COLORADO
Department of Health Care Policy & Financing

Fiscal Year 2016–2017 Site Review Report

for

Denver Health Medicaid Choice and Denver Health Medical Plan

April 2017

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, with revisions published May 2016, requires that states conduct a periodic evaluation of their managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to determine compliance with federal healthcare regulations and managed care contract requirements. Public Law 111-3, Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, requires that each state's Children's Health Insurance Program (CHIP) apply 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+) MCOs and prepaid inpatient health plans (PIHPs) to comply with specified provisions of the BBA. The Department of Health Care Policy & Financing (the Department) has elected to complete the state's requirement for periodic evaluation of Colorado's CHP+ and Medicaid 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) 2016–2017 site review activities for the review period of January 1, 2016, through December 31, 2016, 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. For each of the standard areas reviewed, this section contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 2 contains graphical representations of results for all standards across two three-year cycles. Section 3 describes the background and methodology used for the 2016–2017 compliance monitoring site review. Section 4 describes follow-up on the corrective actions required as a result of the 2015–2016 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 denials 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 2016–2017 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 within the compliance monitoring tool 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 requirements receiving a score of *Met* 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

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I. Coverage and Authorization of Services	35	34	32	0	2	1	94%
II. Access and Availability	13	13	12	1	0	0	92%
Totals	**48**	**47**	**44**	**1**	**2**	**1**	**94%**

*The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements.

Table 1-2 presents the scores for **DHMP** for the denials record review. Details of the findings for the record review are in Appendix B—Record Review Tool.

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

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Denials	100	20	0	20	80	0%
Totals	**100**	**20**	**0**	**20**	**80**	**0%**

*The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements.

Medicaid Results

Table 1-3 presents the Medicaid scores for **DHMC** for each of the standards. Findings for requirements receiving a score of *Met* 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

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I. Coverage and Authorization of Services	35	34	32	2	0	1	94%
II. Access and Availability	13	13	12	1	0	0	92%
XI. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	13	13	8	5	0	0	62%
Totals	**61**	**60**	**52**	**8**	**0**	**1**	**87%**

*The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements.

Table 1-4 presents the Medicaid scores for **DHMC** for the denials record review. Details of the findings for the record review are in Appendix B—Record Review Tool.

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

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Denials	100	71	62	9	29	87%
Totals	**100**	**71**	**62**	**9**	**29**	**87%**

*The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements.

Standard I—Coverage and Authorization of Services

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 reviewed authorization requests for all out-of-network services and for outpatient requests for durable medical equipment, consumable supplies, and home healthcare. No services delivered within the Denver Health and Hospital Authority (DHHA) network required authorization, as capitated payments to providers were considered sufficient motivation to control utilization. The DHHA utilization review department concurrently reviewed out-of-network inpatient and observation services, and coordinated pertinent information with the **DHMC/DHMP** Utilization Management (UM) department. **DHMC/DHMP** contracted for the services of a pharmacy benefits manager (PBM) to manage pharmacy benefits and services. The DHHA pharmacy department reviewed all prior authorization requests to determine medical necessity for non-formulary medications. UM and drug authorization policies and procedures applied to both Medicaid and CHP+ members and accurately addressed comprehensive authorization requirements defined in the standard. The UM program functions under the direction of the **DHMC/DHMP** medical director; and all UM and pharmacy department staff and medical reviewers were licensed healthcare professionals, qualified to make medical necessity determinations.

Policies and procedures incorporated the definition of "medical necessity" as defined in the **DHMC** contract with the Department (see recommendation in the "Summary of Findings Resulting in Opportunities for Improvement" section following), and also included criteria for review of investigational or experimental treatments. **DHMC/DHMP** used InterQual and Hayes Knowledge Center (new technology) criteria for making medical necessity decisions. Staff stated that when neither of these sources apply to the service request, UM staff research clinical consensus criteria and also consider whether or not a denial would impede member care. **DHMC/DHMP** conducted interrater reliability testing for physician and non-physician staff annually. All decisions to deny services were made by a medical director and included consultation with the provider to obtain more information as needed. Policies and procedures accurately addressed time frames for making authorization decisions and defined processes for determining pre-service, post-service, continued stay, expedited, and emergency services authorizations. Staff members stated that the UM department modified the pre-authorization request form to ask the provider when he/she wanted to begin the requested service in order to determine whether or not the authorization decision should be expedited.

DHMC provided written notice to the member and provider regarding both approval and denial of authorization. Notices of action (NOAs) for denied services included all required information, in both English and Spanish, concerning appeals and State fair hearings. **DHMC/DHMP** modified the content of the NOA in October 2016 to accurately reflect the change in the time frame for requesting a State fair hearing to 60 days. When the decision time frame was extended due to lack of information, the extension letter to the member included all required content.

On-site denial record reviews confirmed the following:

Medicaid

- Denial record reviews included 10 new requests; all were standard time frame.
- **DHMC** extended the decision time frame for three cases—in all three cases an extension letter was sent to the member which included all required content.
- HSAG found that in all 10 cases a qualified clinician made the decision, the decision was based on established criteria, and the NOA was sent to the member and provider. The NOA included required content in nine of 10 cases.
- **DHMC** sent NOAs within the required time frame in all 10 cases.
- **DHMC** consulted with the requesting provider in three of the five applicable cases.
- HSAG found that four of 10 NOAs to the member were easy to understand.

CHP+

- Denial record reviews included 10 retrospective claim denials. (No claims were reviewed by UM for authorization.)
- In all cases, **DHMP** sent no written notice of action to the member; therefore, HSAG found:
  - All cases not applicable (NA) for "notice of action includes required content."
  - All cases NA for "correspondence with the member was easy to understand."
- No cases were reviewed by UM for authorization; therefore, HSAG found:
  - All cases NA for "authorization made by qualified clinician."
  - All cases NA for "contact with the requesting provider if denied due to lack of information."
  - All cases NA for "NOA included information on how to obtain wraparound service if denied due to not a covered service."
  - All cases NA for "decision based on established authorization criteria."

DHMC/DHMP policies and procedures, member handbook, and provider manual accurately defined "emergency medical condition" and "emergency services." **DHMC/DHMP** pays for emergency and urgently needed services obtained in or out of network. Utilization review, drug utilization review, and claims adjudication policies, as well as the member handbook, stated that emergency services do not require authorization. Staff members stated that **DHMC/DHMP** automatically pays all emergency services claims without need for review. The member handbook informs members that they are not responsible for the cost of emergency services. The provider manuals clearly state that providers may not try to recover costs of services from the member. **DHMC/DHMP** also requires no authorization for poststabilization care delivered within the DHHA system. When a member is receiving poststabilization care out of network, **DHMC/DHMP** allows the treating provider to determine when a member is stable enough for discharge or transfer. DHHA maintains a 24-hour hotline to enable the out-of-network provider to inform DHHA of member admission and to begin the "repatriation" process. The DHHA UM team works with the out-of-network provider to arrange for member transfer to DHHA when

clinically possible, and communicates progress to the **DHMC/DHMP** UM and claims departments. Staff members stated that out-of-network poststabilization care is never denied up to the point of the member's arranged transfer to DHHA, and that the diagnosis-related group (DRG) claim payment to the provider covers the member's entire inpatient stay for poststabilization care.

Summary of Findings Resulting in Opportunities for Improvement

DHMC and **DHMP** defined "medical necessity" equivalent to the definition included in its contract with the Department. However, the definition of "medical necessity" outlined in the State Medicaid Plan—10 CCR 2505-10 8.076.1.8 (effective August 30, 2016)—created a uniform definition of "medical necessity" to be used across all applicable Medical Assistance programs and included the addition of EPSDT-specific criteria. Therefore, **DHMC/DHMP** is advised to immediately update the definition of "medical necessity" in its policies and procedures accordingly. Please reference 10 CCR 2505-10 8.076.1.8 (a-g) and 8.7016.1.8.1 for guidance.

DHMC provided written NOA to both member and provider. However, HSAG noted during on-site record reviews that the service provider (e.g., DME) rather than the requesting provider received the NOA. Staff members explained that the request is forwarded from the service provider to **DHMC/DHMP** for approval. HSAG recommends that all providers involved in the request for services, including the provider who originated the prior authorization request (PAR) be notified of a service denial.

The Drug Authorization, Utilization Review, and Formulary Management policy addressed required time frames for sending a member NOA, including standard, expedited, extended, and five-day notice exceptions to the advance notice time frame. However, the policy failed to address 10-day advance notice for previously authorized services; for denial of claims, at the time of the action; and for decisions not reached within the required time frame, on the date the time frame expires. HSAG recommends that **DHMC/DHMP** update this policy to include all required time frames for sending an NOA.

DHMP was unable to identify a sample of cases for the on-site denial record review processed through the UM Department during calendar year 2016. All denials in the sample were claims denials for out-of-network services. HSAG noted that it is atypical for a health plan to experience no authorization requests for CHP+ members over an entire year. HSAG recommends that **DHMP** explore reasons that might legitimize such an occurrence.

CHP+ claims denials for out-of-network services observed during on-site denial record reviews involved no UM authorization review process. However, record reviews identified several cases in which there may have been potential need to review for continuity of care rules or for determination of urgently needed services, which may have overridden automatic denials of out-of-network services. Furthermore, five of 10 records denied for out-of-network services involved members who had been enrolled in **DHMP** for approximately one month or less, presenting the question as to whether or not a newly enrolled member could be considered reasonably aware of the prior authorization requirement for out-of-network services. HSAG recommends that:

- **DHMC/DHMP** define a process to more closely align claims adjudication decisions with the UM department authorization processes to ensure that the UM department has had an opportunity to review any potential out-of-network denial to determine regulatory or policy exceptions to the denial (e.g., continuity of care rules or urgently needed services).
- **DHMC/DHMP** evaluate its policies and processes concerning denial of out-of-network services for newly enrolled members, possibly considering a reasonable time frame after enrollment for members and their providers to be informed of **DHMC/DHMP**'s rules concerning in- and out-of-network services.

While **DHMC** met requirements for content of the NOA, HSAG observed that the NOA included excessive content—e.g., separate descriptions of appeal processes and State fair hearing processes (each in both English and Spanish), an appeal request form, and a designated representative form. HSAG recommends that **DHMC/DHMP** review the content of the letters to confirm whether or not the amount of information included is necessary and appropriate and ensures ease of understanding for the member.

While **DHMC**'s template NOAs and nine of 10 denial records reviewed included all required content, one letter neglected to enter the date that the appeal was due. Staff members stated that all NOAs are reviewed by the UM director prior to mailing to ensure that required content is included. HSAG recommends that **DHMC** ensure that its process for reviewing letters for all required content is effective and also includes review of the description of the reason for the denial to ensure ease of understanding.

DHMP denial records were claim denials in which there was no involvement of UM authorization processes; therefore, HSAG was unable to evaluate several denial record requirements related to **DHMP**. HSAG recommends that **DHMP** evaluate whether or not some of the recommendations and required actions applicable to **DHMC** record reviews might also be appropriate to incorporate into **DHMP** processes.

Staff members stated that **DHMC/DHMP** automatically pays all emergency service claims without authorization. However, both the Utilization Review Determinations policy and the Drug Authorization, Utilization Review, and Formulary Management policy stated that "the Emergency Department claim may be denied based on the prudent layperson person standard." (Staff members voiced understanding that the prudent layperson definition of "emergency medical condition" would qualify the claim for approval—not denial.) In addition, the Adjudication of Emergency and Inpatient Stays policy included a statement that the claims department pays the entire emergency/inpatient claim without authorization when the claim is below "X" dollars. (Staff members explained that this process had been discontinued and that the policy was under revision.) These various policy statements are not only confusing, but appear to be in conflict with operating procedures for automatic payment of *all* emergency service claims without question. HSAG recommends that **DHMC/DHMP** clarify statements in its policies and procedures and/or clearly state that all emergency service claims are paid without authorization or review.

The member handbooks included information that appeared to inform the member—in very confusing language—of all the circumstances under which **DHMC/DHMP** is financially responsible for emergency services. The financial responsibility regulations apply to the health plan, not the member;

therefore, HSAG recommends that **DHMC/DHMP** review the member handbooks to determine whether the information is appropriate for the member and to, at a minimum, clarify the language in the member handbooks.

Summary of Findings Resulting in Required Actions

HSAG confirmed in several **DHMC** on-site denial record reviews that the UM medical director consults with the requesting provider, as necessary, prior to making an authorization decision. However, HSAG observed two of 10 cases in which the *requesting* provider was not consulted to obtain or clarify information needed prior to the denial. (In one case, UM attempted to obtain additional information from the service provider rather than from the original requesting provider.) **DHMC** must ensure that the requesting provider is consulted when necessary to obtain information needed for making an authorization decision.

On-site CHP+ denial record reviews consisted of 10 retrospective claim denials for out-of-network services. **DHMP** provided no NOA to the member in 10 of 10 records reviewed. **DHMC/DHMP** requires UM authorization for non-emergent out-of-network services. Any claim denied for lack of authorization for out-of-network services requires a written NOA to the member. **DHMP** must implement mechanisms to ensure that each claim denial for out-of-network services generates a written NOA to the member.

The Utilization Review Determinations policy stated that NOAs were available in English and Spanish and included template letters that appeared to be written in easy-to-understand language. Staff members stated that the UM director reviews each NOA for required content but does not review for ease of understanding of the "reason for denial" description. During **DHMC** denial record reviews, HSAG identified six of 10 records in which the NOA contained language—in the reason for denial section—that was not easy for the member to understand. **DHMC** must develop mechanisms to ensure that the reason for denial in NOA letters is written in language that is easy for members to understand.

CHP+ denial record reviews—all claims denials—failed to notify the member of denial of payment at the time of action affecting the claim. **DHMC** provided no explanation of benefits (EOB) or other notice of action to the member in 10 of 10 cases. **DHMP** must ensure that it mails a notice of action (e.g., EOB) for denial of payment at the time of any action affecting the claim.

Standard II—Access and Availability

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's Access to Care/Services policy and procedure described the standards and methods used to determine the adequacy of the network as including provider-to-member ratios, geographic location of providers in relation to members, appointment standards, and cultural and linguistic diversity. **DHMC/DHMP** also considered the results of member and provider satisfaction surveys, grievance reports, locations of provider offices in relation to public transportation, and enrollment trending.

After determining in FY 2013–2014 that its network was inadequate to meet the needs of its membership, **DHMC/DHMP** began revising existing and implementing new processes as appropriate to improve access. During the review period, **DHMC/DHMP** expanded access by opening a new primary and urgent care clinic and extending office hours at three clinic locations. **DHMC/DHMP** also expanded capacity by contracting with Walgreens Healthcare Clinic and King Soopers Little Clinic. Medicaid and CHP+ members are allowed to access these clinics for urgent care appointments. By adding primary care providers to its nurse advice line staff, **DHMC/DHMP** is able to more thoroughly address the needs of members who may not require face-to-face appointments. **DHMC/DHMP** staff members also improved collaboration between the central appointment center and individual clinics to more efficiently identify and fill open appointments.

Additionally, **DHMC/DHMP** began generating daily "unmet needs" reports, which list all members whom **DHMC/DHMP** was unable to accommodate with a timely appointment. **DHMC/DHMP** assigned staff to work one on one with members and providers (both in- and out-of-network) until each member's needs were addressed. During the on-site interview, **DHMC/DHMP** staff members reported a drastic reduction in the number of members listed on the daily unmet needs reports, indicating that these interventions increased the network's capacity.

DHMC/DHMP's policies and procedures stated that persons with special healthcare needs who require frequent appointments with specialists would be allowed direct access to specialists and that women would be allowed direct access to a women's health specialist for routine and preventive care. **DHMC/DHMP** included these provisions in both Medicaid and CHP+ member handbooks as well as in the provider manuals. **DHMC/DHMP** submitted materials that demonstrated ensuring that covered services are available 24 hours a day, 7 days a week, when medically necessary; that scheduling guidelines are communicated in writing; and that providers are monitored to ensure that they meet scheduling standards.

DHMC/DHMP submitted numerous documents that demonstrated its commitment to the delivery of services in a culturally competent manner, including a Certificate of Distinction in Multicultural Health Care awarded by the National Committee for Quality Assurance (NCQA). **DHMC/DHMP** required all

staff (including providers) to participate in health literacy and culture and diversity training at the time of hire and again annually. **DHMC/DHMP** also offered presentations throughout the year with focus on particular populations (e.g., Asian and Pacific Islander, Middle East, Native American, and Latino-Hispanic).

Summary of Findings Resulting in Opportunities for Improvement

During the on-site interview, **DHMC/DHMP** staff members described several processes implemented in order to expand the network's capacity and improve efficiencies. These processes remained fluid as staff determined the most effective ways for addressing issues. HSAG encourages **DHMC/DHMP** to continue pursuing innovative ways to address capacity issues and suggests that it document these processes in writing as they are finalized.

Summary of Findings Resulting in Required Actions

While **DHMC/DHMP** noted a primary care provider-to-member ratio of 3: 2,000 for Medicaid and 36: 2,000 for CHP+, other components used to measure adequacy (e.g., grievances, satisfaction surveys, and daily unmet demand reports) indicate that the **DHMC/DHMP** provider network was not adequate to ensure timely availability of covered services. **DHMC/DHMP** must continue to expand its network capacity until it can ensure all members timely access to all services covered under the contract.

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services

The following section is applicable to Medicaid managed care only.

Summary of Strengths and Findings as Evidence of Compliance

The Early and Periodic Screening, Diagnostic, and Treatment Benefit (EPSDT) Program policy addressed the comprehensive requirements for EPSDT services through policy statements that replicated the State EPSDT regulations. **DHMC** considered its provider manual to be the primary source for communicating implementation of the various components of the policy. The provider manual included information on components of well-child checkups and the corresponding schedule, immunizations schedule, wraparound services, and the role of the EPSDT outreach coordinator. The provider manual defined provider responsibilities for making primary care appointments for well-child checkups, performing screenings, providing or referring members for diagnostic and treatment services, and contacting **DHMC** care coordinators for assistance with wraparound services. The **DHMC** member handbook described to members in simple language the benefits of EPSDT services, the types of services available, and how to access those services. **DHMC** also mailed an annual reminder to members regarding well-child appointments, was planning an upcoming member newsletter featuring

EPSDT services, and had trained member services staff to assist members with information about EPSDT services.

