Colorado Children's Health Insurance Program
Child Health Plan *Plus* (CHP+)

FY 2012–2013 Site Review Report

for

Denver Health Medical Plan, Inc.

April 2013

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

HSAG HEALTH SERVICES ADVISORY GROUP

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

CONTENTS

Overview of FY 2012–2013 Compliance Monitoring Activities

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

This is the second annual external quality review of compliance with federal managed care regulations performed for the CHP+ program by HSAG. For the fiscal year (FY) 2012–2013 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the four performance areas chosen. The standards chosen were Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement.

The health plan's administrative records were also reviewed to evaluate implementation of National Committee for Quality Assurance (NCQA) Standards and Guidelines related to credentialing and recredentialing. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of 5 records. Using a random sampling technique, HSAG selected the samples from all applicable practitioners who had been credentialed or recredentialed in the previous 36 months. For the record review, the health plan received a score of *Yes* (compliant), *No* (not compliant), or *Not Applicable* for each of the elements evaluated. Compliance with federal managed care regulations was evaluated through review of the four standards. HSAG calculated a percentage of compliance score for each standard and an overall percentage of compliance score for all standards reviewed. HSAG also separately calculated an overall record review score.

This report documents results of the FY 2012–2013 site review activities for the review period—July 1, 2012, through December 31, 2012. Section 2 contains summaries of the findings, strengths, opportunities for improvement, and required actions for each standard area. Appendix A contains details of the findings for the review of the standards. Appendix B contains details of the findings for the credentialing and recredentialing record reviews. Appendix C lists HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process the health plan will be required to complete for FY 2012–2013 and the required template for doing so.

Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the health plan's contract requirements, NCQA Credentialing and Recredentialing Standards and Guidelines, and regulations specified by the BBA, with revisions issued June 14, 2002, and effective August 13, 2002. HSAG conducted a desk review of materials submitted prior to the on-site review activities, a review of documents and materials provided on-site, and on-site interviews of key health plan personnel to determine readiness to comply with federal managed care regulations. Documents submitted for the desk review and during the on-site document review consisted of policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials.

The four standards chosen for the FY 2012–2013 site reviews represent a portion of the Medicaid managed care requirements. Standards that will be reviewed in subsequent years are: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

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

Objective of the Site Review

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

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

Summary of Results

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

Table 1-1 presents the score for **Denver Health Medical Plan, Inc.** (**DHMP**) for each of the standards. Details of the findings for each standard follow in Appendix A—Compliance Monitoring Tool.

Table 1-1—Summary of Scores for the Standards

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
III Coordination and Continuity of Care	9	9	9	0	0	0	100%
IV Member Rights and Protections	5	5	5	0	0	0	100%
VIII Credentialing and Recredentialing	49	47	44	3	0	2	94%
X Quality Assessment and Performance Improvement	11	11	10	1	0	0	91%
Totals	**74**	**72**	**68**	**4**	**0**	**2**	**94%**

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

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

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Credentialing Record Review	80	79	79	0	1	100%
Recredentialing Record Review	80	77	77	0	3	100%
Totals	**160**	**156**	**156**	**0**	**4**	**100%**

2. Summary of Performance Strengths and Required Actions

for **Denver Health Medical Plan, Inc.**

Overall Summary of Performance

DHMP is a wholly owned subsidiary of Denver Health and Hospital Authority (DHHA). As such, **DHMP** benefitted from overall DHHA systems and processes and service provision for members primarily from DHHA clinics located throughout the Denver metropolitan area. For the four standards reviewed by HSAG, **DHMP** earned an overall compliance score of 94 percent. **DHMP**'s strongest performances were in Standard III—Coordination and Continuity of Care and Standard IV—Member Rights and Protections, both of which earned a compliance score of 100 percent. **DHMP** also performed well in Standard X—Quality Assessment and Performance Improvement with 91 percent compliance, and it earned a 94 percent compliance score in Standard VIII—Credentialing and Recredentialing. **DHMP** demonstrated strong performance overall and an understanding of the federal regulations, the CHP+ Managed Care Contract, and NCQA Credentialing and Recredentialing Standards and Guidelines.

Standard III—Coordination and Continuity of Care

Summary of Findings and Opportunities for Improvement

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

During the on-site interview, **DHMP** presented two cases to demonstrate care coordination: one 15-year-old female with anxiety, obesity, and asthma, living with her mother and participating in school, who required interventions for general health improvement and possible mental health support; and one 7-year-old male with multiple emergency and urgent care visits and hospitalizations for a skin condition, behavior problems in school, need for family psychosocial support, whose parent declined CCM following an initial post-hospitalization assessment. Case presentations demonstrated care coordination with multiple providers and agencies, completion of a comprehensive individual needs assessment that included all of the required elements, development of an individual treatment plan based on the assessment and the member's prioritized goals, involvement of the member/family in the care plan, assignment of a PCP, and frequent updates. The case presentations also demonstrated the Altruista Guiding Care software system, which is used to document and support case management activities. HSAG recommended that **DHMP** consider a mechanism to more clearly document the member's agreement with the treatment plan in the Guiding Care system. **DHMP** stated that CCM had very few enrolled CHP+ members, and that **DHMP** was pursuing methods to increase identification of CHP+ members eligible for CCM. **DHMP** staff explained that case managers located in the DHHA specialty clinics often manage members at the highest risk levels with special health care needs. HSAG recommended that **DHMP** develop a means to coordinate with the specialty clinic case managers to ensure compliance with **DHMP** contract requirements and pursue additional means of identifying members appropriate for **DHMP** case management.

Summary of Strengths

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

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

Summary of Required Actions

There were no required actions for this standard.

Standard IV—Member Rights and Protections

Summary of Findings and Opportunities for Improvement

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

Summary of Strengths

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

Summary of Required Actions

There were no required actions for this standard.

Standard VIII—Credentialing and Recredentialing

Summary of Findings and Opportunities for Improvement

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

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

Summary of Strengths

DHMP's credentialing and recredentialing files were well organized and provided clear evidence that primary source verification and recredentialing activities occurred well within the prescribed time frames. Although **DHMP** is a subsidiary of DHHA, **DHMP** entered into a delegation agreement with DHHA to document the relationship and ensure compliance with NCQA standards for credentialing. **DHMP** performed delegation oversight and monitoring activities, as required when credentialing activities are delegated.

Summary of Required Actions

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

The Medical Staff Bylaws did not address notification to applicants regarding their rights under the credentialing program. **DHMP** must develop or revise documents to address notification to DHHA applicants regarding notification of rights under the credentialing program.

The Medical Staff Bylaws addressed the notification to the provider that an action will be taken, the process for the hearing, and the types of actions available to DHHA; but grounds for actions did not include quality of care reasons. **DHMP** must revise or develop documents that describe the range of actions available to DHHA for changing the conditions of a practitioner's status based on quality reasons.

Standard X—Quality Assessment and Performance Improvement

Summary of Findings and Opportunities for Improvement

The **DHMP** Quality Improvement (QI) Program Description and the QI Work Plan outlined a comprehensive approach for monitoring and improving services and outcomes for **DHMP** members. The QI program was accountable to the Board of Directors, with QI oversight responsibilities delegated to the **DHMP** Medical Management Committee (MMC). The QI Work Plan included a comprehensive listing of the QI activities for the coming year, but it did not include measurable goals or benchmarks for performance. HSAG recommended that **DHMP** consider adding measurable goals or benchmarks to the QI Work Plan, as appropriate. The first annual QI Impact Analysis Report will be produced in September 2013 and will include a summary of the preceding year's quality activity, including techniques used to improve performance, outcomes of each PIP, and the overall effectiveness of the QI program. Staff reported that the **DHMP** annual evaluation would be similar to, or combined with, the DMHC QI Impact Analysis report. HSAG recommended that **DHMP** ensure the inclusion of all elements outlined in the requirement, document conclusions and recommendations, and use outcomes from the annual report to establish QI goals for the subsequent year's QI Work Plan.

