Colorado Medicaid and Child Health Plan *Plus* (CHP+)
Managed Care Programs

FY 2015–2016 Site Review Report

for

Denver Health Medicaid Choice and Denver Health Medical Plan

March 2016

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

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Introduction

The Balanced Budget Act of 1997, Public Law 105-33 (BBA), requires that states conduct a periodic evaluation of their Medicaid managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to determine compliance with federal healthcare regulations and contractual requirements. Public Law 111-3, The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, requires that each state's Children's Health Insurance Program (CHIP) applies several provisions of Section 1932 of the Social Security Act in the same manner as the provisions apply under Title XIX of the Act. This requires Child Health Plan *Plus* (CHP+) managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to comply with specified provisions of the BBA requiring that states also conduct a periodic evaluation of their CHP+ MCOs and PIHPs to determine compliance with federal healthcare regulations and managed care contract requirements. The Department of Health Care Policy & Financing (the Department) has elected to complete this requirement for Colorado's CHP+ managed care health plans by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This report documents results of the fiscal year (FY) 2015–2016 site review activities for the review period of January 1, 2015, through December 31, 2015, for **Denver Health Medicaid Choice** (**DHMC**) and for **Denver Health Medical Plan** (**DHMP**), **Denver Health**'s CHP+ HMO. Although the two lines of business were reviewed concurrently with results reported in this combined compliance monitoring report, the results for the CHP+ and Medicaid managed care lines of business are presented separately. This section contains summaries of the findings as evidence of compliance, strengths, findings resulting in opportunities for improvement, and required actions for each of the four standard areas reviewed this year for both lines of business. Section 2 contains graphical representation of results for all standards reviewed over the past three years and trending of required actions. Section 3 describes the background and methodology used for the 2015–2016 compliance monitoring site review. Section 4 describes follow-up on the corrective actions required as a result of the 2014–2015 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the credentialing and recredentialing appeal 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 plan process the health plan will be required to complete for FY 2015–2016 and the required template for doing so. Appendix E contains a detailed description of HSAG's site review activities consistent with the Centers for Medicare & Medicaid Services (CMS) final protocol.

Summary of Results

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

CHP+ Results

Table 1-1 presents the CHP+ scores for **DHMP** for each of the standards. Findings for all requirements are summarized in this section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* follow in Appendix A—Compliance Monitoring Tool.

Table 1-1—Summary of CHP+ 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	13	12	12	0	0	1	100%
IV Member Rights and Protections	5	5	5	0	0	0	100%
VIII Credentialing and Recredentialing	48	48	47	1	0	0	98%
X Quality Assessment and Performance Improvement	17	15	14	1	0	2	93%
Totals	**83**	**80**	**78**	**2**	**0**	**3**	**98%**

Table 1-2 presents the CHP+ scores for **DHMP** for the credentialing and recredentialing record reviews. Details of the findings for the record review are in Appendix B—Record Review Tools.

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

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Credentialing	90	87	87	0	2	100%
Recredentialing	90	83	83	0	7	100%
Totals	**180**	**170**	**170**	**0**	**7**	**100%**

Medicaid Results

Table 1-3 presents the Medicaid score for **DHMC** for each of the standards. Findings for all requirements are summarized in this section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* follow in Appendix A—Compliance Monitoring Tool.

Table 1-3—Summary of Medicaid 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	13	13	12	1	0	0	92%
IV Member Rights and Protections	5	5	5	0	0	0	100%
VIII Credentialing and Recredentialing	48	48	47	1	0	0	98%
X Quality Assessment and Performance Improvement	17	16	14	2	0	1	88%
Totals	**83**	**82**	**78**	**4**	**0**	**1**	**95%**

Table 1-4 presents the Medicaid scores for **DHMC** for the credentialing and recredentialing record reviews. Details of the findings for the record review are in Appendix B—Record Review Tools.

Table 1-4—Summary of Medicaid Scores for the Record Reviews

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Credentialing	90	88	88	0	2	100%
Recredentialing	90	86	86	0	4	100%
Totals	**180**	**174**	**174**	**0**	**6**	**100%**

Standard III—Coordination and Continuity of Care

The following sections summarize the findings applicable to both CHP+ and Medicaid managed care. Any notable differences in compliance between the CHP+ and Medicaid lines of business are identified.

Summary of Strengths and Findings as Evidence of Compliance

DHMC/**DHMP** used the same organizational processes and policies/procedures relating to care coordination and case management (CM) for both **Denver Health**'s Medicaid (**DHMC**) and CHP+ (**DHMP**) lines of business. **DHMC**/**DHMP** had policies and procedures that addressed service accessibility, CM procedures, and continuity of care. The health plan had a robust CM organizational structure. To ensure attention both to individual needs and to treatment planning and goals that included health improvement, health maintenance, and independent living, **DHMC**/**DHMP** had several disease management (DM) programs (for targeting members with conditions such as diabetes and asthma as well as for addressing weight management) and four CM programs. Case management programs included Care Support Services (nonclinical support), Complex Case Management, Intensive Care Transitions, and Targeted High-Risk Case Management. Members were enrolled in one of these five programs based initially on results of a risk assessment and followed by the applicable comprehensive needs assessment based on the identified risks. Case managers (nurses or licensed social workers) performed the comprehensive needs assessments, and treatment planning included treatment objectives, follow-up, and monitoring patient outcomes. Members were identified for DM or CM program enrollment via welcome calls to new members and through referrals from the primary care provider (PCP) or clinic. In addition, **DHMC**/**DHMP** staff members reported that members, once referred, have direct access to specialty providers.

DHMC/**DHMP** had a policy/procedure that addressed member assignment to a primary care facility (PCF) within the **Denver Health** network of clinics (and, within the assigned clinic, assignment to a PCP). **DHMC**/**DHMP** has processes for members to choose and/or change their PCF or PCP. For members with special healthcare needs, the CM programs provide members and the clinics additional supports in coordinating covered services. **DHMC**/**DHMP** staff reported that the health plan has a pediatric obesity specialty clinic to address the needs specific to those members. The new-member welcome-call script included questions to ascertain whether or not the member was pregnant or had special healthcare needs and was receiving services from an out-of-network provider. During the on-site interview, **DHMC**/**DHMP** staff members reported that members who responded with a positive answer to these inquiries were referred to utilization management (UM) staff members for authorization to continue services with the out-of-network provider as required by the contract. In addition, the member handbook informed members of the right to continue services with an out-of-network provider through postpartum and, for members with special healthcare needs, through a 60-day transitional period (75 days for ancillary services).

DHMC/**DHMP** had policies and procedures that addressed Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and included the Bright Futures periodicity schedule.

The member handbook included information explaining EPSDT services. The health plan uses its data system to identify, each month, members with a birthday within the month. These members are sent a birthday card that lists the importance of regular check-ups and the elements that a well-child visit should include. Members are offered a $10 gift card for obtaining a well-child visit at one of **Denver Health**'s school-based health clinics. **DHMC**/**DHMP** has a pediatric work group with the goal of developing quality initiatives to improve well-child visit Healthcare Effectiveness Data and Information Set (HEDIS®)[1-1] rates.

On-site, **DHMC**/**DHMP** staff members provided case examples that demonstrated how the health plan referred members for out-of-network specialty services unavailable within the network, coordinated and collaborated among providers and community resources (including the community centered board [CCB]), and referred members to Healthy Communities for EPSDT wraparound services.

DHMC/**DHMP** provided ample evidence of policies, procedures, and practices designed to ensure compliance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations. Staff training related to HIPAA regulations was robust, and staff members described the process for additional department/job-specific HIPAA training. Case management procedures included use of releases of information, consents to treat, and electronic and physical medical record safeguards. HIPAA policies/procedures also included other safeguards such as staff attestations for confidentiality at orientation and annually and limited physical access based on job duties and requirements.

Summary of Findings Resulting in Opportunities for Improvement

The New Member Outreach Program policy stated that the member services department, following **DHMC**/**DHMP**'s receipt of the enrollment file from the State, contacts all new members to discuss benefits and inform members how to access care in the **Denver Health** and hospital clinic system. **DHMC**/**DHMP** reported that these calls are also designed to begin the risk assessment and needs assessment processes. Staff members reported that new enrollment each month ranged from 200 to 1,000 members in calendar year (CY) 2015. During the on-site interview, staff members reported that these calls are typically only placed during the first week of the month; and due to limited time for calling and erroneous phone numbers and addresses, member services staff typically contact approximately 10 percent of new members monthly. Health plan leadership reported that the health plan continues to evaluate how best to reach new members and that the health plan plans to revise the member onboarding process during FY 2016– 2017.

Summary of Required Actions

On-site, **DHMC** provided reviewers the EPSDT section of the provider manual. The provider manual language did not adequately instruct providers how to refer a member for EPSDT-related wraparound services. In addition, HSAG reviewers noted that the time frame stated for scheduling EPSDT services was two weeks. **DHMC** must ensure that providers are instructed to refer members to the Department's Office of Clinical Services and/or Healthy Communities to obtain EPSDT-

[1-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

related wraparound services not covered under the managed care contract. **DHMC** must revise the provider manual information about referring members for wraparound services and may want to consider adding EPSDT and wraparound referral information as a topic for rotation in the provider newsletters. **DHMC** must also revise the provider manual to reflect a 30-day scheduling time frame consistent with **DHMC**'s managed care contract and its own procedures. (EPSDT contract requirements are applicable only to the Medicaid [**DHMC**] line of business.)

Standard IV—Member Rights and Protections

The following sections summarize the findings applicable to both CHP+ and Medicaid managed care. Any notable differences in compliance between the CHP+ and Medicaid lines of business are identified.

Summary of Strengths and Findings as Evidence of Compliance

The health plan's policies and procedures described the process for providers to take member rights into account when providing services. The policies and procedures addressed both health plan employed and affiliated (contracted) providers. Through on-site interviews, staff demonstrated that both lines of business ensure that members receive information pertaining to member rights. Staff in various departments, including pharmacy benefits, were trained to manage and forward grievances when such arose or were identified during interactions with members. Member rights included the right to grieve without fear of adverse consequences. The CHP+ and Medicaid managed care staff members reported that this right is adhered to within member services staff processes for following up on grievances and by working closely with members to close the loop on issues. If a member remains dissatisfied with a particular provider, that member has freedom of choice to see another in-network provider any time desired.

Through policy, **Denver Health** provided evidence that both lines of business complied with federal and State law pertaining to various forms of discrimination.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no findings resulting in opportunities for improvement for this standard.

Summary of Required Actions

HSAG required no corrective actions for this standard.

Standard VIII—Credentialing and Recredentialing

The following sections summarize the findings applicable to both CHP+ and Medicaid managed care. Any notable differences in compliance between the CHP+ and Medicaid lines of business are identified.

Summary of Strengths and Findings as Evidence of Compliance

Policies and procedures for the credentialing and privileging of providers were thorough and appropriate for both lines of business. The credentialing and recredentialing records reviewed by HSAG were complete and well-organized. It was evident that credentialing team leads for both the CHP+ and Medicaid managed care products are detail-oriented and take necessary consideration to ensure that all National Committee for Quality Assurance (NCQA) requirements are met and that credentialing and recredentialing activities are completed timely. During the on-site interview, staff were able to verbally describe the credentialing process from application to appointment. The process described was in alignment with policy and procedure and also evident in record review.

During the interview, staff described the makeup and function of the credentialing committee for each line of business. Staff were able to clearly describe the process for review of red flags identified in the credentialing process and the applicant's rights throughout the process, including the right to correct erroneous information and the right to appeal actions.

Monitoring providers for sanctions and limitations is conducted regularly, as required by NCQA requirements. All providers reviewed were recredentialed at least every three years or more frequently based on The Joint Commission on Accreditation of Healthcare Organizations. Organizational provider files were still in a paper-based format, but were complete and included all required information.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no findings resulting in opportunities for improvement for this standard.

Summary of Required Actions

DHMC/**DHMP** provided thorough policies and procedures that included all NCQA credentialing and recredentialing requirements. Although office-site quality standards were adequately addressed in policy, during the on-site interview credentialing staff and provider network support staff were unable either to describe the performance threshold for complaints which would warrant site visits or to describe, consistent with policy, the process for addressing such complaints. **DHMC**/**DHMP** must ensure that staff are aware of the threshold for site-related complaints which warrant site visits and the process, pursuant to the health plan's policy, for further follow-up.

Standard X—Quality Assessment and Performance Improvement

The following sections summarize the findings applicable to both CHP+ and Medicaid managed care. Any notable differences in compliance between the CHP+ and Medicaid lines of business are identified.

Summary of Strengths and Findings as Evidence of Compliance

DHMC/**DHMP** used the same organizational processes and policies/procedures relating to quality assessment and performance improvement (QAPI) for both **Denver Health**'s Medicaid Choice (**DHMC**) and CHP+ (**DHMP**) lines of business. **DHMC**/**DHMP**'s QAPI program description addressed HEDIS, Consumer Assessment of Healthcare Providers and Systems Plans (CAHPS®),[1-2] PIP topics, provider satisfaction surveys, member call center metrics, medical record review, mechanisms to detect over- and underutilization, CM programs for members with special healthcare needs, and clinical practice guidelines. The health plan's quality improvement (QI) program description and related documentation (policies, procedures, brochures, articles, and committee meeting minutes) as well as the in depth overview of the QI program provided during the on-site review demonstrated the health plan's commitment to improving quality of care provided to its members. The quality management committee (QMC) was the focal point for the health plan and for quality-related operational processes and activities. The QMC is accountable to the **DHMC**/**DHMP** board of directors and includes healthcare providers from key/applicable specialties. The myriad of committees and work groups reporting to the QMC ensured QI as a priority for the health plan.

DHMC/**DHMP** used its Ambulatory Care Services network, consisting of eight primary care clinics and 15 school-based health centers, as its primary method of service provision. Using data on specified metrics presented to the clinics in a scorecard format as well as HEDIS and CAHPS results, **DHMC**/**DHMC** worked with the clinic staff to address underutilization of key services Underutilization was further identified through risk stratification for specific member populations. Members identified as needing specific services were forwarded to the appropriate CM program for outreach and action. Overutilization was addressed through analysis of medical claims data. As an example, staff reported that the targeted case management (TCM) program was developed to provide case management, to ensure that members receive regular care, and to prevent overutilization of services (e.g., making an emergency room visit to obtain primary care services). In addition, **DHMC**/**DHMP** staff members reported using the standard MedImpact (the health plan's pharmacy benefit manager [PBM]) pharmacy reports to monitor both under- and overutilization of drugs. Under- and overutilization reports were addressed in both the Pharmacy and Therapeutics Committee (P&T Committee) meetings and in the quarterly QMC meetings.

DHMC/**DHMP**'s QMC is the oversight committee for the health plan's intensive case management (ICM) programs. The health plan's program description delineated methods for identifying members for case management and care coordination. During 2014, an intensive care transition

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

program and a TCM program were added, expanding the ICM program. These programs focused on furthering the health plan's efforts to assess the quality and appropriateness of care for members with special healthcare needs, including members with pre- and postnatal care needs.

DHMC/**DHMP** provided the required clinical practice guidelines. The guidelines cited the relevant literature on which the guidelines were based, and the Clinical Practice and Preventive Care policy stated that all requested changes to the guidelines go through the QMC for approval. QMC meeting minutes reflected clinical practice guideline review and consultation with healthcare providers with specialties specific to the respective guidelines. The meeting minutes also provided evidence that the guidelines took into consideration the specific needs of the membership. The clinical practice guidelines were posted on the **DHMC** and **DHMP** websites for providers and members to access at no cost. Newsletters were used to inform the provider community of changes in practice guidelines and as a reminder of how to obtain the guidelines if needed. During the on-site interview, customer service staff members reported having received no calls from members requesting the clinical practice guidelines. During the on-site interview, staff members reported that UM criteria and DM materials were approved by the QMC to ensure consistency with the clinical practice guidelines.