DHMC adequately described the components of well-child checkups to members and providers and demonstrated that the newly implemented Epic electronic record system included a well-child checkup record for documenting the various EPSDT periodic screening components and results. **DHMC** implemented a process for monitoring provision of select components (on a rotating basis) of periodic health screens by providers and expects to use data from the Epic system at a non-designated time in the future to enable more comprehensive and efficient monitoring of periodic health screenings. Primary care providers were expected to make referrals for necessary diagnostic and treatment services and were directed to contact **DHMC** Member Services or case managers for assistance with authorizations or referrals for services not covered by the plan. In addition, providers or members were encouraged to contact **DHMC** care coordinators for assistance with wraparound services. **DHMC**'s unmet demand policy and process stated that any primary care or specialist appointment that cannot be met within the Denver Health provider system must be authorized for out-of-network services within 10 days of request for appointment, enabling timely initiation of necessary treatment services. **DHMC**'s case management policies and procedures described processes for assisting members with complex needs—including EPSDT-eligible members—with access to wraparound services, durable medical equipment (DME), home healthcare, and community resources. Although written utilization review and case management policies did not delineate specific EPSDT requirements, staff members stated that the member services, UM, and care coordination personnel work as an integrated team to ensure that members have access to needed services and that case managers have extensive experience in making referrals to EPSDT-related service providers and agencies.

DHMC communicated EPSDT requirements to providers through an EPSDT-specific section of the provider manual and in a 2016 provider newsletter. **DHMC** scheduled the Department's EPSDT administrator to conduct multi-departmental EPSDT staff training, including the DHHA chief of pediatrics. **DHMC** staff members anticipated that the chief of pediatrics would subsequently suggest additional mechanisms for educating providers on EPSDT program requirements. **DHMC** has developed a strategy for annual evaluation of a sample of medical records to determine compliance with select elements of the EPSDT schedule of periodic health screens. **DHMC** was also working with Epic's information system staff to determine future system capabilities for monitoring and supporting implementation of EPSDT services and requirements. **DHMC** will continue to collect and submit data to the Department to comply with EPSDT federal reporting requirements.

Summary of Findings Resulting in Opportunities for Improvement

While **DHMC** demonstrated that it had implemented processes to communicate EPSDT services to members through the member handbook, annual well-child checkup reminder card, and member services personnel, HSAG encourages **DHMC** to continue developing innovative outreach communications to members. **DHMC** might consider increased communications through provider points of service—e.g., posters, flyers, one-on-one communication with providers and clinic staff—linking to Healthy Communities initiatives, telehealth programs, or member incentive programs. In addition, while Member Services staff members are available to provide members with assistance for

transportation or scheduling appointments, the member handbook does not communicate this availability or how to access it. HSAG recommends that the member handbook and/or other member communications be updated to include this information.

The *Documentation Principles for Healthcare*, applicable to all Denver Health providers, generally paralleled the elements outlined in the EPSDT documentation requirement. **DHMC** provided a sample from the Epic electronic record system that demonstrated documentation of components of a well-child exam, with referrals for follow-up. However, the provider manual included no information to communicate the documentation requirements or to refer the provider to the Epic system for implementation. HSAG recommends that **DHMC** update the provider manual to more clearly communicate the EPSDT documentation expectations and how to access the Epic system for implementation.

Similarly, HSAG recommends that **DHMC** consider the following corrections and enhancements to the **DHMC** provider manual:

- The EPSDT section of the provider manual lists "Denver Health Medical Management" as a source for authorizations or assistance, but provides no contact number. The provider manual also describes the role of the EPSDT outreach coordinators, but provides no contact number. **DHMC** should add contact telephone numbers for these resources.
- The provider manual described the role of EPSDT outreach coordinators without specifically referencing "Healthy Communities," and the services provided by EPSDT outreach coordinators appear to be incomplete (e.g., did not describe assistance with finding a provider). HSAG recommends that **DHMC** review Healthy Communities information resources (available on-line) and consider updating this section of the provider manual.
- The provider manual description of the components of a well-child checkup/screenings failed to include screening for lead toxicity. In addition, the manual does not state that the provider may document that a screening has already been provided to avoid duplication of screenings. HSAG recommends that **DHMC** update the provider manual to incorporate these elements.
- The EPSDT section of the manual defines no responsibility of provider to educate members on the importance or availability of EPSDT services, what the services include, or how to obtain those services. The provider is the most common point of contact between the member and the healthcare system; therefore, **DHMC** may want to consider and define the provider's role in informing the member about EPSDT services.
- Provider responsibilities for implementing EPSDT are briefly defined—providing well-child checks, providing treatment if appropriate, assisting the family in scheduling the next EPSDT screening, ensuring that biannual dental exams occur, explaining importance of having a consistent primary care provider. The provider manual describes wraparound services that may be available for EPSDT-eligible members, but does not say that the provider has a role in arranging these services for members. HSAG recommends that **DHMC** strengthen the language in the provider manual to move beyond an informational/educational context to more clearly define the provider role and responsibility for implementing EPSDT requirements, with particular emphasis on what the EPSDT program requires of providers (shall or must elements)—i.e., the provider must arrange for necessary

referrals and seek authorization when needed; the provider must either arrange for wraparound services or contact **DHMC** case managers or Healthy Communities for assistance.

- The supporting roles of **DHMC** operational departments in the provision of EPSDT services are poorly defined in the provider manual. HSAG suggests supplying to providers contact numbers for the operational departments and more clearly defining for providers the roles of member services (e.g., assistance with transportation and appointments; providing information on EPSDT services), UM (e.g., authorizations and assistance with provider referrals), care management (e.g., assistance with referrals for wraparound services), and Healthy Communities.

DHMC should note that the definition of "medical necessity" outlined in the State Medicaid Plan—10 CCR 2505-10 8.076.1.8 (effective August 30, 2016)—includes the EPSDT-specific criteria per 8.280.4.E. HSAG strongly recommends that the **DHMC** EPSDT policies incorporate the definition of "medical necessity" as outlined in the Findings section of Standard I, Element 4, of the compliance monitoring tool.

While it appears that **DHMC** had processes in place to support the various requirements of the EPSDT program within a number of individual departments, HSAG recommends that **DHMC** ensure a coordinated and cohesive approach to operationalize the program as follows: update utilization review, member services, and case management policies to include EPSDT-specific requirements and applicable procedures; include in the EPSDT Program policy references to procedures for implementing applicable requirements and the individual departments responsible for those procedures; consider periodic evaluation of the cohesiveness or integration of all operational components; and ensure that provider roles and responsibilities are clearly outlined as the core of the program and that supporting processes are clearly communicated to providers.

HSAG encourages **DHMC** to pursue a more direct relationship with the local Healthy Communities program to define mutual responsibilities of each and to effectively integrate Healthy Communities activities with **DHMC** EPSDT program responsibilities—e.g., informing members, making referrals, and coordinating services for members.

HSAG recommends that communications with network providers regarding the EPSDT program include regular and periodic communications—rather than infrequent references such as the provider manual. **DHMC** might consider as additional opportunities for "systematic" communication with providers approaches such as feedback to providers on EPSDT performance measures or a quarterly provider webinar series incrementally focused on different components of the EPSDT program.

Summary of Findings Resulting in Required Actions

While the EPSDT Program policy addressed the comprehensive components of the State's EPSDT program, the policy defined procedures for implementation in a very limited manner, addressing neither accountabilities nor mechanisms for implementation of most requirements. In addition, **DHMC** submitted no corresponding procedures from other departments that specifically addressed EPSDT elements. **DHMC** must enhance its EPSDT policy or related policies and procedures to define or link to organizational procedures which address mechanisms to operationalize all components of the policy.

The EPSDT Program policy stated that **DHMC** implements the American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule. However, it was not apparent that the AAP Bright Futures Periodicity Schedule had been distributed or was available through any organizational source—i.e., policies and procedures, **DHMC** website, provider manual, or other communications. Therefore, it was unclear how **DHMC** intends to implement the Bright Futures Periodicity Schedule, particularly with providers. **DHMC** must enhance its provider communications and provide access to the AAP Bright Futures Periodicity Schedule in order to fully operationalize this component of its EPSDT Program policy.

DHMC demonstrated it had mechanisms in place through the UM department or the Epic electronic record system to assist with referrals to other providers or to Healthy Communities. However, the EPSDT section of the provider manual was vague on the responsibility of the provider to refer the member to an appropriate practitioner (except for dental services) or to Healthy Communities and provided inadequate guidance on how to do so. **DHMC** must enhance EPSDT provider communications to more explicitly address that (if a provider is not licensed or equipped to render necessary treatment) the *provider* is responsible to make a referral to another provider, to Healthy Communities, or to the UM case managers to assist with a referral.

Both the EPSDT Program policy and the provider manual described the roles of the primary care provider to make referrals and to participate in the prior authorization process. However, neither document defined the types of EPSDT services that require an authorization from DHMC (e.g., home health, orthodontia, private duty nursing, and pharmaceuticals) or services to which members may self-refer (e.g., routine vision, dental, hearing, mental health services, or family planning services). **DHMC** must enhance provider communications to ensure that providers are aware of the types of EPSDT services and referrals that *do* or *do not* require prior authorization and clarify the process for obtaining authorization when necessary.

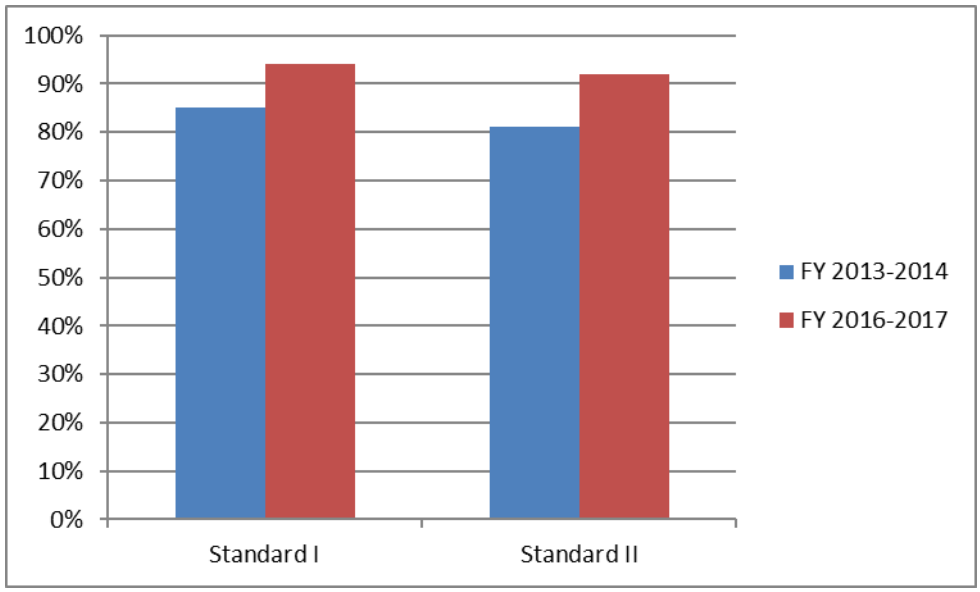
The definition of "medical necessity" and criteria for authorization of EPSDT services outlined in the EPSDT Program policy were not linked to or included in the UM Determinations policy. The UM Determinations policy included criteria that paralleled many elements in the EPSDT definition of "medical necessity," but failed to include: "The service is expected to assist the individual to achieve or maintain maximum functional capacity in performing activities of daily living" and "May be a course of treatment that includes observation or no treatment at all." **DHMC** must incorporate the complete and accurate definition of "medical necessity" for EPSDT services into applicable operating policies and procedures and ensure that the criteria are applied appropriately to authorization decisions for EPSDT-related services. (See recommendations in Opportunities for Improvement preceding.)

Comparison of CHP+ Results

Comparison of FY 2013–2014 Results to FY 2016–2017 Results

Figure 2-1 shows the scores from the FY 2013–2014 site review (when Standard I and Standard II 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.

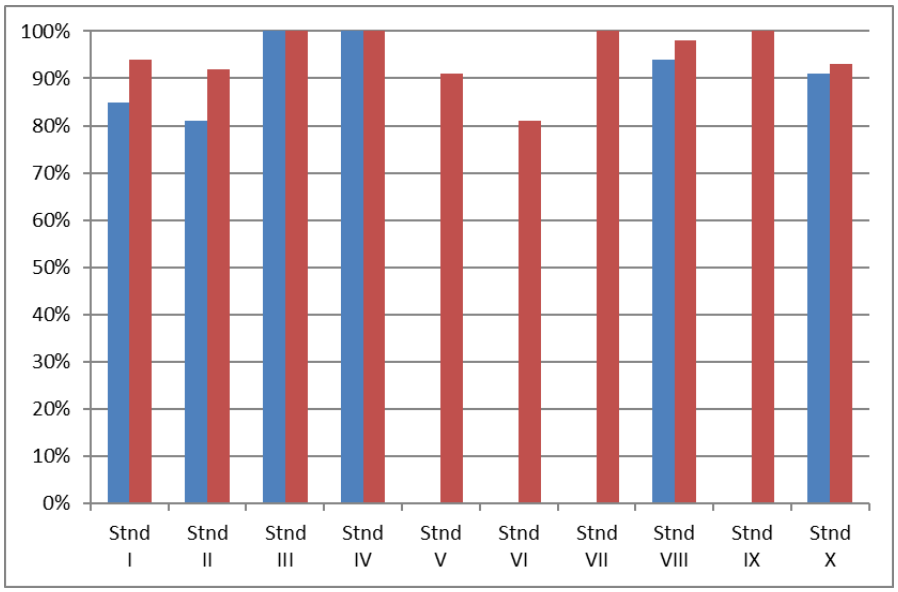
Figure 2-1—Comparison of FY 2013–2014 Results to FY 2016–2017 Results



Review of Compliance Scores for All Standards

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

Figure 2-2—Compliance Scores for All Standards



Note: Results shown in blue are from FY 2012–2013 and FY 2013–2014. Results shown in red are from FY 2014–2015, FY 2015–2016, and FY 2016–2017.

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

Table 2-1—List of Standards by Review Year

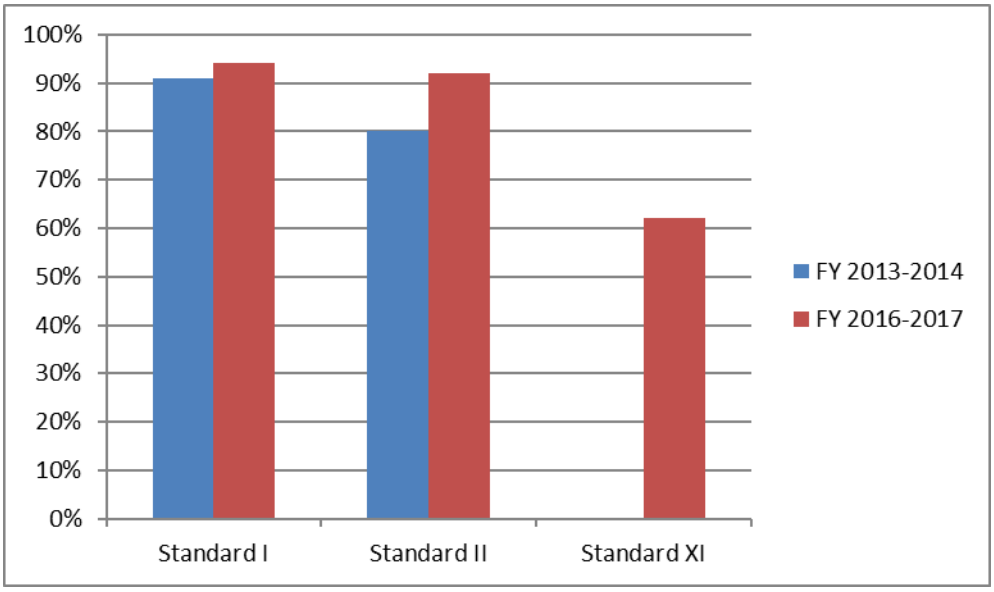
Standard	2012–13	2013–14	2014–15	2015–16	2016–17
I—Coverage and Authorization of Services		X			X
II—Access and Availability		X			X
III—Coordination and Continuity of Care	X			X	
IV—Member Rights and Protections	X			X	
V—Member Information			X		
VI—Grievance System			X		
VII—Provider Participation and Program Integrity			X		
VIII—Credentialing and Recredentialing	X			X	
IX—Subcontracts and Delegation			X		
X—Quality Assessment and Performance Improvement	X			X	

Comparison of Medicaid Results

Comparison of FY 2013–2014 Results to FY 2016–2017 Results

Figure 2-3 shows the scores from the FY 2013–2014 site review (when Standard I and Standard II 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, **DHMC**'s contract with the State may have changed, and may have contributed to performance changes.

