHHA providers.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy clearly delineated the process for making credentialing and recredentialing decisions for physician and non-physician practitioners contracted directly with DHMC. The Medical Staff Bylaws clearly delineated the process for making credentialing and recredentialing decisions for physicians. Although the Medical Staff Bylaws stated that the bylaws applied to AHPs, they did not delineate processes used for making credentialing and recredentialing decisions for the AHPs. During the on-site interview, DHMC and DHHA staff members explained that AHPs are credentialed using different processes and a separate credentialing committee.		
Required Actions: DHMC must either revise the Medical Staff Bylaws or develop policies and procedures that clearly describe the process for making credentialing and recredentialing decisions for DHHA AHPs.		
2.E. The process for managing credentialing/ recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	#1 CRE01 v. 03 Credentialing and Recredentialing of Practitioners.pdf Under Confidentiality on page 6. #2 CRE01 V. 03_ATT B DHH MS ByLaws.pdf Article XVIII Section 12 Confidentiality, see page 51. The process as described in # 1 and # 2 outlines how the files are maintained under strict security and confidentiality according to NCQA standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy and the Medical Staff Bylaws described the process for determining which credentialing files met the required criteria, which was consistent with NCQA requirements. The policy and the bylaws defined clean files, which can be presented to the DHMC medical director for approval for contracted practitioners, or the Medical Staff Executive Committee for DHHA-employed practitioners. The		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
policy also defined red-flagged files, which must be presented to the credentialing committee(s) for discussion and recommendations regarding action to be taken. During the on-site interview, DHMC and DHHA credentialing staff indicated that clean files approved by the DHHA chief medical officer were typically presented to the committee as well as red flagged files, while DHMC (independently contracted) files approved by the DHMC medical director were typically not presented to the DHMC credentialing committee but were available to the committee for review, if requested.		
Required Actions: None.		
2.F. The process for delegating credentialing or recredentialing (if applicable). NCQA CR1—Element A6	#1 CRE05 v.03 Delegation of Credentialing Activities.pdf #2 CRE01 v. 03 Credentialing and Recredentialing of Practitioners.pdf Attachment K: MOU #1 this P&P outlines the requirements for delegation of credentialing activities #2 DHMC & DHHA are sister organizations, therefore there is no official delegation agreement required, but there is a Credentialing Memorandum of Understanding between the DHHA Medical Staff Office and Denver Health Managed Care that describes credentialing responsibilities of each department.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Delegation of Credentialing policy described the processes for delegating credentialing and recredentialing activities. These processes included a pre-delegation audit, assessment of policies and procedures, required provisions for contracting, and oversight procedures. DHMC had a Memorandum of Understanding (MOU) with the Medical Staff Office (MSO), a department within DHHA for the credentialing and recredentialing of DHHA practitioners who provide services to DHMC members. During the on-site interview, DHMC staff members described the agreement as an interdepartmental agreement rather than a formal delegation agreement.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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 CRE01 v.03 Credentialing and Recredentialingof Practitioners.pdf VI PROCEDURES - Nondiscriminatory credentialing and recredentialing, page 3 #2 CRE01 V. 03_ATT B DHH MS Bylaws.pdf Article XVIII – Sec. 2 POLICY, see page 37 The statement of non-discrimination and the steps to ensure decisions are not made 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 is documented in # 1 and 2 above.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:

The Credentialing and Recredentialing of Practitioners policy and the Medical Staff Bylaws 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 the bylaws 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 presented in the application and primary source verification. On-site review of committee minutes confirmed that credentialing decisions were based on the credentialing criteria. On-site, HSAG reviewed evidence that members of the DHMC credentialing committee annually signed attestation/agreements to conduct credentialing committee activities in a nondiscriminatory manner. The policy also described an annual nondiscrimination audit that would occur in response to any discrimination complaints received from practitioners. Each year the director of provider relations informs the credentialing staff whether there had been complaints. If there were complaints, an audit would be conducted. The last query whether there had been complaints regarding discrimination during the credentialing processes was dated 1/6/12. There were no nondiscrimination audits required as a result of this query.

Required Actions:

None.

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as 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 CRE01 v.03, Credentialing and Recredentialing of Practitioners.pdf IV PROCEDURES Practitioner Rights, page 4 # 2 CRE01 V. 03_ATT B DHH MS Bylaws.pdf Article XVIII, Sec. 4, Procedures for Appointment, Credentialing and Recredentialing; C, paragraph. 3, see page 45. The process for notifying practitioners if information obtained during the credentialing/recredentialing process varies substantially from the information they provide is described in the above # 1 and #2.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy and the Medical Staff Bylaws 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 in support of the credentialing application.		
Required Actions: None.		
2.I. The process for ensuring that practitioners are notified of credentialing and recredentialing decisions within 60 calendar days of the committee's decision. NCQA CR1—Element A9	# 1 CRE01 v.03, Credentialing and Recredentialing of Practitioners.pdf IV PROCEDURES Practitioner Rights, #D page 4 plus Attachments G & H (letter templates) #2 CRE01 V. 03_ATT B DHH MS Bylaws.pdf Article XVIII, Sec. 4, letter G, 1st paragraph, pages 43 – 44. DHMP and DHHA both notify practitioners of its credentialing decision within 60 days, as outlined in the referenced P&P and demonstrated in the letter templates	☒ 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. The DHHA Medical Staff Bylaws depicted notification within 30 days. On-site review of 10 credentialing and 10 recredentialing records confirmed notification within the stated time frames.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.J. The medical director's or other designated physician's direct responsibility and participation in the credentialing/ recredentialing program. NCQA CR1—Element A10	#1 CRE01 v.03, Credentialing and Recredentialing of Practitioners.pdf Credentialing Committee and Role of Medical Director, page 5-6 #2 CRE01 v 03 ATT B DHH MS Bylaws.pdf Article XVIII, Sec. 4. E-G and Sec. 5, pages 42-45. #1 describes the medical director's responsibility and participation in the credentialing/ recredentialing program for DHMC independent direct network practitioners. #2 describes the role of the DHHA Med Staff Executive Committee and Chief Medical Officer in the DHHA credentialing process	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy and the Medical Staff Bylaws described the roles of the chief medical officer (for DHHA) and the managed care medical director (for DHMC) regarding clean and red-flagged files and participation in the credentialing committees. During the on-site interview, staff confirmed the respective medical director (or physician-designee) participation in approval of clean files and as chairperson of the respective committees (the DHHA Medical Staff Executive committee, the DHHA AHP credentialing committee, or the DHMC credentialing committee). On-site review of committee meeting minutes for each committee confirmed medical director participation in the committees.		
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 CRE01 v. 03, Credentialing and Recredentialing of Practitioners.pdf Sec. VI PROCEDURES, Confidentiality and PHI, page 6 #1 CRE01 V. 03_ATT B DHH Bylaws.pdf Article XVIII, Sec. 12 Confidentiality, Page 51 All information obtained in the process of credentialing and recredentialing is confidential as described in #1 for DHMC network practitioners, and #2 for DHHA practitioners.	☒ 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. Medical Staff Bylaws stated that all files would be kept under strict security and designated which staff members would be allowed access to credentialing and		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
recredentialing files. On-site, DHHA and DHMC staff members confirmed processes for ensuring the confidentiality of credentialing files. HSAG reviewed signed confidentiality attestations for the DHMC committee members.		
Required Actions: None.		
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	CRE01 v.03 Credentialing and Recredentialing of Practitioners.pdf VI (Procedures), Provider Directories, see page 7 The information contained in the DHMC provider directories is electronically transmitted comes the credentialing database and is managed by the credentialing coordinator.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy stated that, 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 directory was refreshed with current credentialing/recredentialing data monthly. Staff also clarified that the provider directory included only DHHA clinics and practitioners, and that independently contracted providers are specialty practitioners or facilities that are used only upon member referral by a DHHA practitioner.		
Required Actions: None.		
2.M. The right of practitioners to review information submitted to support their credentialing or recredentialing application, upon request. NCQA CR1—Element B1	#1 CRE01 v.03, Credentialing and Recredentialing of Practitioners.pdf VI PROCEDURES, Practitioner Rights #A, page 4 #2 CRE01 V. 03_ATT B DHH Bylaws.pdf Article XVIII, Sec. 13 Practitioner Right to Review Information, see page 51 All practitioners credentialed, both DHHA and network, have the right to review information being used for credentialing purposes except that which is peer protected; they have the right to correct any erroneous information as described in #1 for DHMC network practitioners, and #2 for DHHA practitioners.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The Credentialing and Recredentialing of Practitioners policy and the Medical Staff Bylaws included the right of practitioners to review information submitted to support the credentialing or recredentialing application.		
Required Actions: None.		
2.N. The right of practitioners to correct erroneous information. NCQA CR1—Element B2	#1 CRE01 v.03, Credentialing and Recredentialing of Practitioners.pdf VI PROCEDURES, Practitioner Rights #A, page 4 #2 CRE01 V. 03_ATT B DHH Bylaws.pdf Article XVIII, Sec. 13 Practitioner Right To Review Information, see page 51. Practitioners have the right to correct erroneous information as described in # for DHMC network providers, and #2 for DHHA providers	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy and the Medical Staff Bylaws 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 application. NCQA CR1—Element B3	#1 CRE01 v.03, Credentialing and Recredentialing of Practitioners.pdf VI PROCEDURES, Practitioner Rights #A, page 4 #2 CRE01 V. 03_ATT B DHH Bylaws.pdf Article XVIII, Sec. 13 Practitioner Right to Review Information, see page 51 Practitioners have the right to check on the status of their application as described in #1 for DHMC network practitioners, and #2 for DHHA practitioners.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The Credentialing and Recredentialing of Practitioners policy and the Medical Staff Bylaws included the right of practitioners to check the status of their credentialing or recredentialing application.		
Required Actions: None.		
2.P. The right of applicants to receive notification of their rights under the credentialing program. NCQA CR1—Element B4	#1 CRE01 v.03, Credentialing and Recredentialing of Practitioners.pdf VI. PROCEDURES, Practitioner Rights, #D & Attachments G & H letter templates #2 CRE01 V. 03_ATT B DHH Bylawspdf Article XVIII, Sec. 4. B, Content of Application Form, 1, see Page 39 MCD_PROV_MANUAL_PG55-56.pdf Applicants are notified of their rights via several documents; DHMC independent direct practitioners receive notification through the letter of intent, and the DHMC Providers Manual. #2 describes the process for all DHHA providers	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy included the applicant's right to receive notification of applicant rights. The Medical Staff Bylaws did not address notification to applicants regarding their rights under the credentialing program.		
Required Actions: DHMC must develop or revise documents to address notification to DHHA applicants regarding notification of rights under the credentialing program.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.Q. How the Contractor accomplishes ongoing monitoring of practitioner sanctions, complaints, and adverse events 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 identified instances of poor quality related to the above. NCQA CR9—Element A	#1 CRE01 v.03, Credentialing and Recredentialing of Practitioners.pdf VI PROCEDURES, Ongoing Monitoring, pages 9-10 #2 MCD_PROV_MANUAL_PG55.pdf #3 CRE01 V. 03_ATT B DHH Bylaws.pdf Article XVIII, Sec. 15 Ongoing Monitoring, see page 52, #1 describes the process of ongoing monitoring performed by the DHMC Credentialing Coordinator for all practitioners. #3 describes the process performed by the DHHA Medical Staff office for DHHA practitioners.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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. 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 managed care medical director, the QI director, and the provider relations director for determinations of necessary actions. The Medical Staff Bylaws also listed the mechanisms used for ongoing monitoring of DHHA credentialed practitioners. The bylaws also 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 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. On-site review of credentialing committee meeting minutes demonstrated committee review and appropriate action based on ongoing monitoring for sanction activity.