QMC meeting minutes provided evidence of calculation, analysis, and submission of specified HEDIS measures to the State. **DHMC**/**DHMP** also submitted a PowerPoint presentation (presented to the QMC) that provided detailed insight into the HEDIS results. The meeting minutes provided insight into how the QI staff used the HEDIS Analysis Workbook to develop the QI program and work plan for the upcoming year. Progress/success was documented in the annual Quality Improvement Impact Analysis report. The QMC meeting minutes also referenced a presentation of CAHPS results and included an overview of discussion and analysis of CAHPS and member experience pertaining to website information and the directions provided to members on how to obtain appointments. The Impact Analysis addressed CAHPS results and a member grievance analysis and described planned corrective interventions to address the results. **DHMC**/**DHMP** also tracked and analyzed member disenrollment patterns/trends.

Corrective action plans based on member dissatisfaction were described in the Impact Analysis and in CAHPS corrective action plan (CAP) documents. Interventions included hiring a QI pediatric intervention manager, filling open provider positions, adding 4.5 provider positions, and using a pilot project to move providers at one clinic to a four-day work week to expand clinic hours to include additional weekend and evening hours. **DHMC**/**DHMP** also entered into a three-year contract with the Studer Group in an initiative to study and improve the patient experience and workforce engagement in that patient's experience. The Strategic Network Adequacy Plan identified a new process whereby out-of-network referrals occurred when members are unable to receive timely clinic appointments. Under the CAHPS CAP, **DHMC**/**DHMP** conducted annual secret shopper phone surveys to assess appointment availability at the clinics. The QI team used the data to assist the centralized appointment call center in identifying areas to improve. CAP interventions also included the creation of the pediatric nurse line that allows parents an avenue to speak to a nurse and seek assistance and education regarding medical issues affecting their children.

DHMC/**DHMP** had a quality of care concerns (QOCC) policy that outlined the process for reviewing and addressing QOCC and grievances submitted by members. During the on-site interview, senior health plan leadership explained that all grievances/concerns go through the current process that establishes whether the QOCC grievance is substantiated as a QOCC. Once it is

determined that a grievance is in fact a QOCC, it is then reported to the Department. The **DHMC**/**DHMP** medical director is responsible for final determination as to whether a QOCC grievance should be processed as a QOCC. If not determined a QOCC, the grievance is returned to member services for resolution. QMC meeting minutes emphasized the role of the committee in impacting all quality-related actions, plans, and activities.

DHMC/**DHMP** provided evidence that demonstrated that the information system had capabilities to identify members based on language spoken, to produce reports of EPSDT services provided or needed and not provided, and to track emergency department utilization. The health plan also used its data to identify member demographics for designating a PCF and a PCP within the PCF and to determine staffing and clinic expansion needs. During the review period, **DHMC**/**DHMP** implemented a new claims system that enabled it to expand its ability to report and analyze service utilization. **DHMC**/**DHMP** used the GuidingCare software for care and case management. GuidingCare interfaces with the new claims system, which will further improve efficiencies related to the member's care experience and the health plan's ability to determine access needs. **DHMC**/**DHMP** provided documentation that described its new TriZetto QNXT claims system. The information provided included a high-level overview of how the system was set up to verify the accuracy, timeliness, completeness, and logic of data submitted by providers. The system also accepted information in standard formats. During the on-site interview, additional information was provided regarding the operational structure established to address any claim-related issues. **DHMC**/**DHMP** staff members reported routine use of a number of outlier reports to assist in identifying needed system enhancements. In addition, **DHMC**/**DHMP** and TriZetto management met weekly to discuss those outliers and establish strategies to address issues.

Summary of Findings Resulting in Opportunities for Improvement

Although **DHMC**/**DHMP** tracked disenrollment trends, it did not track reasons when new members disenrolled without cause during the initial 90-day period allowed for disenrollment. **DHMC**/**DHMP** may want to consider tracking reasons for disenrollment during the first 90 days.

DHMC/**DHMP** submitted the Denver Health and Hospital Authority (DHHA) clinical practice guideline for immunizations that stated that data are submitted to the Colorado Immunization Information System daily. During the on-site interview, **DHMC**/**DHMP** staff members stated that verification of submission is a manual process and that the system does not provide an automatic verification of receipt. **DHMC**/**DHMP** may want to consider developing a health plan policy/procedure regarding immunization submissions that addresses both clinic and contractor immunization data.

The comprehensive **DHMC**/**DHMP** QI program met all QAPI standard requirements. During the on-site interview, **DHMC**/**DHMP** leadership identified a number of initiatives already underway to further enhance the QI program and ultimately improve the quality of care and general healthcare experience for its membership. The items listed below were drawn from that list of initiatives. They are presented not as new recommendations for improvement, but rather documentation of self-identified action items for the health plan:

- **DHMC**/**DHMP** staff described plans to integrate the ambulatory scorecard into an overall automated UM tracking, monitoring, and reporting process.
- The health plan also described plans to continue to work closely with the clinics and the school-based health centers to identify and implement innovative steps to improve/increase primary care and well-child visits.

Summary of Required Actions

DHMC/**DHMP**'s clinical practice guideline documents stated a review date of every two years. During the on-site interview, staff members reported that the two-year review timeline is based on URAC standards. Staff members also stated that the QMC has plans for annual review of the guidelines but has not yet implemented an annual review for all guidelines. **DHMC**/**DHMP** must develop a mechanism to track clinical practice guideline review by the QMC to ensure annual review of all guidelines as required by the Medicaid and CHP+ managed care contracts with the State.

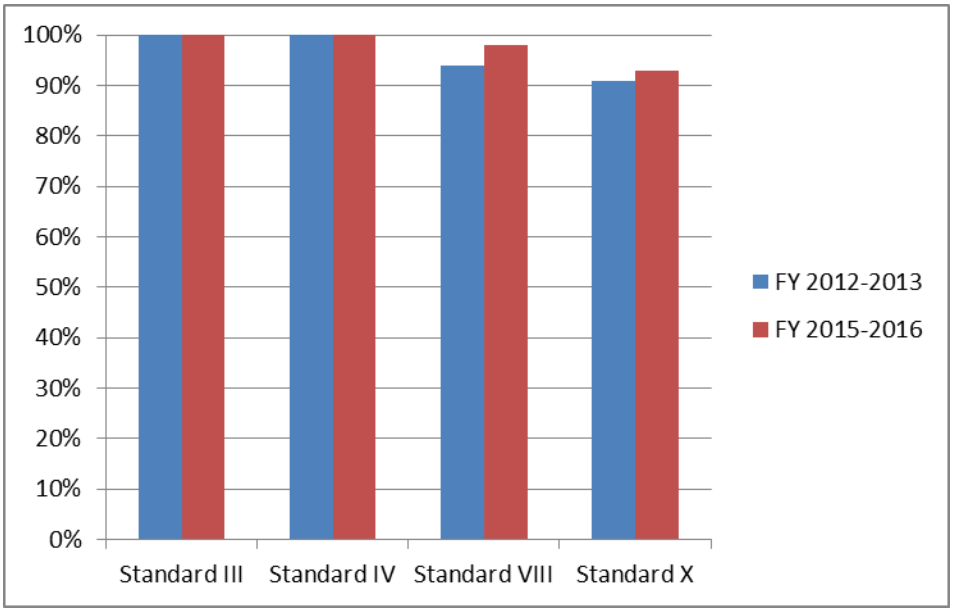
While **DHMC** had a policy that addressed EPSDT services and that referenced the Bright Futures periodicity schedule, the information furnished to providers via the provider manual was outdated. In addition, the key scorecard does measure HEDIS well-child visit measures, but the health plan did not provide sufficient evidence that it adequately measures compliance with the EPSDT periodicity schedule to ensure compliance with such. **DHMC** must develop a mechanism to measure compliance with the periodicity schedule and then develop interventions designed to ensure continued and/or improved compliance. (EPSDT contract requirements are applicable only to the Medicaid [**DHMC**] line of business.)

Comparison of CHP+ Results

Comparison of FY 2012–2013 Results to FY 2015–2016 Results

Figure 2-1 shows the scores from the FY 2012–2013 site review (when Standard III, Standard IV, Standard VIII, and Standard X were previously reviewed) compared with the results from this year's review. The results show the overall percent of compliance with each standard. Although the federal language did not change with regard to requirements, **DHMP**'s contract with the State may have changed and may have contributed to performance changes.

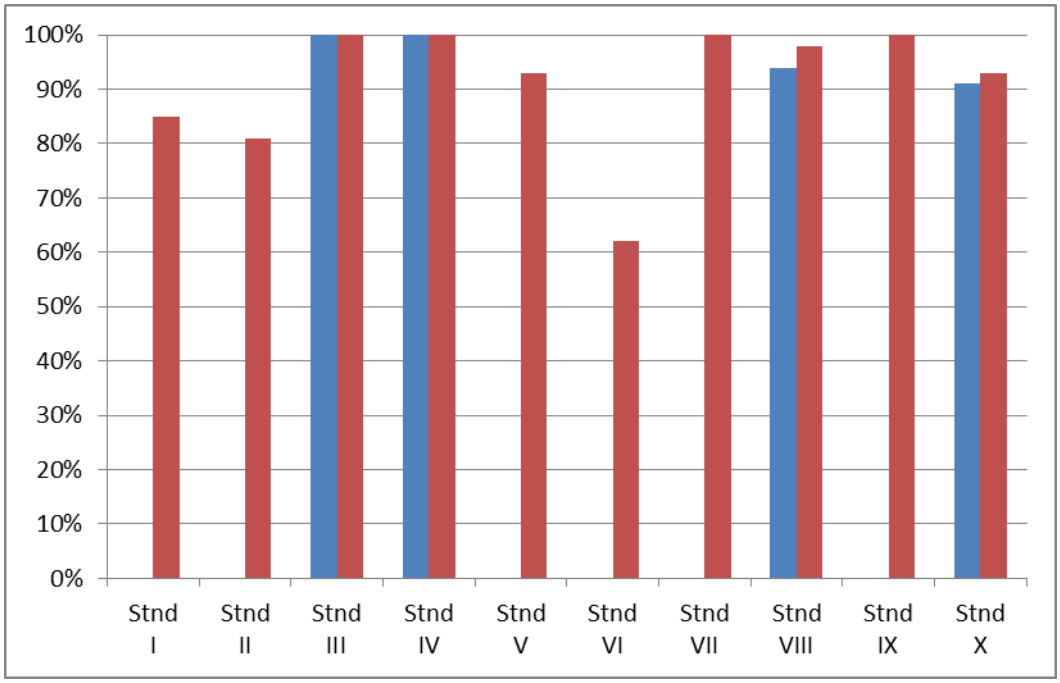
Figure 2-1—Comparison of FY 2012–2013 Results to FY 2015–2016 Results



Review of Compliance Scores for All Standards

Figure 2-2 shows the scores for all standards reviewed over the past four years of compliance monitoring. The figure compares the score for each standard across two review periods, as applicable, and may be an indicator of overall improvement.

Figure 2-2—DHMP's Compliance Scores for All Standards



Note: Results shown in blue are from FY 2012–2013. Results shown in red are from FY 2013–2014, FY 2014–2015, and FY 2015–2016.

Table 2-1 presents the list of standards by review year.

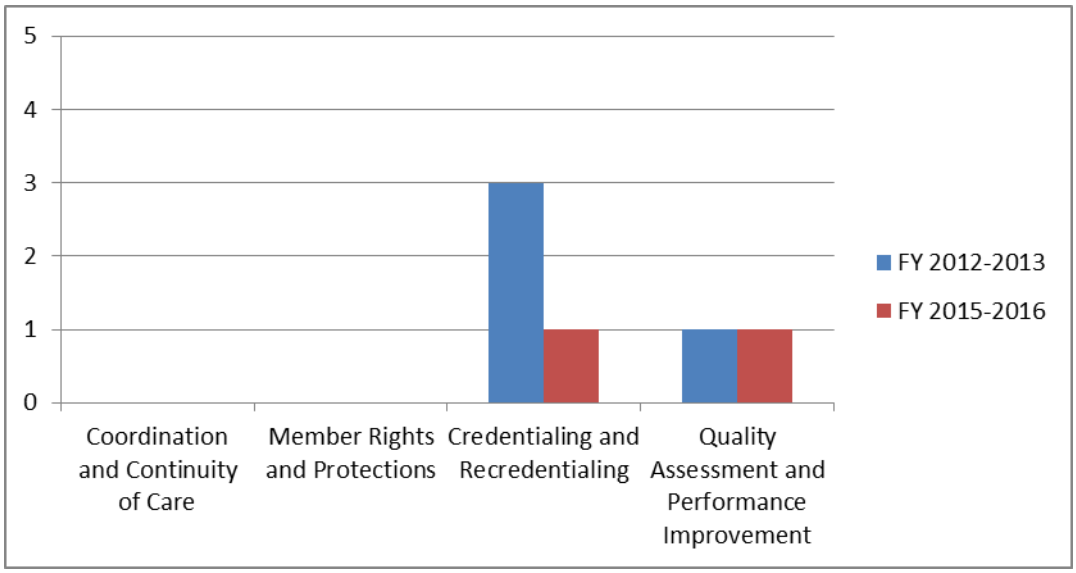
Table 2-1—List of Standards by Review Year

Standard	2012–13	2013–14	2014–15	2015–16
I—Coverage and Authorization of Services		X		
II—Access and Availability		X		
III—Coordination and Continuity of Care	X			X
IV—Member Rights and Protections	X			X
V—Member Information			X	
VI—Grievance System			X	
VII—Provider Participation and Program Integrity			X	
VIII—Credentialing and Recredentialing	X			X
IX—Subcontracts and Delegation			X	
X—Quality Assessment and Performance Improvement	X			X

Trending the Number of Required Actions

Figure 2-3 shows the number of requirements with required actions from the FY 2012–2013 site review (when Standard III, Standard IV, Standard VIII, and Standard X were previously reviewed) compared to the results from this year's review. Although the federal requirements did not change for the standards, **DHMP**'s contract with the State may have changed and may have contributed to performance changes.

Figure 2-3—Number of FY 2012–2013 and FY 2015–2016 Required Actions per Standard

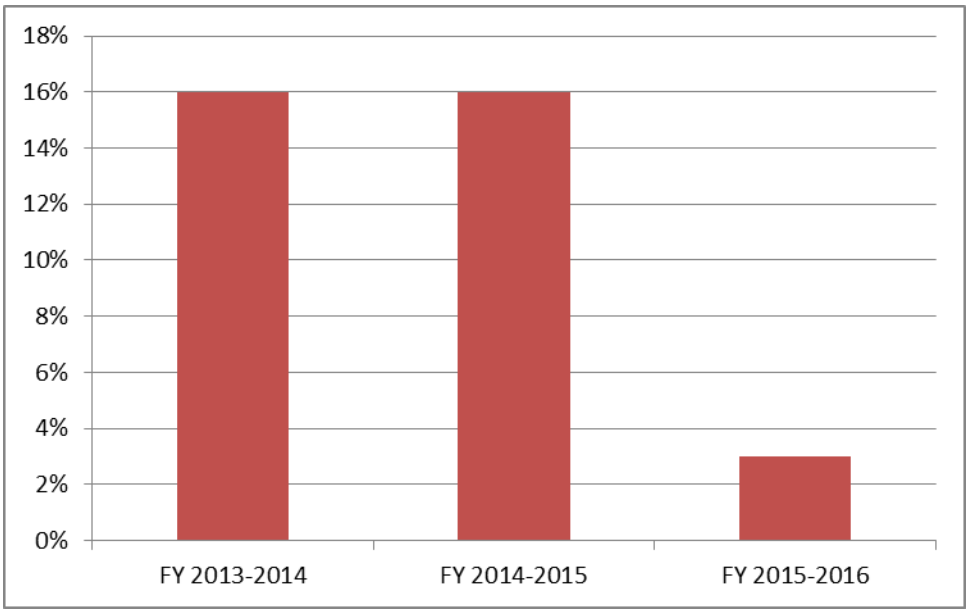


Note: **DHMP** had no required actions for Coordination and Continuity of Care or Member Rights and Protections resulting from the FY 2012–2013 or the FY 2015–2016 site review.