Figure 2-3—Comparison of FY 2013–2014 Results to FY 2016–2017 Results

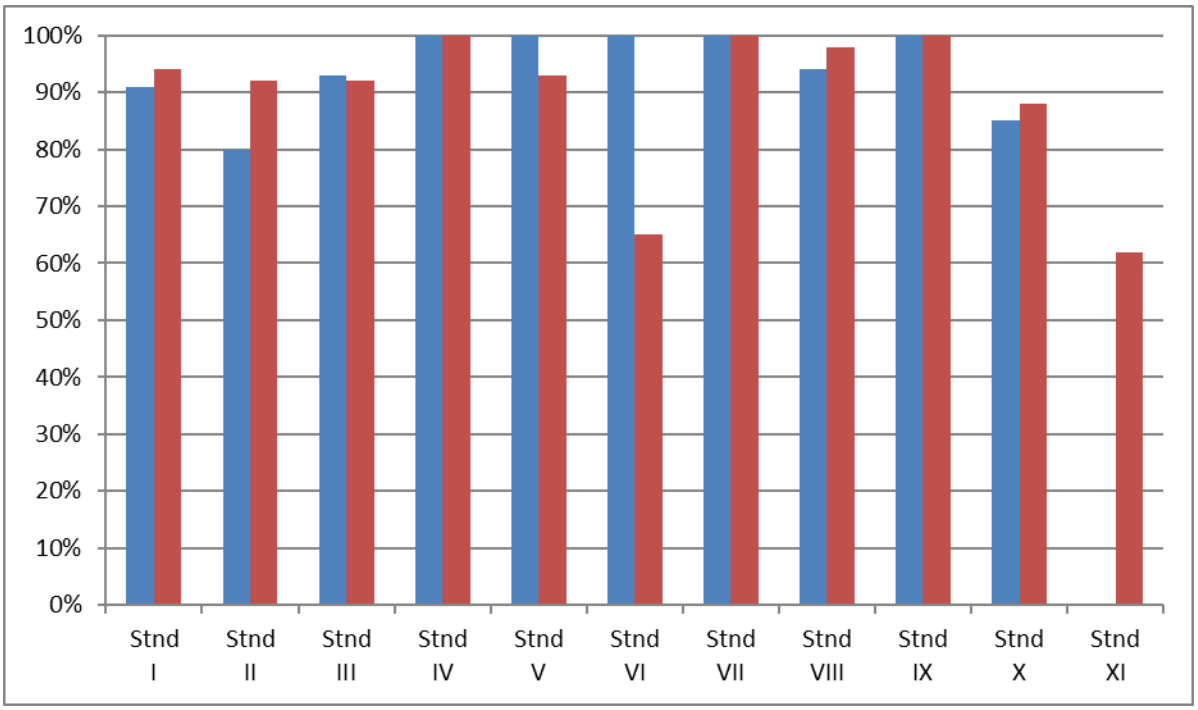


Note: FY 2016–2017 is the first year that HSAG reviewed Standard XI; therefore, results are shown for FY 2016–2017 only.

Review of Compliance Scores for All Standards

Figure 2-4 shows the scores for all standards reviewed over the last two three-year cycles of compliance monitoring. The figure compares the score for each standard across two review periods, as available, and may be an indicator of overall improvement.

Figure 2-4—Compliance Scores for All Standards



Note: Results shown in blue are from FY 2011–2012, FY 2012–2013, and FY 2013–2014. Results shown in red are from FY 2014–2015, FY 2015–2016, and FY 2016–2017.

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

Table 2-2—List of Standards by Review Year

Standard	2011–12	2012–13	2013–14	2014–15	2015–16	2016–17
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	
IX—Subcontracts and Delegation	X			X		
X—Quality Assessment and Performance Improvement		X			X	
XI—EPSDT Services						X

3. Overview and Background

Overview of FY 2016–2017 Compliance Monitoring Activities

For the FY 2016–2017 site review process, the Department requested a review of two areas of performance for the CHP+ health plans and three areas of performance for the Medicaid managed care plans. HSAG developed a review strategy and monitoring tools consisting of three standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services and Standard II—Access and Availability for all managed care plans, plus Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services for the Medicaid managed care plans. FY 2016–2017 was the first year that the newly developed EPSDT standard was reviewed. Compliance with applicable federal managed care regulations and managed care contract requirements was evaluated through review of all three standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the standards, HSAG used the health plan's contract requirements and regulations specified by the BBA, with revisions issued May 6, 2016. 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 health plan service and claims denials.

A sample of the health plan's administrative records related to Medicaid and CHP+ service and claims denials was reviewed to evaluate implementation of Medicaid and CHP+ managed care regulations related to member denials and notices of action. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records for Medicaid and a sample of 10 records with an oversample of five records for CHP+. Using a random sampling technique, HSAG selected the samples from all applicable service and claims denials that occurred between January 1, 2016, and December 31, 2016. For the record review, the health plan received a score of *C* (compliant), *NC* (not compliant), or *NA* (not applicable) for each required element. Results of record reviews were considered in the scoring of applicable requirements in Standard I—Coverage and Authorization of Services. HSAG also separately calculated an overall record review score for both Medicaid and CHP+.

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.[3-1] Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The three standards chosen for the FY 2016–2017 site reviews represent a portion of the Medicaid managed care requirements. The following standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, and Standard X—Quality Assessment and Performance Improvement.

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

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Aug 24, 2016.

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

FY 2015–2016 Corrective Action Methodology

As a follow-up to the FY 2015–2016 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 2015–2016 compliance monitoring site review.

Summary of FY 2015–2016 Required Actions

As a result of the FY 2015–2016 site review, **Denver Health** was required to address two *Partially Met* items that pertained to both the CHP+ and Medicaid lines of business (one related to credentialing and one related to annual review of clinical practice guidelines). **Denver Health** was also required to address two additional *Partially Met* items that pertained to the Medicaid line of business only (one related to EPSDT wraparound services and one related to measuring compliance with the periodicity schedule).

Summary of Corrective Action/Document Review

Denver Health submitted its proposed CAP in May 2016. HSAG and the Department met with **Denver Health** in order to clarify requirements and provide technical assistance. **Denver Health** submitted documents that demonstrated compliance with the proposed plan in August 2016. HSAG and the Department required one additional follow-up submission in January 2017, before determining that **Denver Health** had adequately addressed all required actions.

Summary of Continued Required Actions

Denver Health had no required actions continued from FY 2015–2016.

Appendix A. Compliance Monitoring Tool

The completed compliance monitoring tool follows this cover page.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor must ensure that the services provided are sufficient in amount, duration, or scope to reasonably be expected to achieve the purposes for which the services are furnished. *42 CFR 438.210(a)(3)(i)* Medicaid Contract: Amendment 2, Exhibit A—2.4.1.1 CHP+ Contract: Amendment 6, Exhibit A-5—2.6.3	**Medicaid:** • MCD_CHP_UM01 v.12– Utilization Review Determinations Including Approvals and Actions Pg. 1 Section D • Pediatric Referral Guidelines.pdf • Adult Referral Guidelines.pdf • MCD_CHP_UM27 v. 15- Clinical Criteria for Utilization Management Decisions.pdf • MCD_CHP_RX01 v.08 Drug Authorization, Utilization Review and Formulary Management.pdf **CHP+:** • MCD_CHP_UM01 v.12– Utilization Review Determinations Including Approvals and Actions Pg. 1 Section D • Pediatric Referral Guidelines.pdf • MCD_CHP_UM27 v. 15- Clinical Criteria for Utilization Management Decisions.pdf • MCD_CHP_RX01 v.08 Drug Authorization, Utilization Review and Formulary Management.pdf	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor provides the same standard of care for all members regardless of eligibility category and furnishes services in an amount, duration, and scope no less than services provided to non-CHP+/Medicaid recipients within the same area. *42 CFR 438.210(a)(2)* *(Requirement to be updated 7/2017—see appendix)*	**Medicaid:** • MCD_CHP_UM01 v.12– Utilization Review Determinations Including Approvals and Actions Pg. Section E • MCD_CHP_UM27 v. 15- Clinical Criteria for Utilization Management Decisions.pdf • MCD_CHP_RX01 v.08 Drug Authorization, Utilization Review and Formulary Management.pdf	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Medicaid Contract: Amendment 2, Exhibit A—2.4.1.2 CHP+ Contract: Amendment 6, Exhibit A-5—2.6.3.9	• MCD_PROV_MANUAL_PG7.pdf **CHP+:** • MCD_CHP_UM01 v.12– Utilization Review Determinations Including Approvals and Action Pg. 1 Section E • MCD_CHP_UM27 v. 15- Clinical Criteria for Utilization Management Decisions.pdf • MCD_CHP_RX01 v.08 Drug Authorization, Utilization Review and Formulary Management.pdf • CHP_PROV_MANUAL_PG53.pdf	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
3. Utilization Management shall be conducted under the auspices of a qualified clinician. Medicaid Contract: Amendment 2, Exhibit A—2.6.1.6 CHP+ Contract: Amendment 6, Exhibit A-5—2.8.1.1	**Medicaid:** • 2016 Utilization Management Program Description.pdf **CHP+:** See above doc Utilization Managements.	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42 CFR 438.210(a)(3)(ii)* Medicaid Contract: Amendment 2, Exhibit A—2.4.1.3 CHP+ Contract: Amendment 6, Exhibit A-5—2.6.3.10	**Medicaid:** • MCD_CHP_UM01 v.12– Utilization Review Determinations Including Approvals and Actions Pg. 1 Section B • MCD_CHP_RX01 v.08 Drug Authorization, Utilization Review and Formulary Management.pdf **CHP+:** • MCD_CHP_UM01 v.12– Utilization Review Determinations Including Approvals and Actions Pg. 1 Section B • MCD_CHP_RX01 v.08 Drug Authorization, Utilization Review and Formulary Management.pdf	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. The Contractor may place appropriate limits on a service: • On the basis of criteria applied under the State plan (medical necessity). • For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purposes. *42 CFR 438.210(a)(3)(iii)* *(Requirement to be updated 7/2017—see appendix)* Medicaid Contract: Amendment 2, Exhibit A—2.4.2.3 CHP+ Contract: Amendment 6, Exhibit A-5—2.8.1.1	**Medicaid:** • MCD_CHP_UM27 v. 15- Clinical Criteria for Utilization Management Decisions.pdf • MCD_CHP_UM15 v. 15– Home Health Care Referrals Pg. 4 Section 4 • MCD_CHP_UM13 v. 15– Guidelines for the ordering and authorization of Durable Medical Equipment and Consumable Supplies Pg. 3 Section B • MCD_CHP_UM04 v.11 - Coordination and Continuity of Care for Members with SHCN and Disabilities.pdf • InterQual_Sample Guideline.pdf • CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf • Auth Instructions 2016.pdf	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• MCD_CHP_RX01 v.08 Drug Authorization, Utilization Review and Formulary Management.pdf **CHP+:** See above documents.	
6. **(Medicaid Only)** The Contractor specifies what constitutes "medically necessary services" in a manner that: • Is no more restrictive than that used in the State Medicaid program. – Service will, or is reasonably expected to, prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering or the physical, mental, cognitive, or developmental effects of an illness, injury, or disability. – No other equally effective or substantially less costly course of treatment is suitable for the member's needs. • Addresses the extent to which the Contractor is responsible for covering services related to the following: – The prevention, diagnosis, and treatment of health impairments. – The ability to achieve age-appropriate growth and development.	**Medicaid:** • MCD_CHP_UM15 v. 15– Home Health Care Referrals Pg. 1 Section I • MCD_CHP_UM13 v. 15– Guidelines for the ordering and authorization of Durable Medical Equipment and Consumable Supplies Pg. 3 Section B • MCD_CHP_UM04 v.11 - Coordination and Continuity of Care for Members with SHCN and Disabilities	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– The ability to attain, maintain, or regain functional capacity. *42 CFR 438.210(a)(4)* *(Requirement to be updated 7/2017—see appendix)* Medicaid Contract: Amendment 2, Exhibit A—Exhibit D		

Findings:
DHMC defined "medical necessity" equivalent to the definition included in its contract and outlined in this requirement. However, the definition of "medical necessity" outlined in the State Medicaid Plan—10 CCR 2505-10 8.076.1.8 (effective August 30, 2016)—created a uniform definition of "medical necessity" to be used across all applicable Medical Assistance programs and included the addition of EPSDT-specific criteria. Therefore, DHMC is advised to immediately update the definition of "medical necessity" accordingly. Please reference 10 CCR 2505-10 8.076.1.8 (a–g) and 8.7016.1.8.1 for guidance:

8.076.1.8. Medical necessity means a Medical Assistance program good or service:

a. Will, or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all.
b. Is provided in accordance with generally accepted professional standards for health care in the United States.
c. Is clinically appropriate in terms of type, frequency, extent, site, and duration.
d. Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider.
e. Is delivered in the most appropriate setting(s) required by the client's condition.
f. Is not experimental or investigational.
g. Is not more costly than other equally effective treatment options.

8.076.1.8.1 For EPSDT-specific criteria, see 10 CCR 2505-10, Section 8.280.4.E.
"For the purposes of EPSDT, medical necessity includes a good or service that will, or is reasonably expected to, assist the client to achieve or maintain maximum functional capacity in performing one or more Activities of Daily Living; and meets the criteria set forth in Section 8.076.1.8(b–g)."

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. (**CHP+ Only**) The Contractor specifies what constitutes "medically necessary services" in a manner that: • Is no more restrictive than that used in the State CHP+ program. – Is consistent with the symptoms, diagnosis, and treatment of a member's medical condition. – Is widely accepted by the practitioner's peer group as effective and reasonably safe based upon scientific evidence. – Is not experimental, investigational, unproven, unusual, or uncustomary. – Is not solely for cosmetic purposes. – Is not solely for the convenience of the member, subscriber, physician, or other provider. – Is the most appropriate level of care that can be safely provided to the member. – Failure to provide the covered service would adversely affect the member's health. – When applied to inpatient care, "medically necessary" further means that covered services cannot be safely provided in an ambulatory setting.	New requirement **CHP+:** • MCD_CHP_UM15 v. 15– Home Health Care Referrals.pdf • MCD_CHP_UM13 v. 15– Guidelines for the ordering and authorization of Durable Medical Equipment and Consumable Supplies Pg. 1 Section I • MCD_CHP_UM04 v.11 - Coordination and Continuity of Care for Members with SHCN and Disabilities	**Medicaid:** ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Addresses the extent to which the Contractor is responsible for covering services related to the following: – The prevention, diagnosis, and treatment of health impairments. – The ability to achieve age-appropriate growth and development. – The ability to attain, maintain, or regain functional capacity. *42 CFR 438.210(a)(4)* *(Requirement to be updated 7/2017—see appendix)* CHP+ Contract: Amendment 6, Exhibit A-5—1.1.1.58		

Findings:
DHMP defined "medical necessity" equivalent to the definition outlined in this requirement by applying the definition of "medical necessity" included in the DHMC contract in addition to criteria for experimental and investigational treatments and consideration of potentially impeding care if a service was denied. However, the definition of "medical necessity" outlined in the State Medicaid Plan—10 CCR 2505-10 8.076.1.8 (effective August 30, 2016)—created a uniform definition of "medical necessity" to be used across all applicable Medical Assistance programs. Therefore, DHMP is advised to immediately update the definition of "medical necessity" accordingly. Please reference 10 CCR 2505-10 8.076.1.8 (a-g) for guidance:

8.076.1.8. Medical necessity means a Medical Assistance program good or service:

a. Will, or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all.
b. Is provided in accordance with generally accepted professional standards for health care in the United States.
c. Is clinically appropriate in terms of type, frequency, extent, site, and duration.
d. Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider.
e. Is delivered in the most appropriate setting(s) required by the client's condition.
f. Is not experimental or investigational.
g. Is not more costly than other equally effective treatment options.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor has in place written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42 CFR 438.210(b)* Medicaid Contract: Amendment 2, Exhibit A—2.6.1.1 CHP+ Contract: Amendment 6, Exhibit A-5—2.8.1.2	**Medicaid:** • MCD_CHP_UM10 v.20- Concurrent Utilization Management of Inpatient and Observation Stays.pdf • MCD_CHP_UM01 v.12–Utilization Review Determinations including Approvals and Actions Pg. 8 section D • Auth Instructions 2016.pdf • MCD_CHP_RX01 v.08 Drug Authorization, Utilization Review and Formulary Management Pg. 8 Section b **CHP+:** See above documents.	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor has in place and follows written policies and procedures that include effective mechanisms to ensure consistent application of review for authorizing decisions. *42 CFR 438.210(b)(2)(i)* Medicaid Contract: Amendment 2, Exhibit A—2.6.1.2 CHP+ Contract: Amendment 6, Exhibit A-5—2.8.1.3	**Medicaid:** • MCD_CHP_UM27 v. 15– Clinical Criteria for Utilization Management Decisions.pdf • MCD_CHP_UM05 v. – Inter-Rater Reliability of Utilization Management.pdf **CHP+:** See above documents.	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor has in place and follows written policies and procedures that include a mechanism to consult with the requesting provider when appropriate. *42 CFR 438.210(b)(2)(ii)* Medicaid Contract: Amendment 2, Exhibit A—2.6.1.2 CHP+ Contract: Amendment 6, Exhibit A-5—2.8.1.3	**Medicaid:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 2 Section A • MCD_CHP_RX01 v.08 Drug Authorization, Utilization Review and Formulary Management Pg. 14 Section O-a-i • MCD_PROV_MANUAL_PG67.pdf **CHP+:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 2 Section A • MCD_CHP_RX01 v.08 Drug Authorization, Utilization Review and Formulary Management Pg. 14 Section O-a-i • CHP_PROV_MANUAL_PG30-31.pdf	**Medicaid:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: DHMC/DHMP had written policies which addressed consultation with the requesting provider when necessary to make a UM determination. Procedures and staff members stated that the medical director consults with the provider *prior to* the authorization decision, as necessary. However, HSAG observed during on-site denial record reviews for DHMC, two of 10 cases in which the requesting provider was not consulted to obtain or clarify information needed for authorization. In one of those cases, UM attempted to obtain additional information from the DME company (service provider) rather than from the original requesting provider. (DHMP denial records were claim denials in which there was no involvement of UM authorization processes; therefore, HSAG was unable to observe application of this requirement related to DHMP.)		
Required Actions: DHMC must ensure that the actual requesting provider is consulted when necessary to obtain information needed for making the authorization decision.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor's UM program ensures that any decision to deny a service authorization request or to authorize a service in the amount, duration, or scope that is less than requested be made by a healthcare professional who has appropriate clinical expertise in treating the member's condition or disease. *42 CFR 438.210(b)(3)* *(Requirement to be updated 7/2017—see appendix)* Medicaid Contract: Amendment 2, Exhibit A—2.6.1.5 CHP+ Contract: Amendment 6, Exhibit A-5—2.8.1.3.1	**Medicaid:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 10 section E1ii • MCD_CHP_RX01 v.08 Drug Authorization, Utilization Review and Formulary Management Pg 8 Section ix • MCD_CHP_UM27 v. 15– Clinical Criteria for Utilization Management Decisions.pdf **CHP+:** See above documents.	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor has in place processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested (notice to the provider need not be in writing). *42 CFR 438.210(c)* 10 CCR 2505–10, Sec 8.209.4.A.1 Medicaid Contract: Amendment 2, Exhibit A—2.6.1.2 CHP+ Contract: Amendment 6, Exhibit A-5—2.8.1.3.3	**Medicaid:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 14 Section F2i • MCD_CHP_RX01 v.08 Drug Authorization, Utilization Review and Formulary Management Pg. 10 Section e **CHP+:** See above documents.	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: On-site CHP+ denial record reviews consisted of 10 retrospective claim denials for out-of-network services. DHMP provided no notice of action to the member in 10 of 10 records reviewed. (None of these denials were processed through the Utilization Management Department.) DHMC/DHMP requires UM authorization for non-emergent out-of-network services. As such, any claim denial for lack of authorization requires a written NOA to the member.		
Required Actions: DHMP must implement mechanisms to ensure that claims denials for out-of-network services generate a written notice of action to the member. Furthermore, DHMP should consider implementing processes which strengthen the relationship between the claims adjudication and utilization management departments to ensure that out-of-network services are reviewed for potential authorization determinations. (See "Opportunities for Improvement" in Executive Summary.)		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor provides notice of standard authorization decisions as expeditiously as the member's health condition requires and not to exceed 10 calendar days from receipt of the request for service. *42 CFR 438.210(d)(1)* 10 CCR 2505—10, Sec 8.209.4.A.3(c) Medicaid Contract: Amendment 2, Exhibit J—8.209.4.A(3)(c) CHP+ Contract: Amendment 6, Exhibit A-5—2.8.1.3.3.1	**Medicaid:** • MCD_PROV_MANUAL_PG85.pdf • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 16 Section 5iii • MCD_CHP_RX01 v.08 Drug Authorization, Utilization Review and Formulary Management Pg. 10 Section e **CHP+:** • CHP_PROV_MANUAL_PG19-20.pdf • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 16 Section 5iii • MCD_CHP_RX01 v.08 Drug Authorization, Utilization Review and Formulary Management Pg. 10 Section e	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
14. For cases in which a provider indicates, or the Contractor determines, that the standard authorization timeframe could seriously jeopardize a member's life or health or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization decision and provides notice as expeditiously as the member's health condition requires and not to exceed 3 working days from receipt of the request for service *42 CFR 438.210(d)(2)* *(Requirement to be updated 7/2017—see appendix)* 10 CCR 2505—10, Sec 8.209.4.A.3(c) Medicaid Contract: Amendment 2, Exhibit J—8.209.4.A.6	**Medicaid:** • MCD_PROV_MANUAL_PG85.pdf • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 16 Section 5iii • MCD_CHP_RX01 v.08 Drug Authorization, Utilization Review and Formulary Management Pg. 10 Section e **CHP+:** • CHP_PROV_MANUAL_PG19-20.pdf • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 16 Section 5iii	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
CHP+ Contract: Amendment 6, Exhibit A-5—2.8.1.3.3.2 and 2.8.1.3.3.2.1	• MCD_CHP_RX01 v.08 Drug Authorization, Utilization Review and Formulary Management Pg. 10 Section e	
15. Notices of action must meet the language and format requirements of 42 CFR 438.10 to ensure ease of understanding (6th-grade reading level wherever possible and available in the prevalent non-English language for the service area). *42 CFR 438.404(a); 438.10 (b) and (c)(2)* *(Requirement to be updated 7/2017—see appendix)* 10 CCR 2505—10, Sec 8.209.4.A.1 Medicaid Contract: Amendment 2, Exhibit J—8.209.A.1 CHP+ Contract: Amendment 6, Exhibit Ar-5—2.4.3.1.6	**Medicaid:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg 14 Section 2ii • MCD_CHP_GVT06 v.09Creation, Review and Readability of Member Materials.pdf • MCD_CHP_RX01 v.08 Drug Authorization, Utilization Review and Formulary Management.pdf • MCD Member Handbook, pg.25 **CHP+:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 14 Section 2 ii • MCD_CHP_RX01 v.08 Drug Authorization, Utilization Review and Formulary Management.pdf • CHP Member Handbook, pg. 34 *All member letters, including notices of action, are available in prevalent non-English languages	**Medicaid:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Utilization Review Determinations policy stated that NOAs were available in English and Spanish and included template letters for approval of service, denial of service, and extension of decision that appeared to be written in language easy to understand. The Drug Authorization, Utilization Review, and Formulary Management policy did not address ease-of-understanding requirements. During on-site interviews, staff members stated that, prior to mailing, the UM director reviews each NOA for required content but does not review for ease of understanding of the "reason for denial"		

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
description. During DHMC denial record reviews, HSAG identified six of 10 records in which the NOA contained language (entered in the reason for denial section) that was not easy for the member to understand. The template NOA letters for CHP+ members appeared to be written in language easy for the member to understand but could not be evaluated in the denial record reviews because no NOAs were sent to the members included in the sample. UM processes are the same for DHMC and DHMP; therefore, HSAG recommends that DHMP also review its NOA letters to CHP+ members to ensure that the "reason for denial" language in the letter is easy for the member to understand.		
Required Actions: DHMC must develop mechanisms to ensure that the reason for denial entered into member NOA letters is written in language that is easy for the member to understand.		
16. Notices of action must contain: • The action the Contractor (or its delegate) has taken or intends to take. • The reasons for the action. • The member's or provider's (on behalf of the member) right to file an appeal and procedures for filing. • The date the appeal is due. • The member's right to request a State fair hearing. • The procedures for exercising the right to a State fair hearing. • The circumstances under which expedited resolution is available and how to request it. • The member's right to have benefits continue pending resolution of the appeal and how to request that the benefits be continued.	**Medicaid:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 14 Section 3 • MCD_CHP_RX01 v.08 Drug Authorization, Utilization Review and Formulary Management Pg. 10 Section 2 • MCD Member Handbook, pg. 25 **CHP+:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 14 Section 3 • MCD_CHP_RX01 v.08 Drug Authorization, Utilization Review and Formulary Management Pg 10 Section 2 • CHP Member Handbook, pg. 34 *All member letters, including notices of action, are available in prevalent non-English languages	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The circumstances under which the member may have to pay for the costs of services (if continued benefits are requested). *42 CFR 438.404(b)* *(Requirement to be updated 7/2017—see appendix)* 10 CCR 2505—10, Sec 8.209.4.A.2 Medicaid Contract: Amendment 2, Exhibit J—8.209.4.A2 CHP+ Contract: Amendment 6, Exhibit A-5—2.8.1.3.3		
17. The notices of action must be mailed within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, the notice of action must be mailed at least 10 days before the date of the intended action except: – In as few as 5 days prior to the date of action if the Contractor has verified information indicating probable beneficiary fraud; – No later than the date of action when: o The member has died. o The member submits a signed written statement requesting service termination. o The member submits a signed written statement including information that requires termination or reduction and indicates that the member understands that service termination or reduction will occur.	**Medicaid:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 15 Section 4 • MCD_CHP_RX01 v.08 Drug Authorization, Utilization Review and Formulary Management Pg. 10 Section 2 • MCD Member Handbook, pg.25 **CHP+:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 15 Section 4 • MCD_CHP_RX01 v.08 Drug Authorization, Utilization Review and Formulary Management Pg. 10 Section 2 • CHP Member Handbook, pg.34	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☐ Met ☐ Partially Met ☒ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
○ The member has been admitted to an institution in which the member is ineligible for Medicaid services. ○ The member's address is determined unknown based on returned mail with no forwarding address. ○ The member is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth. ○ A change in the level of medical care is prescribed by the member's physician. ○ The notice involves an adverse determination with regard to preadmission screening requirements. • For denial of payment, at the time of any action affecting the claim. • For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires but within 10 calendar days following receipt of the request for services. • For expedited service authorization decisions, as expeditiously as the member's health condition requires but within 3 working days after receipt of the request for services.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• For service authorization decisions not reached within the required time frames on the date time frames expire. • If the Contractor extends the timeframe, as expeditiously as the member's health condition requires, and no later than the date the extension expires. *42 CFR 438.210 (d)* *42 CFR 438.404(c)* *42 CFR 431.211*, *431.213*, and *431.214* 10 CCR 2505—10, Sec 8.209.4.A.3(a–c) Medicaid Contract: Amendment 2, Exhibit J1—8.209.4.A.3(a) and (b) CHP+ Contract: Amendment 6, Exhibit A-5—2.8.1.3.3		
Findings: The Utilization Review Determinations policy accurately addressed all denial time frames per requirement. The Drug Authorization, Utilization Review, and Formulary Management policy addressed all primary time frames including standard, expedited, extended, and advance notice. However, the CHP+ denial record reviews—all of which were denial of claims—failed to notify the member of denial of payment at the time of action affecting the claim. DHMC provided no explanation of benefits (EOB) or other notice of action to the member in 10 of 10 cases.		
Required Actions: DHMP must ensure that it mails notices of action (e.g., EOB) for denial of payment at the time of any action affecting the claim.		

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. The Contractor may extend the standard or expedited authorization decision time frame up to 14 calendar days if the member requests an extension or if the Contractor justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest. *42 CFR 438.210(d)(1)(2)* Medicaid Contract: Amendment 2, Exhibit J1—8.209.4.A.6(a) CHP+ Contract: Amendment 6, Exhibit A-5—2.8.1.3.3.2	**Medicaid:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg 8 Section C • MCD_CHP_RX01 v.08 Drug Authorization, Utilization Review and Formulary Management Pg. 9 Section ii • MCD Member Handbook, pg.26 • MCD_PROV_MANUAL_PG85.pdf **CHP+:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 8 Section C • MCD_CHP_RX01 v.08 Drug Authorization, Utilization Review and Formulary Management Pg. 9 section ii • CHP Member Handbook, pg.35 • CHP_PROV_MANUAL_PG19-20.pdf	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
19. If the Contractor extends the time frame for making a service authorization decision, it: • Provides the member written notice of the reason for the decision to extend the time frame. • Informs the member of the right to file a grievance if the member disagrees with the decision to extend the time frame. *42 CFR 438.404(c)(4)(i)* 10 CCR 2505—10, Section 8.209.4.A.3(c)(i) Medicaid Contract: Amendment 2, Exhibit J1—8.209.4.A.4 CHP+ Contract: Amendment 6, Exhibit A-5—2.8.1.3.3	**Medicaid:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 8 Section C • MCD_CHP_RX01 v.08 Drug Authorization, Utilization Review and Formulary Management Pg. 9 Section ii 1 **CHP+:** See above documents.	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
20. The Contractor provides that compensation to individuals or entities that conduct utilization management (UM) activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42 CFR 438.210(e)* Medicaid Contract: Amendment 2, Exhibit A—2.6.1.1 CHP+ Contract: Amendment 6, Exhibit A-5—2.8.1.1	**Medicaid:** • MCD_CHP_UM05 v. Inter-Rater Reliability.pdf • MCD_CHP_RX01 v.08 Drug Authorization, Utilization Review and Formulary Management Pg. 5 Section C • MCD Member Handbook, pg.6 under Physician Incentive Plans **CHP+:** • MCD_CHP_UM05 v. Inter-Rater Reliability.pdf • MCD_CHP_RX01 v.08 Drug Authorization, Utilization Review and Formulary Management Pg. 5 Section C • CHP Member Handbook, pg.6 under Physician Incentive Plans	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
21. The Contractor defines "emergency medical condition" as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. • Serious impairment to bodily functions. • Serious dysfunction of any bodily organ or part. *42 CFR 438.114(a)* *(Requirement updated 7/2016—as shown)*	**Medicaid:** • MCD_PROV_MANUAL_PG48.pdf • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 4 Section K • MCD_CHP_RX01 v.08 Drug Authorization, Utilization Review and Formulary Management Pg. 3 Section H • MCD Member Handbook, pg.11 **CHP+:** • CHP_PROV_MANUAL_PG13-15.pdf • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 4 Section K	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Medicaid Contract: Amendment 2, Exhibit A—1.1.1.14 CHP+ Contract: Amendment 6, Exhibit A-5—1.1.1.28	• MCD_CHP_RX01 v.08 Drug Authorization, Utilization Review and Formulary Management Pg. 3 Section H • CHP Member Handbook, pg.11	
22. The Contractor defines "emergency services" as covered inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title and needed to evaluate or stabilize an emergency medical condition. *42 CFR 438.114(a)* *(Requirement updated 7/2016—as shown)* Medicaid Contract: Amendment 2, Exhibit A—1.1.1.15 CHP+ Contract: Amendment 6, Exhibit A-5—1.1.1.29	**Medicaid:** • MCD_PROV_MANUAL_PG48.pdf • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 4 Section K • MCD_CHP_RX01 v.08 Drug Authorization, Utilization Review and Formulary Management Pg. 3 Section I • MCD Member Handbook, pg.10-11 **CHP+:** • CHP_PROV_MANUAL_PG13-15.pdf • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 4 Section K • MCD_CHP_RX01 v.08 Drug Authorization, Utilization Review and Formulary Management Pg. 3 Section I • CHP Member Handbook, pg.11	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
23. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. *42 CFR 438.114(c)(1)(i)* *(Requirement updated 7/2016—as shown)* Medicaid Contract: Amendment 2, Exhibit A—2.4.4.1.4 CHP+ Contract: Amendment 6, Exhibit A-5—2.6.6.1.4	**Medicaid:** • CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 4 Section K • MCD_PROV_MANUAL_PG48.pdf • Auth Instructions 2016.pdf • MCD Member Handbook, pg. 10-11 **CHP+:** • CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 4 Section K • CHP_PROV_MANUAL_PG13-15.pdf • Auth Instructions 2016.pdf • CHP Member Handbook, pg.11	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
24. Members temporarily out of the service area may receive out-of-area emergency services and urgently needed services. Medicaid Contract: Amendment 2, Exhibit A—2.4.4.1.2 CHP+ Contract: Amendment 6, Exhibit A-5—2.6.6.1.2	**Medicaid:** • MCD_PROV_MANUAL_PG48.pdf • CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf • Auth Instructions 2016.pdf • MCD Member Handbook, pg. 10-11 • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 4 Section K **CHP+:** • CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 4 Section K • CHP_PROV_MANUAL_PG13-15.pdf • Auth Instructions 2016.pdf • CHP Member Handbook, pg.11	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
25. The Contractor does not require prior authorization for emergency services or urgently needed services. • The Contractor informs members that prior authorization is not required for emergency services. *42 CFR 438.10(f)(6)(viii)(B)* Medicaid Contract: Amendment 2, Exhibit A—2.4.4.1.3 CHP+ Contract: Amendment 6, Exhibit A-5—2.6.6.1.3	**Medicaid:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 12 Section 4ii • MCD Member Handbook, pg.10-11 • MCD_PROV_MANUAL_PG48.pdf • MCD_PROV_MANUAL_PG49_PG50.pdf • CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf **CHP+:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 12 Section 4ii • CHP Member Handbook, pg.11 • CHP_PROV_MANUAL_PG13-15.pdf • CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
26. The Contractor may not deny payment for treatment obtained under the following circumstances: • A member had an emergency medical condition, and the absence of immediate medical attention ***would*** have had the following outcomes: – Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. – Serious impairment to bodily functions. – Serious dysfunction of any bodily organ or part. • Situations which a prudent layperson who possesses an average knowledge of health and medicine would perceive as an emergency medical condition but the absence of immediate medical attention would ***not*** have had the following outcomes: – Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. – Serious impairment to bodily functions. – Serious dysfunction of any bodily organ or part. • A representative of the Contractor's organization instructed the member to seek emergency services. *42 CFR 438.114(c)(ii)*	**Medicaid:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 4 iii • CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf • Auth Instructions 2016.pdf • MCD_PROV_MANUAL_PG48.pdf • MCD_PROV_MANUAL_PG49_PG50.pdf **CHP+:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 4 iii • CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf • Auth Instructions 2016.pdf • CHP_PROV_MANUAL_PG13-15.pdf	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
(Requirement updated 7/2016—as shown) Medicaid Contract: Amendment 2, Exhibit A—2.4.4.1.4, 2.4.4.1.6, and 2.4.4.3.1 CHP+ Contract: Amendment 6, Exhibit A-5—2.6.6.4.1.3 and 2.6.6.1.4		
27. The Contractor does not: • Limit what constitutes an emergency medical condition on the basis of a list of diagnoses or symptoms. • Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the Contractor, or State agency of the member's screening and treatment within 10 days of presentation for emergency services. *42 CFR 438.114(d)(1)(i) and (ii)* *(Requirement updated 7/2016—as shown)* Medicaid Contract: Amendment 2, Exhibit A—2.4.4.1.7 and 2.4.4.3.1 CHP+ Contract: Amendment 6, Exhibit A-5—2.6.6.3.1, 2.6.6.6.2.1, and 2.6.6.1.6	**Medicaid:** • CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf • MCD_CHP_UM10 v.20 - Concurrent Utilization Management of Inpatient and Observation Stays.pdf • MCD Member Handbook, pg.10-11 • MCD_PROV_MANUAL_PG48.pdf • BHO List and Instructions.pdf **CHP+:** • CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf • MCD_CHPUM 10 v.17 - Concurrent Utilization Management of Inpatient and Observation Stays.pdf • CHP Member Handbook pg.11 • CHP_PROV_MANUAL_PG13-15.pdf • BHO List and Instructions.pdf	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
28. The Contractor will be responsible for emergency services when: • The primary diagnosis is medical in nature, even when the medical diagnosis includes some psychiatric conditions and procedures. (**Medicaid and CHP+**) • The primary diagnosis is psychiatric in nature, even when the psychiatric diagnosis includes some procedures to treat a secondary medical diagnosis. (**CHP+ only**) Medicaid Contract: Amendment 2, Exhibit A—2.4.4.7.2.1 CHP+ Contract: Amendment 6, Exhibit A-5—2.6.6.6.2.1.1–2	**Medicaid:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 7 Section B 1 • BHO List and Instructions.pdf • MCD Member Handbook, pg.10-11 • MCD_PROV_MANUAL_PG48.pdf **CHP+:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions. Pg. 7 Section B 2 • CHP Member Handbook, pg.11 • CHP_PROV_MANUAL_PG13-15.pdf	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
29. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42 CFR 438.114(d)(2)* *(Requirement updated 7/2016—as shown)* Medicaid Contract: Amendment 2, Exhibit A—2.4.4.4.1.1 CHP+ Contract: Amendment 6, Exhibit A-5—2.6.6.1.7	**Medicaid:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 4 iii • MCD Member Handbook, pg.10-11 • MCD_PROV_MANUAL_PG48.pdf **CHP+:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 4 iii • CHP Member Handbook, pg.11 • CHP_PROV_MANUAL_PG13-15.pdf	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
30. The Contractor allows the attending emergency physician or the provider actually treating the member to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor, who is responsible for coverage and payment. *42 CFR 438.114(d)(3)* *(Requirement updated 7/2016—as shown)* Medicaid Contract: Amendment 2, Exhibit A—2.4.4.1.5 CHP+ Contract: Amendment 6, Exhibit A-5—2.6.6.1.5	**Medicaid:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 13 Section iv • MCD_CHP_UM10 v.20 - Concurrent Utilization Management of Inpatient and Observation Stays.pdf • MCD Member Handbook, pg.11 • MCD_PROV_MANUAL_PG49_PG50.pdf **CHP+:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 13 Section iv • MCD_CHP_UM10 v.20 - Concurrent Utilization Management of Inpatient and Observation Stays.pdf • CHP Member Handbook, pg.11 • CHP_PROV_MANUAL_PG13-15.pdf •	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
31. The Contractor defines "poststabilization care services" as covered services, related to an emergency medical condition, that are provided after a member is stabilized to maintain the stabilized condition or provided to improve or resolve the member's condition. *42 CFR 438.114(a)* *(Requirement updated 7/2016—as shown* Medicaid Contract: Amendment 2, Exhibit A—2.4.4.4.2.3 CHP+ Contract: Amendment 6, Exhibit A-5—1.1.1.69	**Medicaid:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 6 Section R • MCD_CHP_UM10 v.20 - Concurrent Utilization Management of Inpatient and Observation Stays.pdf • MCD Member Handbook, pg.11 • MCD_PROV_MANUAL_PG49_PG50.pdf	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	CHP+: • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 6 Section R • MCD_CHP_UM10 v.20 - Concurrent Utilization Management of Inpatient and Observation Stays.pdf • CHP Member Handbook, pg.11 • CHP_PROV_MANUAL_PG13-15.pdf	
32. The Contractor is financially responsible for post stabilization care services obtained within or outside the network that ***have been*** pre-approved by a plan provider or other organization representative. *42 CFR 438.114(e)* *42 CFR 422.113(c)(i)* *(Requirement updated 7/2016—as shown)* Medicaid Contract: Amendment 2, Exhibit A—3.4.4.4.2.1 CHP+ Contract: Amendment 6, Exhibit A-5—2.6.6.4.1.4	**Medicaid:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 13 Section v • MCD_CHP_UM10 v.20 - Concurrent Utilization Management of Inpatient and Observation Stays.pdf • CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf • Auth Instructions 2016.pdf • MCD Member Handbook, pg.11 • MCD_PROV_MANUAL_PG49_PG50.pdf **CHP+:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 13 Section v • MCD_CHP_UM10 v.20 - Concurrent Utilization Management of Inpatient and Observation Stays.pdf • CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Auth Instructions 2016.pdf • CHP Member Handbook, pg.11 • CHP_PROV_MANUAL_PG13-15.pdf	
33. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that ***have not been*** pre-approved by a plan provider or other organization representative but are administered to maintain the member's stabilized condition under the following circumstances: • Within 1 hour of a request to the organization for pre-approval of further poststabilization care services. • The Contractor does not respond to a request for pre-approval within 1 hour. • The Contractor cannot be contacted. • The Contractor's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a plan physician; and the treating physician may continue with care of the patient until a plan physician is reached or the Contractor's financial responsibility for poststabilization care services it *has not* pre-approved ends. *42 CFR 438.114(e)* *42 CFR 422.113(c)(ii) and (iii)*	**Medicaid:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 13 Section vi • MCD_CHP_UM10 v.20 - Concurrent Utilization Management of Inpatient and Observation Stays.pdf • CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf • Auth Instructions 2016.pdf • MCD Member Handbook, pg.11 • MCD_PROV_MANUAL_PG49_PG50.pdf **CHP+:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 13 Section vi • MCD_CHP_UM10 v.20 - Concurrent Utilization Management of Inpatient and Observation Stays.pdf • CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf • Auth Instructions 2016.pdf • CHP Member Handbook, pg.11 • CHP_PROV_MANUAL_PG13-15.pdf	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
(Requirement updated 7/2016—as shown) Medicaid Contract: Amendment 2, Exhibit A—2.4.4.4.2.2 and 2.4.4.4.2.3 CHP+ Contract: Amendment 6, Exhibit A-5—2.6.6.4.1.5 and 2.6.6.4.1.6.1–3		
34. The Contractor's financial responsibility for poststabilization care services it ***has not*** pre-approved ends when: • A plan physician with privileges at the treating hospital assumes responsibility for the member's care. • A plan physician assumes responsibility for the member's care through transfer. • A plan representative and the treating physician reach an agreement concerning the member's care. • The member is discharged. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)* *(Requirement updated 7/2016—as shown)* Medicaid Contract: Amendment 2, Exhibit A—2.4.4.4.4 CHP+ Contract: Amendment 6, Exhibit A-5—2.6.6.4.1.8.1–4	**Medicaid:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 13 Section vii • MCD_CHP_UM10 v.20 - Concurrent Utilization Management of Inpatient and Observation Stays.pdf • CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf • Auth Instructions 2016.pdf • MCD Member Handbook, pg.11 • MCD_PROV_MANUAL_PG49_PG50.pdf **CHP+:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 13 Section vii • MCD_CHP_UM10 v.20 - Concurrent Utilization Management of Inpatient and Observation Stays.pdf • CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf • Auth Instructions 2016.pdf • CHP Member Handbook, pg.11 • CHP_PROV_MANUAL_PG13-15.pdf	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
35. The Contractor must limit charges to members for poststabilization care services to an amount no greater than what the Contractor would charge the member if he or she had obtained the services through the Contractor. *42 CFR 438.114(e)* *42 CFR 422.113(c)* *(Requirement updated 7/2016—as shown)* Medicaid Contract: Amendment 2, Exhibit A—2.4.4.4.3 CHP+ Contract: Amendment 6, Exhibit A-5—2.6.6.4.1.7	**Medicaid:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions.pdf • MCD_CHP_UM10 v.20 - Concurrent Utilization Management of Inpatient and Observation Stays.pdf • CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf • Auth Instructions 2016.pdf • MCD Member Handbook, pg.11 **CHP+:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions.pdf • MCD_CHP_UM10 v.20 - Concurrent Utilization Management of Inpatient and Observation Stays.pdf • CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf • Auth Instructions 2016.pdf • CHP Member Handbook, pg.11-12	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Medicaid Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	32	X	1.00	=	32
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	34	**Total Score**		=	32