Required Actions:

None.

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.R. The range of actions available to the Contractor against the practitioner (for quality reasons). NCQA CR10—Element A1	#1 CRE03 v.03 Practitioner Appeal Rights.pdf # VII, page 3. #2 CRE01 V. 03_ATT B DHH Bylaws.pdf Article XIX, Medical Staff Fair Hearing Plan, A, Right to A Hearing, #1& #2, see page 53. # 1The range of actions DHMC may take against practitioners who do not meet the DHMC standards in relation to quality of care concerns are outlined in the P&P referenced above. #2 Outlines the range of actions that would be taken by DHHA towards a DHHA practitioner under the same circumstances	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DHMC's policy regarding practitioner hearings and appeals listed a range of actions that might be taken by DHMC if a provider does not meet DHMC's standards of quality. These actions included a recommended counseling, letter of concern, reduction of services, temporary suspension of services, or termination. The Medical Staff Bylaws addressed the notification to the provider that an action will be taken, the process for the hearing, and the types of actions available to DHHA; but grounds for actions did not include quality of care reasons.		
Required Actions: DHMC must revise or develop documents that describe the range of actions available to DHHA for changing the conditions of a practitioner's status based on quality reasons.		
2.S. If the Contractor has taken action against a practitioner for quality reasons, the Contractor reports the action to the appropriate authorities (including State licensing agencies for each practitioner type and the National Practitioner Data Bank [NPDB]). NCQA CR10—Element A2 and B	#1 CRE03 v.03 Practitioner Appeal Rights.pdf VI Procedures, #L #2 CRE01 V. 03_ATT B DHH Bylaws.pdf Article XIX, I, Reporting Requirements, see page 59. Review actions, based on reasons related to professional competence or conduct that adversely affect participation with the Company for a period longer than thirty calendar days, must be reported to the appropriate State and Federal regulatory agencies. The responsibility for notification rests with the	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Company Quality Improvement Department in conjunction with the Company Medical Director. Notification shall be done so in writing to the appropriate agency including, but not limited to the: 1. National Practitioner Data Bank (NPDB) 2. Appropriate State Board 3. OIG	
Findings: DHMC's policy regarding practitioner hearings and appeals and Medical Staff Bylaws stated that DHMC/DHHA would report any actions taken and deemed reportable under applicable Colorado State law, the Health Care Quality Improvement Act of 1986, and the National Practitioner Data Bank (NPDB).		
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 which includes: ◆ Providing written notification indicating that a professional review action has been brought against the practitioner, reasons for the action, and a summary of the appeal rights and process. ◆ Allowing the practitioner to request a hearing and the specific time period for submitting the request. ◆ Allowing at least 30 days after the notification for the practitioner to request a hearing. ◆ Allowing the practitioner to be represented by an attorney or another person of the	**#1** CRE03 v.03 Practitioner Appeal Rights.pdf VI Procedures, Appeals Process page 5 #2 CRE01 V. 03_ATT B DHH Bylaws.pdf Article XIX, Medical Staff Fair Hearing Plan,, A Right to a Hearing. Pages 1 & 2, Page 53 Notice of Adverse Action, page 53 Request for Hearing, page 54 Request for Hearing, page 55 Appeal to the Governing Body, page 57 Appeal to the Governing Body, #9 and #10, page 58 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 defined in: #1 for DHMC independent direct network practitioners #2 for DHHA practitioners	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
practitioner's choice. ◆ Appointing a hearing officer or panel of the individuals to review the appeal. ◆ Providing written notification of the appeal decision that contains the specific reasons for the decision. NCQA CR10—Element A3and C		
Findings: DHMC and 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. The appeal process was delineated in the Medical Staff Bylaws and in DHMC's policy regarding practitioner hearings and appeals.		
Required Actions: None.		
2.U. Making the appeal process known to practitioners. NCQA CR10—Element A4	Please see Provider Manual MCD_PROV_MANUAL_PG55-56.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Medical Staff Bylaws and the Credentialing and Recredentialing of Practitioners policy 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.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as 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 CRE01 v. 03, Credentialing and Recredentialing of Practitioners.pdf VI, Procedures, Credentialing Committee and Role of Medical Director, page 5 #2 CRE01 V. 03_ATT B DHH Bylaws.pdf Article XVIII, Sec. 4, Procedure for Appointment, Credentialing, and Privileging, F, Medical Staff Executive Committee Review, # 1, see pages 42-43 #1 DHMC utilizes a peer review process by a credentialing committee made up according to NCQA standards, outline in the P&P referenced above. #2 DHHA follows both JC & NCQA requirements, utilizing the Med Staff Executive Committee as outline in MSO Bylaws referenced above	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:

The Credentialing and Recredentialing of Practitioners policy stated that the Credentialing Subcommittee (of the Medical Management Committee) is composed of a range of participating practitioners. The Medical Staff Bylaws specified that the Medical Staff Executive Committee (the committee responsible for credentialing DHHA practitioners) is composed 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. Review of the DHHA credentialing committee meeting minutes (for physicians and for AHPs) and the DHMC committee meeting minutes confirmed processes as stated in the policies.

Required Actions:

None.