DHMP monitored underutilization through Healthcare Effectiveness Data and Information Set (HEDIS®)[2-1] measures and overutilization through quarterly reports of routine utilization measures and a dashboard of costs for services used. The program also monitored member satisfaction, grievance trends, quality of care concerns, provider access, and results of designated performance improvement projects (PIPs). **DHMP** had a health care information system that collected and integrated member, provider, and services data to support QI functions. **DHMP** developed and adopted the specifically required clinical practice guidelines (CPGs). Practice guidelines were developed in compliance with the required contract criteria and were integrated with the Denver Health system guidelines through the Denver Health Guidelines Committee. CPGs were available to providers through multiple channels and to members upon request. The **DHMP** policy stated that CPGs were available to the public at cost.

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

[2-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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

Summary of Strengths

DHMP had a comprehensive QI Program Description that incorporates multiple QI monitoring components. DHHA's Medicaid line of business has developed processes to ensure compliance with contract requirements similar to the requirements of the CHP+ program. This enabled **DHMP** to combine analysis for CHP+ members with Medicaid members, when appropriate, and provided experience and a format for CHP+ QI program activities, including the 2013 QI Impact Analysis Report. In addition, many **DHMP** QI activities were conducted in conjunction with the QI activities performed in the DHHA delivery system, which enhanced the integration of quality of care for **DHMP** members within the overall DHHA care delivery system. This integration was facilitated through the participation of **DHMP** staff and providers in the QI committees and efforts of both **DHMP** and DHHA staff members. Staff described the activities of the DHHA Guidelines Committee as an example of these efforts.

DHMP had an integrated health information system that captured data from multiple sources, produced routine and ad-hoc reports for QI monitoring, and supported operational applications such as case management. In addition, the **DHMP** health information system had the ability to electronically access and share information with DHHA's clinical data system to support managed care programs.

Summary of Required Actions

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

Appendix A. Compliance Monitoring Tool
for Denver Health Medical Plan, Inc.

The completed compliance monitoring tool follows this cover page.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has written policies and procedures to ensure timely coordination with any of a member's other providers of the provision of Covered Services to its members and to ensure: ◆ Service accessibility. ◆ Attention to individual needs. ◆ Continuity of care to promote maintenance of health and maximize independent living. Contract: Exhibit A—2.7.4.1	1. Care Coordination Overview.pdf 2. Care Coordination Visio.pdf These two documents provide a narrative and illustrative overview of the care coordination activities by DH Managed Care. 3. CM01 v.01 Case Management Program Description.pdf This document describes how the various units within the CM department function to make sure the members can access the services they need. 4. HW01 v.02 Behavioral Health & Wellness Program Description.pdf Pages 5-8 describe the role of the BHW Program in promoting the improvement/maintenance of member health and maximizing independent living. 5. MCD Choice CHP UM04 v 02 Members w SHCNs.pdf This policy details the processes for coordination of services for members with Special Health Care Needs. 6. MS_New_Mbr_Welcome_Call_Flow.final.vsd This Visio illustrates the process for the New Member Welcome Call and the specific department interventions. 7. MS New Member Welcome Call Script.doc This script includes the questions asked during for the New Member Welcome Call. 8. CS01 Referral Revew.pdf This Visio illustrates how member needs are identified and referred to appropriate department for intervention.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor's procedures are designed to address those members who may require services from multiple providers, facilities, and agencies; and require complex coordination of benefits and services and those members who require ancillary, social, or other community services. The Contractor coordinates with the member's mental health providers to facilitate the delivery of mental health services, as appropriate. *42CFR438.208(b)(2)* Contract: Exhibit A—2.7.4.2, 2.7.4..3..2, 2.7.4.3.3	1. Care Coordination Documentation.pdf 2. Care Coordination Visio.pdf These two documents provide a narrative and illustrative overview of the care coordination activities by DH Managed Care. 3. CM01 v.01 Case Management Program Description.pdf Pages 4-8 discuss the CCM and UM activities related to coordination with various providers and resources. 4. HW01 v.02 Behavioral Health & Wellness Program Description.pdf Page 7, d, describes the integration of the health coaches into the community health clinics. Section #4 on pages 8-9, describes the telephonic counseling for depression and anxiety program. 6. HC_CCM_CM_CS comparison chart.pdf This chart differentiates the Managed Care Resources available for member with special health care needs. 7. DOP – Community Resources.pdf Program guidelines that outlines how to address members with multiple needs, requiring community referrals. 8. Community Resources Script.xls This questionnaire is used to document in Guiding Care™ the Community Resource Referrals made by the staff. 9. CS01 Referral Review.pdf This Visio illustrates the process used by Care Support staff to evaluate members' needs and refer members to the appropriate programs for services.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	10. CS02 Appointments.pdf This Visio illustrates the process for coordinating care including scheduling appointments. 11. CO03 Transportation.pdf Visio illustrating process for coordinating care including arranging transportation to/from appointments. 12. CS07 Post Discharge Call.pdf Visio illustrating the process for making calls to members upon discharge from hospital – often coordinating with pharmacy, home health, DME, etc. 13. Post Discharge Call Script.xls Copy of the questions (script) asked during the post-discharge call – asking questions to determine coordination needs. 14. MS_New_Mbr_Welcome_Call_Flow.final.vsd This Visio illustrates the process for the New Member Welcome Call and the specific department interventions. 15. MS New Mbr Welcome Call Script.doc This script includes the questions asked during for the New Member Welcome Call. 16. CCM Introduction Letter.doc Copy of letter sent to members new to Complex Case Management – explaining CCM role in coordinating with multiple providers. 17. CM Program Consent.docx Consent form that is sent to members new to Complex Case	