Total Score ÷ Total Applicable	=	94%

CHP+ Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	32	X	1.00	=	32
	Partially Met	=	0	X	.00	=	0
	Not Met	=	2	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	34	**Total Score**		=	32

Total Score ÷ Total Applicable	=	94%

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
The Contractor ensures that all covered services are available and accessible to members through compliance with the following requirements:		
1. The Contractor maintains and monitors a network of appropriate providers sufficient to provide adequate access to all services covered under the contract. In order for the Contractor's network to be considered to provide adequate access, the Contractor includes the following provider types and ensures a minimum provider-to-member caseload ratio as follows: • 1:2,000 primary care physician (PCP)/provider-to-member ratio. PCP includes physicians designated to practice family medicine and general medicine. • 1:2,000 physician specialist-to-members ratio. Physician specialist includes physicians designated to practice cardiology, otolaryngology, endocrinology, gastroenterology, neurology, orthopedics, pulmonary medicine, general surgery, ophthalmology, and urology. • Appropriate access to certified nurse practitioners and certified nurse midwives. • Physician specialists designated to practice internal medicine, gerontology, obstetrics and gynecology (OB/GYN), and pediatrics shall be counted as either PCP or physician specialist, but not both. *42 CFR 438.206(b)(1)* *(Requirement to be updated 7/2018—see appendix)* Medicaid Contract: Amendment 2, Exhibit A—2.5.1.1.3, 2.5.1.1.4, and 2.5.1.1.8	**Medicaid:** • MCD_CHP_QI10 v.06– Access to Care_Services.pdf – a policy that defines how the Contractor monitors and maintains compliance with network adequacy • Strategic Access Report FY_15_16 MCD and CHP+.pdf **CHP+:** See above documents.	**Medicaid:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
CHP+ Contract: Amendment 6, Exhibit A-5—2.5.10, 2.7.1.1.5, and 2.7.1.1.9		
Findings: Denver Health appeared to calculate its provider-to-member ratios using the total number of contracted providers compared to the number of members enrolled in the Medicaid or the CHP+ program, without considering that these providers are also responsible for providing care to members affiliated with other lines of business. So, while Denver Health noted a primary care provider-to-member ratio of 3: 2,000 for Medicaid and 36: 2,000 for CHP+, other components used to measure adequacy (e.g., grievances, satisfaction surveys, and daily unmet demand reports) indicate that the Denver Health provider network was not adequate to ensure timely availability of covered services.		
Required Actions: Denver Health must continue to expand its network until it maintains a sufficient number of providers to ensure adequate access to all services covered under the contract.		
2. In establishing and maintaining the network, the Contractor considers: • The anticipated Medicaid/CHP+ enrollment. • The expected utilization of services, taking into consideration the characteristics and healthcare needs of specific Medicaid/CHP+ populations represented in the Contractor's service area. • The numbers, types, and specialties of providers required to furnish the contracted Medicaid/CHP+ services. • The number of network providers accepting/not accepting new members. • The geographic location of providers in relationship to where Medicaid/CHP+ members live, considering distance, travel time, and means of transportation used by members.	**Medicaid:** • Strategic Access Report FY_15_16 MCD and CHP+. pdf • Pediatric Referrals Guidelines.pdf • Adult Referral Guidelines.pdf **CHP+:** See above documents. Description of Process: The Network Adequacy Strategic Report is a report that is created by the Contractor and given to HCPF on a quarterly basis.	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Members have access to a provider within 30 miles or 30 minutes' travel time, whichever is larger, to the extent such services are available. • Physical access to locations for members with disabilities. *42 CFR 438.206(b)(1)(i) through (v)* *(Requirement to be updated 7/2018—see appendix)* Medicaid Contract: Amendment 2, Exhibit A—2.5.1.1.5 and 2.5.1.3.1 CHP+ Contract: Amendment 6, Exhibit A-5—2.7.1.3.1 and 2.7.1.1.3.1		
3. The Contractor provides female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive healthcare services. This is in addition to the member's designated source of primary care if that source is not a women's healthcare specialist. *42 CFR 438.206(b)(2)* Medicaid Contract: Amendment 2, Exhibit A—2.5.1.1.6 CHP+ Contract: Amendment 6, Exhibit A-5—2.7.1.1.7	**Medicaid:** • MCD_CHP_QI10 v.06– Access to Care_Services.pdf • MCD Member Handbook, pg.14 • MCD_PROV_MANUAL_PG69.pdf **CHP+:** • MCD_CHP_QI10 v.06– Access to Care_Services.pdf • CHP Member Handbook, pg.14	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor allows persons with special healthcare needs who use specialists frequently to maintain these types of specialists as PCPs or be allowed direct access/standing referrals to specialists. *42 CFR 438.208(c)(4)* Medicaid Contract: Amendment 2, Exhibit A—2.5.5.5 CHP+ Contract: Amendment 6, Exhibit A-5—2.7.5.4	**Medicaid:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions.pdf • MCD_CHP_UM04 v.11 - Coordination and Continuity of Care for Members with SHCN and Disabilities.pdf • MCD Member Handbook, pg.17 • MCD_PROV_MANUAL_PG86.pdf **CHP+:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions.pdf • MCD_CHP_UM04 v.11 - Coordination and Continuity of Care for Members with SHCN and Disabilities.pdf • CHP Member Handbook, pg.16 • CHP_PROV_MANUAL_PG 31.pdf	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. The Contractor provides for a second opinion from a qualified healthcare professional within the network or arranges for the member to obtain one outside the network if there is no other qualified health care professional within the network, at no cost to the member. *42 CFR 438.206(b)(3)* Medicaid Contract: Amendment 2, Exhibit A—2.5.1.1.7 CHP+ Contract: Amendment 6, Exhibit A-5—2.7.1.1.8	**Medicaid:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 8 Section D 1i • MCD Member Handbook, pg.10 • MCD_PROV_MANUAL_PG67.pdf **CHP+:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions Pg. 8 Section D 1i • CHP Member Handbook, pg.10 • CHP_PROV_MANUAL_PG30-31.pdf	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. If the Contractor is unable to provide covered services to a particular member within its network, the Contractor adequately and timely provides the covered services out of network for as long as the Contractor is unable to provide them. *42 CFR 438.206(b)(4)* Medicaid Contract: Amendment 2, Exhibit A—2.5.1.2.1 CHP+ Contract: Amendment 6, Exhibit A-5—2.7.1.2	**Medicaid:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions.pdf • MCD_CHP_UM04 v.11 - Coordination and Continuity of Care for Members with SHCN and Disabilities.pdf • MCD Member Handbook, pg.10 • MCD_PROV_MANUAL_PG86.pdf **CHP+:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions.pdf • MCD_CHP_UM04 v.11 - Coordination and Continuity of Care for Members with SHCN and Disabilities.pdf • CHP Member Handbook, pg.10	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
7. The Contractor coordinates with out-of-network providers with respect to payment and ensures that the cost to the member is no greater than it would be if the services were furnished within the network. *42 CFR 438.206(b)(5)* Medicaid Contract: Amendment 2, Exhibit A—2.5.1.2. CHP+ Contract: Amendment 6, Exhibit A-5—2.7.1.2.2.1	**Medicaid:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions.pdf • MCD_PROV_MANUAL_PG86.pdf **CHP+:** • MCD_CHP_UM01 v.12 – Utilization Review Determinations Including Approvals and Actions.pdf	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor ensures that covered services are available 24 hours a day, 7 days a week when medically necessary. *42 CFR 438.206(c)(1)(iii)* Medicaid Contract: Amendment 2, Exhibit A—2.4.4.1.1 CHP Contract: Amendment 6, Exhibit A-5—2.6.3.1, 2.6.3.4 and 2.7.1.4.1.1	**Medicaid:** • MCD_CHP_QI10 v.06– Access to Care_Services.pdf • MCD_PROV_MANUAL_PG47.pdf • MCD Member Handbook, pg.12 • Choice Matters Member Newsletter_Winter_2016 **CHP+:** • MCD_CHP_QI10 v.06– Access to Care_Services.pdf • CHP_PROV_MANUAL_PG13-15.pdf • CHP Member Handbook, pg.12 • Care Matters Member Newsletter_Winter_2016	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor must require its providers to offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to other Medicaid/CHP+ providers. *42 CFR 438.206(c)(1)(ii)* Medicaid Contract: Amendment 2, Exhibit A—2.5.1.1.1.2 CHP+ Contract: Amendment 6, Exhibit A-5—2.5.1	**Medicaid:** • MCD_CHP_QI10 v.06– Access to Care_Services.pdf • MCD_PROV_MANUAL_PG7.pdf **CHP+:** • MCD_CHP_QI10 v.06– Access to Care_Services.pdf • CHP_PROV_MANUAL_PG53.pdf	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services taking into account the urgency of the need for services: **(Medicaid)** • Urgently needed services are provided within 48 hours of notification of the primary care physician or the Contractor. • Non-urgent healthcare and non-symptomatic well-care physical examinations are scheduled within 30 days. **(CHP+)** • Within 48 hours for urgently needed services. • Within 14 calendar days for: – Diagnosis and treatment of a non-emergent, non-urgent substance use disorder. – Diagnosis and treatment of a non-emergent, non-urgent mental health condition. • Within 30 calendar days for: – Non-emergent, non-urgent medical problems. – Non-urgent, symptomatic medical problems. – Non-symptomatic well-care physical examinations. *42 CFR 438.206(c)(1)(i)* Medicaid Contract: Amendment 2, Exhibit A—2.5.1.6.2 CHP+ Contract: Amendment 6, Exhibit A-5—2.6.3.2, 2.6.3.3.1–5, and 2.7.1.5.2.5–6	**Medicaid:** • MCD_CHP_QI10 v.06– Access to Care_Services.pdf • Strategic Access Report FY_15_16 MCD and CHP+.pdf • MCD Member Handbook, pg.12 • MCD Member Handbook, pg.13 • MCD_PROV_MANUAL_PG47.pdf • Choice Matters Member Newsletter_Winter_2016.pdf **CHP+:** • MCD_CHP_QI10 v.06– Access to Care_Services.pdf • Strategic Access Report FY_15_16 MCD and CHP+. pdf • CHP Member Handbook, pg.12 • CHP_PROV_MANUAL_PG13-15.pdf • Care Matters Member Newsletter_Winter_2016.pdf	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor communicates all scheduling guidelines in writing to participating providers. Medicaid Contract: Amendment 2, Exhibit A—2.5.1.6.4 CHP+ Contract: Amendment 6, Exhibit A-5—2.7.1.5.4	**Medicaid:** • MCD_CHP_QI10 v.06– Access to Care_Services.pdf • MCD_PROV_MANUAL_PG47.pdf • MCD Member Handbook, pg.12 **CHP+:** • MCD_CHP_QI10 v.06– Access to Care_Services.pdf • CHP_PROV_MANUAL_PG13-15.pdf • Care Matters Member Newsletter_Winter_2016.pdf • CHP Member Handbook, pg.12	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor has mechanisms to ensure compliance by providers with standards for timely access, monitors providers regularly to determine compliance with standards for timely access, and takes corrective action if there is a failure to comply with standards for timely access. *42 CFR 438.206(c)(1)(iv) through (vi)* Medicaid Contract: Amendment 2, Exhibit A—2.5.1.6.4 CHP+ Contract: Amendment 6, Exhibit A-5—2.7.1.5.4	**Medicaid:** • Strategic Access Report FY_15_16 MCD and CHP+. pdf • MCD_PROV_MANUAL_PG47.pdf • Adult Referral Guidelines.pdf • Pediatric Referrals Guidelines.pdf **CHP+:** • Strategic Access Report FY_15_16 MCD and CHP+. pdf • CHP_PROV_MANUAL_PG13-15.pdf • Pediatric Referrals Guidelines.pdf	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. (Includes policies and procedures, training, and member communications.) *42 CFR 438.206(c)(2)* *(Requirement to be updated 7/2018—see appendix)* Medicaid Contract: Amendment 2, Exhibit A—2.5.6.3 CHP+ Contract: Amendment 6, Exhibit A-5—2.7.7.2	**Medicaid:** • MCD_CHP_GVT06 v.09new, Review and Readability of Member Materials.pdf • MCD_CHP_GVT10 v.11Evaluating Member's Non-English Language Needs for Language Translation Services.pdf • MCD_CHP_QI07 v. 08Cultural and Linguistic Appropriate Services Program Description.pdf • CLAS Program Description_2016_FINAL.pdf • MCD Provider Directory 2016.pdf • MCD Member Handbook, pg.1 notification of language services • CLAS Workgroup Charter 2015 FINAL.pdf • CHP+ REL Dashboard • MCD REL Dashboard • 2015 HEDIS Disparities Analysis Report • CLAS 2016 Workplan • Equity Pledge - 5 Areas of Focus • Health Equity Work plan for CLAS **DHA Cultural Policies List** • DHA Cultural Policies Cultural Religious Considerations Policy.pdf • DHA Cultural Policies Interpreter and Translation Services and Auxiliary Communication Devices.pdf • DHA Equal Employment Opportunity.pdf • DHA WorkforceDiversity.pdf	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Description of Process • MCD_CHP_GVT06 v.09, MCD_CHP_GVT10 v.11, See also: DHA Cultural Policies List (above) outlines how the organization provides health services that are responsive to members' culture and language needs • CLAS Program Description_2016_FINAL.pdf – Describes the program the Medical Plan has in place to address the cultural diversity of our membership. **Denver Health Training Materials** outlines our cultural competency training for staff including providers • DHA Staff Training Record.pdf • DHA Training Materials (rev12 22 09) entire document.pdf • Interpreter Services Annual online training DH Staff & Providers.pdf • Culture & Diversity Annual Online Training DH Providers & Staff.pdf • Managed Care Cultural TRAINING SUMMARY.pdf • Managed Care_Attachment A_Culture_Diversity_Calendar.pdf • Managed care_Attachment B_C_DH CULTURAL TRAINING.pdf • Managed Care_Attachment D_Culture_Diversity_KP_ Training Evaluation.pdf • NEO - Diversity Information (2016).ppt • NEO Agenda 2016.pdf • NEO Booklet - Diversity Pages 2016.pdf	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• MCD Provider Directory 2016.pdf, Medicaid Readability Log.xls, Provider Newsletter no. 1_9_2016 shows that we have made a reasonable effort to address member needs based on the Member Demographic Assessment including language needs of providers, low literacy needs of members and available interpreter services within the organization and how to access services. • MS_Alternate_Mbr_Materials_Process_2016.pdf • MS_Call Flow Process for Hearing Impaired_2016.pdf • Health Literacy Training Slides_2016_01_28.ppt • Health Literacy and Cultural Awareness Checklist.doc • Health Literacy Training_1_28_16_Sign In and Survey • CLAS Culture and Diversity Training Calendar 2015.doc • CLAS Training_Native American Populations_2015_11_11 FINAL.ppt • CLAS Training_Latino-Hispanic_2015_10_14FINAL.ppt • CLAS Training_LGBTI_2015_06_10.ppt • Cultural Diversity Training_Middle East Populations_2015_04_08.ppt • CLAS Training_Asian and Pacific Islander Health_2015_05_13 • Asian and Pacific Islander Health.ppt • 2015 03 11 Cultural Diversity Training_Multigenerational Employees_Final.ppt • 2015 02 11 Cultural Diversity Training African American Black Populations.ppt • NEO Diversity Information (2016) PG. 18	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Denver Health Accreditation and Certification • NCQA Certification for Distinction in Multicultural Health Care (2016) • NCQA Letter for Distinction in Multicultural Health Care (2016) **CHP+:** Also see Medicaid Documents **Items Unique to CHP+** • CHP+ Provider Directory 2016.pdf • CHP Member Handbook, pg.1 and 12 Notification of language services	