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as 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 CRE01 v. 03, Credentialing and Recredentialing of Practitioners, VI PROCEDURES, Credentialing Committee and Role of Medical Director, F-I, page 5 #2 DHMP Credentialing Subcommittee Minutes (will be provided during on-site review) #1 defines the process #2 presents evidence #3 CRE01 V. 03_ATT B DHH Bylaws.pdf Article XVIII, Section 4, F, Medical Staff Executive Committee Review, #1, see page 42. #4 DHH MSEC Minutes (will be provided during on-site review) #3 defines the process #4 presents evidence DHMC follows NCQA standards regarding credentialing providers who do not meet criteria (red flag) as described in #1 & #3. There is evidence of the appointed committee's review of and participation in the decision of red flagged applicants in the meeting minutes of #2 DHMC for network providers and #4 for DHHA practitioners.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: On-site review of credentialing committee meeting minutes demonstrated that DHMC and DHHA followed these credentialing committee processes, as described in policies.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as 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 (verification time limit = 180 calendar days). ◆ A valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (effective at the time of the credentialing decision). ◆ Education and training, including board certification, if applicable (verification of the highest of graduation from medical/ professional school, residency, or board certification [board certification time limit = 180 calendar days]). ◆ Work history (verification time limit = 365 calendar days) (non-primary verification—most recent 5 years). ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (verification time limit = 180 calendar days). NCQA CR3—Elements A and B	#1 CRE01 v. 03, Credentialing and Recredentialing of Practitioners.pdf VI. PROCEDURES, Initial credentialing for independent network practitioner, page 7 #2 CRE01 v.03 Attachment A – CHCP Credentialing Application #3 CRE01 V. 03_ATT B DHH MS Bylaws.pdf Article XVIII, Sec. 4, 2C, last sentence, See pages 40-41 DHMC and DHHA both use the CHCP Credentialing Application for credentialing and recredentialing of all practitioners. Information regarding each of the bullets of #5 is requested in this application, and each is verified within the 180 day time limit, using appropriate NCQA acceptable resources.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy and the Medical Staff Bylaws included the required time frames for primary source verification of each piece of documentation. On-site review of 10 credentialing records and 10 recredentialing records confirmed that all primary source verification was completed within the prescribed time frames for the records reviewed.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: None.		
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/professional liability insurance coverage (minimums = physician—.5mil/1.5mil; facility—.5mil/3mil). ◆ The correctness and completeness of the application. NCQA CR4—Element A NCQA CR7—Element C C.R.S.—13-64-301-302	#1 CR01 v.03 Credentialing and Recredentialing of Practitioners.pdf VI PROCEDURES, Application and Attestation, page 6. #2 CRE01 v.03 Attachment A – CHCP Credentialing Application pages 21-26 #3 CRE01 V. 03_ATT B DHH Bylaws.pdf Article XVIII, Sec. 4, Procedure for Appointment, Credentialing and Privileging, Letters A and B, pages 39-40 DHMC and DHHA both use the CHCP Credentialing Application for credentialing and recredentialing of all practitioners. Each bullet of #6 is 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 #1for DHMC independent direct practitioners and #3 for DHHA practitioners	☒ 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 10 credentialing records and 10 recredentialing records confirmed use of this application.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor verifies the following sanction activities for initial credentialing and recredentialing: ◆ State sanctions, restrictions on licensure, or limitations on scope of practice. ◆ Medicare and Medicaid sanctions. *42CFR438.610(b)(3)* NCQA CR5—Element A NCQA CR7—Element D	#1 CRE01 v.03, Credentialing and Recredentialing of Practitioners.pdf VI PROCEDURES, Initial Credentialing page 7, Recredentialing, page 8-9. #2 CRE01 V. 03_ATT B DHH Bylaws.pdf XVIII, Sec. 4, Procedure for Appointment, credentialing and Privileging, Letter C Credentialing and Processing the DHHA Medical Staff Application, page 40 DHMC and DHHA both verify each bullet of #7 within the 180 day time limit according to NCQA standards.	☒ 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 the Medical Staff Bylaws stated that verification would be completed prior to the credentialing decision and within 180 days of the application date via the NPDB, OIG, or the State practice boards. On-site record review demonstrated that DHMC queried the required online databases at credentialing and recredentialing to confirm that providers did not have sanctions and were eligible for Medicaid program participation.		
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 standards and performance thresholds for: ◆ Physical accessibility. ◆ Physical appearance. ◆ Adequacy of waiting and examining room space. ◆ Adequacy of treatment record-keeping. NCQA CR6—Element A	# 1 CR02 v. 03 Practitioner Office Site Quality.pdf VI.PROCEDURES, # A, Page 2 **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 as 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 when warranted. The policy went on to specify that DHMC would conduct a site visit when the threshold of two grievances related to physical accessibility, physical appearance, adequacy of waiting and exam room space, or adequacy of treatment record-keeping was met. The Site Visit Evaluation Form included the required elements. During the on-site interview, DHMC staff members reported that there had been no site visits based on office site quality complaints performed 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 a complaint threshold was met. ◆ Documenting follow-up visits for offices that had subsequent deficiencies. NCQA CR6—Element B	# 1 CR02 v. 03 Practitioner Office Site Quality.pdf VI. Procedures, Letter A, Page 2 Highlight **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
Findings: The Practitioner Office Site Quality policy was consistent with NCQA standards and included all of the required elements.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as 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 (verification time limit = 180 calendar days). ◆ A valid DEA or CDS certificate (effective at the time of recredentialing). ◆ Board certification (verification time limit = 180 calendar days). ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (verification time limit = 180 calendar days). NCQA CR7—Elements A and B NCQA CR8—Element A	#1 CRE01 V. 03_ATT B DHH Bylaws.pdf Article XVIII, Section 5, Procedure for Reappointment, page 44 #2 CRE v.03 Credentialing and Recredentialing of Practitioners.pdf VI Procedures, Initial Credentialing for Independent Network Practitioners, A-H pages 7-8 **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 #1 and network providers are recredentialed on the NCQA cycle of every 36 months as described in #2.	☒ 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. The Medical Staff Bylaws stated that reappointment (recredentialing) occurred every two years. The recredentialing process, as stated in the policy and the bylaws, 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 DHHA providers reviewed were recredentialed within two years of the previous credentialing date, DHMC-contracted providers were recredentialed every three years, and primary source verification was completed within the prescribed time frames. On-site, DHMC staff members stated that DHHA practitioners are recredentialed every two years based on The Joint Commission (TJC) accreditation requirements.

Required Actions:

None.