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

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The Case Management Program Description and the Care Coordination Overview defined CHP+ members requiring care coordination as those who require services from multiple providers, including mental health, ancillary, social, or other community services. The program delineated how individuals with special health care needs are identified, individual needs assessed, and a treatment plan implemented. The Behavioral Health and Wellness Program Description stated that behavioral health coaches facilitate the integration of behavioral and physical health needs either telephonically or on-site at Denver Health primary care. DHMP submitted numerous documents that addressed procedures related to various case management program functions. The Community Resources procedure outlined the process for the coordination of services with external community service providers and agencies. The Coordination of Mental Health procedures addressed accessing members' mental health needs and facilitating access to mental health services. The procedure stated that a member-signed release of information form, specific to mental health information, was required for coordinating care with mental health providers. During the on-site interview, staff presented two care coordination cases: a 15-year-old female with anxiety, obesity, and asthma, living with her mother and participating in school, who required interventions for general health improvement and possible mental health support; and a 7-year-old male with multiple emergency and urgent care visits, hospitalizations for a skin condition, behavior problems in school, need for family psychosocial support, whose parent declined CCM following an initial post-hospitalization assessment. These case presentations demonstrated care coordination with multiple physical health providers, coordination with school-based services, ancillary services, and assistance with coordinating benefits. HSAG found evidence that mental health needs were assessed; however, at the time of on-site review, neither case had progressed to the provision of a mental health referral.		
Required Actions: None.		
3. The Contractor has a mechanism to ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating covered services furnished to the member. If a member does not select a primary care physician (PCP), the Contractor assigns the member to a PCP or a primary care facility and notifies the member, by telephone or in writing, of his/her facility's or PCP's name, location, and office telephone number. *42CFR438.208(b)(1)* Contract: Exhibit A—2.5.8.2	1. 2012-2013_Member Services_MCD-CHP_New_Member_Survey_&_Follow_up_Prrocess_2012.vsd This document demonstrates the process Member Services utilizes to contact new members and provide them information regarding selecting or changing their PCP. 2. GV03 v.02_PCP Assignment.pdf Describes plan's policies related to PCP assignment.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The PCP Assignment policy and the Member Services Welcome Call flow diagram delineated the process for a member to select, change, or be assigned to a PCP by the member services (MS) department. The policy also described communicating PCP assignment through dissemination of the member identification card. The policy stated that the PCP is responsible for routine member care and for coordinating covered services provided to the member. The DHMP Provider Manual informed providers of the process for PCP assignment, the responsibility of the PCP to actively manage care coordination with other providers, and the availability of case management services to coordinate care for members with complex health care needs. The CHP+ Member Handbook informed the member of the process for selecting a PCP and the responsibility of the PCP to coordinate care for the member. The on-site care coordination case presentations demonstrated that members had an assigned PCP and a complex case manager responsible for coordination of services.		
Required Actions: None.		
4. The Contractor implements procedures to provide an individual needs assessment after enrollment and at any other necessary time, including the screening for special health care needs (e.g., mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems). The assessment mechanisms must use appropriate health care professionals. *42CFR438.208(c)(2)* Contract: Exhibit A—2.7.4.3.1.1	1. Care Coordination Overview.pdf This document provides a narrative and illustrative overview of the care coordination activities by DH Managed Care. 2. CM01 v.01 Case Management Program Description.pdf Pages 3-7 describe multiple processes by Care Support, Complex Case Management and Utilization Management for identifying and assessing members with special health care needs. 3. HW01 v.02 Behavioral Health & Wellness Program Description.pdf Pages 2-4 list the qualifications of the program staff and Page 7, section c. details the assessments used to identify member needs. 4. MCD Choice CHP UM04 v 02 Members w SHCNs.pdf Pages 2-3 of this policy detail some of the procedures used to assess the individual needs of members. 5. Policy CCM04 v.01 CCM Member Referral Process 6. Policy CCM03 v.01 CCM Member Identification Process These two policies describe the processes by which members are	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	13. 2012-2013_Member Services_MCD-CHP_New_Member_Survey_&_Follow_up_Prrocess_2012.vsd This document demonstrates the process Member Services utilizes to contact new members and provide them information regarding selecting or changing their PCP.	
Findings: The Case Management Program Description stated that the care support staff conducted an initial survey with new CHP+ members to identify members with special health care needs, and that the CCM process used a comprehensive assessment of the member's individual needs, including input from the member, member's family/caregiver, the PCP, and medical record review. The CCM Comprehensive Assessment, included in the on-site presentation of care coordination cases, confirmed assessment of all of the elements outlined in the requirement. The CCM Case Identification diagram illustrated that members can be identified for CCM through health information system (HIS) utilization reports, provider or member referral, or new member health risk assessment (HRA). DHMP staff submitted additional documents that outlined specific procedures related to member assessments and member identification for CCM. During the on-site interview, staff confirmed that CCM assessments are performed by appropriate health care professionals (i.e., licensed nurses or social workers). During the on-site interview, staff stated that few CHP+ members were engaged in CCM, and that DHMP is pursuing mechanisms to increase the number of referrals of CHP+ members to CCM. Staff stated that the CHP+ population tends to be more healthy, and that many members are either difficult to reach or opt out of CCM. In addition, staff stated that Denver Health case managers are embedded in several DHHA specialty clinics and provide the case management for many of the high-risk (level 4) members with special health care needs.		
Required Actions: None.		
5. The Contractor shares with other health care organizations serving the member with special health care needs, the results of its identification and assessment of that member's needs, to prevent duplication of those activities. *42CFR438.208(b)(3)* Contract: Exhibit A—2.7.5.2	1. Care Coordination Documentation.pdf 2. Care Coordination Visio.pdf These two documents provide a narrative and illustrative overview of the care coordination activities by DH Managed Care. 3. CM01 v.01 Case Management Program Description.pdf This document describes how the various units within the CM department function to make sure the members can access the services they need.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	4. DOP – Pediatric Referrals to Children's Hospital CO.pdf This document outlines the process used by Managed Care referral coordinators – to facilitate sharing of relevant medical records between Denver Health and Children's Hospital Colorado. 5. Medical Mgt Documentation Form.pdf Managed Care staff use this form to document member updates. The form is then uploaded into EDM – for viewing by all Denver Health providers. 6. DH Release of Information Form.pdf DHHA form that provides consent for staff to assist in care coordination activities with multiple providers, agencies and/or services. 7. DH Behavioral Health Coordination Program.doc This document describes the coordination efforts between the Managed Care Pharmacy Department and the members' behavioral health providers.	
Findings: The Case Management Program Description stated that UM staff conducts prior authorization for referrals to non-Denver Health providers, identifies any care coordination or continuity issues, and provides care coordination services and referrals for members with less complex needs. The Pediatric Referrals to Children's Hospital policy described the procedure for exchanging the assessment of member needs and clinical information between Children's Hospital and DHHA. During the on-site interview, staff stated that the CCM assessment and treatment plan and the member's DHHA medical record are accessible within the DHHA HIS. Staff stated that the release of information is obtained from members to allow complex case managers to disclose member information that is pertinent to a particular agency's services.		
Required Actions: None.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor implements procedures to develop an individual treatment plan as necessary. *42CFR438.208(c)(3)* Contract: Exhibit A—2.7.4.3.1.2	1. CM01 v.01 Case Management Program Description.pdf Pages 5-6 outline the CCM process, including Care Plan Development and Implementation. 2. HW01 v.02 Behavioral Health & Wellness Program Description.pdf Pages 7-8 describe the process used by the Health Coaches to develop treatment plans with their members. 3. CCM06 CCM process.pdf Visio illustrates the CCM program elements including assessment of individual needs, identification of barriers and other special health care needs. 4. Care Plan Process Training.pdf Training presented to staff about using Guiding Care™ to create and update individualized care plans. 5. Care Plan Examples.doc Screenshot examples from Guiding Care™ of individual treatment/care plans. 6. SMAP_ENG.pdf 7. SMAP_SPA.pdf Tool used to improve members self-management skills and involvement in treatment planning activities.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Case Management Program Description stated that case managers work with the member/family to develop an individualized patient-centered plan of care that included goals, interventions, and regular progress notes. The Behavioral Health and Wellness Program Description defined the processes for health coaches to assist members with a self-management care plan. The Care Plan Process training document outlined the process for documenting and updating the member care plan in the Guiding Care case management system. DHMP submitted examples of care plans. During the on-site interview, staff stated that the care plan assessment results would auto-generate goals and interventions in the Guiding Care system, or case managers could define		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
customized goals and interventions, as appropriate. The coordination of care case presentations documented the development and implementation of an individualized care coordination plan based on the member assessment, which included prioritized goals, interventions, time frames for completion, and case manager progress notes with frequent follow-up.		
Required Actions: None.		
7. The Contractor's procedures for individual needs assessment and treatment planning are designed to: ◆ Accommodate the specific cultural and linguistic needs of the members. ◆ Allow members with special health care needs direct access to a specialist as appropriate to the member's conditions and needs. *42CFR438.208(c)(3)(iii)* Contract: Exhibit A—2.7.4.3.1.4	1. CM01 v.01 Case Management Program Description.pdf Pages 5-6 outline the CCM process, including Care Plan Development and Implementation. 2. HW01 v.02 Behavioral Health & Wellness Program Description.pdf Page 5 includes discussion of staff training, including cultural competency 3. MCD Choice CHP UM04 v 02 Members w SHCNs.pdf Page 4 of this policy describes the Case Management process, to include individual needs assessment and treatment planning. 4. Policy P-2.100 Interpreter and Translation Services and Auxiliary Communication Devices 10-12-12.pdf DHHA policy for use of interpreter and/or translation services. 5. LLS-Training Reference Guide.pdf 6. Quick Reference Guide_DHHA.pdf Reference tools for staff when utilizing interpretation services for members. 7. Language Proficiency Testing_visio 8. Language Proficiency Test Info.pdf 9. Language Proficiency Test FAQs.pdf 10. Sample LLS Proficiency Test.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	11. Language Proficiency_Test Taking Tips.pdf These documents show Managed Care's process to ensure staffs are adequately equipped to accommodate special linguistic needs of members. 12. CCM Initial Comprehensive Assessment.xls (Q5 and Q10) 13. Health Coaching Initial Comprehensive assessment.xls (Q5 and Q9) Questions in the initial assessments for these programs include evaluation of cultural and linguistic needs, preferences or limitations.	