Medicaid Results for Standard II—Access and Availability							
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 II—Access and Availability							
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%

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services (Medicaid Only)		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
The Contractor must comply with the following requirements based on 42 CFR 441.50 through 441.62 effective October 1, 2015 and Code of Colorado Regulations 10 CCR 2505-10 8.280 effective April 30, 2016. Compliance References Contract Amendment A2, Exhibit A—2.5.7.2.2 The Contractor shall comply with all EPSDT regulations set forth in 1905(a), 42 USC 1396d(r)(5) and 42 USC 1396d(a), and 42 CFR 441.50 through 441.62. Contract: Amendment 2, Exhibit D The Contractor must meet all State and federal requirements for EPSDT benefits under 42 CFR Sections 441.50 through 441.61 and 10 CCR 2505-10, Section 8.280. (Services include comprehensive well-child examinations, immunizations, assessment, diagnosis and treatment, providing benefit information, scheduling assistance, and case management.) Additional Resources State Medicaid Manual/Section 5 offers further detailed instructions and guidance regarding the various components of the EPSDT Program.		
1. The Contractor must have written policies and procedures for providing EPSDT services to members age 20 and under, including lead testing and immunizations. 10 CCR 2505-10 8.280.2 and 8.280.8A Contract: Amendment A2, Exhibit A—2.5.7.2.1	• MCD_QI16 v.5 Early and Periodic Screening, Diagnostic, and Treatment Benefit (EPSDT) Program Age: Pg. 1 Section I and III Lead Testing: Pg. 6 Section VI-B # 1F Immunization Pg. 5 Section VI-B # 1E • MCD Member Handbook, pg. 15. • MCD_PROV_MANUAL_PG91-94.pdf	**Medicaid:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The Early and Periodic Screening, Diagnostic, and Treatment Benefit (EPSDT) Program policy addressed the comprehensive requirements for EPSDT services through policy statements that replicated the State EPSDT regulations. However, the policy defined procedures for implementation in a very limited manner, addressing neither accountabilities nor mechanisms for implementation of most requirements. In addition, DHMC submitted no corresponding procedures from other departments that specifically addressed EPSDT elements. The provider manual defined responsibilities of		

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services (Medicaid Only)		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
providers for implementing some components of the policy. During on-site interviews, staff members stated that they considered the provider manual to be the primary source to communicate procedures for operationalizing the policy and noted that other procedures and systems already in place throughout the broader DHHA system were also applicable.		
Required Actions: DHMC must enhance its EPSDT policy or related policies and procedures to define or link to organizational procedures which address mechanisms to operationalize all components of the policy.		
2. The Contractor must notify Members age 20 and under of the benefits and options for children and adolescents under Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) and is responsible for ensuring that children and their families are able to access the services appropriately. The Contractor must: • Provide a combination of written and oral methods to inform all eligible members (or their families) about the EPSDT program within 60 days of enrollment and annually thereafter. – Member communications must effectively inform those individuals who are blind or deaf or who cannot read or understand the English language. • Using clear and nontechnical language, provide information about the following— – The benefits of preventive healthcare. – The services available under the EPSDT program and where and how to obtain those services.	• MCD_QI16 v.5 Early and Periodic Screening, Diagnostic, and Treatment Benefit (EPSDT) Program Pg. 3 section VI-A #1i Pg. 3 section VI-A #1ii Pg. 3 section VI-A #1iii Pg. 3 section VI-A #1 v ii Pg. 4 section VI-A #1x Pg. 4 section VI-A #1ix Pg. 3-4 section VI-A #2 and # 1iv Pg. 7 section VI-D #4 • DHMC website http://www.denverhealthmedicaid.org/about • MCD Member Handbook, pg. 15 • MCD Member Handbook pg. 1 • MCD Member Handbook, pg. 23	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services (Medicaid Only)		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– That the services under the EPSDT program are provided without cost to members 20 and under. – That necessary transportation and scheduling assistance for EPSDT services is available to members upon request. • Provide information about the full range of EPSDT wraparound benefits and mental health treatment services available through State Medicaid. *42 CFR 441.56(a)(1)–(4)* 10 CCR 2505-10 8.280.8.D (1) Contract: Amendment A2, Exhibit A—2.5.7.2.3.1 and Exhibit D		
3. The Contractor must implement the American Academy of Pediatrics Bright Futures periodicity schedule. *42 CFR 441.58(a) and (b)* 10 CCR 2505-10 8.280.4.A (1), 8.280.4.A (2) Contract: Amendment A2, Exhibit A1—2.5.7.2.3	• MCD_QI16 v.5 Early and Periodic Screening, Diagnostic, and Treatment Benefit (EPSDT) Program Pg. 5 Section VI-B #1ii • MCD Member Handbook, pg. 15	**Medicaid:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The EPSDT Program policy states that DHMC implements the Bright Futures Periodicity Schedule, but does not state *how* it is implemented. The policy also includes an attachment that includes guidance for conducting some types of screenings, but is not the AAP Bright Futures Periodicity Schedule; nor was there evidence that the information in the attachment is communicated outside the policy. The policy states that the periodicity schedule is available to members on the DHMC website and that members are informed through the member handbook. However, the member handbook does not include such communication, and the periodicity schedule's placement on the website was not apparent to HSAG reviewers. The provider manual does not contain the Bright Futures Periodicity Schedule, reference the periodicity schedule by name, or direct providers to other sources to obtain the periodicity schedule. Furthermore, the description of EPSDT services in the provider manual is high level and does not represent the clinical detail included in the		

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services (Medicaid Only)		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
actual Bright Futures Periodicity Schedule. Therefore, it is unclear how DHMC intends to implement the Bright Futures Periodicity Schedule, particularly with providers.		
Required Action: DHMC must enhance its provider communications and provide access to the AAP Bright Futures Periodicity Schedule and provide access to the periodicity schedule in order to fully operationalize this component of its EPSDT Program policy.		
4. The Contractor must ensure the provision of all required components of periodic health screens to EPSDT beneficiaries who request it. Screening includes: • Comprehensive health and developmental history. • Comprehensive unclothed physical examination. • Appropriate vision testing. • Appropriate hearing testing. • Appropriate laboratory tests. – As defined in the periodicity schedule. – Lead toxicity blood screening between 36 and 72 months of age if not previously tested. • Dental screening services, including an assessment of mouth, oral cavity, and teeth; and referral to a dentist for children by 1 year of age or at the eruption of the first tooth. • Developmental screening to determine whether a child's emotional and developmental processes fall within a benchmarked range according to the child's age group and cultural background. Includes self-care skills, gross and fine motor development, communication skills or language development,	• MCD_QI16 v.5 Early and Periodic Screening, Diagnostic, and Treatment Benefit (EPSDT) Program pg. 5 Section VI-B #1iii-a pg. 5 Section VI-B #1iii-b pg. 5 Section VI-B #1iii-c pg. 5 Section VI-B #1iii-c pg. 6 Section VI-B #1iii-g pg. 6 Section VI-B #1iii-f (Lead Toxicity) pg. 5 Section VI-B #1iii-c pg. 5 Section VI-B #1iii-d pg. 6 Section VI-B #1iii-h pg. 6 Section VI-B #1iv pg. 6 Section VI-B #1iv pg. 5 Section VI-B #1iii • MCD Member Handbook, pg. 15 • Pediatric and Adolescent Preventive Healthcare Guidelines.pdf • Epic Medicaid Chart Sample_Redacted.pdf	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services (Medicaid Only)		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
social-emotional development, cognitive skills, and appropriate mental/behavioral health screening. • Health education and anticipatory guidance. • Screenings shall be performed by a provider qualified to furnish primary medical and/or mental health services. • Screenings shall be performed in a culturally and linguistically sensitive manner. • To avoid duplicate screening services, written verification that any age-appropriate screening services due under the periodicity schedule have already been provided. *42 CFR 441.56 (b)(i) through (vi) and 441.59 (b)* 10 CCR 2505-10 8.280.8.C, 8.280.4.A.3, and 8.280.4.A.4 Contract: Amendment A2, Exhibit A1—2.5.7.2.3 and Exhibit D1		
5. Results of screenings and examinations shall be recorded in the child's medical record. Documentation shall include, at a minimum, identified problems and negative findings and further diagnostic studies and/or treatments needed and the date ordered. 10 CCR 2505-10 8.280.4.A (5)	MCD_QI16 v.5 Early and Periodic Screening, Diagnostic, and Treatment Benefit (EPSDT) Program Pg. 9 Section VI-H #2 • Documentation Principles for Healthcare.pdf • Epic Medicaid Chart Sample_Redacted.pdf	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services (Medicaid Only)		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor must provide diagnostic services in addition to treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedure—even if the services are not included in the plan—including: • Diagnosis of and treatment for defects in vision and hearing, including eyeglasses and hearing aids. • Dental care at as early an age as necessary for relief of pain and infections, restoration of teeth, and maintenance of dental health. • Appropriate immunizations. (If determined at the time of screening that immunization is needed and appropriate to provide at the time of screening, then immunization treatment must be provided at that time.) *42 CFR 441.56 (c)* 10 CCR 2505-10 8.280.4.A (3) (e) and 8.280.4.C (3) Contract: Amendment A2, Exhibit D1	• MCD_QI16 v.5 Early and Periodic Screening, Diagnostic, and Treatment Benefit (EPSDT) Program pg. 8 Section VI-F #1 • MCD Member Handbook, pg. 15	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services (Medicaid Only)		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. If the screening provider is not licensed or equipped to render necessary treatment or further diagnosis, the provider shall refer the individual to an appropriate practitioner or facility or to the Outreach and Case Management Office (Healthy Communities) for assistance in finding a provider. 10 CCR 2505-10 8.280.4.C.2 Contract: Amendment A2—2. 5.7.2.3.5	• MCD_QI16 v.5 Early and Periodic Screening, Diagnostic, and Treatment Benefit (EPSDT) Program pg. 6 Section VI-C #2 • MCD_CHP_UM01 v.12– Utilization Review Determinations Including Approvals and Actions.pdf Pg. 11 Section E #1iv. • Healthy Communities Pediatric Care Coordination.pdf • Epic Medicaid Chart Sample_Redacted.pdf	**Medicaid:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The EPSDT Program policy included this requirement verbatim, but did not outline procedures for implementation. DHMC provided documents that demonstrated that mechanisms are in place to assist with provider referrals to other providers or Healthy Communities through the UM Department and that an automated referral capability is offered through the new Epic electronic record system. However, the EPSDT section of the provider manual was vague on the responsibility of the provider to refer the member to an appropriate practitioner (except for dental services), listing "Denver Health Medical Management" (no contact number) as a source for authorizations or assistance. The provider manual also describes the role of the EPSDT outreach coordinators (which did not include assistance with finding a provider) with no reference to the provider making a referral to Healthy Communities or a contact number to do so.		
Required Actions: This requirement is a provider responsibility; therefore, DHMC must enhance EPSDT provider communications to more explicitly state that (if a provider is not licensed or equipped to render necessary treatment) the *provider* is responsible to make a referral to another provider, make a referral to Healthy Communities, or make a referral to the UM case managers to assist with a referral. DHMC should ensure that operational processes intended to support this requirement are clearly defined within policies or other written procedures to ensure accountability for fulfilling this requirement. (See "Opportunities for Improvement" in Executive Summary.)		

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services (Medicaid Only)		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor must employ processes to ensure timely initiation of treatment, if required, generally within an outer limit of six months after the request for screening services. *42 CFR 441.56 (e)*	• MCD_CHP_UM_DOP02 v.02 Unmet Demand for Pending MCD Choice- pg. 1 Section I • MCD Member Handbook pg. 12 • Unmet Demand Sample from Epic_Redacted.pdf	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. A referral from the member's primary care physician may be required for care provided by anyone other than the primary care physician. • Members may self-refer for routine vision, dental, hearing, or mental health services; or family planning services. • Providers shall be responsible for obtaining prior authorization when required for identified services such as home health, orthodontia, private duty nursing, and pharmaceuticals. 10 CCR 2505-10 8.280.6 and 8.280.7 Contract: Amendment A2--2.5.7.2.3.2	• MCD_QI16 v.5 Early and Periodic Screening, Diagnostic, and Treatment Benefit (EPSDT) Program pg. 3 Section VI-A #1i and #1ii • MCD Member Handbook pg. 4 • MCD Member Handbook pg. 23 • MCD Member Handbook pg. 19 • MCD_PROV_MANUAL_PG6-8.pdf	**Medicaid:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The EPSDT Program policy states that the screening provider will refer individuals to an appropriate practitioner for necessary treatment or further diagnosis; but, it does not address provider responsibility for obtaining authorization for specific EPSDT services, what the EPSDT services are, or for what services the member may self-refer. The provider manual generally describes the responsibility of the primary care physician to make referrals and participate in the prior authorization process, but does not describe EPSDT services that require an authorization from DHMC or services for which members may self-refer.		
Required Actions: DHMC must enhance provider communications to ensure that providers are aware of the types of EPSDT services and referrals that *do* or *do not* require prior authorization and clarify the process for obtaining authorization when necessary.		