Trending the Percentage of Required Actions

Figure 2-4 shows the percentage of requirements that resulted in required actions over the past three-year cycle of compliance monitoring. Each year represents the results for review of different standards, as indicated in Table 2-1.

Figure 2-4—Percentage of Required Actions—All Standards Reviewed

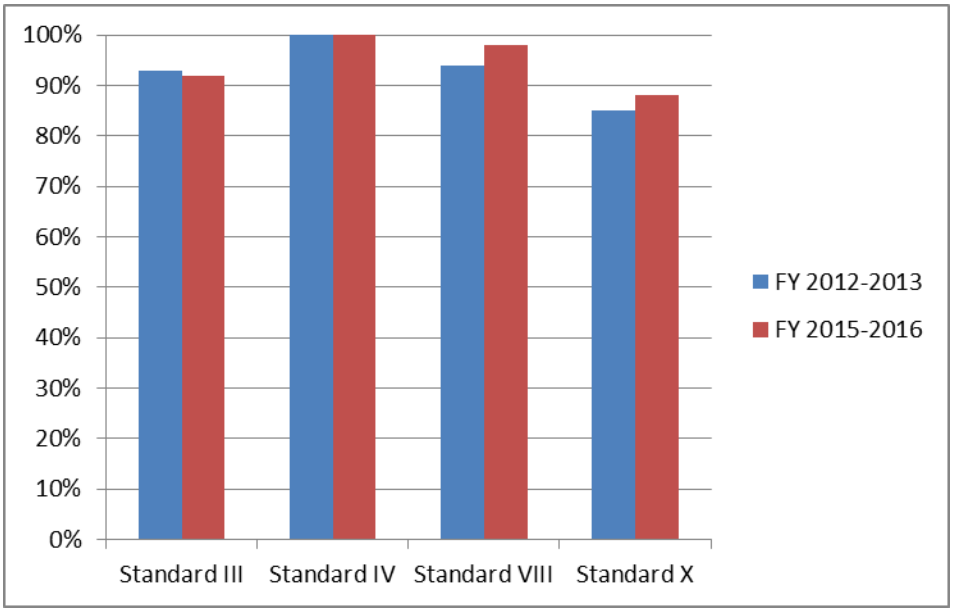


Comparison of Medicaid Results

Comparison of FY 2012–2013 Results to FY 2015–2016 Results

Figure 2-5 shows the scores from the FY 2012–2013 Medicaid site review (when Standard III, Standard IV, Standard VIII, and Standard X were previously reviewed) compared with the results from this year's Medicaid review. The results show the overall percent of compliance with each standard. Although the federal language did not change with regard to requirements, **DHMC**'s contract with the State changed in July 2015 and may have contributed to performance changes.

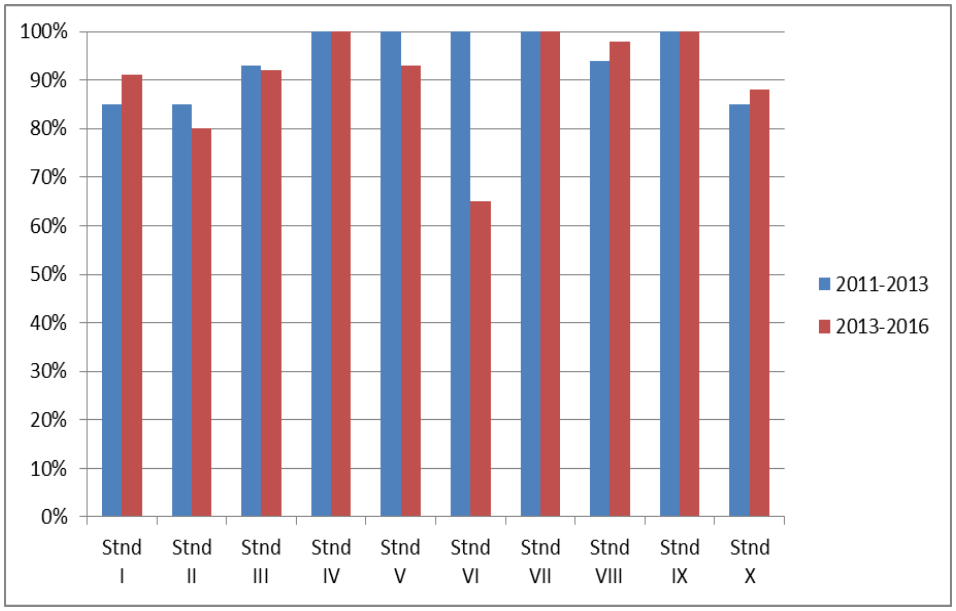
Figure 2-5—Comparison of FY 2012–2013 Medicaid Results to FY 2015–2016 Medicaid Results



Review of Compliance Scores for All Standards

Figure 2-6 shows the scores for all standards reviewed over the last two three-year cycles of Medicaid compliance monitoring. The figure compares the score for each standard across two review periods and may be an indicator of overall improvement.

Figure 2-6—DHMC Compliance Scores for All Standards



Note: The previous results are shown in blue. The most recent review results are shown in red.

Table 2-2 presents the list of standards by review year.

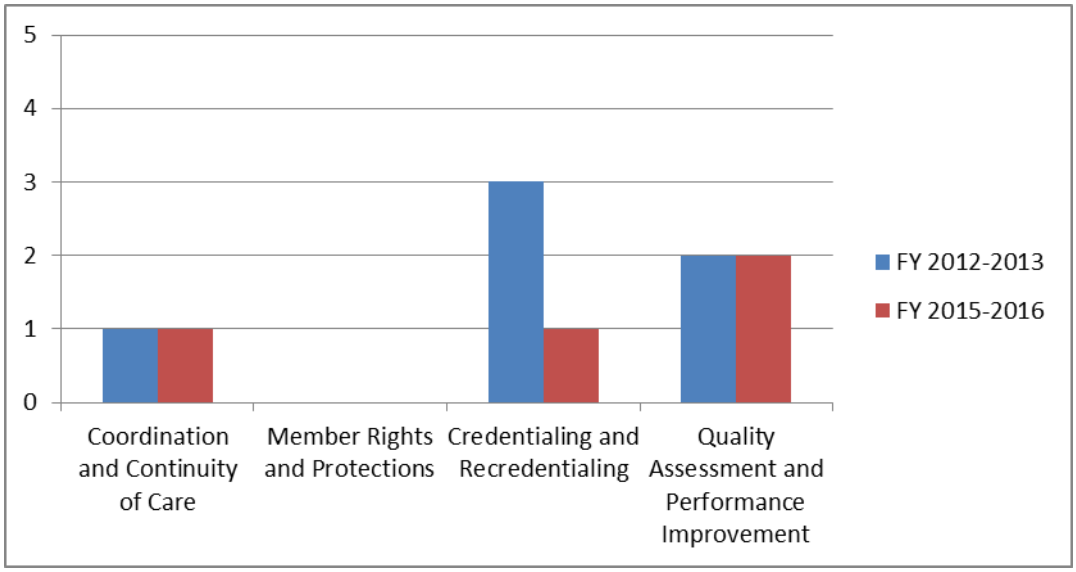
Table 2-2—Medicaid List of Standards by Review Year

Standard	2010–11	2011–12	2012–13	2013–14	2014–15	2015–16
I—Coverage and Authorization of Services	X			X		
II—Access and Availability	X			X		
III—Coordination and Continuity of Care			X			X
IV—Member Rights and Protections			X			X
V—Member Information		X			X	
VI—Grievance System		X			X	
VII—Provider Participation and Program Integrity		X			X	
VIII—Credentialing and Recredentialing	X		X			X
IX—Subcontracts and Delegation		X			X	
X—Quality Assessment and Performance Improvement			X			X

Trending the Number of Required Actions

Figure 2-7 shows the number of requirements with required actions from the FY 2012–2013 Medicaid site review (when Standard III, Standard IV, Standard VIII, and Standard X were previously reviewed) compared to the results from this year's review. Although the federal requirements did not change for the standards, **DHMC**'s contract with the State changed in July 2015 and may have contributed to performance changes.

Figure 2-7—Number of FY 2012–2013 and FY 2015–2016 Medicaid Required Actions per Standard

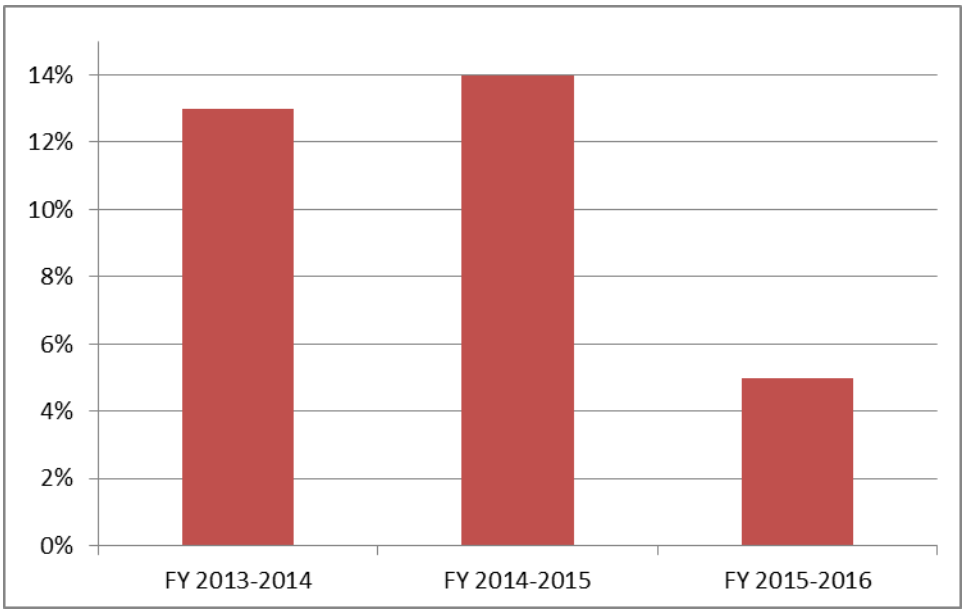


Note: **DHMC** had no required actions for Member Rights and Protections resulting from the FY 2012–2013 or the FY 2015–2016 site review.

Trending the Percentage of Required Actions

Figure 2-8 shows the percentage of requirements that resulted in required actions over the past three-year cycle of Medicaid compliance monitoring. Each year represents the results of review of different standards.

Figure 2-8—Percentage of Medicaid Required Actions—All Standards Reviewed



Overview of FY 2015–2016 Compliance Monitoring Activities

For the FY 2015–2016 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 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. Compliance with federal managed care regulations and managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the health plan's contract requirements and regulations specified by the BBA, with revisions issued June 14, 2002, and effective August 13, 2002. HSAG conducted a desk review of materials submitted prior to the on-site review activities; a review of records, documents, and materials provided on-site; and on-site interviews of key health plan personnel to determine compliance with federal managed care regulations and contract requirements. Documents submitted for the desk review and on-site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to CHP+ grievances and appeals and Medicaid grievances and appeals. HSAG documented detailed findings in the Compliance Monitoring tool for any requirement receiving a score *Partially Met* or *Not Met*.

A sample of the health plan's administrative records related to Medicaid and CHP+ credentialing and recredentialing were also reviewed to evaluate implementation of federal healthcare regulations and compliance with National Committee for Quality Assurance (NCQA) requirements, effective July 2015. HSAG used standardized monitoring tools to review records and document findings. Using a random sampling technique, HSAG selected a sample of 10 records with an oversample of five records from all Medicaid and CHP+ credentialing and recredentialing records that occurred between January 1, 2015, and December 31, 2015, to the extent available at the time of the site-review request. HSAG reviewed a sample of 10 credentialing records and 10 recredentialing records for each line of business, to the extent possible. For the record review, the health plan received a score of *M* (met), *N* (not met), or *NA* (not applicable) for each of the required elements. Results of record reviews were considered in the review of applicable requirements in Standard VIII—Credentialing and Recredentialing. HSAG also separately calculated a credentialing record review score, a recredentialing record review score, and an overall record review score for both DHMC and DHMP.

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Appendix E contains a detailed description of HSAG's site review

activities consistent with those outlined in the CMS final protocol. The four standards chosen for the FY 2015–2016 site reviews represent a portion of the Medicaid managed care requirements. These standards will be reviewed in subsequent years: 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.

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 healthcare regulations and managed care 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 healthcare 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 recommended to improve the quality of the health plan's services related to the standard areas reviewed.

4. Follow-up on Prior Year's Corrective Action Plan

for **Denver Health**

FY 2014–2015 Corrective Action Methodology

As a follow-up to the FY 2014–2015 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 it successfully completed each of the required actions. HSAG and the Department continued to work with **Denver Health** until it completed each of the required actions from the FY 2014–2015 compliance monitoring site review.

Summary of 2014–2015 Required Actions

As a result of the 2014–2015 site review, **Denver Health** was required to address 11 *Partially Met* scores for its Medicaid line of business and seven *Partially Met* scores for its CHP+ line of business. Required actions included:

- Provide the address members may write to with State-level grievances.
- Revise its drug utilization policy/procedure to depict that the termination, suspension, or reduction of a previously authorized service (in this case, medication) is an action.
- Develop a mechanism to ensure that appeal and grievance acknowledgement and resolution letters are consistently sent to members within the required time frames and that they include all required elements.
- Ensure that appeal decisions are reviewed by providers with clinical expertise who have not been involved in a previous level of decision.
- Review applicable policies and member and provider materials to ensure that they include accurate timely filing requirements relating to the continuation of previously authorized services that **DHMC/DHMP** is proposing to terminate, suspend, or reduce.
- Revise the CHP+ member handbook to accurately reflect appointment standards.
- Revise member handbook to accurately state that EPSDT services are available for members aged 20 and under, and completely describe EPSDT and related services.

Summary of Corrective Action/Document Review

Denver Health submitted its CAP in April. After HSAG and the Department reviewed and approved the plan, **Denver Health** began submitting documents to demonstrate compliance with the proposed plan. As of December 2015, **Denver Health** had completed nine of the 11 required actions related to its Medicaid line of business and all required actions related to its CHP+ line of business.

Summary of Continued Required Actions

DHMC must revise member handbook sections related to EPSDT to:

- Improve the clarity of EPSDT information provided to members.
- Incorporate the Exception to Benefits Limits (limitations/special considerations in 10 CCR 2505-10 8.280.5) into the proposed EPSDT member handbook changes.
- Correct the description of EPSDT benefits to remove the description of general Medicaid wrap-around services and to list all EPSDT benefits or to reference the proposed EPSDT section of the member handbook, and include a complete and accurate description of all EPSDT benefits in that section.
- Revise the description of Healthy Communities to clarify that it is a resource for outreach/case management related EPSDT services.
- Define medical necessity for EPSDT services as outlined in 10 CCR 2505-10 8.280.1.