Findings:
The Case Management Program Description and submitted assessment documents addressed the member's cultural and linguistic needs. DHMP also submitted evidence of programs and procedures that assist staff in addressing the language proficiency needs of members. The Coordination and Continuity of Care for Members with Special Health Care Needs and/or Disabilities policy stated that the PCP may provide a standing referral to a specialist appropriate to the member's needs. The policy also stated that if necessary specialty care is not available in the DHMP network, staff would arrange for the member to see an out-of-network provider. The Compliance with Requirements of the Americans with Disabilities Act and Rehabilitation Act policy addressed the provision of special services to accommodate the needs of members with disabilities. The CHP+ Member Handbook communicated that members with special needs could continue care with existing providers for a period of time when transitioning into or out of the plan. The member handbook also stated that members must have a PCP referral to see a specialist. During the on-site interview, staff stated that the PCP referral is intended to facilitate the transfer of necessary information between providers, and that no authorization is required for in-network referrals. Staff also stated that after initial referral by the PCP, a member may re-access the specialist without a referral. HSAG recommended that DHMP review the member handbook and the provider manual to determine the clarity and consistency of communications that members with special health care needs may have direct access to a specialist, or clearly describe DHMP's process for standing referrals.

Required Actions:
None.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that they are applicable. In all other operations as well the Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42CFR438.208(b)(4)* *42CFR438.224* Contract: Exhibit A—2.7.4.1, 3.1.4.3 (RMHP—3.1.3.3)	1. HIP01 v.04_Confidentiality, Privacy, and Security of Member Information .pdf Demonstrates that each member's privacy is protected and that individually identifiable health information is used and disclosed in accordance with the privacy requirements in 45CFR parts 160 and 164, subparts A and E. 2. CHP_CTS301.pdf 3. DH Code of Conduct 2011.pdf (pgs. 8 & 20) 4. New Employee Orientation - HIPAA Compliance.ppt	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Confidentiality, Privacy, and Security of Member Information policy stated that all providers, employees, vendors, and subcontractors are required to maintain confidentiality of member information; and they may only disclose information for treatment, payment, and operations associated with administering patient care, including care management. The policy stated that DHMP would obtain appropriate member authorization for other uses or disclosures, and it detailed multiple circumstances in which member authorization is and is not required. DHMP required employees to sign a confidentiality agreement and included confidentiality requirements in provider contracts. The policy outlined the process of documenting and tracking disclosures of protected health information (PHI) through the compliance department; and it described the administrative, physical, and technical safeguards to protect PHI. DHMP submitted information related to employee communications and training related to member confidentiality, PHI, and HIPAA privacy requirements. The Community Resources and Coordination of Mental Health procedure included a requirement to obtain a release of information to share PHI or mental health information.		
Required Actions: None.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor's procedures include a strategy to ensure that all members and/or authorized family members are involved in treatment planning and consent to medical treatment. Contract: Exhibit A—2.7.4.3.4	1. CM01 v.01 Case Management Program Description.pdf Pages 5-6 discuss inclusion of authorized family members/caregivers in the CCM process. 2. DOP – Community Resources.pdf Program procedure that outlines how member and/or family/caregiver involvement in the coordination and referral for community resources. 3. DOP – Coordination of Mental Health.pdf Pages 2-3 discuss ways in which the members and/or family members are involved in the mental health referral/coordination process. 4. CCM Initial Comprehensive Assessment.xls (Q7-Q9) 5. Health Coaching Initial Comprehensive Assessment.xls (Q7-Q9) Initial assessment of member health status, including specific question about family, caregiver and/or support system involvement. 6. CM Program Consent.docx Letter sent to members to obtain consent for CM services.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Case Management Program Description stated that member involvement in complex case management is voluntary and requires written member consent. It also stated that complex case managers include the member and/or family and caregivers in the development of the member care plan, self-management goals, and interventions. The case management assessment documents identified the family/caregivers that the member would like to be involved in the treatment plan. The Coordination of Mental Health policy and the Community Resources policy included procedures for obtaining a member or legal guardian release of information for sharing pertinent information with external mental health or community services agencies. The care coordination case presentations demonstrated that the care coordination plan used a check mark to designate the individual goals that the member designated as being high-priority goals. One care coordination case demonstrated a teenage member's request to protect specific PHI from family members. Care plan progress notes also documented frequent contact with the member. HSAG recommended that DHMP explore a mechanism to more clearly document the member's and family's agreement with the treatment plan in the Guiding Care case management system.		
Required Actions: None.		

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

Total Score ÷ Total Applicable	=	100%

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has written policies and procedures regarding member rights. *42CFR438.100(a)(1)* Contract: Exhibit A—3.1.1.1	1. GV02 v.04_Member Rights and Responsibilities.pdf – Outlines DHMP policies and procedures regarding member rights. 2. DHMP_UMG1023.pdf Outlines DHMP policies and procedures regarding member rights to Advance Directives.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Member Rights and Responsibilities policy included each of the rights at 42CFR438.100 and as described in the Colorado CHP+ Managed Care contract. DHMP also had topic-specific policies that addressed specific member rights such as grievances and appeals, advance directives, and providing culturally and linguistically appropriate services.		
Required Actions: None.		
2. The Contractor ensures that its staff and affiliated network providers take member rights into account when furnishing services to members. *42CFR 438.100(a)(2)* Contract: Exhibit A—3.1.1.1.1	1. GV02 v.04_Member Rights and Responsibilities.pdf Demonstrates that DHMP has policies and procedures in place regarding member rights that staff and affiliated network providers must follow when providing services to members.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The CHP+ Member Handbook informed members of their rights under the CHP+ program. The DHMP Provider Manual (distributed via the intranet for DHHA providers and mailed to independently contracted providers) listed member rights and included a discussion that informed providers of the expectation that providers understand the rights listed and treat members of the DHMP health plan with respect. The May 25, 2012, Provider Newsletter (distributed via the intranet for DHHA providers and mailed to independently contracted providers) included an article titled "Shared Decision Making" that described the benefits of including members in treatment decisions. DHMP may want to consider including additional topic-specific member rights articles in provider newsletters periodically. During the on-site interview, DHMP staff described methods of keeping the topic of member rights visible to staff and providers. Methods included periodic discussions and trainings in DHHA provider meetings and DHMP leadership meetings and availability of rights lists on the Web site and company portal. Staff members also reported that customer service and grievance staff members are encouraged to take the opportunity to explain member rights to ensure member understanding during member telephone calls.		
Required Actions: None.		