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor has (and implements) 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	CRE04 v.04 Assessment of Organizational Providers.pdf VI. PROCEDURES #A & B DHMC performs initial assessment of organizational providers prior to contracting, and re-assessment on 3 year intervals. This process includes confirming that the provider is in good standing with State and federal regulatory bodies by obtaining a copy of all licenses and verifying if applicable through Colorado state web pages.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DHMC's Assessment of Organizational Providers policy included the procedures 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 five organizational provider files confirmed that DHMC 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 that the provider has been reviewed and approved by an accrediting body. NCQA CR11—Element A2	CRE04 v.04 Assessment of Organizational Providers.pdf VI. PROCEDURES #A & B DHMC confirms accreditation if applicable by obtaining a copy of the body's letter of approval; verification may be done through the accrediting body's web page.	☒ 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 DHMC confirmed whether the organization had been accredited.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11.C. The Contractor conducts an on-site quality assessment if there is no accreditation status. NCQA CR11—Element A3	CRE04 v.04 Assessment of Organizational Providers.pdf VI. PROCEDURES #B, 8-10 DHMC's Contracting/Provider Relations Director will conduct an on-site quality assessment of a potential Organization Provider if they are (1) not accredited, and (2) not certified by CMS or have not had a CMS survey within the past 3 years.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The policy described the process for conducting a site visit if the organization is not accredited by one of the accrediting bodies accepted by DHMC. On-site review of organizational provider records demonstrated that three nonaccredited providers had a Colorado Department of Public Health and Environment (CDPHE) site survey in the file. The other two files reviewed on-site were accredited organizations.		
Required Actions: None.		
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 has no accreditation status. NCQA CR11—Element A	CRE04 v.04 Assessment of Organizational Providers.pdf VI. PROCEDURES #C Reassessment DHMC will reassessment providers every 3 years, the same steps followed and criteria used for initial assessment is used for reassessment. A site visit will be conducted if the provider is (1) not accredited, and (2) not certified by CMS or have not had a CMS survey within the past 3 years. ORG_SITE_VISIT_TOOL.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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 and on-site record review demonstrated that organizational providers were assessed every three years.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11.E. The Contractor's policies list the accrediting bodies the Contractor accepts for each type of organizational provider. (If the Contractor only contracts with organizational providers that are accredited, the Contractor must have a written policy that states it does not contract with nonaccredited facilities.) NCQA CR11—Element A	CRE04 v.04 Assessment of Organizational Providers.pdf VI. PROCEDURES #B, 3 DHMC lists the approved accrediting bodies, accreditation is not a requirement	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The policy listed the following acceptable accrediting bodies: Accreditation Association for Ambulatory Health Care (AAAHC), Accreditation Commission for Health Care (ACHC), Commission on Accreditation of Rehabilitation Facilities (CARF), Continuing Care Accreditation Commission (CCAC), CDPHE, Community Health Accreditation Program (CHAP), The Joint Commission (TJC), and National Committee for Quality Assurance (NCQA). Organizational provider records reviewed on-site included accreditation by CHAP and TJC.		
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	CRE04 v.04 Assessment of Organizational Providers.pdf VI. PROCEDURES #B. Initial Assessment Organizational Providers to be assessed are selected and referred to credentialing by the Director of Contracting/Provider Relations. Assessment is conducted as outlined in P&P Initial Assessment; a site visit is conducted by Contracting/Provider Relations in the case of nonaccredited providers. ORG_SITE_VISIT_TOOL.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Assessment of Organizational Providers policy described the criteria organizational providers must meet to contract with DHMC.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as 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	CRE04 v.04 Assessment of Organizational Providers.pdf VI. PROCEDURES #B 10 If an Organizational Provider **is not accredited, and is not surveyed by CMS or the State**, the Director of Contracting/Provider Relations shall conduct an onsite quality assessment prior to contracting; the site visit will evaluate the applicant's policies and procedures, quality assurance process, patient safety, medical record keeping practices, and the process for credentialing or screening staff. The Organizational provider must pass the site assessment by a minimum of 85% to be approved. ORG_SITE_VISIT_TOOL.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: During the on-site interview, DHMC staff stated that for nonaccredited organizations also not surveyed by CDPHE, Centers for Medicare & Medicaid Services (CMS), or Colorado's Division of Behavioral Health (DBH), the director of provider relations would review credentialing and recredentialing policies and procedures for the organization and document the review in the provider-specific file. DHMC may want to consider documenting the review of credentialing/recredentialing policies and procedures directly on the site review form. Staff also reported that although DHMC has a process for conducting site reviews if needed, it is rare for DHMC to contract with a nonaccredited organization not reviewed by CDPHE, CMS, or DBH.		
Required Actions: None.		
14. If the Contractor chooses to substitute a CMS or State review in lieu of the required site visit, the Contractor must obtain the report from the organizational provider to verify that the review has been performed and that the report meets its standards. (CMS or State review or certification does not serve as accreditation of an institution.) A letter from CMS or the applicable State agency which shows that the facility was reviewed and indicates that it passed inspection is acceptable in	CRE04 v.04 Assessment of Organizational Providers.pdf VI. PROCEDURES #B 8 If a provider is not accredited, passing a CMS or state review within 3 years of assessment date is acceptable in lieu of a site visit. To verify certification, the provider must supply a copy of the most recent Colorado State survey or a letter from CMS or state agency indicating that the facility passed inspection and the date the inspection took place; the Company may also utilize the CDPHE web page to verify certification status.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
lieu of the survey report if the organization reviewed and approved the CMS or State criteria as meeting the organization's standard. NCQA CR11—Element A		
Findings: The Assessment of Organizational Providers policy stated that DHMC credentialing staff has reviewed the State Operation Manual and determined that CDPHE ensures that surveyed organizations credential their practitioners. Staff also confirmed on-site that the DBH site survey form also indicates that DBH ensures that organizations surveyed by DBH credential their practitioners.		
Required Actions: None.		
15. The Contractor's organizational provider assessment policies and process include assessment of at least the following medical providers: ◆ Hospitals. ◆ Home health agencies. ◆ Skilled nursing facilities. ◆ Free-standing surgical centers. NCQA CR11—Element B	CRE04 v.04 Assessment of Organizational Providers.pdf III SCOPE DHMC requires assessment of the following Organizational Provider types: 1. Hospitals 2. Home Health Agencies 3. Skilled Nursing Facilities 4. Free Standing Surgical Centers. 5. Hospice/Long Term Care Centers 6. Renal Dialysis Centers 7. Behavioral Healthcare facilities providing mental health or substance abuse services in an inpatient, residential, or ambulatory setting.	☒ 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, hospice/long-term care centers, renal dialysis centers, and behavioral health facilities providing mental health or substance abuse services in an inpatient, residential, or ambulatory setting. Organizational provider files reviewed on-site included files for a hospital, a home health facility, and skilled nursing facilities.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The Contractor has documentation that it has assessed contracted medical health care (organizational) providers. NCQA CR11—Element D	CRE04 v.04 Assessment of Organizational Providers.pdf VI PROCEDURES #A The Company will maintain documentation on all contracted/assessed organizational providers and a tracking spreadsheet to demonstrate initial and reassessment.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Organizational provider files reviewed on-site provided evidence that DHMC assessed organizational providers as required and documented each assessment activity in the organization-specific file.		
Required Actions: None.		
17. If the Contractor delegates any NCQA-required credentialing activities, there is evidence of oversight of the delegated activities. NCQA CR12	CRE05 v.03 Delegation of Credentialing Activities.pdf VI PROCEDURES #B Ongoing Delegation Activities DHMC performs oversight of all entities who are delegated to perform any type of credentialing activities on its behalf. This is done by reporting and an annual delegation audit from each delegate. The P&P outlines the process and requirements. Documentation of yearly audits performed is available onsite.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Although DHMC is a line of business within DHHA, and the MSO of DHHA credentials DHHA providers, DHMC has entered into an interdepartmental memorandum of understanding (MOU) with the MSO to document the relationship and ensure understanding of the requirements. On-site review of documentation that DHMC received and reviewed regular reports from DHHA regarding credentialing activities performed, and review of completed site audit reports, demonstrated oversight by DHMC.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. 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 (including revocation of the contract) if the delegate does not fulfill its obligations. NCQA CR12—Element A	CRE05 v.03 Delegation of Credentialing Activities.pdf Attachment A Delegated Credentialing Letter of Agreement (Template) This P&P addresses the requirements for each bulleted item. Attachment A LOA Template contains requirements for each bulleted item. Available onsite are copies of signed agreements with each delegated entity for credentialing activities.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The MOU between DHMC and the MSO was signed by both parties and included all of the required provisions.		
Required Actions: None.		
19. If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes: ◆ A list of allowed use of PHI. ◆ 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.	CRE05 v.03 Delegation of Credentialing Activities.pdf Attachment A Delegated Credentialing Letter of Agreement (Template) B #9 Template language: DHMC requires that delegates follow the rules and standards laid out in The Health Insurance Portability and Accountability (HIPPA) Act.	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
◆ 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		
Findings: Not Applicable.		
Required Actions: None.		
20. 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 agreement. NCQA CR12—Element C	CRE05 v.03 Delegation of Credentialing Activities.pdf Attachment A Delegated Credentialing Letter of Agreement (Template) A #3 Template language: DHMC retains the right to approve, suspend, or terminate any provider selected by the Delegate to treat DHMC enrollees.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The MOU between DHMC and the MSO included the required provision that DHMC retains the right to approve, suspend, or terminate providers. DHMC provided evidence of reviewing reports from DHHA to ensure having the required information needed to exercise this right.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
21. For delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity before the delegation document was signed. NCQA CR12—Element D	CRE05 v.03 Delegation of Credentialing Activities.pdf VI. PROCEDURES #A 1-8 This requirement is in the P&P, however DHMC has not been required to perform any predelegation assessments as all delegates have been active for more than 12 months.	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Findings: Not Applicable.		
Required Actions: None.		
22. 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	CRE05 v.03 Delegation of Credentialing Activities.pdf VI PROCEDURES #B DHMC performs yearly file audits on each delegated entity who is not NCQA accredited; utilizing the NCQA 8/30 rule, examining both initial and recredentialing files. Documentation of file audits is available onsite.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: On-site review of DHMC's delegation file for DHHA demonstrated that DHMC audited DHHA credentialing and recredentialing files annually for compliance with NCQA standards.		
Required Actions: None.		
23. For delegation arrangements in effect 12 months or longer, the Contractor performs an annual substantive evaluation of delegated activities against NCQA standards and organization expectations. NCQA CR12—Element F	CRE05 v.03 Delegation of Credentialing Activities.pdf VI. PROCEDURES #B Attachment A Delegated Credentialing Letter of Agreement (Template) Attachment B Audit Tool Summary P&P: For delegation arrangements in effect for 12 months or longer, the Company will conduct an annual performance evaluation of the delegate's credentialing, recredentialing, and practitioner monitoring	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	activities Delegated Letters of Agreement have this requirement listed. An audit tool summary is provided to each delegated entity. Documented yearly audits are available onsite for review.	
Findings: DHMC's annual audit activities included a review of DHHA's policies and procedures against NCQA standards.		
Required Actions: None.		
24. For delegation arrangements in effect 12 months or longer, the Contractor evaluates regular reports (at least semiannually). NCQA CR12—Element G	CRE05 v.03 Delegation of Credentialing Activities.pdf VI. PROCEDURES #C Attachment A Delegated Credentialing Letter of Agreement (Template) Reporting requirements are outlined in the P&P and the Letter of Agreement. Reports are required on at least a quarterly basis, for adds and terms.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: On-site review of DHMC credentialing committee meeting minutes demonstrated that the committee reviewed monthly reports from DHHA regarding credentialing activities performed.		
Required Actions: None.		
25. The Contractor identifies and follows up on opportunities for improvement, if applicable. NCQA CR12—Element H	CRE05 v.03 Delegation of Credentialing Activities.pdf VI. PROCEDURES #B #9 For any identified deficiencies, improvement suggestions will be made; the delegate must respond within 30 days with a prospective corrective action plan; if agreed upon the delegate is required to report when CAP is completed.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Delegation of Credentialing policy described the process for corrective action if the delegate failed to meet DHMC's standards and requirements. There were no instances of noncompliance requiring corrective action during the review period.		
Required Actions: None.		