In addition, **DHMC**/**DHMP** have outstanding required actions from FY 2013–2014 related to access and availability of services as follows:

- **DHMC/DHMP** were required to develop a mechanism to more fully explore wait list processes and a process to specifically track, by individual, the length of time members remain on the wait list, to work with the Department to problem solve solutions to barriers that create the need for the wait list, and to develop mechanisms to ensure that new adult Medicaid members are not wait-listed beyond the required access to care standards. As of December 2015, **DHMC/DHMP** have not yet submitted metrics to be used for evaluating compliance with this requirement and to be included in the quarterly network adequacy and annual strategic access reports.
- **DHMC** was required to evaluate appointment capacity within the DHHA provider system and to develop a mechanism to accommodate Medicaid and CHP+ populations equally. **DHMC** has not yet resubmitted a detailed plan to address mechanisms to effectively monitor individual member access to provider appointments within the defined appointment standards.

Appendix A. Compliance Monitoring Tool *for* Denver Health

The completed compliance monitoring tool follows this cover page.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
1. The Contractor has written policies and procedures to address the coordination and provision of covered services in conjunction with other medical and behavioral health plans and to promote: ◆ Service accessibility. ◆ Attention to individual needs. ◆ Continuity of care. ◆ Maintenance of health. ◆ Independent living. *42CFR438.208(b)(2)* Medicaid Contract: Exhibit A—2.5.4.1 CHP+ Contract: Exhibit A4—2.5.4.1	**1. Member Services_MCD-CHP_New_Member_Welcome_Survey_&_Follow_up_Process .vsd** This document, both the workflow and the script, illustrates the Member Services departmental process for conducting new member welcome calls, assessing special healthcare needs of new members, and forwarding on of information for subsequent departmental interventions. **2. UM_MCD_CHP_UM04 v. 09.pdf** This policy details the processes for coordination of services for Member's with Special Health Care Needs. **3. Care Coordination_narrative_2015.pdf** **4. Care Coordination visio_2015.pdf** These two documents provide a narrative and illustrative overview of the care coordination activities by DH Managed Care. **5. ICM Program Description 2015_FINAL.pdf** This document describes the Intensive Case Management Program (three CM programs and support services) function to make sure the members can access the services they need. **6. CCM04 Referral Review Process.pdf** This Visio illustrates how member needs are identified and referred to appropriate department for intervention. **7. Medical Management Referral form 2015.pdf** **8. ICM flyer_2015**	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	9. UM_MCD_CHP_CM01 v. 6.pdf This policy and procedure describes Case Management for Medicaid Choice and Child Health Plan Plus Members. **10. UM_MCD_CHP_UM13 v. 13.pdf** This policy and procedure describes the Guidelines for the Ordering and Authorization of durable Medical Equipment and Consumable Supplies. **11. UM_MCD_CHP_UM15 v. 13.pdf** This policy and procedure relates to Home Health Care Referrals. **12. UM_MCD_CHP_UM10 v. 18.pdf** This Policy and procedure describes Concurrent Utilization Management of Inpatient and Observation Stays. **13. BHWS Department Description 2015.pdf** This document outlines the Behavioral Health and Wellness department's goals and objectives (pg. 5) and how its staff helps our members better manage their health though various interventions (pg. 5-6). Highlights the focus on interdepartmental collaboration and continuity of care to best help our high risk members (pg. 7). **14. Behavioral Health and Wellness Services Staff Daily Checklist.pdf** This document further demonstrates the staff's attention to individual needs. **15. HW Depression Flyer.pdf** **16. HW Depression flyer SPA.pdf**	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	17. DH 607-Diabetes Program Flyer.pdf **18. DHMP_cooking matter flyer_ENG_SP2015.pdf** **19. DHMP_Cooking Matters at the Store flyer_ENG_SP15.pdf** **20. Diabetes Prevention Flyer ENG_SP October 2015_w text program.pdf** **21. GEN_BHW_2015 BHWS Service flyer_2-19-15_ENG.pdf** **22. GEN_BHW_StrongBody-2015 LearnBurnFlyer_2-12-15_NOCROP.pdf** **23. Health Coaching Initial Comprehensive Assessment**	
2. 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. ◆ The Contractor allows, to the extent possible, each member to choose a primary care physician (PCP). ◆ If a member does not select a 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)* Medicaid Contract: Exhibit A—2.5.3.1; 2.5.3.2 CHP+ Contract: Exhibit A4—2.5.8.2	**1. Member Services_MCD-CHP_New_Member_Welcome_Survey_&_Follow_up_Process.vsd** This document, both the workflow and the script, illustrates the Member Services departmental process for conducting new member welcome calls, assessing special healthcare needs of new members, and forwarding on of information for subsequent departmental interventions.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
3. The Contractor's procedures are designed to address those members who require complex coordination of benefits and services and may require services from multiple providers, facilities and agencies, ancillary or nonmedical services, including social services and other community resources. Procedures also address: ◆ Coordinating services for children with special healthcare needs with other agencies or entities such as those dealing with mental health and substance abuse, public health, home and community-based care, developmental disabilities, local school districts, child welfare, IDEA programs, Title V, families, caregivers, and advocates. ◆ Criteria for making referrals and coordinating care by specialists, subspecialists, and community-based organizations. Medicaid Contract: Exhibit A—2.5.4.3.2; 2.5.4.3.3; 2.7.4.3.5; 2.5.5.5 CHP+ Contract: Exhibit A4—2.7.4.3.2; 2.7.4.3.3; 2.7.4.3.5; 2.7.5.5	**1. Behavioral Health Coordination Program and Criteria to Fill at DH Pharmacy.doc-** This document describes the process of pharmacist review and monitoring for members with behavioral health medications as well as the requirements for medication coordination at a Denver Health pharmacy. **2. Member Services_MCD-CHP_New_Member_Welcome_Survey_&_Follow_up_Process .vsd** This document, both the workflow and the script, illustrates the Member Services departmental process for conducting new member welcome calls, assessing special healthcare needs of new members, and forwarding on of information for subsequent departmental interventions. **3. Care Coordination_narrative_2015.pdf** **4. Care Coordination visio_2015.pdf** These two documents provide a narrative and illustrative overview of the care coordination activities by DH Managed Care. **5. ICM Program Description 2015_FINAL.pdf** This document describes the Intensive Case Management Program (three CM programs and support services) function to make sure the members can access the services they need. **6. DOP_Identifying and Referring Members to Community Resources.pdf** Program guidelines that outlines how to address members with multiple needs, requiring community referrals.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	7. Community Resources Script.pdf This questionnaire is used to document in Guiding Care™ the Community Resource Referrals made by the staff. **8. CCM04 Referral Review Process.pdf** This Visio illustrates the process used by Care Support staff to evaluate members' needs and refer members to the appropriate programs for services. **9. CS02 appt reminder call.pdf** This Visio illustrates the process for coordinating care including scheduling appointments. **10. CS07 post discharge call_2015.pdf** Visio illustrating the process for making calls to members upon discharge from hospital – often coordinating with pharmacy, home health, DME, etc. **11. Post Discharge Call Script_Adult** **12. Post Discharge Call Script_Mom and Baby** **13. Post Discharge Call Script_Peds** Copy of the questions (script) asked during the post-discharge call – asking questions to determine coordination needs. **14. CM Introduction Letter.pdf** Copy of letter sent to members new to Complex Case Management – explaining CCM role in coordinating with multiple providers. **15. CM Program Consent.doc**	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	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. **16. DH Release of Info.pdf** DHHA form that provides consent for staff to assist in care coordination activities with multiple providers, agencies and/or services. **17. LCR Electronic Referral System.pdf** Screenshots that illustrate the electronic form used to refer members for intervention. **18. EDM Assessment_fillable** Managed Care staff use this form to document member updates. The form is then uploaded into EDM – for viewing by all Denver Health providers. **19. MCD_DOP Identifying and Referring Mbrs to MH providers.pdf** Program guidelines that outlines how to address members with multiple needs, requiring coordination – including mental health providers and services. **20. MCD_CCM08 Member Referral Process** **21. MCD_CCM07_CCM Member Identification Process** These two policies describe the processes by which members are assessed and identified as appropriate for Complex Case Management.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	22. ICM01 Case Identification.pdf Visio illustrates the process used to identify members with special health care needs. **23. CCM06 CCM Process.pdf** Visio illustrates the CCM program elements including assessment of individual needs, identification of barriers and other special health care needs. **24. ICM Initial Comprehensive Assessment Script_Adult.pdf** **25. ICM Initial Comprehensive Assessment Script_Peds.pdf** These initial assessments for Intensive Case Management are comprehensive – including medical and behavioral health, social issues, support systems, cultural/linguistic preferences, etc. **26. Utilization Management Program Description 2015.pdf** **27. UM Program Evaluation 2014.pdf** These documents describe the scope of Utilization Management Programs and Activities. **28. DOP_Identifying and Referring Members to Mental Health Providers .pdf** This describes how case management Identifies and Refers Members to Mental Health Providers.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
4. The Contractor implements procedures to provide an individual needs assessment after enrollment and at any other necessary time, including the screening for special healthcare 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 healthcare professionals. *42CFR438.208©(2)* Medicaid Contract: Exhibit A—2.5.4.3.1.1 CHP+ Contract: Exhibit A4—2.7.4.3.1.1	**1. Behavioral Health Coordination Program and Criteria to Fill at DH Pharmacy.doc** This document describes the process of pharmacist review and monitoring for members with behavioral health medications as well as the requirements for medication coordination at a Denver Health pharmacy. **2. Member Services_MCD-CHP_New_Member_Welcome_Survey_&_Follow_up_Process .vsd** This document, both the workflow and the script, illustrates the Member Services departmental process for conducting new member welcome calls, assessing special healthcare needs of new members, and forwarding on of information for subsequent departmental interventions. **3. Care Coordination_narrative_2015.pdf** **4. Care Coordination visio_2015.pdf** These two documents provide a narrative and illustrative overview of the care coordination activities by DH Managed Care. **5. ICM Program Description 2015_FINAL.pdf** This document describes the Intensive Case Management Program (three CM programs and support services) function to make sure the members can access the services they need. **6. EDM Assessment_fillable** Managed Care staff use this form to document member updates. The form is then uploaded into EDM – for viewing by all Denver Health providers.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	7. DH Release of Info.pdf DHHA form that provides consent for staff to assist in care coordination activities with multiple providers, agencies and/or services. **8. Utilization Management Program Description 2015.pdf** This document describes the scope of Utilization Management Programs and Activities. **9. UM_MCD_CHP_UM04 v. 09.pdf** This policy details the processes for coordination of services for Member's with Special Health Care Needs. **10. Health Coaching Initial Comprehensive Assessment.xls** These initial assessments for Complex Case Management and Health Coaching are comprehensive – including medical and behavioral health.	
5. The Contractor shares with other healthcare organizations serving the member with special healthcare needs, the results of its identification and assessment of that member's needs, to prevent duplication of those activities. *42CFR438.208(b)(3)* Medicaid Contract: Exhibit A—2.5.5.2 CHP+ Contract: Exhibit A4—2.7.5.2	**Behavioral Health Coordination Program and Criteria to Fill at DH Pharmacy.doc.** This document describes the process of pharmacist review and monitoring for members with behavioral health medications as well as the requirements for medication coordination at a Denver Health pharmacy. **Care Coordination_narrative_2015.pdf** **Care Coordination visio_2015.pdf** These two documents provide a narrative and illustrative overview of the care coordination activities by DH Managed Care. **ICM Program Desciption_2015_FINAL.pdf** This document describes the Intensive Case Management Program (three CM programs and support services) function to make sure the	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	members can access the services they need. **EDM Assessment_fillable** Managed Care staff use this form to document member updates. The form is then uploaded into EDM – for viewing by all Denver Health providers. **DH Release of Info.pdf** DHHA form that provides consent for staff to assist in care coordination activities with multiple providers, agencies and/or services. **Utilization Management Program Description 2015.pdf** **UM Program Evaluation 2014.pdf** These documents describe the scope of Utilization Management Programs and Activities. **DOP_Pediatric Referrals to Children's Hospital Colorado.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.	
6. The Contractor implements procedures to develop an individual treatment plan based on the needs assessment. The treatment plan addresses treatment objectives, treatment follow-up, monitoring of outcomes, and is revised as necessary. *42CFR438.208(c)(3)* Medicaid Contract: Exhibit A—2.5.4.3.1.2; 2.5.4.3.1.3 CHP+ Contract: Exhibit A4—2.7.4.3.1.2; 2.7.4.3.1.3	**1. ICM Program Description 2015_FINAL.pdf** **2. CCM06 CCM process.pdf** Visio illustrates the CCM program elements including assessment of individual needs, identification of barriers and other special health care needs. **3. Care Plan Process Training.pdf** Training presented to staff about using Guiding Care™ to create and update individualized care plans.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	4. Care Plan Example.doc Screenshot example from Guiding Care™ of individual treatment/care plans. **5. SMAP_ENG and SP.pdf** Tool used to improve members self-management skills and involvement in treatment planning activities. **6. Utilization Management Program Description 2015.pdf** These documents describe the scope of Utilization Management Programs and Activities. **7. BHWS Department Description 2015.pdf** This document outlines the Behavioral Health and Wellness department's goals and objectives (pg. 5) and how its staff helps our members better manage their health though various interventions (pg. 5-6). Highlights the focus on interdepartmental collaboration and continuity of care to best help our high risk members (pg. 7).	
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 healthcare needs direct access to a specialist as appropriate to the member's conditions and needs. *42CFR438.208©(3)(iii)* Medicaid Contract: Exhibit A—2.5.4.3.1.4 CHP+ Contract: Exhibit A4—2.7.4.3.1.4	**1. UM_MCD_CHP_UM04 v. 09.pdf** This policy details the processes for coordination of services for Member's with Special Health Care Needs. **2. Health Coaching Initial Comprehensive assessment.xls** Questions in the initial assessments for these programs include evaluation of cultural and linguistic needs, preferences or limitations. **3. Behavioral Health and Wellness Services Staff Daily Checklist.pdf** This document further demonstrates the staff's attention to individual needs.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
8. The Contractor ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that they are applicable. In all other operations as well, the Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42CFR438.208(b)(4)* *42CFR438.224* Medicaid Contract: Exhibit A—2.5.4.1; 10.B.1 CHP+ Contract: Exhibit A4—2.7.4.1; 3.1.4.3	**1. MCD_CHP_HIP_01 v.05: Confidentiality, Privacy, and Security of Member Information.** 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. New Employee Orientation – HIPAA Compliance** This document demonstrates new employee education and training on HIPAA compliance. **3. ICM Program Description 2015_FINAL.pdf (pg.14)**	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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. Medicaid Contract: Exhibit A—2.5.4.3.4 CHP+ Contract: Exhibit A4—2.7.4.3.4	**1. ICM Program Description 2015_FINAL.pdf (pg. 4)** **2. DOP_Identifying and Referring Members to Community Resources.pdf** Program procedure that outlines how member and/or family/caregiver involvement in the coordination and referral for community resources. **3. DOP Identifying and Referring Members to Mental Health Providers.pdf** Pages 2-3 discuss ways in which the members and/or family members are involved in the mental health referral/coordination process. **4. ICM Initial Comprehensive Assessment Script_Adult.pdf (Q3 and Q6)**	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	5. ICM Initial Comprehensive Assessment Script_Peds.pdf (Q4 and Q5) Initial assessment of member health status, including specific question about family, caregiver and/or support system involvement. **6. CM Program Consent.doc** Letter sent to members to obtain consent for CM services. **7. Health Coaching Initial Comprehensive Assesment.xls**	
10. The Contractor's procedures provide for continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services. ◆ The Contractor informs new members with special healthcare needs involved in an ongoing course of treatment that he/she: ▪ May continue to receive covered services for 60 calendar days from his/her current provider. ▪ May continue to receive covered services from ancillary or non-network providers for a period of 75 calendar days. ◆ The Contractor informs a new member who is in her second or third trimester of pregnancy that she may continue to see her current provider until the completion of postpartum care. Medicaid Contract Exhibit A—2.5.4.3.6; 2.5.5.1.1; 2.5.5.1.2; 2.5.5.1.3 CHP+ Contract: Exhibit A4—2.7.4.3.6; 2.7.5.1.1; 2.7.5.1.2; 2.7.5.1.3	**1. Member Services_MCD-CHP_New_Member_Welcome_Survey_&_Follow_up_Process .vsd** This document, both the workflow and the script, illustrates the Member Services departmental process for conducting new member welcome calls, assessing special healthcare needs of new members, and forwarding on of information for subsequent departmental interventions. **2. UM_ MCD_CHP_CM01 v. 06.pdf** This Policy and Procedure describes Case Management for Medicaid Choice and Child Health Plan Plus members. **3. UM_ MCD_CHP_UM04 v. 9.pdf** This Policy and Procedure discusses the coordination and Continuity of Care for Members with Special Health Care Needs and/or disabilities. **4. UM_ MCD_CHP_UM15 v. 13.pdf** This Policy and Procedure describes Home Health Care Referrals.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	5. Utilization Management Program Description 2015.pdf These documents describe the scope of Utilization Management Programs and Activities. **6. DOP_Identifying and Referring Members to Community Resources.pdf** Program procedure that outlines how member and/or family/caregiver involvement in the coordination and referral for community resources.	
11. If necessary primary or specialty care cannot be provided to members with special healthcare needs within the Contractor's plan, the Contractor makes arrangements for members to access these providers outside the network. Medicaid Contract: Exhibit A—2.5.5.2 CHP+ Contract: Exhibit A4—2.7.5.2	**1. UM_ MCD_CHP_UM01 v. 10.pdf** This Policy and Procedure describes Utilization Review Determinations Including Approvals and Actions. **2. UM_ MCD_CHP_UM04 v. 9.pdf** This Policy and Procedure discusses the coordination and Continuity of Care for Members with Special Health Care Needs and/or disabilities. **3. UM_MCD_CHP_UM22 v. 03** This policy and procedure describes the Protocols for Authorization of Out-Of-Network Referrals. **4. DHMC Member Handbook pg. 17** (found in the common documents folder) Explains the process for members with special healthcare needs.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
12. The Contractor allows members with special healthcare needs direct access to a specialist (for example, through a standing referral), as appropriate for the member's condition, and/or to maintain these types of specialists as PCPs. *42CFR438.208(c)(4)* Medicaid Contract: Exhibit A—2.5.5.4 CHP+ Contract: Exhibit A4—2.7.5.4	**1. UM_ MCD_CHP_UM04 v. 9.pdf** This Policy and Procedure discusses the coordination and Continuity of Care for Members with Special Health Care Needs and/or disabilities.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. The Contractor must assure the provision of all required components of periodic health screens as set forth by the American Academy of Pediatrics Bright Futures periodicity schedule. At a minimum, such efforts include: ◆ Education and outreach to eligible members of the importance of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. ◆ A proactive approach to ensure eligible members obtain EPSDT services. ◆ A process to assure that the medically necessary EPSDT services not covered by the Contractor (wraparound services) are referred to the Office of Clinical Services for action. ▪ The Contractor instructs its providers on how to refer a member for wraparound services. *10 CCR 2505-10— 8.280.8.C and D.5* Medicaid Contract: Exhibit A—2.5.7.2.3.1; 2.5.7.2.3.2; 2.5.7.2.3.5; 2.4.4.9.2	Education, Outreach and a Proactive Approach: **AG_Denver Heatl Managed Care_Kids_English_6_9.pdf** **AG_Denver Heatl Managed Care_Kids_Spanish_6_9.pdf** **AG_Denver Heatl Managed Care_Teens_English_6_9.pdf** **AG_Denver Heatl Managed Care_Teens_Spanish_6_9.pdf** Each month, all children with a birthday are sent a postcard with a reminder and checklist to obtain an exam. The postcard is sent in both English and Spanish to children between the ages of 2-19 **AG School Based Health flyer_7_25_14_SP.pdf** **AG School Based Health flyer_7_29_14.pdf** Children who go to participating schools with a School Based Clinic and are a part of one of our insurance plans are eligible to enroll in SBHC and receive a gift card for obtaining their annual visit. **MCD_QI16v. 04 EPSDT**	Medicaid ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A CHP+ ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	EPSDT_2015_Annual Report – annual report that addresses the overall data for the medical plans EPSDT program **Peds QI Workgroup Minutes 03_04_2015 –** Workgroup that addresses gaps of care for children. In this document are embedded documents addressing improvement projects and collaborative efforts to address bright future recommendations.	
Findings: DHMC had policies and procedures that addressed EPSDT services and included the Bright Futures periodicity schedule. The member handbook included information explaining EPSDT services. The health plan also had processes to identify members for outreach to encourage members to schedule well- child visits. DHMC has a pediatric work group with the goal of developing quality initiatives to improve well-child visit HEDIS rates. On-site, DHMC provided reviewers the EPSDT section of the provider manual. The provider manual language did not adequately instruct providers how to refer a member for EPSDT-related wraparound services. In addition, HSAG reviewers noted that the time frame stated for scheduling EPSDT services was two weeks.		
Required Actions: DHMC must ensure that providers are instructed to refer members to the office of clinical services and/or Healthy Communities to obtain EPSDT-related wraparound services not covered under the managed care contract. DHMC must revise the provider manual information about referring members for wraparound services and may want to consider adding EPSDT and wraparound referral information as a topic for rotation in the provider newsletters. DHMC must also revise the provider manual to reflect a 30-day scheduling time frame to be consistent with the managed care contract and the health plan's procedures.		