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's policies and procedures ensure that each member is treated by staff and affiliated network providers in a manner consistent with the following specified rights: ◆ Receive information in accordance with information requirements (42CFR438.10). ◆ Be treated with respect and with due consideration for his or her dignity and privacy. ◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. ◆ Participate in decisions regarding his or her health care, including the right to refuse treatment. ◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. ◆ Request and receive a copy of his or her medical records and request that they be amended or corrected. ◆ Be furnished health care services in accordance with requirements for access and quality of services (42CFR438.206 and 42CFR438.210). *42CFR438.100(b)(2) and (3)* Contract: Exhibit A—3.1.1.1	1. CHP+ Member Handbook ENG.pdf – (found in the common documents folder) Demonstrates that members receive information in accordance with information requirements. 2. GV02 v.04_Member Rights and Responsibilities.pdf – Outlines DHMP policies and procedures which ensure that each member is treated with respect, receives information about treatment options and alternatives, participates in his or her health care, is free from any restraint or seclusion, and can request a copy of his or her medical records. 3. QI SBHC flyer v6.pdf - Is furnished health care services in accordance with requirements for access and quality of services for children within 5 miles of Denver Health School based systems. 4. CHP_QIM1305.pdf Demonstrates that we address Cultural and Linguistic Appropriate Services and train staff. 5. CHP_QI01 v.01 Quality Improvement Program Description.pdf (Page 5 under heading #5 titled Cultural and Linguistic Competency) 6. Denver Health has specific Policies that apply to all employees and address cultural awareness: a. American with Disabilities Act 4-144 b. Cultural and Religious Considerations Relative to Provision of Care 4-141 c. Equal Opportunity Employment 2-100 Workforce Diversity 4-108	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	7. DHMP_UMG1023.pdf Outlines DHMP policies and procedures regarding member rights to Advance Directives.	
Findings: DHMP staff members reported that routine and most specialty services (unless not available within the DHHA system) are provided to DHMP members by the staff providers and clinics of DHHA. The Member Rights and Responsibilities policy included each of the member rights. The list of member rights was published in the CHP+ Summer 2012 Member Newsletter. The provider manual included each of the member rights. The May 25, 2012, Provider Newsletter contained an article about shared decision-making in providing medical care. DHMP also had several policies that described processes to ensure cultural awareness and linguistically appropriate services. DHMP staff members reported that DHMP member rights staff members provide presentations regarding member rights and related processes during DHHA staff orientation. Staff stated that DHHA Patient Advocate staff are trained regarding DHMP member rights and grievance and appeals processes and will refer members to the managed care staff to follow up on any member concerns expressed to DHHA staff members. Staff also stated that grievance staff members review member grievances to determine if there are trends or patterns that indicate member rights have been violated.		
Required Actions: None.		
4. The Contractor ensures that each member is free to exercise his or her rights and that exercising those rights does not adversely affect the way the Contractor or its providers treat the member. *42CFR438.100(c)* Contract: Exhibit A—3.1.1.1.7	1. CHP+ Member Handbook ENG.pdf , pg. 49 – (found in the common documents folder) Demonstrates that DHMP notifies each member of their rights and that practicing these rights will not result in adverse treatment from Contractor or providers. 2. GV02 v.04_Member Rights and Responsibilities.pdf (part VI.A.x) Demonstrates that plan has policies in place that ensure that its members are free to exercise their rights without any adverse effect in the way they are treated.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The members' right to freely exercise rights without fear of retaliation is on the list of rights in the Member Rights and Responsibilities policy, the member handbook, the Summer 2012 member newsletter, and the provider manual. The Grievances section of the member handbook informed members that they will not lose CHP+ benefits because of filing a grievance. DHMP staff reported that member rights are listed in the member newsletter at least once per year and that the newsletter is a quarterly publication distributed via U.S. mail.		
Required Actions: None.		

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. Contractor complies with any other federal and State laws that pertain to member rights including Title VI of the Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act, and titles II and III of the Americans with Disabilities Act. *42CFR438.100(d)* Contract: 21.A	1. Americans With Disabilities Act (ADA) 4-144.pdf 2. Cultural and Religious Considerations Relative to Provision of Care 4-141.pdf 3. EqualEmploymentOpportunity2-100.pdf 4. Workforce Diversity 4-108.pdf 5. InternalDiscriminationInvestigationProcess4-109.pdf 6. CHOICE_MBR801 Compliance with Requirements of the American Disabilities Act of 1990 and Section 504 of the Rehabilitation A.PDF 7. SexualHarassmentNonDiscrimination4-106.pdf Demonstrates that Denver Health complies to non-discriminatory procedures. 8. CHP_ADM109.pdf Demonstrates that the plan has policies in place that mandate compliance with Federal and State laws	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DHMP provided several policies that articulated DHMP's commitment to federal nondiscrimination regulations in its interactions with employees and members. The member handbook included a statement that informs members that DHMP will not discriminate based on members' religion, race, national origin, color, ancestry, handicap, sex, sexual choice, or age. The CHP+ Compliance with Federal and State Laws policy described the processes to ensure compliance with federal and State Laws, including nondiscrimination laws.		
Required Actions: None.		