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	44	X	1.00	=	44
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	2	X	NA	=	NA
Total Applicable		=	47	**Total Score**		=	44

Total Score ÷ Total Applicable	=	94%

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an ongoing Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. *42CFR438.240*(a) DH Contract: II.I.1 RMHP Contract: II.J.1	1. MCD_QI01 v.04_Quality Improvement Program Description.docx demonstrates that we have a QAPI Program Description Program. There is documentation of the purpose, scope, policy and the responsibility of the QI Program. The remaining document describes in more detail all of the components of the QI Program. 2. DH MCD QI Impact Analysis.pdf - demonstrate current and future QAPI activities. The entire report demonstrates how we integrate finding and opportunities for improvement identified from focused studies, HEDIS measurements, enrollee satisfaction surveys, and other monitoring and quality activities. 3. DHMC_QI_WorkPlan2012 –demonstrates future QI activities	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:

The DHMC QI Program Description policy described the purpose and the major focus areas of the QI program. The program description defined accountabilities and responsibilities of the QI committees and staff. The policy stated that the Board of Directors has ultimate accountability for the QI program, and the Board has charged the DHMC Medical Management Committee (MMC), executive director, and medical director with the oversight and advisory responsibilities for DHMC QI activities and outcomes.

The DHMC QI Work Plan documented the planned monitoring activities of the QI program, including reviewing member satisfaction data (Consumer Assessment of Healthcare Providers and Systems [CAHPS] surveys), Healthcare Effectiveness Data and Information Set (HEDIS) measures, grievance reporting and trending, quality of care concerns (QOCCs), provider access, focus studies, and performance improvement projects (PIPs). The DHMC QI Impact Analysis Report (annual report) included summary data results, analysis, opportunities for improvement, and action plans related to each of the major components of the QI program. The DHMC Board of Directors meeting minutes documented approval of the QI Program Description, QI Work Plan, and QI Impact Analysis Report. HSAG recommended that DHMC ensures that the MMC also reviews and approves the QI Work Plan and QI Impact Analysis Report given the MMC's stated responsibility for oversight of QI activities and outcomes. HSAG also recommended that DHMC consider incorporating specific performance benchmarks or measurable goals in the QI Work Plan.

Required Actions:

None.