Medicaid Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	12	X	1.00	=	12
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	13	**Total Score**		=	12

Total Score ÷ Total Applicable	=	92%

CHP+ Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	12	X	1.00	=	12
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	12	**Total Score**		=	12

Total Score ÷ Total Applicable	=	100%

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
1. The Contractor has written policies and procedures regarding member rights. *42CFR438.100(a)(1)* Medicaid Contract: Exhibit A—3.1.1.1 CHP+ Contract: Exhibit A4—3.1.1.1	**1. GV02 v.06_Member Rights and Responsibilities.pdf** – Outlines DHMC policies and procedures regarding member rights. **2. MCD_CHP_GVT12 v. 07.pdf**- Outlines DHMC Policies and Procedures regarding member rights to Advanced Directives. **3. 3Q2015 Pharmacy Agent Call Audit Report** **4. 3Q2015 Pharmacy Call Audit**	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor ensures that its staff and affiliated and network providers take member rights into account when furnishing services to members. *42CFR 438.100(a)(2)* Medicaid Contract: Exhibit A—3.1.1.1.1 Contract: Exhibit A4—3.1.1.1.1	**1. GV02 v.06_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 serviced to members.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
3. The Contractor's policies and procedures ensure that each member is treated by staff and affiliated 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 healthcare, including the right to refuse treatment. ◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. ◆ Request and receive a copy of his or her medical records and request that they be amended or corrected. ◆ Obtain family planning services from any duly licensed provider in or out of network without a referral. ◆ Be furnished healthcare services in accordance with federal healthcare regulations for access and availability, care coordination, and quality. *42CFR438.100(b)(2) and (3)* Medicaid Contract: Exhibit A—3.1.1.1.2–3.1.1.1.6; 3.1.1.3.1 CHP+ Contract: Exhibit A4—3.1.1.1.2–3.1.1.1.6; 3.1.1.3.2	**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.06_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.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. MCD_CHP_QI07 V.08.pdf-** Demonstrates that we address Cultural and Linguistic Appropriate Services and train staff. **5. MCD CHP+_QI Program Description.pdf** (page 14-16 under heading Cultural and Linguistic Objectives) **6. Denver Health has specific Policies that apply to all employees and address cultural awareness**: a. American with Disabilities Act ADA 4-144.pdf b. Cultural and Religious Considerations Relative to Provision of Care 4-141.pdf c. Equal Opportunity Employment 2-100.pdf d. Workforce Diversity 4-108.pdf	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	7. MCD_CHIP_GVT12 v. 07.pdf- Outlines DHMC policies and procedures regarding member rights to Advanced Directives.	
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 treats the member. *42CFR438.100(c)* Medicaid Contract: Exhibit A—3.1.1.1.7 CHP+ Contract: Exhibit A4—3.1.1.1.7	**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 Eng.pdf pgs. 5 & 10 –** 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.06_Member Rights and Responsibilities.pdf (part VI.A.x)** Demonstrates that plan has policies in place that ensure that its members are free to exercise their rights without any adverse effect in the way they are treated. **4. 3Q2015 Pharmacy Agent Call Audit Report** **5. 3Q2015 Pharmacy Call Audit**	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
6. 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)* Medicaid Contract: 20.A CHP+ Contract: 21.A	**1. Americans With Disabilities Act ADA 4-144.pdf** **2. Cultural and Religious Considerations Relative to Provision of Care 4-141.pdf** **3. Equal Employment Opportunity 2-100.pdf** **4. Workforce Diversity 4-108.pdf** **5. Internal Discrimination Investigation Process 4-109.pdf** **6. CMP14 V. 05 Compliance with State and Federal Laws the American Disabilities Act of 1990 and Section 504 of the Rehabilitation A.PDF**	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	7. Prohibition of Harassment, Discrimination & Retaliation 4-106.pdf- (Demonstrates that Denver health complies to non-discriminatory procedures.) **8. CMP14 V. 05.pdf** (Demonstrates that the plan has policies in place that mandate compliance with Federal and State laws)	