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services (Medicaid Only)		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor defines "Medical Necessity for EPSDT Services" as: • A service that is found to be equally effective treatment among other less conservative or more costly treatment options. • Meets one of the following criteria: – The service is expected to prevent or diagnose the onset of an illness, condition, or disability. – The service is expected to cure, correct, or reduce the physical, mental, cognitive, or developmental effects of an illness, injury, or disability. – The service is expected to reduce or ameliorate the pain and suffering caused by an illness, injury, or disability. – The service is expected to assist the individual to achieve or maintain maximum functional capacity in performing activities of daily living. • May be a course of treatment that includes observation or no treatment at all. – The Contractor's UM process provides for approval of healthcare services if the need for services is identified and meets the following requirements: o The service is medically necessary. o The service is in accordance with generally accepted standards of medical practice.	• MCD_CHP_UM01 v.12– Utilization Review Determinations Including Approvals and Actions Pg. 1 Section 1 • MCD_QI16 v.5 Early and Periodic Screening, Diagnostic, and Treatment Benefit (EPSDT) Program Pg. 7 Section VI-D #1	**Medicaid:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services (Medicaid Only)		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
o The service is clinically appropriate in terms of type, frequency, extent, and duration. o The service provides a safe environment or situation for the child. o The service is not for the convenience of the caregiver. o The service is not experimental and is generally accepted by the medical community for the purpose stated. *42 CFR 441.57* 10 CCR 2505-10 8.280.1 and 8.280.4.E Contract: Amendment A2—2.5.7.2.3.7; Exhibit D1		
Findings: The EPSDT Program policy outlined the definition of "medical necessity" and criteria for UM approval specifically as outlined in the requirement. However, these criteria were not linked to or included in the UM Determinations policy. The UM Determinations policy included criteria that paralleled the elements in the definition of "medical necessity," *excepting* the EPSDT-specific elements—"The service is expected to assist the individual to achieve or maintain maximum functional capacity in performing activities of daily living" and "May be a course of treatment that includes observation or no treatment at all."—which were not included. DHMC should note that the definition of "medical necessity" outlined in the State Medicaid Plan—10 CCR 2505-10 8.076.1.8--(effective 08/30/16) includes the EPSDT-specific criteria per 8.280.4.E. HSAG strongly recommends that the DHMC EPSDT policies incorporate the definition of "medical necessity" as outlined in the Findings section of Standard I, Element 4 of this tool.		
Required Actions: DHMC must incorporate the complete and accurate definition of "medical necessity" for EPSDT services into applicable operating policies and procedures and ensure that the criteria are applied appropriately to authorization decisions for EPSDT-related services.		

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services (Medicaid Only)		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor must provide a case management system and coordination with other providers to ensure that clients receive covered services. Contract: Amendment A2, Exhibit D1	• MCD_CHP_CM01 v. 07 Case Management for Medicaid Choice and CHP Members Pg. 1 • Unmet Demand Sample from Epic_Redacted.pdf	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor must provide referral assistance for treatment not covered by the plan but found to be needed as a result of conditions disclosed during screening and diagnosis. • The Contractor must make appropriate use of State health agencies, State vocational rehabilitation agencies, and Title V grantees (Maternal and Child Health/Health Care Program for Children with Special needs. Further, the Contractor should make use of other public health, mental health, and education programs and related programs such as Head Start, Title XX (Social Services) programs, and the Special Supplemental Food Program for Women, Infants and Children (WIC). – Includes Child Find, Early Intervention Colorado, and the Accountable Care Collaborative. • The Contractor must offer, and provide if the member/family requests, assistance with transportation and assistance with scheduling appointments for services.	• MCD_CHP_UM01 v.12– Utilization Review Determinations Including Approvals and Actions pg.11 iv. MCD_QI16 v.5 Early and Periodic Screening, Diagnostic, and Treatment Benefit (EPSDT) Program pg. 10 Section VI-K #1 and #3 • Epic_EIS_Redacted • MCD Member Handbook pg. 23	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services (Medicaid Only)		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The contractor must have a process to ensure that medically necessary services not covered by the Contractor are referred to the Office of Clinical Services for action. *42 CFR 441.61 and 441.62* 10 CCR 2505-10 8.280.8.D Contract: Amendment A2—2.5.7.2.3.5; Exhibit D1		
13. The Contractor ensures provision of all required components of periodic health screens through: • Systematic communication with network providers regarding the Department's EPSDT requirements. • A proactive approach to ensure that eligible members obtain EPSDT screens. • A process to measure and ensure compliance with the EPSDT schedule. • Complying with all reporting requirements and data needs for federal reporting. 10 CCR 8.280.8.D (2), (3), (4), and (6) Contract: Amendment A2—2.5.7.2.3.2, 2.5.7.2.3.3, 2.5.7.2.3.4, and 2.5.7.2.3.6	• MCD_QI16 v.5 Early and Periodic Screening, Diagnostic, and Treatment Benefit (EPSDT) Program Pg. 9 Section VI-E #2 Pg. 9 Section VI-G Pg. 9 Section VI-I#2 and #3 Pg. 9 Section VI-I #1 • MCD_CHP_QI02 v.07 Clinical Practice and Preventive Care Guidelines.pdf • MCD_Provider Newsletter_2016	**Medicaid:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Medicaid Results for Standard XI—EPSDT Services							
Total	Met	=	8	X	1.00	=	8
	Partially Met	=	5	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	13	**Total Score**		=	8

Total Score ÷ Total Applicable	=	62%

Appendix B. Record Review Tool

The completed record review tool follows this cover page.

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2016–2017 Denials Record Review Tool
for Denver Health Medical Plan

Review Period:	January 1, 2016—December 31, 2016
Date of Review:	February 8–9, 2017
Reviewer:	Rachel Henrichs
Participating Plan Staff Member:	Emilia Creetchfield

Requirements	File 1	File 2	File 3	File 4	File 5
Member	AA	BW	CH	MR	EG
Date of initial request	04/04/16	09/21/16	01/26/16	08/20/16	08/20/16
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	CL	CL	CL	CL	CL
Standard (S), Expedited (E), or Retrospective (R)	R	R	R	R	R
Date notice of action sent	04/12/16	10/04/16	02/21/16	09/06/16	08/30/16
Notice sent to provider and member? (C or NC)	NC	NC	NC	NC	NC
Number of days for decision/notice	8	13	26	17	10
Notice sent within required time frame? (C or NC) (S = 10 Cal days after; E = 3 Bus days after; T = 10 Cal days before)	NC	NC	NC	NC	NC
Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
If extended, extension notification sent to member? (C, NC, or NA)	NA	NA	NA	NA	NA
If extended, extension notification includes required content? (C, NC, or NA)	NA	NA	NA	NA	NA
Notice of Action includes required content? (C or NC)	NA	NA	NA	NA	NA
Authorization decision made by qualified clinician? (C, NC, or NA)	NA	NA	NA	NA	NA
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (C, NC, or NA)	NA	NA	NA	NA	NA
If denied due to *not a covered service* but covered by Medicaid Fee-for-Service/wraparound service, did the notice of action include clear information about how to obtain the service? (C, NC, or N/A)	NA	NA	NA	NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	NA	NA	NA	NA	NA
Was correspondence with the member easy to understand? (C or NC)	NA	NA	NA	NA	NA
Total Applicable Elements	**2**	**2**	**2**	**2**	**2**
Total Compliant Elements	**0**	**0**	**0**	**0**	**0**
Score (Number Compliant / Number Applicable) = %	**0%**	**0%**	**0%**	**0%**	**0%**

C = Compliant **NC** = Not Compliant **NA** = Not Applicable **Y** = Yes **N** = No (not scored—informational only)
Cal = Calendar **Bus** = Business

Requirements	File 6	File 7	File 8	File 9	File 10
Member	DS	PJ	TB	RM	AE
Date of initial request	04/21/16	03/22/16	Omitted	05/12/16	Omitted
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	CL	CL		CL	
Standard (S), Expedited (E), or Retrospective (R)	S	S		S	
Date notice of action sent	05/03/16	03/29/16		05/24/16	
Notice sent to provider and member? (C or NC)	NC	NC		NC	
Number of days for decision/notice	12	7		12	
Notice sent within required time frame? (C or NC) (S = 10 Cal days after; E = 3 Bus days after; T = 10 Cal days before)	NC	NC		NC	
Was authorization decision timeline extended? (Y or N)	N	N		N	
If extended, extension notification sent to member? (C, NC, or NA)	NA	NA		NA	
If extended, extension notification includes required content? (C, NC, or NA)	NA	NA		NA	
Notice of Action includes required content? (C or NC)	NA	NA		NA	
Authorization decision made by qualified clinician? (C, NC, or NA)	NA	NA		NA	
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (C, NC, or NA)	NA	NA		NA	
If denied due to *not a covered service* but covered by Medicaid Fee-for-Service/wraparound service, did the notice of action include clear information about how to obtain the service? (C, NC, or N/A)	NA	NA		NA	
Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	NA	NA		NA	
Was correspondence with the member easy to understand? (C or NC)	NA	NA		NA	
Total Applicable Elements	**2**	**2**		**2**	
Total Compliant Elements	**0**	**0**		**0**	
Score (Number Compliant / Number Applicable) = %	**0%**	**0%**		**0%**	

C = Compliant **NC** = Not Compliant **NA** = Not Applicable **Y** = Yes **N** = No (not scored—informational only)
Cal = Calendar **Bus** = Business

Requirements	OS 1	OS 2	OS 3	OS 4	OS 5
Member	RO	LL	EH		
Date of initial request	Omitted	03/08/16	02/08/16		
What type of denial? (Termination [T], New Request [NR], or Claim [CL])		CL	CL		
Standard (S), Expedited (E), or Retrospective (R)		S	S		
Date notice of action sent		03/22/16	02/16/16		
Notice sent to provider and member? (C or NC)		NC	NC		
Number of days for decision/notice		14	8		
Notice sent within required time frame? (C or NC) (S = 10 Cal days after; E = 3 Bus days after; T = 10 Cal days before)		NC	NC		
Was authorization decision timeline extended? (Y or N)		N	N		
If extended, extension notification sent to member? (C, NC, or NA)		NA	NA		
If extended, extension notification includes required content? (C, NC, or NA)		NA	NA		
Notice of Action includes required content? (C or NC)		NA	NA		
Authorization decision made by qualified clinician? (C, NC, or NA)		NA	NA		
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (C, NC, or NA)		NA	NA		
If denied due to *not a covered service* but covered by Medicaid Fee-for-Service/wraparound service, did the notice of action include clear information about how to obtain the service? (C, NC, or N/A)		NA	NA		
Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)		NA	NA		
Was correspondence with the member easy to understand? (C or NC)		NA	NA		
Total Applicable Elements		**2**	**2**		
Total Compliant Elements		**0**	**0**		
Score (Number Compliant / Number Applicable) = %		**0%**	**0%**		

C = Compliant **NC** = Not Compliant **NA** = Not Applicable **Y** = Yes **N** = No (not scored—informational only)
Cal = Calendar **Bus** = Business

Total Record Review Score	Total Applicable Elements: 20	Total Compliant Elements: 0	Total Score: 0%

Notes:

FOR ALL FILES: Denver Health notified the provider, but provided no member with a written notice of action or explanation of benefits (EOB) related to the denial of claims payment. Because there was no written notice of action, HSAG scored "notice of action includes required content," and "was correspondence with the member easy to understand" as not applicable. All denial decisions appeared to be solely based on lack of prior authorization for out-of-network services. The claims were not reviewed by UM for authorization; therefore, HSAG scored "authorization decision made by qualified clinician," "if denied due to lack of information…" "if denied due to not a covered service…" and "decision based on established authorization criteria" as not applicable.

File 1 (AA): The member had been continuously enrolled at DHMP for about 10 months on the date of service. Notes on file indicated that the member sought services based on a suspected broken arm; however, this was an out-of-network provider with no urgent care designation, and the appointment was billed as routine. Denver Health denied the claim for routine office visit because the member had no prior authorization to seek services from an out-of-network provider. Denver Health provided no evidence that the utilization management team reviewed the case to determine if the member qualified for an exception (i.e., out-of-network urgent care requires no authorization).

File 2 (BW): The member had been enrolled at DHMP for five days on the date of service. Notes on file indicated that the member sought physical therapy from an out-of-network provider. Denver Health denied the claim because the member had no prior authorization to seek services from an out-of-network provider. Denver Health provided no evidence that the utilization management team reviewed the case to determine if the member qualified for an exception (e.g., the continuity of care rules).

File 3 (CH): The member had been enrolled at DHMP for 35 days on the date of service. Notes on file indicated that the member attended a routine office appointment with an out-of-network provider. Denver Health denied the claim because the member had no prior authorization to seek services from an out-of-network provider. Denver Health provided no evidence that the utilization management team reviewed the case to determine if the member qualified for an exception (e.g., continuity of care rules).

File 4 (MR): The member had been enrolled at DHMP for 33 days on the date of service; however, the welcome packet with member ID was mailed two days *after* the date of service. Notes on file indicated that the member attended a routine office appointment with an out-of-network provider. Denver Health denied the claim because the member had no prior authorization to seek services from an out-of-network provider. Denver Health provided no evidence that the utilization management team reviewed the case to determine if the member qualified for an exception (e.g., continuity of care rules).

File 5 (EG): The member had been enrolled at DHMP for 16 days on the date of service. Notes on file indicated that the member attended a routine office appointment with an out-of-network provider. Denver Health denied the claim because the member had no prior authorization to seek services from an out-of-network provider. Denver Health provided no evidence that the utilization management team reviewed the case to determine if the member qualified for an exception (e.g., continuity of care rules).

File 6 (DS): The member had been enrolled at DHMP for more than 10 months on the date of service. Notes on file indicated that the member obtained a psychological evaluation from an out-of-network provider. Denver Health denied the claim because the member had no prior authorization to seek services from an out-of-network provider.

File 7 (PJ): The member had been enrolled at DHMP for six days on the date of service. This provider submitted an original claim that Denver Health paid. The provider resubmitted the claim, revised to include additional

services. Denver Health denied the additional services for the reason that they "exceeded allowed benefit amount." Denver Health provided no evidence that the utilization management team reviewed the case.

File 8 (TB): HSAG omitted this file because it represented a duplicate claim—administrative denial.

File 9 (RM): The member had been enrolled at DHMP for five months on the date of service. Notes on file indicated that the member sought services for an earache from an out-of-network provider. Denver Health denied the claim because the member had no prior authorization to seek services from an out-of-network provider.

File 10 (AE): HSAG omitted this file because it represented a duplicate claim—administrative denial.

File OS1 (RO): HSAG omitted this file because it represented an administrative denial (claim submitted using wrong form).

File OS2 (LL): The member had been enrolled at DHMP for three months on the date of service. Notes on file indicated that the member obtained a vision exam from an out-of-network provider. Denver Health denied the claim because the member had no prior authorization to seek services from an out-of-network provider.

File OS3 (EH): The member had been enrolled at DHMP for more than five months on the date of service. Notes on file indicated that the member attended a routine office appointment with an out-of-network provider. Denver Health denied the claim because the member had no prior authorization to seek services from an out-of-network provider.

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2016–2017 Denials Record Review Tool
for Denver Health Medicaid Choice

Review Period:	January 1, 2016—December 31, 2016
Date of Review:	February 8, 2017
Reviewer:	Kathy Bartilotta
Participating Plan Staff Member:	Norma Stiglich

Requirements	File 1	File 2	File 3	File 4	File 5
Member	DA	CC	MD	CG	DH
Date of initial request	11/21/16	02/01/16	09/26/16	09/07/16	10/10/16
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	NR	NR	NR	NR
Standard (S), Expedited (E), or Retrospective (R)	S	S	S	S	S
Date notice of action sent	11/28/16	02/05/16	10/19/16	09/14/16	10/14/16
Notice sent to provider and member? (C or NC)	C	C	C	C	C
Number of days for decision/notice	7	4	23	7	4
Notice sent within required time frame? (C or NC) (S = 10 Cal days after; E = 3 Bus days after; T = 10 Cal days before)	C	C	C	C	C
Was authorization decision timeline extended? (Y or N)	N	N	Y	N	N
If extended, extension notification sent to member? (C, NC, or NA)	NA	NA	C	NA	NA
If extended, extension notification includes required content? (C, NC, or NA)	NA	NA	C	NA	NA
Notice of Action includes required content? (C or NC)	C	C	C	C	C
Authorization decision made by qualified clinician? (C, NC, or NA)	C	C	C	C	C
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (C, NC, or NA)	NA	NA	C	NA	NA
If denied due to *not a covered service* but covered by Medicaid Fee-for-Service/wraparound service, did the notice of action include clear information about how to obtain the service? (C, NC, or N/A)	NA	NA	NA	NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C	C	C	C
Was correspondence with the member easy to understand? (C or NC)	NC	NC	C	C	C
Total Applicable Elements	**6**	**6**	**9**	**6**	**6**
Total Compliant Elements	**5**	**5**	**9**	**6**	**6**
Score (Number Compliant / Number Applicable) = %	**83%**	**83%**	**100%**	**100%**	**100%**

C = Compliant **NC** = Not Compliant **NA** = Not Applicable **Y** = Yes **N** = No (not scored—informational only)
Cal = Calendar **Bus** = Business **TBD** = To Be Determined (scored NA, referred to Department for additional review)

Requirements	File 6	File 7	File 8	File 9	File 10
Member	CH	LJ	FL	MM	MM
Date of initial request	05/02/16	11/22/16	08/02/16	01/08/16	08/10/16
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	NR	NR	NR	NR
Standard (S), Expedited (E), or Retrospective (R)	S	S	S	S	S
Date notice of action sent	05/10/16	12/16/16	08/22/16	01/11/16	08/18/16
Notice sent to provider and member? (C or NC)	C	C	C	C	C
Number of days for decision/notice	8	24	20	3	8
Notice sent within required time frame? (C or NC) (S = 10 Cal days after; E = 3 Bus days after; T = 10 Cal days before)	C	C	C	C	C
Was authorization decision timeline extended? (Y or N)	N	Y	Y	N	N
If extended, extension notification sent to member? (C, NC, or NA)	NA	C	C	NA	NA
If extended, extension notification includes required content? (C, NC, or NA)	NA	C	C	NA	NA
Notice of Action includes required content? (C or NC)	C	C	NC	C	C
Authorization decision made by qualified clinician? (C, NC, or NA)	C	C	C	C	C
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (C, NC, or NA)	NC	C	C	NA	NC
If denied due to *not a covered service* but covered by Medicaid Fee-for-Service/wraparound service, did the notice of action include clear information about how to obtain the service? (C, NC, or N/A)	NA	NA	NA	NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C	C	C	C
Was correspondence with the member easy to understand? (C or NC)	NC	NC	NC	C	NC
Total Applicable Elements	**7**	**9**	**9**	**6**	**7**
Total Compliant Elements	**5**	**8**	**7**	**6**	**5**
Score (Number Compliant / Number Applicable) = %	**71%**	**89%**	**78%**	**100%**	**71%**

C = Compliant **NC** = Not Compliant **NA** = Not Applicable **Y** = Yes **N** = No (not scored—informational only)
Cal = Calendar **Bus** = Business **TBD** = To Be Determined (scored NA, referred to Department for additional review)

Total Record Review Score	Total Applicable Elements:	Total Compliant Elements:	Total Score:
	71	62	87%

Notes:

File #1 (DA)—The explanation of the reason for denial was not easy for the member to understand.