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42CFR438.240(b)(3)* DH Contract: II.I.2.e RMHP Contract: II.J.2.e	1. CO2012_HEDIS-Aggregate_Report_F1.pdf - **2012** MCD Choice HEDIS report - demonstrates that we track results from year to year to detect underutilization and overutilization. MCD 2012 HEDIS Summary of results - demonstrates that we compare to the previous year and evaluate any statistically significant change and to detect underutilization and overutilization 2. HEDIS Presentation MMC 08-7-12.ppt - Please refer to slides 2-6, 12 for pertinent information. [#3-8 shows mechanisms to detect both underutilization and overutilization of services for our members] 3. MCD_Rates_only.xls 4. Medicaid Choice CHI_STATS 2012.xls 5. EPDST Meeting Agenda Items_2012.docx 6. EPDST_2012Jul19_Minutes.docx 7. DHMC SFY 13 1Q Network Adequacy Report.pdf 8. MC Adult Interventions_Outreach_2012.doc Demonstrates how we address underutilization	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DHMC submitted sample data reports of HEDIS results used to monitor underutilization of services. The Adult Interventions/Outreach document and EPSDT meeting minutes documented numerous interventions related to improving HEDIS measures. During the on-site interview, staff provided evidence of additional utilization tracking reports (e.g., trended inpatient data, emergency room (ER) visits, cost of services). Staff stated that the utilization reports are reviewed by the Retention Committee to identify areas for improvement, as well as operations management personnel (including the QI director), who reports results to the MMC. Staff identified several initiatives that resulted from utilization monitoring.		
Required Actions: None.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care for persons with special health care needs. *42CFR438.240(b)(4)* DH Contract: II.I.2.d.4 RMHP Contract: II.J.2.d.4	1. DH MCD QI Impact Analysis.pdf - Description: Demonstrates how we access the quality and appropriateness of care for persons with special health care needs. 2. Medical Record Audit for Charting Standards_HEDIS_2012.Results.doc 3. CM01 v. 01 Case Management Program Description.docx 4. DH MC Care Coordination_combo.pdf 5. Behavior Health CoC PIP FY11-12 Final Version 11-27-12.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The QI Impact Analysis and other submitted reports documented three PIPs related to persons with special health care needs. The Strategic Access Report evaluated provider network adequacy for members with special language needs, and the Case Management Program Description policy outlined the processes for coordination of care for members with complex medical and social service needs.		
Required Actions: None.		
4. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis. The annual report describes: ◆ Techniques used by the Contractor to improve performance. ◆ The outcome of each performance improvement project. ◆ The overall impact and effectiveness of the QAPI program. *42CFR438.240(e)(2)* DH Contract: II.I.2.h RMHP Contract: II.J.h	1. HEDIS Presentation MMC 08-7-12.ppt - Please refer to slides 2-6, 12 for pertinent information. 2. 2012 HEDIS _MCD_results.ppt 3. MCD_Rates_only.xls - Please refer to 2012 tab. 4. Medicaid Choice CHI_STATS 2012.xls - Technique used by DH MCD Choice: MCD 2012 HEDIS Summary of Results - we conduct chi stat to determine statistically significant change, especially negative trends 5. FINAL_MCD_AAP PIP Summary Form.pdf Demonstrates how we follow the CMS Protocol requirements. Techniques used by DH MCD Choice: Collaborative Activities within DH to improve performance. Participate on the Preventive Cancer Screening Meetings - please see minutes for evidence of implementing standard work in the clinics and having a registry to capture data 6. DH MCD QI Impact Analysis.pdf Demonstrates techniques used to improve performance by identifying barriers (refer to performance by identifying barriers (refer to page 15	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	– Medication Reminders, and evaluating the impact of interventions refer to page 22). Additionally, this document demonstrates the outcome of each QAPI activity as well as the impact and effectiveness of the QAPI program. Refer to the entire document for evidence of compliance.	
Findings: The DHMC QI Impact Analysis Report included an overview of QI program goals and the organizational structure for QI. The report included summary results of each major QI program component. Each topic area included findings, analysis, interventions, opportunities for improvement, and action plans for the subsequent year. The report did not include an analysis or statement of the overall impact and effectiveness of the QI program.		
Required Actions: DHMC must include a summary or statement of the overall impact and effectiveness of the QI program in the annual QI Impact Analysis Report.		
5. The Contractor shall adopt practice guidelines for the following: ◆ Perinatal, prenatal, and postpartum care for women. ◆ Conditions related to persons with a disability or special health care needs. ◆ Well child care. DH Contract: II.I.2.a.1 RMHP Contract: II.J.2.a.1	1. Master Copy of Medicaid Choice Guidelines and Coverage Criteria.xls Description: demonstrate that we have clinical and preventive guidelines that address special needs. 2.CHOICE_QIM1302 Clinical Practice Guidelines and Preventive Care Guidelines.pdf – page 2 demonstrates guidelines for perinatal, prenatal, postpartum care women and well child care. 3. CHOICE_QIM1302 Clinical Practice Guidelines and Preventive Care Guidelines.pdf CHF Guideline for special health care needs. demonstrate conditions related to special health care needs on page 2 under the purpose section of the Clinical Practice Guidelines. 5. DH MCD QI Impact Analysis.pdf Description: demonstrates quality activities related to prenatal and postpartum care for women (page 12-13) and a DME coordinator dedicated to the special needs population (page 4).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The DHMC Clinical Practice Guidelines and Preventive Care Guidelines policy (CPG Policy) and the QI Impact Analysis Report included a list of clinical and preventive guidelines adopted by DHMC for members with special needs, as well as guidelines for prenatal care and well-child care for all age groups, and for immunizations. All required clinical practice guidelines (CPGs) were available on the DHMC provider Web site.		
Required Actions: None.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor ensures that practice guidelines comply with the following requirements: ◆ Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. ◆ Consider the needs of the Contractor's members. ◆ Are adopted in consultation with contracting health care professionals. ◆ Are reviewed and updated annually. *42CFR438.236(b)* DH Contract: II.I.2.a.2 RMHP Contract: II.J.2.a.2	1. DH MCD QI Impact Analysis.pdf - demonstrates that we have practice guidelines 2. CHOICE_QIM1302 Clinical Practice Guidelines and Preventive Care.pdf – demonstrates that we meet the following requirements: Documentation that shows that guidelines are based on valid and reliable clinical evidence, how we consider the needs of our members, and that we review/update annually. 3. Master Copy of Medicaid Choice Guidelines and Coverage Criteria.xls Description: demonstrate that we have clinical and preventive guidelines that address special needs.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The CPG Policy stated that guidelines are developed through a task force of the MMC. The policy outlined the specific steps in the guideline development process and addressed each of the elements in the requirement. The policy stated that guidelines are reviewed and updated annually through the MMC. During the on-site interview, staff explained that the DHHA Practice Guidelines Committee oversees all DHHA CPG development and ensures that DHMC CPGs are integrated into the DHHA system-wide CPGs.		
Required Actions: None.		
7. The Contractor disseminates the guidelines to all affected providers, and upon request, to members and potential members, at no cost. *42CFR438.236(c)* DH Contract: II.I.2.a.3 RMHP Contract: II.J.2.a.3	1. CHOICE_QIM1302 Clinical Practice Guidelines and Preventive Care.pdf – Under the Section Policy it shows how we disseminate the guidelines to all our affected providers, members, potential members and the public at no cost. [#2-4] Print screens of the internal website for Providers that demonstrates that we have made guidelines available to our providers. 2. clinical practice and preventive care guidelines.png 3. clinical practice and preventive care guidelines 2.png 4. clinical practice and preventive care guidelines 3.png	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	5. Choice Matters_Member Newsletter – page 8 6. DHMC Member Handbook ENG.pdf - pgs. 16-17 under Utilization Management – Demonstrates that DHMC notifies members that they can request guideline information upon request by calling Member Services (can be found in common documents)	
Findings: The CPG Policy stated that DHMC disseminates practice guidelines to providers through provider newsletters, the DHMC Web site, the DHHA intranet, or provider mailings. The policy stated that DHMC disseminates CPGs annually to members; however, during the on-site interview, staff clarified that members must request practice guidelines from Member Services. The DHMC Member Handbook did not inform members of the availability of CPGs or how to request them, and DHMC did not provide other evidence of distribution of CPGs to members (per policy). All guidelines were available on the DHHA intranet for access by internal providers, and contracted providers may request copies. The CPG Policy stated that guidelines are available to members and providers at no cost and to the public at cost.		
Required Actions: DHMC must modify its policy and procedures to allow the public (potential members) to request and receive clinical practice guidelines at no cost. DHMC must also inform members of the availability of CPGs and how to request the guidelines.		
8. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42CFR438.236(d)* DH Contract: II.I.2.a.4 RMHP Contract: II.J.2.a.4	1. CHOICE_QIM1302 Clinical Practice Guidelines and Preventive Care.pdf -Under Procedures Section, Part C, #8	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The CPG Policy stated that DHMC staff will be educated on clinical guidelines to ensure that utilization and case management decisions, member education, covered benefits, and other clinical materials are consistent with the guidelines. During the on-site interview, staff stated that the DHMC case management staff uses the clinical guidelines for reference when working with members. Staff also stated that many of the activities that require use of the CPGs (i.e., committee review of quality information, development of health education materials, and utilization management) are performed within the DHHA system. Staff stated that representation of DHMC staff and providers in the DHHA activities ensures that DHMC practice guidelines are integrated into applicable operational processes. The MMC is responsible for overseeing the integration of clinical practice guidelines into DHMC QI processes.		
Required Actions: None.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42CFR438.242(a)* DH Contract: II.I.2.k.1 RMHP Contract: II.J.2.k.1	The Xcelys Claims Based Processing System, Case and Care Management Screens, as well as the Pharmacy PAR Screens, Med Impact is PBM and has the RX Navigator and we can access the Denver Health data warehouse Reports to supplement claims data. There are no documents for this requirement. These websites, links, reports will be available for onsite review	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: During the on-site interview, DHMC staff members provided an overview of the XCELYS health information system (HIS), which collects and integrates data from enrollment files, claims, pharmacy, authorizations, credentialing, member services, and case management systems. Data are analyzed and maintained in the data repository to generate files and reports for routine and customized purposes. DHMC presented an overview of the Altruista case management system and multiple HIS reports used for QI purposes, which verified that the HIS integrates information from multiple databases. During the on-site interview, staff stated that DHMC can access and exchange information with the DHHA HIS, which maintains patient treatment records, laboratory data, patient registries and a data warehouse for reporting.		
Required Actions: None.		
10. The Contractor collects data on member and provider characteristics and on services furnished to members. *42CFR438.242(b)(1)* DH Contract: II.I.2.k.2 RMHP Contract: II.J.2.k.2	1. ProviderDirectory 2012.pdf Description: demonstrates collection of data on provider characteristics and on services furnished to members**.** 2. MHC 4&5_CLAS Program Evaluation.pdf: Demonstrates the collection of data on member race/ethnicity characteristics (pg. 9), member spoken language (pg. 11), and provider race/ethnicity/language data (pg. 12). 3. DHMC SFY 13 1Q Network Adequacy Report.pdf Description**:** demonstrates collection of data on member and provider characteristics and on services furnished to members.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: During the on-site interview, staff stated that DHMC collects and maintains provider characteristics in the credentialing database and collects member demographics and characteristics through the enrollment and eligibility files, updated through member contacts. DHMC collects and maintains information on services provided to members through the claims database, supplemented with data available in the DHHA data warehouse, such as clinical information and disease registries. DHMC submitted several example reports using member and provider information as the basis for analysis.		
Required Actions: None.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor monitors member perceptions of accessibility and adequacy of services provided. Tools shall include: ◆ Member surveys (Consumer Assessment of Healthcare Providers and Systems [CAHPS]). ◆ Anecdotal information. ◆ Grievance and appeals data. ◆ Enrollment and disenrollment information. DH Contract: II.H.2.d.1 & 2 RMHP Contract: II.J.2.d.1 & 2	1. Medicaid Choice CAHPS Results 2012 Final.png Description: CAHPS member perception of accessibility and adequacy of services provided. Screenshot from Morpace vendor report. 2. Strategic Access Report FY_11_12 Final Report.docx: Description: demonstrates our accessibility and adequacy of services grievance and enrollment and disenrollment information.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:

The DHMC QI Program Description stated that DHMC would monitor and analyze member satisfaction with access to services through CAHPS and HEDIS data, member grievances, and member disenrollment data. The Strategic Access Report and QI Impact Analysis Report included data and analysis of these findings, including opportunities for improvement and corrective actions. The Strategic Access Report stated that results are reported to the Access Committee and Operations Team. During the on-site interview, staff clarified that the DHHA Access Committee has representatives from the DHHA provider network and from DHMC and identifies opportunities for improved access throughout the DHHA delivery system (e.g., clinics and appointment center). Staff stated that activities of the Access Committee are reported to the DHMC Board of Directors through the participating DHMC executives. Staff stated that member disenrollment codes are evaluated monthly and that most disenrollments were due to the member's pre-existing relationship with a non-network provider. The MMC meeting minutes documented review of annual CAHPS results, the annual HEDIS report, and grievance and appeals data; however, minutes did not include conclusions or recommendations related to results.