Medicaid 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%

CHP+ 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 Submitted by 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. ◆ The Contractor's credentialing program shall comply with the standards of the National Committee for Quality Assurance (NCQA) for initial credentialing and recredentialing of participating providers. Medicaid Contract: Exhibit A—3.2.1.1; 3.2.1.3 CHP+ Contract: Exhibit A4—3.2.1.1; 3.2.1.3 NCQA CR1	Denver Health and Hospital Authority (DHHA) Medical Staff Bylaws 2015.pdf (Article XVIII Medical Staff Appointment Procedures, Section 4: page 42-50) Denver Health Medical Plan Policy: CRE01 v. 11 Credentialing and Recredentialing of Practitioners Describes the formal process DHMC uses for credentialing and recredentialing of independent direct network practitioners	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners to credential and recredential. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. (Examples include MDs, DOs, podiatrists, nurse practitioners, and each type of behavior health provider.) *42CFR438.214(a)* NCQA CR1—Element A1	Denver Health and Hospital Authority (DHHA) Medical Staff Bylaws 2015.pdf (Article XVIII Medical Staff Appointment Procedures, Section 2 and 3 page 40-41) Denver Health Medical Plan Policy: CRE01 v. 11 Credentialing and Recredentialing of Practitioners (page 1, section III) DHMC requires credentialing of the following types of providers: 1. Medical Doctor (MD) 2. Doctor of Osteopathy (DO) 3. Doctor of Podiatric Medicine (DPM) 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.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by Health Plan**	**Score**
	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.B. The verification sources used. NCQA CR1—Element A2	Denver Health and Hospital Authority (DHHA) Medical Staff Bylaws 2015.pdf (Article XVIII Medical Staff Appointment Procedures, Section 4 paragraph C. Elements page 44) Denver Health Medical Plan Policy: CRE01 v. 11 Credentialing and Recredentialing of Practitioners (page 22, Attachment 3 Acceptable Certification Sources for Practitioner Credentials)	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	Denver Health and Hospital Authority (DHHA) Medical Staff Bylaws 2015.pdf (Article XVIII Medical Staff Appointment Procedures, Section 4 paragraph C) Denver Health Medical Plan Policy: CRE01 v. 11 Credentialing and Recredentialing of Practitioners page 7-8 Attachment: File Criteria (Practitioner Credentialing Criteria for Initial and Recredentialing)	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by Health Plan**	**Score**
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	Denver Health and Hospital Authority (DHHA) Medical Staff Bylaws 2015.pdf (Article XVIII Medical Staff Appointment Procedures, Section 4 paragraph G page 46-47) Denver Health Medical Plan Policy: CRE01 v. 11 Credentialing and Recredentialing of Practitioners (Page 2; Independent Direct Network Practitioners & 7; Credentialing Files)	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.E. The process for managing credentialing/ recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	Denver Health and Hospital Authority (DHHA) Medical Staff Bylaws 2015.pdf (Article XVIII Medical Staff Appointment Procedures, Section 4 paragraph G page 46 (MSEC review) Denver Health Medical Plan Policy: CRE01 v. 11 Credentialing and Recredentialing of Practitioners (Page 8; Confidentiality) The process outlines how the files are maintained under strict security and confidentiality according to NCQA standards.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.F. The process for delegating credentialing or recredentialing (if applicable). NCQA CR1—Element A6	Denver Health and Hospital Authority (DHHA) Medical Staff Bylaws 2015.pdf (Article XVIII Medical Staff Appointment Procedures, Section 4 paragraph C. page 43 (DH does not delegate) last paragraph on page) Denver Health Medical Plan Policy: CRE05 v. 05 Delegation of Credentialing Activities; outlines the requirements for delegation of credentialing activities	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by Health Plan**	**Score**
	CRE01 Credentialing and Recredentialing of Practitioners; 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.	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.G. The process for ensuring that credentialing and recredentialing are conducted in a nondiscriminatory 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; and that it takes proactive steps to prevent and monitor discriminatory practices). NCQA CR1—Element A7	Denver Health and Hospital Authority (DHHA) Medical Staff Bylaws 2015.pdf (Article XVIII Medical Staff Appointment Procedures, Section 2 page 40) Denver Health Medical Plan Policy: CRE01 v. 11 Credentialing and Recredentialing of Practitioners (page 4, section VI) 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	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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	Denver Health and Hospital Authority (DHHA) Medical Staff Bylaws 2015.pdf (Article XVIII Medical Staff Appointment Procedures, Section 14 page 55. Also in instructions sent electronically for completion of application. Application instructions) Denver Health Medical Plan Policy: CRE01 v. 11 Credentialing and Recredentialing of Practitioners (page 5, Practitioner Rights) The process for notifying practitioners if information obtained during the credentialing/recredentialing process varies substantially from the information they provide	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by Health Plan**	**Score**
2.I. The process for ensuring that practitioners are notified of credentialing and recredentialing decisions within 60 calendar days of the credentialing committee's decision. NCQA CR1—Element A9	Denver Health and Hospital Authority (DHHA) Medical Staff Bylaws 2015.pdf (Article XVIII Medical Staff Appointment Procedures, Section 4 paragraph H page 47) Denver Health Medical Plan Policy: CRE01 v. 11 Credentialing and Recredentialing of Practitioners (page 5, Practitioner Rights section D) DHMP notify practitioners of its credentialing decision within 60 days, as outlined in the referenced P&P	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.J. The medical director or other designated physician's direct responsibility and participation in the credentialing/recredentialing program. NCQA CR1—Element A10	Denver Health and Hospital Authority (DHHA) Medical Staff Bylaws 2015.pdf (Article XVIII Medical Staff Appointment Procedures, Section 4 paragraph G page 46) Denver Health Medical Plan Policy: CRE01 v. 11 Credentialing and Recredentialing of Practitioners (page 6, Credentialing Committee and Role of Medical Director) Describes the medical director's responsibility and participation in the credentialing/ recredentialing program for DHMC independent direct network practitioners.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.K. The process for ensuring the confidentiality of all information obtained in the credentialing/ recredentialing process. NCQA CR1—Element A11	Denver Health and Hospital Authority (DHHA) Medical Staff Bylaws 2015.pdf (Article XVIII Medical Staff Appointment Procedures, Section 13 page 55) Denver Health Medical Plan Policy: CRE01 v. 11 Credentialing and Recredentialing of Practitioners (page 8, Confidentiality and PHI)	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by Health Plan**	**Score**
	All information obtained in the process of credentialing and recredentialing is confidential as described in the P&P.	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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	Denver Health Medical Plan Policy: CRE01 v. 11 Credentialing and Recredentialing of Practitioners (page 8 & 9, Listings in Provider Directory and Member Materials) The information contained in the DHMC provider directories is electronically transmitted.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.M. The Contractor notifies practitioners about their rights: ◆ The right to review information submitted to support their credentialing or recredentialing application. NCQA CR1—Element B1	Denver Health and Hospital Authority (DHHA) Medical Staff Bylaws 2015.pdf (Article XVIII Medical Staff Appointment Procedures, Section 14 page 55) Denver Health Medical Plan Policy: CRE01 v. 11 Credentialing and Recredentialing of Practitioners (page 5, Practitioner Rights) All practitioners credentialed 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.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by Health Plan**	**Score**
2.N. The right to correct erroneous information. NCQA CR1—Element B2	Denver Health and Hospital Authority (DHHA) Medical Staff Bylaws 2015.pdf (Article XVIII Medical Staff Appointment Procedures, Section 14 page 55) Denver Health Medical Plan Policy: CRE01 v. 11 Credentialing and Recredentialing of Practitioners (page 5, Practitioner Rights) Practitioners have the right to correct erroneous information as described.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.O. The right to receive the status of their credentialing or recredentialing application, upon request. NCQA CR1—Element B3	Denver Health and Hospital Authority (DHHA) Medical Staff Bylaws 2015.pdf (Article XVIII Medical Staff Appointment Procedures, Section 14 page 55) Denver Health Medical Plan Policy: CRE01 v. 11 Credentialing and Recredentialing of Practitioners (page 5, Practitioner Rights) Practitioners have the right to check on the status of their application as described.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by Health Plan**	**Score**
2.P. 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 CR6—Element A	Denver Health and Hospital Authority (DHHA) Medical Staff Bylaws 2015.pdf (Article XVIII Medical Staff Appointment Procedures, Section 16 page 55) Denver Health Medical Plan Policy: CRE01 v. 11 Credentialing and Recredentialing of Practitioners (pages 12-13, Ongoing Monitoring) Process of ongoing monitoring performed by the DHMC Credentialing Coordinator for all practitioners.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.Q. The range of actions available to the Contractor against the practitioner (for quality reasons). NCQA CR7—Element A1	Denver Health and Hospital Authority (DHHA) Medical Staff Bylaws 2015.pdf (Article IX Corrective Action page 23-28) Denver Health Medical Plan Policy: CRE03 v. 05 Practitioner Appeal Rights; (Section VI, H page 3) The 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.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by Health Plan**	**Score**
2.R. 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 CR7—Elements A2 and B	Denver Health and Hospital Authority (DHHA) Medical Staff Bylaws 2015.pdf (Article XIX Medical Staff Fair Hearing Plan Section 9 page 62.) Denver Health Medical Plan Policy: CRE03 v. 05 Practitioner Appeal Rights (Section VI, M page 4) 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 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: *National Practitioner Data Bank (NPDB) *Appropriate State Board *OIG	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.S. A well-defined appeal process for instances in which the Contractor has taken action against a practitioner for quality reasons, 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	Denver Health and Hospital Authority (DHHA) Medical Staff Bylaws 2015.pdf (Article XIX Medical Staff Fair Hearing Plan Section, 9 page 56- 63) Denver Health Medical Plan Policy: CRE03 v. 05 Practitioner Appeal Rights (Section VI pages 2-5) 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.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by Health Plan**	**Score**
attorney or another person of the 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 CR7—Elements A3and C		
2.T. Making the appeal process known to practitioners. NCQA CR7—Elements A4 and C	Denver Health and Hospital Authority (DHHA) Medical Staff Bylaws 2015.pdf (Article XVIII Medical Staff Appointment Procedures Section 4 paragraph B #1.) Denver Health Medical Plan Policy: CRE03 v. 05 Provider Manual MCD_PROV_MANUAL_PG55-56.pdf	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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 A1	Denver Health and Hospital Authority (DHHA) Medical Staff Bylaws 2015.pdf (Article V Section 2 MSEC page 13 -14). Denver Health Medical Plan Policy: CRE01 v. 11 Credentialing and Recredentialing of Practitioners (page 6, Credentialing Committee and Role of Medical Director) DHMC utilizes a peer review process by a credentialing committee made up according to NCQA standards, outline in the P&P referenced above.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by Health Plan**	**Score**
4. The credentialing committee: ◆ Reviews credentials for practitioners who do not meet established thresholds. ◆ Ensures that files which meet established criteria are reviewed and approved by a medical director or designated physician. NCQA CR2—Elements A2 and A3	Denver Health and Hospital Authority (DHHA) Medical Staff Bylaws 2015.pdf (Article XVIII Section 4 paragraph G page 46.) Denver Health Medical Plan Policy: CRE01 v. 11 Credentialing and Recredentialing of Practitioners (page 6, Credentialing Committee and Role of Medical Director) DHMC follows NCQA standards regarding credentialing providers who do not meet criteria (red flag) as described. There is evidence of the appointed committee's review of and participation in the decision of red flagged applicants in the meeting minutes.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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 is 180 calendar days). ◆ A valid Drug Enforcement Administration (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 is 180 calendar days). ◆ Work history (verification time limit is 365 calendar days; nonprimary verification is most recent five years).	Denver Health and Hospital Authority (DHHA) Medical Staff Bylaws 2015.pdf (Article XVIII Section 4 paragraph C page 43) Denver Health Medical Plan Policy: CRE01 v. 11 Credentialing and Recredentialing of Practitioners (section Initial Credentialing for IDNPs) DHMP use the CHCP Credentialing Application for credentialing and recredentialing of all practitioners. Information regarding each of the bullets is requested in this application, and each is verified within the 180 day time limit, using appropriate NCQA acceptable resources.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by Health Plan**	**Score**
◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (verification time limit is 180 calendar days). NCQA CR3—Element A		
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—0.5mil/1.5mil; facility—0.5mil/3mil). ◆ The correctness and completeness of the application. NCQA CR3—Element C Medicaid Contract: 3.2.2.1.1; 3.2.2.1.2 CHP+ Contract: Exhibit A4—3.2.2.1.1; 3.2.2.1.2	Denver Health and Hospital Authority (DHHA) Medical Staff Bylaws 2015.pdf (Article XVIII Section 3 paragraph B page 41-42.) Denver Health Medical Plan utilizes the Colorado Health Care Professional Credentials Application version 9/1/2015 (pages 19, 20, 25 and 26. Denver Health Medical Plan Policy: CRE01 v. 11 Credentialing and Recredentialing of Practitioners (section Application and Attestation page 8) CHCP Credentialing Application addresses all of the questions in the bullets.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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. NCQA CR3—Element B	Denver Health and Hospital Authority (DHHA) Medical Staff Bylaws 2015.pdf (Article XVIII Section 4 paragraph C page 43-44.) Denver Health Medical Plan Policy: CRE01 v. 11 Credentialing and Recredentialing of Practitioners (pages 10 & 11; Initial Sanction Information)	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by Health Plan**	**Score**
		CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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 CR5—Element A	Denver Health and Hospital Authority (DHHA) Medical Staff Bylaws 2015.pdf (Article XVIII Section 15 page 55.) Denver Health Medical Plan Policy: CRE02 v. 09 Practitioner Office Site Quality (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.	Medicaid ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A CHP+ ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: DHMC/DHMP had policies and procedures that pertained to office-site quality standards. During the on-site interview, DHMC/DHMP provider network support and credentialing staff members were unable to provide, consistent with the policy, the performance threshold of complaint which would warrant a site visit.		
Required Actions: DHMC/DHMP must ensure that staff members are aware of the threshold for site-related complaints which warrant a site visit and further follow-up pursuant to the health plan's policy.		
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.	Denver Health and Hospital Authority (DHHA) Medical Staff Bylaws 2015.pdf (Article XVIII Section 15 page 55) Denver Health Medical Plan Policy: CRE02 v. 09 Practitioner Office Site Quality (section VI B & C) DHMC has set office site quality thresholds, and has a process to ensure the offices of all practitioners meet these thresholds	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by Health Plan**	**Score**
◆ 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 CR5—Element B	according to NCQA requirements.	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. The Contractor formally recredentials its practitioners at least every 36 months. NCQA CR4	Denver Health and Hospital Authority (DHHA) Medical Staff Bylaws 2015.pdf (Article XVIII Section 5 page 47.) Denver Health Medical Plan Policy: CRE01 v. 11 Credentialing and Recredentialing of Practitioners (page 11; Recredentialing, section A) DHMC has a formal recredentialing process as required by NCQA and CMS standards.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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—initially and at least every three years—that the provider is in good standing with state and federal regulatory bodies. NCQA CR8—Element A1	Denver Health Medical Plan Policy: CRE07 v. 23 Assessment of Organizational Providers (page 2; Initial Assessment and page 4; Reassessment) 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.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by Health Plan**	**Score**
11.B. The Contractor confirms—initially and at least every three years—that the provider has been reviewed and approved by an accrediting body. NCQA CR8—Element A2	Denver Health Medical Plan Policy: CRE07 v. 23 Assessment of Organizational Providers (section VI, 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.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11.C. The Contractor conducts—initially and at least every three years—an on-site quality assessment if there is no accreditation status. NCQA CR8—Element A3	Denver Health Medical Plan Policy: CRE07 v. 23 Assessment of Organizational Providers (section H page 3 &4) 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.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11.D. The Contractor's policies specify the sources used to confirm: ◆ That providers are in good standing with state and federal requirements. ◆ The provider's accreditation status. (Includes applicable state or federal agency or applicable accrediting bodies for each type of organizational	Denver Health Medical Plan Policy: CRE07 v. 23 Assessment of Organizational Providers (page 2; section VI) 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,	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by Health Plan**	**Score**
provider, agent of the applicable agency/accrediting body, copies of credentials—e.g., licensure, accreditation report or letter—from the provider.) NCQA CR8—Element A, Factors 1 and 2	and (2) not certified by CMS or have not had a CMS survey within the past 3 years. Attachment: Site Visit Tool	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11.E. The Contractor's policies and procedures include: ◆ On-site quality assessment criteria for each type of unaccredited organizational provider. ◆ A process for ensuring that that the provider credentials its practitioners. NCQA CR8—Element A, Factor 3	Denver Health Medical Plan Policy: CRE07 v. 23 Assessment of Organizational Providers DHMC lists the approved accrediting bodies, accreditation is not a requirement Attachment: Org Prov Initial Assessment Application Attachment: Org Prov Initial Reassessment Application	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: ◆ The CMS or state review is no more than three years old. ◆ The organization obtains a survey report or letter from CMS or the state, from either the provider or from the agency, stating that the facility was reviewed and passed inspection. ◆ The report meets the organization's quality assessment criteria or standards. NCQA CR8—Element A, Factor 3	Denver Health Medical Plan Policy: CRE07 v. 23 Assessment of Organizational Providers (section VI, B) 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.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by Health Plan**	**Score**
13. 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 CR8—Element B	Denver Health Medical Plan Policy: CRE07 v. 23 Assessment of Organizational Providers (page 1; section III) 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.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
14. The Contractor's organizational provider assessment policies and process include assessment of at least the following behavioral health and substance abuse settings: ◆ Inpatient. ◆ Residential. ◆ Ambulatory. NCQA CR8—Element C	Denver Health Medical Plan Policy: CRE07 v. 23 Assessment of Organizational Providers (page 1; section III) 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.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by Health Plan**	**Score**
15. The Contractor has documentation that it has assessed contracted medical healthcare (organizational) providers. NCQA CR8—Element D	Denver Health Medical Plan Policy: CRE07 v. 23 Assessment of Organizational Providers (page 1; section III) The Company will maintain documentation on all contracted/assessed organizational providers and a tracking spreadsheet to demonstrate initial and reassessment.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
16. The Contractor has documentation that it has assessed contracted behavioral healthcare (organizational) providers. NCQA CR8—Element E	Denver Health Medical Plan Policy: CRE07 v. 23 Assessment of Organizational Providers (page 1; section III)	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by Health Plan**	**Score**
17. If the Contractor delegates any NCQA-required credentialing activities, there is evidence of oversight of the delegated activities. NCQA CR9	Denver Health Medical Plan Policy: CRE05 v. 05 Delegation of Credentialing Activities (section VI Procedure; B Ongoing Delegation Activities Attached; Example_Signed Delegation Agreement. DHMC performs oversight of all entities that 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.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
18. The Contractor has a written delegation document with the delegate that: ◆ Is mutually agreed upon. ◆ Describes the delegated activities and responsibilities of the Contractor and the delegated entity. ◆ 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 delegation agreement) if the delegate does not fulfill its obligations. NCQA CR 9—Element A	Denver Health Medical Plan Policy: CRE05 v. 05 Delegation of Credentialing Activities 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.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by Health Plan**	**Score**
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. ◆ 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 CR9—Element B	Denver Health Medical Plan: CRE05 v. 05 Delegation of Credentialing Activities Attachment A Delegated Credentialing Letter of Agreement (Template) Attached: Template language: DHMC requires that delegates follow the rules and standards laid out in The Health Insurance Portability and Accountability (HIPPA) Act.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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 CR9—Element C	Denver Health Medical Plan: Denver Health Medical Plan: CRE05 v. 05 Delegation of Credentialing Activities Attachment A Delegated Credentialing Letter of Agreement (Template) Attached: Template language: DHMC retains the right to approve, suspend, or terminate any provider selected by the Delegate to treat DHMC enrollees.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by 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 CR9—Element D	Denver Health Medical Plan Policy CRE05 v. 05 Delegation of Credentialing Activities (section VI Procedures; A) This requirement is in the P&P; however DHMC has not been required to perform any pre-delegation assessments as all delegates have been active for more than 12 months.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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 CR9—Element E1	Denver Health Medical Plan Policy: CRE05 v. 05 Delegation of Credentialing Activities (section VI Procedure; B) DHMC performs yearly file audits on each delegated entity who is not NCQA accredited; utilizing the NCQA 5 percent or 50 of its files, whichever is less, to ensure that information is verified appropriately. At a minimum, the sample includes at least 10 credentialing files and 10 recredentialed files. If fewer than 10 practitioners were credentialed or recredentialed since the last annual audit, the organization audits the universe of files rather than a sample.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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 CR9—Element E2	Denver Health Medical Plan Policy: CRE05 v. 05 Delegation of Credentialing Activities (section VI Procedure; B) Attachment A Delegated Credentialing Letter of Agreement (Template) Attachment B Audit Tool Summary	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by Health Plan**	**Score**
	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 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.	CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
24. For delegation arrangements in effect 12 months or longer, the Contractor evaluates regular reports (at least semiannually). NCQA CR9—Element E3	Denver Health Medical Plan Policy: CRE05 v. 05 Delegation of Credentialing Activities (section VI, B) Attachment: 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.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
25. The Contractor identified and followed up on opportunities for improvement (at least once in each of the past two years), if applicable. NCQA CR9—Element F	Denver Health Medical Plan Policy: CRE05 v. 05 Delegation of Credentialing Activities (section VI, B) 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.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Medicaid Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	47	X	1.00	=	47
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	48	**Total Score**		=	47

Total Score ÷ Total Applicable	=	98%

CHP+ Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	47	X	1.00	=	47
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	48	**Total Score**		=	47