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

Total Score ÷ Total Applicable	=	100%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. NCQA CR1	#1 CRE01 v. 03 Credentialing and Recredentialing of Practitioners.pdf #2 CRE05 v.03 Delegation of Credentialing Activities.pdf Attachment A Delegated Credentialing Letter of Agreement Template #1 describes the formal process DHMP uses for credentialing and recredentialing of independent direct network practitioners following NCQA standards #2 this template outlines the requirements for delegated entities for credentialing & recredentialing activities performed on behalf of DHMP.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: During the on-site interview, DHMP staff members described DHMP's credentialing processes. DHMP is a wholly-owned subsidiary of DHHA and a separate legal entity. DHHA provided the majority of services to DHMP members. DHMP contracted directly with very few independent practitioners (about 35 at the time of the site review). DHMP's Credentialing and Recredentialing of Practitioners policy applied to independent practitioners contracted with DHMP. The DHHA Medical Staff Bylaws, Rules and Regulations, Fair Hearing Plan, and Appointment Procedures (the Medical Staff Bylaws), applied to DHHA staff practitioners. Together, these documents provided evidence that DHMP had a well-defined credentialing and recredentialing process for DHHA's employed practitioners as well as for practitioners contracted directly with DHMP for service provision. The policy and the Medical Staff Bylaws were consistent with NCQA's *2012 Standards and Guidelines for Health Plans.*		
Required Actions: None.		
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners to credential and recredential. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor.	CRE01 v. 03 Credentialing and Recredentialing of Practitioners.pdf DHMP requires credentialing of the following types of providers: 1. Medical Doctor (MD) 2. Doctor of Osteopathy (DO) 3. Doctor of Podiatric Medicine (DPM) 4. Doctor of Optometry (OD) 5. Oral Surgeons who are Dentists providing care under medical benefits 6. Non-physician practitioners who are licensed or certified by	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
(Examples include doctors of medicine [MDs], doctors of osteopathy [DOs], podiatrists, and each type of behavioral health provider). *42CFR438.214(a)* NCQA CR1—Element A1	the state, have an independent relationship with the organization, and provide care under the organization's medical benefits. 7. Allied Health Professionals (AHP) who are licensed by the state and permitted to practice independently under state law: Nurse Practitioners (NP), Physician Assistants (PA), Certified Nurse Midwives (CNM), Certified Registered Nurse Anesthetists (CRNA). 8. Master's level clinical social workers who are state licensed	
Findings: The Credentialing and Recredentialing of Practitioners policy specified that the policy applies to all practitioners contracted with DHMP, including medical doctors (MDs); doctors of osteopathic medicine (DO), doctors of podiatric medicine (DPM), and doctors of optometry (OD);non-physician practitioners; masters-level clinical social workers who are State-certified or licensed; and allied health professionals (AHPs). The policy defined AHPs as licensed professionals who are permitted to practice independently under State law (nurse practitioners [NPs], physician assistants [PAs], certified nurse midwives [CNMs], clinical nurse specialists [CNSs], and certified registered nurse anesthetists [CRNAs]). The Medical Staff Bylaws (applicable to DHHA staff practitioners) addressed credentialing and recredentialing of physician and non-physician practitioners employed by DHHA.		
Required Actions: None.		
2.B. The verification sources used. NCQA CR1—Element A2	CRE01 v. 03 Credentialing and Recredentialing of Practitioners.pdf VI Procedures-page 3, & Attachment F DHMP uses only NCQA accepted resources for primary source verifications	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Attachment F to the Credentialing and Recredentialing of Practitioners policy (applicable to contracted practitioners) identified the primary sources for verification of licenses, license sanctions, U.S. Drug Enforcement Administration (DEA) certification, malpractice claims history, and Medicare/Medicaid sanctions. The Medical Staff Bylaws (applicable to DHHA practitioners) also described primary sources used for verification of each required element.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	#1 CRE01 v. 03 Credentialing and Recredentialing of Practitioners.pdf, VI-Procedures, Pages 3-10 #2 CRE05 v.03 Delegation of Credentialing Activities.pdf - Attachment A Delegated Credentialing Letter of Agreement Template #1 Page 3-10 of this P&P outlines DHMP's criteria for credentialing and recredentialing of practitioners. #2 Delegated entities are held to the same DHMP criteria for credentialing and recredentialing which is outlined in the LOA template	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy included the conditions and requirements practitioners must comply with for participation in the DHMP contracted network. The Medical Staff Bylaws listed the general and basic qualifications (e.g., licensure and federal health care eligibility, clinical knowledge, communication skills, and professionalism) as well as conditions and requirements for appointment to a DHHA staff position.		
Required Actions: None.		
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	#1 CRE01 v. 03 Credentialing and Recredentialing of Practitioners.pdf, VI. Procedures DHMP has a well-defined process for making credentialing and recredentialing decisions which utilizes the Credentialing Committee and the Medical Director, outlined in the P&P under Credentialing Committee and Role of Medical Director	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy clearly delineated the process for making credentialing and recredentialing decisions for physician and non-physician practitioners contracted directly with DHMP. The Medical Staff Bylaws clearly delineated the process for making credentialing and recredentialing decisions for physicians. Although the Medical Staff Bylaws stated that the bylaws applied to AHPs, they did not delineate processes used for the AHPs. During the on-site interview, DHMP and DHHA staff members explained that AHPs are credentialed using different processes and a separate credentialing committee.		
Required Actions: DHMP must either revise the Medical Staff Bylaws or develop policies and procedures that clearly describe the process for making credentialing and recredentialing decisions for DHHA AHPs.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.E. The process for managing credentialing/ recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	#1 CRE01 v. 03 Credentialing and Recredentialing of Practitioners.pdf Under Confidentiality on page 6. The process as described in this P&P outlines how the files are maintained under strict security and confidentiality according to NCQA standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy and the Medical Staff Bylaws described the process for determining which credentialing files met the required criteria, which was consistent with NCQA requirements. The policy and the bylaws defined clean files, which can be presented to the DHMP medical director for approval for contracted practitioners, or to the Medical Staff Executive Committee for DHHA-employed practitioners. The policy also defined red-flagged files, which must be presented to the credentialing committee(s) for discussion and recommendations regarding action to be taken. During the on-site interview, DHMP and DHHA credentialing staff indicated that clean files approved by the DHHA chief medical officer were typically presented to the committee as well as red-flagged files, while DHMP (for independently contracted providers) files approved by the DHMP medical director were typically not presented to the DHMP credentialing committee but were available to the committee for review, if requested.		
Required Actions: None.		
2.F. The process for delegating credentialing or recredentialing (if applicable). NCQA CR1—Element A6	#1 CRE05 v.03 Delegation of Credentialing Activities.pdf This P&P outlines the process and standards for delegation of credentialing activities	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Delegation of Credentialing policy described the processes for delegating credentialing, and recredentialing activities. These processes included a pre-delegation audit, assessment of policies and procedures, required provisions for contracting, and oversight procedures. DHMP had a delegation agreement with the Medical Staff Office (MSO), a department within DHHA, for the credentialing and recredentialing of DHHA practitioners who provide services to DHMP members. During the on-site interview, DHMP staff members described the agreement as a formal delegation agreement.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.G. The process for ensuring that credentialing and recredentialing are conducted in a non-discriminatory manner, (i.e., must describe the steps the Contractor takes to ensure that it does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes). NCQA CR1—Element A7	#1 CRE01 v.03 Credentialing and Recredentialing of Practitioners.pdf, VI PROCEDURES Steps DHMP takes to ensure the process for non-discriminatory credentialing and recredentialing are outline in this P&P under Nondiscriminatory credentialing and recredentialing, page 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:

The Credentialing and Recredentialing of Practitioners policy and the Medical Staff Bylaws specifically stated that the granting of privileges would be made without regard to race, sex, national origin, color, religion, age, military status, sexual orientation, marital status, or the types of procedures or patients in which the practitioner specializes. The policy and the bylaws described the credentialing process as designed to ensure that decisions are made based on standardized criteria, which precludes discriminatory decision-making. During the on-site interview, DHMP and DHHA credentialing staff confirmed that credentialing and recredentialing decisions were based on the criteria. On-site review of committee meeting minutes confirmed that credentialing decisions were based on the credentialing criteria. On-site, HSAG reviewed evidence that members of the DHMP credentialing committee annually signed attestation/agreements to conduct credentialing committee activities in a nondiscriminatory manner. The policy also described an annual nondiscrimination audit that would occur in response to any discrimination complaints received from practitioners. Each year the director of provider relations informs the credentialing staff whether there had been complaints. If there were complaints, an audit would be conducted. The last query whether there had been complaints regarding discrimination during the credentialing processes was dated 1/6/12.

Required Actions:

None.