HSAG recommended that DHMC ensure that when committees within the DHHA system review required data, the analyses and recommendations of those committees are reported to the MMC as the QI program oversight body. In addition, HSAG recommended that MMC meeting minutes document the conclusions and recommendations of the committee related to the member surveys, member grievances, and enrollment data.

Required Actions:

None.

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor develops a corrective action plan when members report statistically significant levels of dissatisfaction, when a pattern of complaint is detected, or when a serious complaint is reported. DH Contract: II.H.2.d.3 RMHP Contract: II.J.2.d.3	1. Medicaid Choice CAHPS Results 2012.png Description: demonstrates we have no statistically significant levels of dissatisfaction.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:

The Notification and Investigation of Potential Quality of Care Complaints policy outlined the specific procedures for investigation of QOCCs identified by members through the member grievance process. The policy stated that potential QOCCs were reviewed, corrected, trended, and reported quarterly to the MMC. During the on-site interview, staff stated that QOCCs in the past have resulted in system-wide improvements within the DHHA delivery system.

The QI Impact Analysis Report explained the process for review of QOCCs and reported that only one QOCC during the report year was determined to be substantiated. The QI Impact Analysis Report included CAHPS member satisfaction results and annual member grievance trends, with the highest number of grievances related to access and availability. The QI Impact Analysis Report discussed opportunities for improvement and actions taken related to access and availability. The Strategic Access Report stated that member grievances related to access and availability would be discussed with the MMC regarding opportunities for improvement and that CAHPS member satisfaction results were presented to applicable operating areas with corrective actions implemented. The MMC meeting minutes did not include review or discussion of the Strategic Access Report or the QI Impact Analysis Report.

HSAG recommended that DHMC ensure that the outcomes of analysis of QOCCs, patterns of grievances, or patterns of dissatisfaction be reported to the MMC with documentation of corrective actions, as indicated in various policies, procedures, and reports.

Required Actions:

None.

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor shall review compliance with the following criteria each year by reviewing and documenting at least one statistically valid sample of encounter claims submitted to the Department: ◆ Accuracy of all required fields. ◆ Completeness of encounter claims submitted. ◆ Presence of Medical Record documentation for each encounter claim. *42CFR438.242(b)(2)* DH Contract: II.H.6.c.5.b RMHP Contract: Exhibit I-II.D.5 & 6	1. 2012 Medicaid Choice Annual Claims Audit Report FINAL.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The DHMC Claims Testing audit procedures described the selection of a statistically valid sample of claims for testing of claims processing requirements, claims documentation adequacy, and medical record substantiation of claims information. The 2012 Medicaid Choice Annual Audit Report, conducted by the Denver Health and Hospital Authority Office of Integrity, documented the summary findings and recommended corrective actions related to completeness, accuracy, and verification of claims information.		
Required Actions: None.		

Results for Standard X—Quality Assessment and Performance Improvement							
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%

Appendix B. Record Review Tools for Denver Health Medicaid Choice

The completed record review tools follow this cover page.

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix B. Colorado Department of Health Care Policy and Financing
Credentialing Record Review Tool
for Denver Health Medicaid Choice

Review Period:	January 2009–December 2012	**Reviewer:**	Rachel Henrichs
Date of Review:	February 4, 2013	**Participating Plan Staff Member:**	Sherry DiQuinzio

SAMPLE	**1**		**2**		**3**		**4**		**5**		**6**		**7**		**8**		**9**		**10**	
Provider ID#																				
Provider Type (MD, PhD, NP, PA, MSW, etc.)	OD		OD		OD		MD		PA		MD		MD		PA		NP		MD	
Application Date	12/3/09		12/8/09		12/9/09		4/1/09		4/12/11		7/10/11		5/24/11		11/10/11		11/27/11		2/16/12	
Specialty	Optometry		Optometry		Optometry		Emerg Med		Orthopedics		Intern Med		Pediatric/Card		Surgery		Comm Med		Rad/Oncology	
Credentialing Date (Committee/Medical Director Approval Date)	1/28/10		1/28/10		1/28/10		5/26/11		6/23/11		8/25/11		9/22/11		11/17/11		12/23/11		3/22/12	
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		X		X		X		X		X		X		X		X	
♦ Credentials (i.e., education and training, including board certification if the practitioner states on the application that he or she is 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 history of professional liability claims)	X		X		X		X		X		X		X		X		X		X	
♦ Verification that the provider has not been excluded from federal 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	
♦ The provider's 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	**8**		**8**		**8**		**8**		**8**		**8**		**8**		**8**		**8**		**8**	
Point Score	**8**		**8**		**8**		**8**		**8**		**8**		**8**		**8**		**8**		**8**	
Percentage Score	**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**	
Total Record Review Score									**Total Applicable: 80**				**Total Point Score: 80**				**Total Percentage: 100%**			
Notes:																				

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix B. Colorado Department of Health Care Policy and Financing
Recredentialing Record Review Tool
for Denver Health Medicaid Choice

Review Period:	January 2009–December 2012	**Reviewer:**	Rachel Henrichs
Date of Review:	February 4, 2013	**Participating Plan Staff Member:**	Sherry DiQuinzio

SAMPLE	1		2		3		4		5		6		7		8		9		10	
Provider ID#																				
Provider Type (MD, PhD, NP, PA, MSW, etc.)	MD		DPM		MD		MD		MD		MD		DO		MD		NP		MD	
Application/Attestation Date	6/10/11		10/14/11		10/12/12		11/19/12		3/27/12		12/18/12		5/31/11		5/15/12		3/16/12		11/15/11	
Specialty	Ped Opthal		Podiatry		Ped Opthal		Gen Surgery		Family Med		Cardiology		Orthopedic		Endocrinology		Family Med		Occupat Med	
Last Credentialing/Recredentialing Date	8/25/08				12/21/09		1/25/11		6/17/10		3/24/11		6/16/11		8/26/10		6/10/10		3/25/10	
Recredentialing Date (Committee/Medical Director Approval Date)	7/28/11		11/22/11		11/26/12		12/20/12		5/24/12		1/24/13		7/23/09		7/26/12		5/24/12		2/23/12	
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		X		X		X	
♦ A valid DEA or CDS certificate (if applicable)	X				X		X		X		X		X		X		X		X	
♦ Credentials (i.e., verified board certification only if the practitioner states on the recredentialing application that there is new board certification since last credentialing/recredentialing date)	X				X		X		X		X		X		X		NA		X	
♦ Current malpractice insurance in the required amount (with history of professional liability claims)	X				X		X		X		X		X		X		X		X	
♦ Verification that the provider has not been excluded from federal participation	X				X		X		X		X		X		X		X		X	
♦ Signed application and attestation	X				X		X		X		X		X		X		X		X	
♦ The provider's recredentialing was completed within verification time limits (see specific verification element—180/365 days)	X				X		X		X		X		X		X		X		X	
♦ Recredentialing was completed within 36 months of last credentialing/recredentialing date	X				X		X		X		X		X		X		X		X	
Applicable Elements	**8**				**8**		**8**		**8**		**8**		**8**		**8**		**7**		**8**	
Point Score	**8**				**8**		**8**		**8**		**8**		**8**		**8**		**7**		**8**	
Percentage Score	**100%**				**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**	

Appendix B. Colorado Department of Health Care Policy and Financing
Recredentialing Record Review Tool
for Denver Health Medicaid Choice

OVERSAMPLE	1		2		3		4		5									
Provider ID#																		
Provider Type (MD, PhD, NP, PA, MSW)	MD																	
Application/Attestation Date	5/31/11																	
Specialty	Urology																	
Last Credentialing/Recredentialing Date	9/24/09																	
Recredentialing Date (Committee/Medical Director Approval Date)	8/25/11																	
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																	
♦ A valid DEA or CDS certificate (if applicable)	X																	
♦ Credentials (i.e., verified board certification only if the practitioner states on the recredentialing application that there is new board certification since last credentialing/recredentialing date)	NA																	
♦ Current malpractice insurance in the required amount (with history of professional liability claims)	X																	
♦ Verification that the provider has not been excluded from federal participation	X																	
♦ Signed application and attestation	X																	
♦ The provider's recredentialing was completed within verification time limits (see specific verification element—180/365 days)	X																	
♦ Recredentialing was completed within 36 months of last credentialing/recredentialing date	X																	
Applicable Elements	**7**																	
Point Score	**7**																	
Percentage Score	**100%**																	
Total Record Review Score									**Total Applicable: 78**		**Total Point Score: 78**				**Total Percentage: 100%**			

Notes: Provider Number 2 had not been recredentialed yet. The file was an initial credentialing file. A file from the oversample was used to obtain a full sample of 10 recredentialing records. Provider Number 9 was a nurse practitioner with prescriptive authority. The file included a CDS certificate.