Total Score ÷ Total Applicable	=	98%

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by 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)* Medicaid Contract: Exhibit A—2.7.1 CHP+ Contract: Exhibit A4—2.9.1	**MCD_CHP+_QI_Program_Description.pdf** – demonstrates that we have a QI program in place. There is documentation of the program scope, goals, objectives and structure. **QI Work Plan Yearly Planned Activities 2015-2016.pdf –** demonstrates our yearly planned activities for our QI program **QMC minutes_09_15_15** of approval of the QI program. Bottom of page 3-6	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42CFR438.240(b)(3)* Medicaid Contract: Exhibit A—2.7.2.5.1 CHP+ Contract: Exhibit A4—2.9.4.4.1	**Denver Health Medicaid Choice and CHP+ Impact Analysis.pdf –** demonstrates the analysis of the QI program's past year activities including barrier analysis and action plans for the upcoming year. **HEDIS 2014 Analysis Workbook MasterList** – This workbook trends both MCD and CHP+ HEDIS data against the national percentiles and where we stand on reaching either the percentile above or below the current rate. This masterbook is used for interventions and analysis for both the QI team and leadership (including providers involved). **ICM Program Description 2015.pdf** – ICM has programs in place to detect both overutilization and underutilization of services for our members. Including risk stratification and predictive modeling, identifying care gaps utilizing GuidingSigns (part of our guiding care) and case management framework	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
3. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care for persons with special healthcare needs. *42CFR438.240(b)(4)* Medicaid Contract: Exhibit A—2.7.2.4.4 CHP+ Contract: Exhibit A4—None	**ICM Program Description 2015.pdf –** Page 6, 8-10 reviews programs and services available to members with complex needs. **Denver Health Medicaid Choice and CHP+ Impact Analysis.pdf**- Page 24-36 **UM_MCD_CHP_UM04 v. 09 – Coordination and Continuity of Care for Members with Special Health Care Needs.pdf** This policy and procedure describes the Coordination and Continuity of Care for Members with Special Health Care Needs and/or Disabilities.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. The Contractor adopts practice guidelines for the following: ◆ Perinatal, prenatal, and postpartum care for women. ◆ Conditions related to persons with a disability or special healthcare needs. ◆ Well child care. Medicaid Contract: Exhibit A—2.7.2.1.1 CHP+ Contract: Exhibit A4—2.9.2.1.1	**Prenatal Care Guideline** – Practice guideline that reviews perinatal, prenatal and postpartum care for women **Well Child Visit Guideline** **Treatment of Depression in Adults in Primary Care Guideline** **Management of Asthma in Adults and Children Guideline**	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. The Contractor ensures that practice guidelines comply with the following requirements: ◆ Are based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field. ◆ Consider the needs of the Contractor's members. ◆ Are adopted in consultation with contracting healthcare	**MCD_CHP_QI02 v. 06 – Clinical Practice and Preventive Care Guidelines Policy** ◆ Are based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field. – Page 3 of the policy under VI. Procedures B ◆ Consider the needs of the Contractor's members. –Page 3, under VI. Procedures #A4 ◆ Are adopted in consultation with contracting healthcare	Medicaid ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
professionals. ◆ Are reviewed and updated annually. *42CFR438.236(b)* Medicaid Contract: Exhibit A—2.7.2.1.2 CHP+ Contract: Exhibit A4—2.9.2.1.2	professionals. – Page 4, Element D ◆ Are reviewed and updated annually. – Page 6, Element I-1	CHP+ ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: DHMC/DHMP provided the required clinical practice guidelines. The guidelines cited the relevant literature on which the guidelines were based, and the Clinical Practice and Preventive Care policy stated that all requested changes to the guidelines go through the QMC for approval. QMC meeting minutes reflected clinical practice guideline review and consultation with healthcare providers with specialties specific to the respective guidelines. The meeting minutes also provided evidence that the guidelines took into consideration the specific needs of the membership The clinical practice guidelines were posted on the DHMC and DHMP websites for providers and members to access at no cost. Newsletters were used to inform the provider community of changes in practice guidelines and as a reminder of how to obtain the guidelines if needed. The Guidelines themselves, however, stated a review date of every two years. During the on-site interview, staff members reported that the two-year review timeline is based on URAC standards. Staff members also stated that the QMC has plans for annual review of the guidelines but has not yet implemented an annual review for all guidelines.		
Required Actions: DHMC/DHMP must develop a mechanism to track clinical practice guideline review by the QMC to ensure annual review of all guidelines as required by the Medicaid and CHP+ managed care contracts with the State.		
6. The Contractor disseminates the guidelines to all affected providers, and upon request to members, the Department, other nonmembers, and the public, at no cost. *42CFR438.236(c)* Medicaid Contract: Exhibit A—2.7.2.1.3 CHP+ Contract: Exhibit A4—2.9.2.1.3	**Quality Improvement Program _ Denver Health Medicaid Choice Website.pdf** **Quality Improvement Program _ Denver Health Medical Plan Website.pdf** Both DHMP and DHMC has a Quality Improvement site where the Clinical Practice Guidelines are available to members, nonmembers and providers at no cost **Provider_ManagedCareMinute__Clinical Practice Guidelines** – Newsletter sent out to our providers electronically that informed them of the guidelines.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	CHP+ Member Handbook **DHMC Member Handbook** (found in the common documents folder) On page 17 of both the DHMP and DHMC handbook talks about Clinical Practice Guidelines **MCD_CHP_QI02 v. 06 - Clinical Practice and Preventive Care Guidelines Policy –** Page 5, Element F	
7. 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)* Medicaid Contract: Exhibit A—2.7.2.1.4 CHP+ Contract: Exhibit A4—2.9.2.1.4	**ICM Program Description 2015.pdf –** page 10-11 reviews Practice Guidelines and adherence to evidence based guidelines for ICM. **UM_MCD_CHP_UM27 v. 13 .pdf** This policy and procedure describes Clinical Criteria for Utilization Management Decisions. **UM_MCD_CHP_UM13 v. 13** Guidelines for the Ordering and Authorization of Durable Medical Equipment and Consumable Supplies. **UM_MCD_CHP_UM05 v. 3.pdf** Inter-Rater Reliability of Utilization Management.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. The Contractor calculates and submits specified HEDIS measures determined by collaboration between the Department and the Contractor's quality improvement committee. The Contractor: ◆ Analyzes and responds to results indicated in the HEDIS measures. ◆ Calculates additional mandatory federal performance measures when they are required by CMS. Medicaid Contract: Exhibit A—2.7.2.3.1.1; 2.7.2.3.1.2; 2.7.2.3.2.1 CHP+ Contract: Exhibit A4—2.9.4.1.1; 2.9.4.1.2; 2.9.4.2.1	**QMC presentation Medicaid CHP+ 9 15 15** (slides 8-19) **QMC minutes_9_15_15** (Top of page 4) - Each year the health plan submits any requested HEDIS measures to the State at the end of the HEDIS season. The state then aggregates the information and creates a report which is sent out to all participating health plans. The State also holds an annual on-site meeting where they present the comparative HEDIS data for the health plans. Then the QI Director shares this information with the QMC. This year it was presented with the annual review of the MCD/CHP program. **Denver Health Medicaid Choice and CHP+ Impact Analysis.pdf** – Starting on page 7 to page 23, the Impact Analysis analyzes and	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	responds to HEDIS measures for both MCD and CHP. **HEDIS 2014 Analysis Workbook MasterList –** This workbook trends both MCD and CHP+ HEDIS data against the national percentiles and where we stand on reaching either the percentile above or below the current rate. This masterbook is used for interventions and analysis for both the QI team and leadership (including providers involved).	
9. The Contractor monitors member perceptions of accessibility and adequacy of services provided. Tools shall include: ◆ Member Surveys (CAHPS). ◆ Anecdotal information. ◆ Grievance and appeals data. ◆ Enrollment and disenrollment information. Medicaid Contract: 2.7.2.4.1 CHP+ Contract: Exhibit A4—2.9.4.3.2	**Denver Health Medicaid Choice and CHP+ Impact Analysis.pdf –** CAHPS – Page 36-39 G&A – Page 40-41 Anecdotal – Anecdotal information can be found throughout the Impact Analysis **Strategic Network Adequacy Plan_MCD_CHP_2014-2015.pdf-** Enrollment and disenrollment information can be found on page 19-20 **QMC minutes _7_14_15 –** Page 5-7 review CAHPS trends	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. For Medicaid members— 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. Medicaid Contract: Exhibit A—2.7.2.4.3 CHP+ Contract: Exhibit A4—None	**Denver Health Medicaid Choice and CHP+ Impact Analysis.pdf –** CAHPS – Page 36-39 G&A – Page 40-41 **CHP+ CAHPS Corrective Action Plan.doc** **Analysis & Action Plan for Medicaid CAHPS.doc**	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
11. The Contractor must assure the provision of all required components of periodic health screens as set forth by the American Academy of Pediatrics Bright Futures periodicity schedule. At a minimum, such efforts include a process to measure and assure compliance with the EPSDT schedule. *10 CCR 2505-10—8.280.8.C and .D.4* Medicaid Contract: Exhibit A—2.5.7.2.3.4 CHP+ Contract: Exhibit A4—None	**MCD_QI16v. 04 EPSDT** Policy that reviews the process and program we have in place for EPSDT. **EPSDT_2015_Annual Report** – annual report that addresses the overall data for the medical plans EPSDT program **Peds QI Workgroup Minutes 03_04_2015 –** Workgroup that addresses gaps of care for children. In this document are embedded documents addressing improvement projects and collaborative efforts to address bright future recommendations.	Medicaid ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A CHP+ ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
Findings: While DHMC had a policy that addressed EPSDT services and that referenced the Bright Futures periodicity schedule, the information furnished to providers via the provider manual was outdated. In addition, the Ambulatory Quality Scorecards do measure HEDIS well-child visit measures, but the health plan did not provide sufficient evidence that it adequately measures compliance with the EPSDT periodicity schedule to ensure compliance with such.		
Required Actions: DHMC must develop a mechanism to measure compliance with the periodicity schedule and then develop interventions designed to ensure continued and/or improved compliance.		
12. The Contractor investigates any alleged quality of care concerns. ◆ Upon request, the Contractor shall submit a letter to the Department that includes a brief but clear description of the issue, the efforts that the Contractor took to investigate the issue, the outcome of the review, and what action the Contractor intends to take with the providers involved. Medicaid Contract: Exhibit A—2.7.2.6.1; 2.7.2.6.2 CHP+ Contract: Exhibit A4—2.9.4.5.1; 2.9.4.5.2	**MCD_CHP_QI12 v. 19 - Notification and Investigation of Quality of Care Concerns.pdf**– Policy that reviews the process we have in place for quality of care concerns. We have not received any requests from the Department regarding any of the QOCCs	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
13. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis. ◆ Upon request, this information shall be made available to providers and members at no cost. For Medicaid— ◆ The annual QAPI report includes: ▪ Techniques used by the Contractor to improve performance. ▪ Outcome of each performance improvement project. ▪ Overall impact and effectiveness of the quality assessment and improvement program. For CHP+— ◆ The Contractor has a Quality Improvement Committee to assess and implement measures of quality, access, and customer satisfaction. ◆ The annual QAPI report includes: ▪ Specific preventive care priorities, and services covered in and goals of the program over the prior 12-month period. ▪ Status and results of each performance improvement project (PIP) started, continuing, or completed during the prior 12-month period. ▪ Results of member satisfaction surveys completed during the prior 12-month period. ▪ Detailed description of the findings of the program impact analysis. ▪ Techniques used by the Contractor to improve performance. ▪ Overall impact and effectiveness of the QAPI	**Denver Health Medicaid and CHP+ Impact Analysis.pdf –** An annual evaluation that encompasses the QI program including projects/interventions, member satisfaction results, action plans and overall impact and effectiveness. Websites: **Quality Improvement Program _ Denver Health Medicaid Choice Website.pdf** **Quality Improvement Program _ Denver Health Medical Plan Website.pdf** Both websites have the Impact Analysis available online at no cost for both Medicaid and CHP+ **QMC minutes_7_14_15 –** Committee review of the status of the Transitions of Care PIP – page 8 **QMC minutes_9_15_15 -** approval of the QI program and evaluations of the overall impact and effectiveness for both Medicaid and CHP+. Bottom of page 3-5	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
Program during the prior 12-month period. *42CFR438.240(e)(2)* Medicaid Contract: Exhibit A—2.7.2.8; 2.7.2.8.2 CHP+ Contract: Exhibit A4—2.9.4.7; 2.9.4.6.1		
14. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data, including, but not limited to, information on utilization, grievances and appeals, encounters, and disenrollment. *42CFR438.242(a)* Medicaid Contract: Exhibit A—2.7.2.11.1 CHP+ Contract: Exhibit A4—2.9.4.10.1	**AltruistaHealth-DHHA-ETL-Process-1510** - Overview of Extraction/Transformation/Loading Process for guiding care **AltruistaHealth-Products-DHHA-1510 –** Data integration review and support of the CM, UM and G&A **Trizetto_Information System.doc –** Document that reviews the types of health information collected and how it is processed.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
15. The Contractor collects data on member and provider characteristics and on services furnished to members. *42CFR438.242(b)(1)* Medicaid Contract: Exhibit A—2..7.2.11.2 CHP+ Contract: Exhibit A4—2.9.4.10.2	**Strategic Network Adequacy Plan_MCD-CHP_2014-2015.pdf –** On page 9-10 and 31-32 of the report you will see member population demographics and characteristics. Provider characteristics can be found on page 15-16 and 29-30. On page 20-21 the availability of services is detailed. Page 24-29 special health care needs, EPSDT and CLAS service information is detailed. **Denver Health Medicaid and CHP+ Impact Analysis.pdf –** Annual report that analyzes QI Interventions (services) provided to members.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
16. The Contractor's health information system includes a mechanism to ensure that data received from providers are accurate and complete by: ◆ Verifying the accuracy and timeliness of reported data. ◆ Screening the data for completeness, logic, and consistency. ◆ Collecting service information in standardized formats to the extent feasible and appropriate. *42CFR438.242(b)(2)* Medicaid contract: Exhibit A—2.6.7.2.4.1; 2.6.7.4.5.1; 2.6.7.4.4.1; 2.6.7.4.5.2; 2.6.7.4.5.3 CHP+ Contract: None	**Trizetto_Information System.doc –** Document that reviews the health information systems and how the system ensures the accuracy, completeness and formats of the data collected.	Medicaid ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
17. For CHP+ members— The Contractor submits immunization information for all covered members to the Colorado Immunization Information System (CIIS) monthly. CHP+ Contract: Exhibit A4—2.9.4.10.6	**Denver Health Immunization Practices Policy.pdf -** Can be found under #3 -Documentation of Immunizations element F on the top of page 5 A file of all eligible members who receive vaccinations at Denver Health are sent over daily to the State. The information is collected in VaxTrax and sent over in the evenings	Medicaid ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A CHP+ ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Medicaid Results for Standard X—Quality Assessment and Performance Improvement							
Total	Met	=	14	X	1.00	=	14
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	16	**Total Score**		=	14

Total Score ÷ Total Applicable	=	88%

CHP+ Results for Standard X—Quality Assessment and Performance Improvement							
Total	Met	=	14	X	1.00	=	14
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	2	X	NA	=	NA
Total Applicable		=	15	**Total Score**		=	14

Total Score ÷ Total Applicable	=	93%

The completed record review tools follow this cover page.