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.H. The process for notifying practitioners if information obtained during the Contractor's credentialing/recredentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A8	CRE01 v.03, Credentialing and Recredentialing of Practitioners.pdf, IV PROCEDURES, Practitioner Rights, page 4 The process for notifying practitioners if information obtained during the credentialing/recredentialing process varies substantially from the information they provide is described in the referenced P&P.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy and the Medical Staff Bylaws included the provision to notify providers, either in writing or by telephone call, if the information obtained during the credentialing process varied substantially from the information they provided in support of the credentialing application.		
Required Actions: None.		
2.I. The process for ensuring that practitioners are notified of credentialing and recredentialing decisions within 60 calendar days of the committee's decision. NCQA CR1—Element A9	CRE01 v.03, Credentialing and Recredentialing of Practitioners.pdf IV PROCEDURES Practitioner Rights.pdf , #D page 4 plus Attachments G & H (letter templates) DHMP notifies practitioners of it credentialing decision within 60 days, as outlined in the referenced P&P and demonstrated in the letter templates	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy stated that applicants will be notified in writing within 60 calendar days of the decision. The DHHA Medical Staff Bylaws indicated notification within 30 days. On-site review of 10 credentialing and 10 recredentialing records confirmed notification within the stated time frames.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.J. The medical director's or other designated physician's direct responsibility and participation in the credentialing/ recredentialing program. NCQA CR1—Element A10	CRE01 v.03, Credentialing and Recredentialing of Practitioners.pdf, Credentialing Committee and Role of Medical Director, page 5-6 The reference above describes the medical director's responsibility and participation in the credentialing/ recredentialing program for DHMP independent direct network practitioners.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy and the Medical Staff Bylaws described the roles of the chief medical officer (for DHHA) and the managed care medical director (for DHMP) regarding clean and red-flagged files and participation in the credentialing committees. During the on-site interview, staff confirmed the respective medical director (or physician-designee) participation in approval of clean files and as chairperson of the respective committees (the DHHA Medical Staff Executive Committee, the DHHA AHP credentialing committee, or the DHMP credentialing committee). On-site review of committee meeting minutes for each committee confirmed medical director participation in the committees.		
Required Actions: None.		
2.K. The process for ensuring the confidentiality of all information obtained in the credentialing/ recredentialing process, except as otherwise provided by law. NCQA CR1—Element A11	CRE01 v. 03, Credentialing and Recredentialing of Practitioners.pdf, Sec. VI PROCEDURES, Confidentiality and PHI, page 6 All information obtained in the process of credentialing and recredentialing is confidential, the process to ensure this is described in the above reference	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The DHMP Credentialing and Recredentialing of Practitioners policy stated that DHMP will maintain and respect the confidentiality of all discussions, records, and files; that files would be kept in a locked cabinet; and that committee members would be required to sign a confidentiality statement. The Medical Staff Bylaws stated that all files would be kept under strict security and designated which staff members would be allowed access to credentialing and recredentialing files. On-site, DHHA and DHMP staff members confirmed processes for ensuring the confidentiality of credentialing files. Signed confidentiality attestations for the DHMP committee members were reviewed on-site.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.L. The process for ensuring that listings in provider directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty. NCQA CR1—Element A12	CRE01 v.03, Credentialing and Recredentialing of Practitioners.pdf, VI PROCEDURES, Provider Directories, see page 7 The information contained in the DHMP provider directories is electronically transmitted comes the credentialing database and is managed by the credentialing coordinator.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy stated that, to ensure that information in all directories (print and online) is consistent with the information obtained during the credentialing process, all published information would come directly from the credentialing database. During the on-site interview, DHMP staff reported that the online directory was refreshed with current credentialing/recredentialing data monthly. Staff also clarified that the provider directory included only DHHA clinics and practitioners, and that independently contracted providers are specialty practitioners or facilities that are used only upon member referral by a DHHA practitioner.		
Required Actions: None.		
2.M. The right of practitioners to review information submitted to support their credentialing or recredentialing application, upon request. NCQA CR1—Element B1	CRE01 v.03, Credentialing and Recredentialing of Practitioners.pdf, VI PROCEDURES, Practitioner Rights #A, page 4 All practitioners credentialed, both DHHA and network, have the right to review information being used for credentialing purposes except that which is peer protected; they have the right to correct any erroneous information as described in the reference above.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy and the Medical Staff Bylaws included the right of practitioners to review information submitted to support the credentialing or recredentialing application.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.N. The right of practitioners to correct erroneous information. NCQA CR1—Element B2	CRE01 v.03, Credentialing and Recredentialing of Practitioners.pdf, VI PROCEDURES, Practitioner Rights #A, page 4 Practitioners have the right to correct erroneous information as described in the above reference.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy and the Medical Staff Bylaws specified the right of practitioners to correct erroneous information and included the process practitioners may use to correct any erroneous information.		
Required Actions: None.		
2.O. The right of practitioners, upon request, to receive the status of their application. NCQA CR1—Element B3	CRE01 v.03, Credentialing and Recredentialing of Practitioners.pdf, VI PROCEDURES, Practitioner Rights #A, page 4 Practitioners have the right to check on the status of their application as described in the above reference	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy and the Medical Staff Bylaws included the right of practitioners to check the status of their credentialing or recredentialing application.		
Required Actions: None.		
2.P. The right of the applicant to receive notification of their rights under the credentialing program. NCQA CR1—Element B4	CRE01 v.03, Credentialing and Recredentialing of Practitioners.pdf, VI. PROCEDURES, Practitioner Rights, #D & Attachments G & H letter templates CHP_PROV_MANUAL_PG54.pdf Applicants are notified of their rights through the letter of intent, and the DHMP Provider Manual.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy included the applicant's right to receive notification of applicant rights. The Medical Staff Bylaws did not address notification to applicants regarding their rights under the credentialing program.		
Required Actions: DHMP must develop or revise documents to address notification to DHHA applicants regarding notification of rights under the credentialing program.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.Q. How the Contractor accomplishes ongoing monitoring of practitioner sanctions, complaints, and adverse events between recredentialing cycles including: ◆ Collecting and reviewing Medicare and Medicaid sanctions. ◆ Collecting and reviewing sanctions or limitations on licensure. ◆ Collecting and reviewing complaints. ◆ Collecting and reviewing information from identified adverse events. ◆ Implementing appropriate interventions when it identified instances of poor quality related to the above. NCQA CR9—Element A	CRE01 v.03, Credentialing and Recredentialing of Practitioners.pdf, VI PROCEDURES, Ongoing Monitoring, pages 9-10 CHP_PROV_MANUAL_PG54.pdf All the bullets listed in 2Q are covered under the ongoing monitoring process outlined in the reference above.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:

The Credentialing and Recredentialing of Practitioners policy stated that the credentialing department conducts monthly searches of State licensing boards (for all licensed health care professionals), the Office of Inspector General (OIG), and the Medicare Opt Out Report. The policy also stated that member complaints related to practitioners are received and forwarded to the quality improvement (QI) department. These complaints are also forwarded to the credentialing department to be included in the provider file and reviewed during the recredentialing process. The policy stated that any DHMP practitioner identified as requiring actions is presented to the managed care medical director, the QI director, and the provider relations director for determinations of necessary actions. The Medical Staff Bylaws also listed the mechanisms used for ongoing monitoring of credentialed practitioners. The bylaws also included details of the circumstances under which a DHHA provider would be subject to a corrective action, the process for implementing and monitoring a corrective action, and the types of corrective actions. DHMP's policy regarding practitioner hearings and appeals delineated the process used by DHMP to collect and review information in response to a quality-of-care concern. This policy also described the process of implementing corrective actions, when necessary. On-site review of monthly printouts from the OIG list of excluded entities and the Colorado Department of Regulatory Agencies (DORA) demonstrated ongoing monitoring for sanctions. On-site review of credentialing committee meeting minutes demonstrated committee review and appropriate action based on ongoing monitoring for sanction activity.

Required Actions:

None.