Appendix C. Site Review Participants
for Denver Health Medicaid Choice

Table C-1 lists the participants in the FY 2012–2013 site review of **DHMC**.

Table C-1—HSAG Reviewers and BHO Participants	
HSAG Review Team	**Title**
Barbara McConnell, MBA, OTR	Director, State & Corporate Services
Katherine Bartilotta, BSN	Project Manager
Rachel Henrichs	Project Coordinator
DHMC Participants	**Title**
Analicia Baer	Government Products Specialist
Mary-Kartherine Barroso	QI Clinical Project Manager
Michelle Beozzo	Director of Pharmacy
David Brody	Medical Director
Sherry DiQuinzio	Compliance Analyst
Leann Donovan	Executive Director, Managed Care
Nettie Finn	RN Case Manager Supervisor
Richard French	Director, Member Services
Craig Gurule	Government Products Manager
Scott Hoye	Interim General Counsel, Denver Health and Hospital Authority (DHHA)
Allison Kennedy	QI Special Projects Specialist
Suzan Livengood	Medical Compliance Specialist
Rachael Meir	Clinical Director, Behavioral Health and Wellness Services
Deborah Mitchum	Director, Case Management/Utilization Management
Lorna Pate	Director, Compliance and Grievance and Appeals
Sandra Taylor	Medical Staff Services Manager
Westley Reed	QI Intervention Manager
Shelly Siedelberg	QI Program Manager
Christine Tagliaferri	QI Intervention Manager
Karen Valentine	Supervisor, Complex Case Management
Department Observers	**Title**
Teresa Craig	Contract Manager
Russ Kennedy	Quality and Compliance Specialist
Jeremy Sax	Physical Managed Care Contract Specialist

Appendix D. Corrective Action Plan Process for FY 2012–2013 for Denver Health Medicaid Choice

If applicable, the health plan 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 required action, 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 health plan must submit documents based on the approved timeline.

Table D-1—Corrective Action Plan Process

Step 1	**Corrective action plans are submitted**
	If applicable, the health plan 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 to HSAG and the Department. The health plan will submit the CAP using the template provided. 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 health plan 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 or HSAG will notify the health plan via e-mail whether: ◆ The plan has been approved and the health plan 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 health plan has received Department approval of the CAP, the health plan 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 health plan to submit regular reports to the Department detailing progress made on one or more open elements of the CAP.

Table D-1—Corrective Action Plan Process	
Step 6	**Documentation substantiating implementation of the plans is reviewed and approved**
	Following a review of the CAP and all supporting documentation, the Department or HSAG will inform the health plan 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 health plan must submit additional documentation. The Department or HSAG will inform each health plan in writing when the documentation substantiating implementation of all Department-approved corrective actions is deemed sufficient to bring the health plan into full compliance with all the applicable federal Medicaid managed care regulations and contract requirements.

The template for the CAP follows.

Table D-2—FY 2012–2013 Corrective Action Plan *for* DHMC					
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**
Standard III—Coordination and Continuity of Care 15. The Contractor maintains policies describing its (EPSDT) screening package and the methods used to assure that screening requirements are met.	Staff stated that the EPSDT screening requirements and monitoring methods were not outlined in a formal DHMC policy. DHMC must develop and approve a policy and procedure that outlines the EPSDT screening package and methods to ensure that screening requirements are met.				
Standard VIII—Credentialing and Recredentialing 2.D. The process for making credentialing and recredentialing decisions.	Although the Medical Staff Bylaws stated that the bylaws applied to AHPs, they did not delineate processes used for making credentialing and recredentialing decisions for the AHPs. During the on-site interview, DHMC and DHHA staff members explained that AHPs are credentialed using different processes and a separate credentialing committee. DHMC must either revise the Medical Staff Bylaws or				

Table D-2—FY 2012–2013 Corrective Action Plan *for* DHMC					
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**
	develop policies and procedures that clearly describe the process for making credentialing and recredentialing decisions for DHHA AHPs.				
2.P. The right of applicants to receive notification of their rights under the credentialing program.	The Medical Staff Bylaws did not address notification to applicants regarding their rights under the credentialing program. DHMC must develop or revise documents to address notification to DHHA applicants regarding notification of rights under the credentialing program.				
2.R. The range of actions available to the Contractor against the practitioner (for quality reasons).	The Medical Staff Bylaws addressed the notification to the provider that an action will be taken, the process for the hearing, and the types of actions available to DHHA; but grounds for actions did not include quality of care reasons. DHMC must revise or develop documents that describe the range of actions available to				

Table D-2—FY 2012–2013 Corrective Action Plan *for* DHMC					
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 for changing the conditions of a practitioner's status based on quality reasons.				
Standard X—Quality Assessment and Performance Improvement 4. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis. The annual report describes: ◆ Techniques used by the Contractor to improve performance. ◆ The outcome of each performance improvement project. ◆ The overall impact and effectiveness of	The DHMC QI Impact Analysis Report did not include an analysis or statement of the overall impact and effectiveness of the QI program. DHMC must include a summary or statement of the overall impact and effectiveness of the QI program in the annual QI Impact Analysis Report.				

Table D-2—FY 2012–2013 Corrective Action Plan *for* DHMC					
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**
the QAPI program.					
7. The Contractor disseminates the guidelines to all affected providers, and upon request, to members and potential members, at no cost.	The CPG policy stated that DHMC disseminates CPGs annually to members; however, during the on-site interview, staff clarified that members must request practice guidelines from Member Services. The DHMC Member Handbook did not inform members of the availability of CPGs or how to request them, and DHMC did not provide other evidence of distribution of CPGs to members (per policy). DHMC must modify its policy and procedures to allow the public (potential members) to request and receive clinical practice guidelines at no cost. DHMC must also inform members of the availability of CPGs and how to request the guidelines.				

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

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

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Planned for Monitoring Activities**
	Before the compliance monitoring review: ◆ HSAG and the Department held teleconferences to determine the content of the review. ◆ HSAG coordinated with the Department and the health plan to set the dates 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 to discuss the FY 2012–2013 compliance monitoring review process and answer questions as needed. ◆ HSAG assigned staff to the review team. ◆ Prior to the review, HSAG representatives also responded to questions 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 the health plans were prepared for the compliance monitoring review.
Activity 2:	**Obtained Background Information From the Department**
	◆ HSAG used the BBA Medicaid managed care regulations, NCQA Credentialing and Recredentialing Standards and Guidelines, and the health plan's Medicaid managed care contract with the Department to develop HSAG's monitoring tool, on-site agenda, record review tool, and report template. ◆ HSAG submitted each of the above documents to the Department for its review and approval. ◆ HSAG submitted questions to the Department regarding State interpretation or implementation of specific Managed Care regulations or contract requirements. ◆ HSAG considered the Department responses when determining compliance and analyzing findings.
Activity 3:	**Reviewed Documents**
	◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the health plan in writing of the desk review request via e-mail delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. ◆ Documents submitted for the desk review and during the on-site document review consisted of the completed desk review form, the compliance monitoring tool with the health plan's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials.

Table E-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG completed the following activities:**
	◆ 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.
Activity 4:	**Conducted Interviews**
	◆ During the on-site portion of the review, HSAG met with the health plan's key staff members to obtain a complete picture of the health plan's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan'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.)
Activity 6:	**Analyzed and Compiled Findings**
	◆ Following the on-site portion of the review, HSAG met with health plan staff to provide an overview of preliminary findings. ◆ HSAG used the FY 2012–2013 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 health plan to achieve full compliance with Medicaid managed care regulations and associated contract requirements.
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 2012–2013 Site Review Report. ◆ HSAG submitted the site review report to the health plan and the Department for review and comment. ◆ HSAG incorporated the health plan's and Department's comments, as applicable, and finalized the report. ◆ HSAG distributed the final report to the health plan and the Department.