Appendix B. Colorado Department of Health Care Policy & Financing
2015–2016 Credentialing Record Review Tool
for Denver Health Medical Plan

Review Period:	January 1, 2015–December 31, 2015
Date of Review:	January 5, 2016
Reviewer:	Barbara McConnell and Gina Stepuncik
Participating Plan Staff Member:	Sandra Taylor and Jennifer Taylor

SAMPLE	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Provider ID#	110*******	147*******	150*******	161*******	176*******	154*******	156*******	138*******	108*******	126*******
Provider Type (MD, PhD, NP, PA, MSW)	PsyD	CNC, NP	MD	OD	PA	MD	MD	MD	LPC	MD
Application/Attestation Date	12/08/2014	03/18/2015	04/02/2015	07/01/2015	06/11/2015	06/08/2015	07/07/2015	08/30/2015	10/15/2015	08/08/2015
Credentialing Date (Committee/Medical Director Approval Date)	01/15/2015	04/16/2015	04/23/2015	07/10/2015	07/16/2015	08/27/2015	08/27/2015	10/22/2015	11/19/2015	11/19/2015
The Contractor, using primary sources, verifies that the following are present:										
◆ A current, valid license to practice (with verification that no State sanctions exist)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ A valid DEA or CDS certificate (if applicable)	Y☐ N☐ NA☒	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☐ N☐ NA☒	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☐ N☐ NA☒	Y☒ N☐ NA☐
◆ Education and training, including board certification (if the practitioner states on the application that he or she is board certified)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Work history	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ History of professional liability claims	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Current malpractice insurance in required amount	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Verification that the provider has not been excluded from federal participation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Signed application and attestation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ The provider credentialing was completed within verification time limits (see specific verification element—180/365 days)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
# Applicable elements	8	9	9	8	9	9	9	9	8	9
# Compliant elements	8	9	9	8	9	9	9	9	8	9
Percentage compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Total Record Review Score					**Total Applicable: 87**		**Total Compliant: 87**		**Total Percentage: 100%**	

Comments:

Appendix B. Colorado Department of Health Care Policy & Financing
2015–2016 Recredentialing Record Review Tool
for Denver Health Medical Plan

Review Period:	January 1, 2015–December 31, 2015
Date of Review:	January 5, 2016
Reviewer:	Gina Stepuncik
Participating Plan Staff Member:	Sandra Taylor

SAMPLE	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Provider ID#	153*******	100*******	185*******	150*******	177*******	164*******	144*******	122*******	133*******	165*******
Provider Type (MD, PhD, NP, PA, MSW)	PhD	CNS, NP	MD	MD	NP	MD	NP	MD	CNM, NP	MD
Application/Attestation Date	10/07/2014	01/12/2015	11/12/2014	02/05/2015	04/20/15	05/19/2015	06/15/2015	06/11/2015	09/05/2015	09/11/2015
Last Credentialing/Recredentialing Date	02/28/2013	02/28/2013	02/28/2013	05/23/2013	06/27/2013	08/22/2013	09/26/2013	10/24/2013	11/21/2013	12/19/2013
Recredentialing Date (Committee/Medical Director Approval Date)	01/15/2015	01/15/2015	01/22/2015	04/23/2015	05/21/2015	07/17/2015	08/20/2015	09/24/2015	10/15/2015	11/19/2015
The Contractor, using primary sources, verifies that the following are present:										
◆ A current, valid license to practice (with verification that no State sanctions exist)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ A valid DEA or CDS certificate (if applicable)	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐
◆ Board certification status (verifies status only if the practitioner states on the application that he/she is board certified)	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☐ N☐ NA☒	Y☒ N☐ NA☐	Y☐ N☐ NA☒	Y☒ N☐ NA☐	Y☐ N☐ NA☒	Y☒ N☐ NA☐
◆ History of professional liability claims	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Current malpractice insurance in the required amount	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Verification that the provider has not been excluded from federal participation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Signed application and attestation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ The provider recredentialing was completed within verification time limits (see specific verification element—180/365 days)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Recredentialing was completed within 36 months of last credentialing/recredentialing date	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
# Applicable elements	7	7	9	9	8	9	8	9	8	9
# Compliant elements	7	7	9	9	8	9	8	9	8	9
Percentage compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Total Record Review Score					**Total Applicable: 83**		**Total Point Score: 83**		**Total Percentage:100%**	

Comments:

Appendix B. Colorado Department of Health Care Policy & Financing
2015–2016 Credentialing Record Review Tool
for Denver Health Medicaid Choice

Review Period:	January 1, 2015–December 31, 2015
Date of Review:	January 5, 2016
Reviewer:	Barbara McConnell
Participating Plan Staff Member:	Sandra Taylor

SAMPLE	1	2	3	4	5	6	7	8	9	10
Provider ID#	140*******	149*******	116*******	173*******	150*******	110*******	110*******	170*******	119*******	141*******
Provider Type (MD, PhD, NP, PA, MSW)	NP	MD	MD	MD	PA	MD	DPM	MD	DO	LCSW
Application/Attestation Date	02/10/2015	03/30/2015	06/10/2015	03/4/2015	07/29/2015	06/22/2015	05/06/2015	08/27/2015	08/13/2015	10/12/2015
Credentialing Date (Committee/Medical Director Approval Date)	02/19/2015	07/17/2015	07/17/15	07/17/15	08/20/2015	8/27/2015	08/27/2015	09/24/2015	10/22/2015	11/19/2015
The Contractor, using primary sources, verifies that the following are present:										
◆ A current, valid license to practice (with verification that no State sanctions exist)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ A valid DEA or CDS certificate (if applicable)	Y☐ N☐ NA☒	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☐ N☐ NA☒
◆ Education and training, including board certification (if the practitioner states on the application that he or she is board certified)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Work history	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ History of professional liability claims	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Current malpractice insurance in required amount	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Verification that the provider has not been excluded from federal participation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Signed application and attestation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ The provider credentialing was completed within verification time limits (see specific verification element—180/365 days)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
# Applicable elements	8	9	9	9	9	9	9	9	9	8
# Compliant elements	8	9	9	9	9	9	9	9	9	8
Percentage compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Total Record Review Score					**Total Applicable: 88**		**Total Compliant: 88**		**Total Percentage: 100%**	

Comments:

Appendix B. Colorado Department of Health Care Policy & Financing
2015–2016 Recredentialing Record Review Tool
for Denver Health Medicaid Choice

Review Period:	January 1, 2015–December 31, 2015
Date of Review:	January 5, 2016
Reviewer:	Barbara McConnell and Gina Stepuncik
Participating Plan Staff Member:	Sandra Taylor and Jennifer Taylor

SAMPLE	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Provider ID#	115*******	111*******	131*******	123*******	182*******	191*******	151*******	138*******	170*******	115*******
Provider Type (MD, PhD, NP, PA, MSW)	MD	MD	LCSW	MD	MD	MD	MD	PhD	MD	MD
Application/Attestation Date	08/21/2015	03/11/2015	03/11/2015	02/23/2015	04/17/2015	05/14/2015	04/22/2015	05/01/2015	06/10/2015	10/22/2015
Last Credentialing/Recredentialing Date	01/24/2013	05/23/2013	07/25/2013	08/23/2013	08/22/2013	07/25/2013	08/22/2013	09/26/2013	10/24/2013	11/16/2013
Recredentialing Date (Committee/Medical Director Approval Date)	01/22/2015	04/23/2015	06/18/2015	07/17/2015	07/17/2015	07/17/2015	07/17/2015	08/20/2015	09/24/2015	11/13/2015
The Contractor, using primary sources, verifies that the following are present:										
◆ A current, valid license to practice (with verification that no State sanctions exist)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ A valid DEA or CDS certificate (if applicable)	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☐ N☐ NA☒	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☐ N☐ NA☒	Y☒ N☐ NA☐	Y☒ N☐ NA☐
◆ Board certification status (verifies status only if the practitioner states on the application that he/she is board certified)	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☐ N☐ NA☒	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☐ N☐ NA☒	Y☒ N☐ NA☐	Y☒ N☐ NA☐
◆ History of professional liability claims	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Current malpractice insurance in the required amount	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Verification that the provider has not been excluded from federal participation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Signed application and attestation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ The provider recredentialing was completed within verification time limits (see specific verification element—180/365 days)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Recredentialing was completed within 36 months of last credentialing/recredentialing date	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
# Applicable elements	9	9	7	9	9	9	9	7	9	9
# Compliant elements	9	9	7	9	9	9	9	7	9	9
Percentage compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Total Record Review Score					**Total Applicable: 86**		**Total Point Score: 86**		**Total Percentage: 100%**	

Comments:

Appendix C. Site Review Participants for Denver Health

Table C-1 lists the participants in the FY 2015–2016 site review of **Denver Health**.

Table C-1—HSAG Reviewers and Health Plan Participants

HSAG Review Team	Title
Barbara McConnell, MBA, OTR	Executive Director, State & Corporate Services
Gina Stepuncik	Project Manager
Matt Sobczyk	Director, State & Corporate Services
Denver Health Participants	**Title**
Allison Heyne	Health Programs Unit Supervisor
Cindy Ashley	Benefit Interpretations
Craig Gurule	Government Products Manager
Holly Batal	Medical Interim Director, Managed Care
Jennifer Taylor	Medical Compliance
Joshua Raines	Clinical Pharmacist–Formulary Management
Karen Valentine	Director, Intensive Case Management
Kristie Richardson	Contract Administrator, Managed Care
Laura Coleman	Pediatric Intervention Manager (via phone)
LeAnn Donovan	Chief Executive Officer/Executive Director of Medical Care
Lorna Pate	Director, Denver Health Medical Plan Compliance
Marilyn Gaipa	Director, Quality Improvement and Accreditation
Mark Watanabe	Clinical Pharmacist, Behavioral Health
Michael Robinson	Director, Provider Relations
Natassia Martinez	Government Products Analyst
Rachael Meir	Director, Behavioral Health and Wellness
Rebecca Browning	Pharmacy Technician
Richard French	Director—Member Services, Appeals and Grievances
Sandra Taylor	Manager, Medical Staff Services
Sarah Hipp	Administrative Coordinator—Member Services, Appeals and Grievances
Sarah Spillane	Director, Case and Utilization Management
Department Observers	**Title**
Allison Kennedy	Quality Improvement Project Admin
Chris Tzortas	Managed Care and Enrollment Broker Specialist
Gina Robinson	EPSDT Coordinator, Quality and Health Improvement Unit
Russ Kennedy	Quality Specialist, Quality and Health Improvement Unit
Teresa Craig	CHP+ Program and Contract Manager

Appendix D. Corrective Action Plan Template for FY 2015–2016 *for* Denver Health

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

For this step,	HSAG completed the following activities:
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 compliance site review report via e-mail or through the file transfer protocol (FTP) site (with an e-mail notification to HSAG and the Department). The health plan must submit the CAP using the template provided. For each element receiving a score of *Partially Met* or *Not Met*, the CAP must describe interventions designed to achieve compliance with the specified requirements, persons responsible, 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.

For this step,	HSAG completed the following activities:
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 healthcare regulations and managed care contract requirements.

The template for the CAP follows.

Table D-2—FY 2015–2016 Corrective Action Plan *for* Denver Health

Standard III—Coordination and Continuity of Care *(This requirement applies only to the Medicaid line of business.)*		
Requirement	**Findings**	**Required Action**
13. The Contractor must assure the provision of all required components of periodic health screens as set forth by the American Academy of Pediatrics Bright Futures periodicity schedule. At a minimum, such efforts include: ◆ Education and outreach to eligible members of the importance of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. ◆ A proactive approach to ensure eligible members obtain EPSDT services. ◆ A process to assure that the medically necessary EPSDT services not covered by the Contractor (wraparound services) are referred to the Office of Clinical Services for action. ▪ The Contractor instructs its providers on how to refer a member for wraparound services.	The provider manual language did not adequately instruct providers how to refer a member for EPSDT-related wraparound services. In addition, HSAG reviewers noted that the time frame stated for scheduling EPSDT services was two weeks.	DHMC must ensure that providers are instructed to refer members to the office of clinical services and/or Healthy Communities to obtain EPSDT-related wraparound services not covered under the managed care contract. DHMC must revise the provider manual information about referring members for wraparound services and may want to consider adding EPSDT and wraparound referral information as a topic for rotation in the provider newsletters. DHMC must also revise the provider manual to reflect a 30-day scheduling time frame to be consistent with the managed care contract and the health plan's procedures.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard VIII—Credentialing and Recredentialing *(This requirement applies to the CHP+ and Medicaid lines of business.)*		
Requirement	**Findings**	**Required Action**
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.	DHMC/DHMP had policies and procedures that pertained to office-site quality standards. During the on-site interview, DHMC/DHMP provider network support and credentialing staff members were unable to provide, consistent with the policy, the performance threshold of complaint which would warrant a site visit.	DHMC/DHMP must ensure that staff members are aware of the threshold for site-related complaints which warrant a site visit and further follow-up pursuant to the health plan's policy.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard X—Quality Assessment and Performance Improvement *(This requirement applies to the CHP+ and Medicaid lines of business.)*		
Requirement	**Findings**	**Required Action**
5. The Contractor ensures that practice guidelines comply with the following requirements: ◆ Are based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field. ◆ Consider the needs of the Contractor's members. ◆ Are adopted in consultation with contracting healthcare professionals. ◆ Are reviewed and updated annually.	DHMC/DHMP clinical practice guidelines stated they would be reviewed every two years. During the on-site interview, staff members reported that the two-year review timeline is based on URAC standards. Staff members also stated that the QMC has plans for annual review of the guidelines but has not yet implemented an annual review for all guidelines.	DHMC/DHMP must develop a mechanism to track clinical practice guideline review by the QMC to ensure annual review of all guidelines as required by the Medicaid and CHP+ managed care contracts with the State.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard X—Quality Assessment and Performance Improvement *(This requirement applies only to the Medicaid line of business.)*		
Requirement	**Findings**	**Required Action**
11. The Contractor must assure the provision of all required components of periodic health screens as set forth by the American Academy of Pediatrics Bright Futures periodicity schedule. At a minimum, such efforts include a process to measure and assure compliance with the EPSDT schedule.	DHMC's Ambulatory Quality Scorecards measure HEDIS well-child visit measures, but the health plan did not provide sufficient evidence that it adequately measures compliance with the EPSDT periodicity schedule to ensure compliance with such.	DHMC must develop a mechanism to measure compliance with the periodicity schedule and then develop interventions designed to ensure continued and/or improved compliance.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review Protocol Activities *for* Denver Health

The following table describes the activities performed throughout the compliance monitoring process. The activities listed below are consistent with CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal healthcare regulations and managed care contract requirements: ◆ HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. ◆ HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, on-site agendas; and set review dates. ◆ HSAG submitted all materials to the Department for review and approval. ◆ HSAG conducted training for all site reviewers to ensure consistency in scoring across plans.
Activity 2:	**Perform Preliminary Review**
	◆ HSAG attended the Department's Medical Quality Improvement Committee (MQuIC) meetings and provided group technical assistance and training, as needed. ◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the health plan in writing of the request for desk review documents via email 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 and on-site activities. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. ◆ Documents submitted for the desk review and on-site 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. The health plan also submitted lists of all CHP+ credentialing and recredentialing files and all Medicaid credentialing and recredentialing records that occurred between January 1, 2015, and December 31, 2015, to the extent available at the time of the site review request. HSAG used a random sampling technique to select records for review during the site visit. ◆ 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 3:	**Conduct Site Visit**
	◆ 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.

For this step,	HSAG completed the following activities:
	◆ HSAG reviewed a sample of administrative records to evaluate implementation of managed care regulations related to CHP+ and Medicaid credentialing and recredentialing. ◆ Also while on-site, 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 confidential or proprietary, or were requested as a result of the pre-on-site document review.) ◆ At the close of the on-site portion of the site review, HSAG met with health plan staff and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	◆ HSAG used the FY 2015–2016 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. ◆ HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the State**
	◆ HSAG populated the report template. ◆ 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.