File #2 (CC)—The explanation of the reason for denial was not easy for the member to understand.

File #3 (MD)—The authorization request included multiple types of services and was approved/denied in pieces. Some services were initially approved, but other services required more clinical information from the provider. An extension letter was sent to the member and provider based on the need for more information; the extension letter included required content. The medical director consulted with the requesting provider, but no additional clinical information was provided. Therefore, the remaining services were denied due to lack of medical necessity. Notice to the provider was oral.

File #6 (CH)—UM attempted to obtain additional information from the DME company rather than from the original requesting provider. After three attempts, UM was unable to obtain needed clinical information; and the request was denied based on lack of medical necessity. UM should have consulted the requesting provider—not the DME vendor—to obtain necessary clinical information. The explanation of the reason for denial was not easy for the member to understand.

File #7 (LJ)—Outreach to requesting provider to obtain additional information, but provider stated that he had not seen patient who had been referred to the oncology clinic. Reviewer obtained additional information from oncology record. Decision time frame extended on Day 10 with denial for medical necessity on Day 24. Notice to provider sent to DME, not original requesting provider. The NOA included extensive unnecessary explanation of reason for denial not easy for the member to understand.

File #8 (FL)—Decision time frame extended on Day 6 with denial for medical necessity on Day 20. The NOA did not include information on the required date for filing an appeal (this part of template not completed). The explanation of the reason for denial was not easy for the member to understand.

File #10 (MM)—The 1-year-old member was referred to Children's Hospital for consult and follow-up ultrasound of a previously diagnosed urology condition. Medical records reviewed by UM staff indicated that the previous ultrasound did not confirm the diagnosis indicated in the request for the follow-up ultrasound. Denied due to lack of medical necessity based on medical record information. Medical Director failed to consult with requesting physician regarding conflicting clinical information. The information included in the explanation of the reason for denial was not easy for the member to understand.

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2016–2017 site review of **Denver Health**.

Table C-1—HSAG Reviewers and Denver Health and Department Participants

HSAG Review Team	Title
Kathy Bartilotta, BSN	Senior Project Manager
Rachel Henrichs	External Quality Review (EQR) Compliance Auditor
Denver Health Participants	**Title**
Gregg Kamas	Director, Quality Improvement
Patricia Williams	Claims Manager
Emilia Creetchfield	Claims
Theresa Foster	Member Services
Jordan Clothier	Manager, Government Products
Kristie Richardson	Director, Provider Relations and Contracts
Rosanne Day	Manager, Utilization Management/Care Management
Cindy Ashley	Utilization Management Benefit Interpretation
Charlie Crevling	Interim Chief Executive Officer
Kathryn Cagle	Intervention Manager
Christina Williams	Manager, Unmet Demands
Erika Bracken	Analyst, Pharmacy Compliance
Michelle Beozzo	Director of Pharmacy
Norma Stiglich	Interim Medical Director
Lorna Pate	Director, Compliance
Sambridhi Deoja	Analyst, Government Products
Kunal Bhat	Manager, Utilization Management Program
Michael Robinson	Director, Government Products
Erika Tovar	Government Product Specialist
Department Observers	**Title**
Chris Tzortzis	Medicaid Contract Manager
Gina Robinson	Program Administrator
Russ Kennedy	Quality Unit
Teresa Craig	CHP+ Contract Manager

Appendix D. Corrective Action Plan Template for FY 2016–2017

If applicable, the health plan is required to submit a CAP to the Department for all elements within each standard scored as *Partially Met* or *Not Met*. The CAP must be submitted within 30 days of receipt of the final report. For each required action, the health plan should identify the planned interventions and complete the attached CAP template. Supporting documents should not be submitted and will not be considered until the CAP has been approved by the Department. Following Department approval, the health plan must submit documents based on the approved timeline.

Table D-1—Corrective Action Plan Process

Step	Action
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 email or through the file transfer protocol (FTP) site, with an email 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, 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 email 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 email or the FTP site, with an email 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.

Step	Action
Step 6	**Documentation substantiating implementation of the plan 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 CAP template follows.

Table D-2—FY 2016–2017 Corrective Action Plan for Denver Health

Standard I—Coverage and Authorization of Services—Medicaid Only		
Requirement	**Findings**	**Required Action**
10. The Contractor has in place and follows written policies and procedures that include a mechanism to consult with the requesting provider when appropriate.	DHMC/DHMP had written policies which addressed consultation with the requesting provider when necessary to make a UM determination. Procedures and staff members stated that the medical director consults with the provider prior to the authorization decision, as necessary. However, HSAG observed during on-site denial record reviews for DHMC, two of 10 cases in which the requesting provider was not consulted to obtain or clarify information needed for authorization. In one of those cases, UM attempted to obtain additional information from the DME company (service provider) rather than from the original requesting provider.	DHMC must ensure that the actual requesting provider is consulted when necessary to obtain information needed for making the authorization decision.
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 I—Coverage and Authorization of Services—CHP+ Only		
Requirement	**Findings**	**Required Action**
12. The Contractor has in place processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested (notice to the provider need not be in writing).	On-site CHP+ denial record reviews consisted of 10 retrospective claim denials for out-of-network services. DHMP provided no notice of action to the member in 10 of 10 records reviewed. (None of these denials were processed through the Utilization Management Department.) DHMC/DHMP requires UM authorization for non-emergent out-of-network services. As such, any claim denial for lack of authorization requires a written NOA to the member.	DHMP must implement mechanisms to ensure that claims denials for out-of-network services generate a written notice of action to the member. Furthermore, DHMP should consider implementing processes which strengthen the relationship between the claims adjudication and utilization management departments to ensure that out-of-network services are reviewed for potential authorization determinations. (See "Opportunities for Improvement" in Executive Summary.)
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 I—Coverage and Authorization of Services—Medicaid Only		
Requirement	**Findings**	**Required Action**
15. Notices of action must meet the language and format requirements of 42 CFR 438.10 to ensure ease of understanding (6th-grade reading level wherever possible and available in the prevalent non-English language for the service area).	The Utilization Review Determinations policy stated that NOAs were available in English and Spanish and included template letters for approval of service, denial of service, and extension of decision that appeared to be written in language easy to understand. The Drug Authorization, Utilization Review, and Formulary Management policy did not address ease-of-understanding requirements. During on-site interviews, staff members stated that, prior to mailing, the UM director reviews each NOA for required content but does not review for ease of understanding of the "reason for denial" description. During DHMC denial record reviews, HSAG identified six of 10 records in which the NOA contained language (entered in the reason for denial section) that was not easy for the member to understand. The template NOA letters for CHP+ members appeared to be written in language easy for the member to understand but could not be evaluated in the denial record reviews because no NOAs were sent to the members included in the sample. UM processes are the same for DHMC and DHMP; therefore, HSAG recommends that DHMP also review its NOA letters to CHP+ members to ensure that the "reason for denial" language in the letter is easy for the member to understand.	DHMC must develop mechanisms to ensure that the reason for denial entered into member NOA letters is written in language that is easy for the member to understand.
Planned Interventions:		

Standard I—Coverage and Authorization of Services—Medicaid Only		
Requirement	**Findings**	**Required Action**
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 I—Coverage and Authorization of Services—CHP+ Only		
Requirement	**Findings**	**Required Action**
17. The notices of action must be mailed within the following time frames: • For denial of payment, at the time of any action affecting the claim.	The Utilization Review Determinations policy accurately addressed all denial time frames per requirement. The Drug Authorization, Utilization Review, and Formulary Management policy addressed all primary time frames including standard, expedited, extended, and advance notice. However, the CHP+ denial record reviews—all of which were denial of claims—failed to notify the member of denial of payment at the time of action affecting the claim. DHMC provided no explanation of benefits (EOB) or other notice of action to the member in 10 of 10 cases.	DHMP must ensure that it mails notices of action (e.g., EOB) for denial of payment at the time of any action affecting the claim.
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 II—Access and Availability—CHP+ and Medicaid		
Requirement	**Findings**	**Required Action**
1. The Contractor maintains and monitors a network of appropriate providers sufficient to provide adequate access to all services covered under the contract. In order for the Contractor's network to be considered to provide adequate access, the Contractor includes the following provider types and ensures a minimum provider-to-member caseload ratio as follows: • 1:2,000 primary care physician (PCP)/provider-to-member ratio. PCP includes physicians designated to practice family medicine and general medicine. • 1:2,000 physician specialist-to-members ratio. Physician specialist includes physicians designated to practice cardiology, otolaryngology, endocrinology, gastroenterology, neurology, orthopedics, pulmonary medicine, general surgery, ophthalmology, and urology. • Appropriate access to certified nurse practitioners and certified nurse midwives. • Physician specialists designated to practice internal medicine, gerontology, obstetrics and gynecology (OB/GYN), and pediatrics shall be counted as either PCP or physician specialist, but not both.	Denver Health appeared to calculate its provider-to-member ratios using the total number of contracted providers compared to the number of members enrolled in the Medicaid or the CHP+ program, without considering that these providers are also responsible for providing care to members affiliated with other lines of business. So, while Denver Health noted a primary care provider-to-member ratio of 3: 2,000 for Medicaid and 36: 2,000 for CHP+, other components used to measure adequacy (e.g., grievances, satisfaction surveys, and daily unmet demand reports) indicate that the Denver Health provider network was not adequate to ensure timely availability of covered services.	Denver Health must continue to expand its network until it maintains a sufficient number of providers to ensure adequate access to all services covered under the contract.

Standard II—Access and Availability—CHP+ and Medicaid		
Requirement	**Findings**	**Required Action**
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 XI—Early and Periodic Screening, Diagnostic, and Treatment—Medicaid Only		
Requirement	**Findings**	**Required Action**
1. The Contractor must have written policies and procedures for providing EPSDT services to members age 20 and under, including lead testing and immunizations.	The Early and Periodic Screening, Diagnostic, and Treatment Benefit (EPSDT) Program policy addressed the comprehensive requirements for EPSDT services through policy statements that replicated the State EPSDT regulations. However, the policy defined procedures for implementation in a very limited manner, addressing neither accountabilities nor mechanisms for implementation of most requirements. In addition, DHMC submitted no corresponding procedures from other departments that specifically addressed EPSDT elements. The provider manual defined responsibilities of providers for implementing some components of the policy. During on-site interviews, staff members stated that they considered the provider manual to be the primary source to communicate procedures for operationalizing the policy and noted that other procedures and systems already in place throughout the broader DHHA system were also applicable.	DHMC must enhance its EPSDT policy or related policies and procedures to define or link to organizational procedures which address mechanisms to operationalize all components of the 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 XI—Early and Periodic Screening, Diagnostic, and Treatment—Medicaid Only		
Requirement	**Findings**	**Required Action**
3. The Contractor must implement the American Academy of Pediatrics Bright Futures periodicity schedule.	The EPSDT Program policy states that DHMC implements the Bright Futures Periodicity Schedule, but does not state *how* it is implemented. The policy also includes an attachment that includes guidance for conducting some types of screenings, but is not the AAP Bright Futures Periodicity Schedule; nor was there evidence that the information in the attachment is communicated outside the policy. The policy states that the periodicity schedule is available to members on the DHMC website and that members are informed through the member handbook. However, the member handbook does not include such communication, and the periodicity schedule's placement on the website was not apparent to HSAG reviewers. The provider manual does not contain the Bright Futures Periodicity Schedule, reference the periodicity schedule by name, or direct providers to other sources to obtain the periodicity schedule. Furthermore, the description of EPSDT services in the provider manual is high level and does not represent the clinical detail included in the actual Bright Futures Periodicity Schedule. Therefore, it is unclear how DHMC intends to implement the Bright Futures Periodicity Schedule, particularly with providers.	DHMC must enhance its provider communications and provide access to the AAP Bright Futures Periodicity Schedule and provide access to the periodicity schedule in order to fully operationalize this component of its EPSDT Program policy.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment—Medicaid Only		
Requirement	**Findings**	**Required Action**
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment—Medicaid Only		
Requirement	**Findings**	**Required Action**
7. If the screening provider is not licensed or equipped to render necessary treatment or further diagnosis, the provider shall refer the individual to an appropriate practitioner or facility or to the Outreach and Case Management Office (Healthy Communities) for assistance in finding a provider.	The EPSDT Program policy included this requirement verbatim, but did not outline procedures for implementation. DHMC provided documents that demonstrated that mechanisms are in place to assist with provider referrals to other providers or Healthy Communities through the UM Department and that an automated referral capability is offered through the new Epic electronic record system. However, the EPSDT section of the provider manual was vague on the responsibility of the provider to refer the member to an appropriate practitioner (except for dental services), listing "Denver Health Medical Management" (no contact number) as a source for authorizations or assistance. The provider manual also describes the role of the EPSDT outreach coordinators (which did not include assistance with finding a provider) with no reference to the provider making a referral to Healthy Communities or a contact number to do so.	This requirement is a provider responsibility; therefore, DHMC must enhance EPSDT provider communications to more explicitly state that (if a provider is not licensed or equipped to render necessary treatment) the *provider* is responsible to make a referral to another provider, make a referral to Healthy Communities, or make a referral to the UM case managers to assist with a referral. DHMC should ensure that operational processes intended to support this requirement are clearly defined within policies or other written procedures to ensure accountability for fulfilling this requirement. (See "Opportunities for Improvement" in Executive Summary.)
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 XI—Early and Periodic Screening, Diagnostic, and Treatment—Medicaid Only		
Requirement	**Findings**	**Required Action**
9. A referral from the member's primary care physician may be required for care provided by anyone other than the primary care physician. • Members may self-refer for routine vision, dental, hearing, or mental health services; or family planning services. • Providers shall be responsible for obtaining prior authorization when required for identified services such as home health, orthodontia, private duty nursing, and pharmaceuticals.	The EPSDT Program policy states that the screening provider will refer individuals to an appropriate practitioner for necessary treatment or further diagnosis; but, it does not address provider responsibility for obtaining authorization for specific EPSDT services, what the EPSDT services are, or for what services the member may self-refer. The provider manual generally describes the responsibility of the primary care physician to make referrals and participate in the prior authorization process, but does not describe EPSDT services that require an authorization from DHMC or services for which members may self-refer.	DHMC must enhance provider communications to ensure that providers are aware of the types of EPSDT services and referrals that *do* or *do not* require prior authorization and clarify the process for obtaining authorization when necessary.
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 XI—Early and Periodic Screening, Diagnostic, and Treatment—Medicaid Only		
Requirement	**Findings**	**Required Action**
10. The Contractor defines "Medical Necessity for EPSDT Services" as: • A service that is found to be equally effective treatment among other less conservative or more costly treatment options. • Meets one of the following criteria: – The service is expected to prevent or diagnose the onset of an illness, condition, or disability. – The service is expected to cure, correct, or reduce the physical, mental, cognitive, or developmental effects of an illness, injury, or disability. – The service is expected to reduce or ameliorate the pain and suffering caused by an illness, injury, or disability. – The service is expected to assist the individual to achieve or maintain maximum functional capacity in performing activities of daily living. • May be a course of treatment that includes observation or no treatment at all. – The Contractor's UM process provides for approval of healthcare services if the need for services is identified and meets the following requirements: o The service is medically necessary.	The EPSDT Program policy outlined the definition of "medical necessity" and criteria for UM approval specifically as outlined in the requirement. However, these criteria were not linked to or included in the UM Determinations policy. The UM Determinations policy included criteria that paralleled the elements in the definition of "medical necessity," *excepting* the EPSDT-specific elements—"The service is expected to assist the individual to achieve or maintain maximum functional capacity in performing activities of daily living" and "May be a course of treatment that includes observation or no treatment at all."—which were not included. DHMC should note that the definition of "medical necessity" outlined in the State Medicaid Plan—10 CCR 2505-10 8.076.1.8--(effective 08/30/16) includes the EPSDT-specific criteria per 8.280.4.E. HSAG strongly recommends that the DHMC EPSDT policies incorporate the definition of "medical necessity" as outlined in the Findings section of Standard I, Element 4 of this tool.	DHMC must incorporate the complete and accurate definition of "medical necessity" for EPSDT services into applicable operating policies and procedures and ensure that the criteria are applied appropriately to authorization decisions for EPSDT-related services.

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment—Medicaid Only		
Requirement	**Findings**	**Required Action**
o The service is in accordance with generally accepted standards of medical practice. o The service is clinically appropriate in terms of type, frequency, extent, and duration. o The service provides a safe environment or situation for the child. o The service is not for the convenience of the caregiver. o The service is not experimental and is generally accepted by the medical community for the purpose stated.		
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

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 Medicaid managed care regulations and 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 three 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 plans also submitted a list of all Medicaid service and claims denials that occurred between January 1, 2016, and December 31, 2016. 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.

For this step,	HSAG completed the following activities:
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. • HSAG reviewed a sample of administrative records to evaluate implementation of Medicaid managed care regulations related to health plan service and claims denials and notices of action. • 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 2016–2017 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 draft 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.