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

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: DHMP's policy regarding practitioner hearings and appeals and Medical Staff Bylaws stated that DHMP/DHHA would report any actions taken and deemed reportable under applicable Colorado State law, the Health Care Quality Improvement Act of 1986, and the National Practitioner Data Bank (NPDB).		
Required Actions: None.		
2.T. A well-defined appeal process for instances in which the Contractor chooses to alter the conditions of a practitioner's participation based on issues of quality of care or service which includes: ◆ Providing written notification indicating that a professional review action has been brought against the practitioner, reasons for the action, and a summary of the appeal rights and process. ◆ Allowing the practitioner to request a hearing and the specific time period for submitting the request. ◆ Allowing at least 30 days after the notification for the practitioner to request a hearing. ◆ Allowing the practitioner to be represented by an attorney or another person of the practitioner's choice. ◆ Appointing a hearing officer or panel of the individuals to review the appeal. ◆ Providing written notification of the appeal decision that contains the specific reasons for the decision. NCQA CR10—Element A3and C	CRE03 v.03 Practitioner Appeal Rights.pdf VI Procedures, Appeals Process page 5 DHMP has the right to alter a provider's conditions of participation if deemed necessary based on quality issues. Whenever DHMP chooses to exercise this right, the provider has an appeal process which is well defined in the above reference.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: DHMP and DHHA had a well-defined appeal process for practitioners who receive a notice of an adverse recommendation that will result in revocation of staff membership or reduction or suspension of clinical privileges. The appeal process was delineated in the Medical Staff Bylaws and in DHMP's policy regarding practitioner hearings and appeals.		
Required Actions: None.		
2.U. Making the appeal process known to practitioners. NCQA CR10—Element A4	MCD_PROV_MANUAL_PG54.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Medical Staff Bylaws and the Credentialing and Recredentialing of Practitioners policy stated that a practitioner is notified of his or her right to appeal an adverse recommendation or decision in the Notice of Adverse Action letter.		
Required Actions: None.		
3. The Contractor designates a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions. The committee includes representation from a range of participating practitioners. NCQA CR2—Element A	CRE01 v. 03, Credentialing and Recredentialing of Practitioners.pdf VI, Procedures, Credentialing Committee and Role of Medical Director, page 5 DHMP utilizes a peer review process by a credentialing committee made up according to NCQA standards, outlined in the P&P referenced above.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Credentialing and Recredentialing of Practitioners policy stated that the Credentialing Subcommittee (of the Medical Management Committee) is composed of a range of participating practitioners. The Medical Staff Bylaws specified that the Medical Staff Executive Committee (the committee responsible for credentialing DHHA practitioners) is composed of members from the following specialties: medicine, community medicine, family practice, emergency medicine, dentistry and oral surgery, psychiatry, anesthesiology, obstetrics/gynecology, orthopedics, pathology, pediatrics, and radiology. Review of the DHHA credentialing committee meeting minutes (for physicians and for AHPs) and the DHMP committee meeting minutes confirmed processes as stated in the policies.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: None.		
4. The Contractor provides evidence of the following: ◆ Credentialing committee review of credentials for practitioners who do not meet established thresholds. ◆ Medical director or equally qualified individual review and approval of clean files. NCQA CR2—Element B	#1 CRE01 v. 03, Credentialing and Recredentialing of Practitioners.pdf VI PROCEDURES, Credentialing Committee and Role of Medical Director, F-I, page 5 #2 DHMP Credentialing Subcommittee Minutes (will be provided during on-site review) #1 defines the process #2 minutes presents evidence	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: On-site review of credentialing committee meeting minutes demonstrated that DHMP and DHHA followed these credentialing committee processes as described in policies.		
Required Actions: None.		
5. The Contractor conducts timely verification (at credentialing) of information, using primary sources, to ensure that practitioners have the legal authority and relevant training and experience to provide quality care. Verification is within the prescribed time limits and includes: ◆ A current, valid license to practice (verification time limit = 180 calendar days). ◆ A valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (effective at the time of the credentialing decision). ◆ Education and training, including board certification, if applicable (verification of the	#1 CRE01 v. 03, Credentialing and Recredentialing of Practitioners.pdf VI. PROCEDURES, Initial credentialing for independent network practitioner, page 7 #2 CRE01 v.03 Attachment A – CHCP Credentialing Application.pdf DHMP uses the CHCP Credentialing Application for credentialing and recredentialing of all practitioners. Each of the bullets of #5 are addressed in this application, each is verified within the 180 day time limit, using acceptable NCQA sources.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
highest of graduation from medical/ professional school, residency, or board certification [board certification time limit = 180 calendar days]). ◆ Work history (verification time limit = 365 calendar days) (non-primary verification—most recent 5 years). ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (verification time limit = 180 calendar days). NCQA CR3—Elements A and B		
Findings: The Credentialing and Recredentialing of Practitioners policy and the Medical Staff Bylaws included the required time frames for primary source verification of each piece of documentation. On-site record review of 10 credentialing records and 10 recredentialing records confirmed that all primary source verification was completed within the prescribed time frames for the records reviewed.		
Required Actions: None.		
6. Practitioners complete an application for network participation (at initial credentialing and recredentialing) that includes a current and signed attestation and addresses the following: ◆ Reasons for inability to perform the essential functions of the position, with or without accommodation. ◆ Lack of present illegal drug use. ◆ History of loss of license and felony convictions. ◆ History of loss or limitation of privileges or disciplinary actions.	#1 CR01 v.03 Credentialing and Recredentialing of Practitioners.pdf VI PROCEDURES, Application and Attestation, page 6. #2 CRE01 v.03 Attachment A – CHCP Credentialing Application.pdf pages 21-26 DHMP uses the CHCP Credentialing Application for credentialing and recredentialing of all practitioners as required by the state of Colorado. Each bullet of #6 is addressed in this application. The applicant is required to attest to its correctness and completeness; and verification is completed.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
◆ Current malpractice/professional liability insurance coverage (minimums = physician—.5mil/1.5mil; facility—.5mil/3mil), ◆ The correctness and completeness of the application. NCQA CR4—Element A NCQA CR7—Element C C.R.S.—13-64-301-302		
Findings: Schedule A of the Colorado Healthcare Professional Credentials Application (the application used by DHHA for staff provider applicants as well as for DHMP contracted providers) included all required elements as part of the attestation. On-site review of 10 credentialing records and 10 recredentialing records confirmed use of this application.		
Required Actions: None.		
7. The Contractor verifies the following sanction activities for initial credentialing and recredentialing: ◆ State sanctions, restrictions on licensure or limitations on scope of practice. ◆ Medicare and Medicaid sanctions. *42CFR438.610(b)(3)* NCQA CR5—Element A NCQA CR7—Element D	#1 CRE01 v.03, Credentialing and Recredentialing of Practitioners.pdf VI PROCEDURES, Initial Credentialing page 7, Recredentialing, page 8-9. #2 CRE05 v.03 Delegation of Credentialing Activities Attachment A Delegated Credentialing Letter of Agreement Template #D & E DHMP verifies each bullet of #7 within the 180 day time limit according to NCQA standards for both initial and recredentialing. DHMP requires the same of its delegated entities.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The credentialing application required all applicants to disclose all sanctions, restrictions on licensure, or limitations on scope of practice. The Credentialing and Recredentialing of Practitioners policy and the Medical Staff Bylaws stated that verification would be completed prior to the credentialing decision and within 180 days of the application date via the NPDB, OIG, or the State practice boards. On-site record review demonstrated that DHMP queried the required online databases at credentialing and recredentialing to confirm that providers did not have sanctions and were eligible for Medicaid program participation.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor has a process to ensure that the offices of all practitioners meet its office-site standards. The organization sets standards and performance thresholds for: ◆ Physical accessibility. ◆ Physical appearance. ◆ Adequacy of waiting and examining room space. ◆ Adequacy of treatment record-keeping. NCQA CR6—Element A	CR02 v. 03 Practitioner Office Site Quality.pdf VI. Procedures, #A & D DHMP has set an office site quality threshold of two complaints received within 24 months regarding all bulleted standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Office Site Quality policy stated that DHMP will perform a site visit to any practitioner's office when warranted. The policy went on to specify that DHMP would conduct a site visit when the threshold of two grievances related to physical accessibility, physical appearance, adequacy of waiting and exam room space, or adequacy of treatment record-keeping is met. The Site Visit Evaluation Form included the required elements. During the on-site interview, DHMP staff members reported that there had been no site visits based on office site quality complaints performed during the review period.		
Required Actions: None.		
9. The Contractor implements appropriate interventions by: ◆ Conducting site visits of offices about which it has received member complaints. ◆ Instituting actions to improve offices that do not meet thresholds. ◆ Evaluating effectiveness of the actions at least every six months, until deficient offices meet the thresholds. ◆ Continually monitoring member complaints for all practitioner sites and performing a site	CR02 v. 03 Practitioner Office Site Quality.pdf VI. Procedures #G-K DHMP has a process addressing each bullet in its P&P	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
visit within 60 days of determining a complaint threshold was met. ◆ Documenting follow-up visits for offices that had subsequent deficiencies. NCQA CR6—Element B		
Findings: The Practitioner Office Site Quality policy was consistent with NCQA standards and included all of the required elements.		
Required Actions: None.		
10. The Contractor formally recredentials its practitioners (at least every 36 months) through information verified from primary sources. The information is within the prescribed time limits and includes: ◆ A current, valid license to practice (verification time limit = 180 calendar days). ◆ A valid DEA or CDS certificate (effective at the time of recredentialing). ◆ Board certification (verification time limit = 180 calendar days). ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (verification time limit = 180 calendar days). NCQA CR7—Elements A and B NCQA CR8— Element A	#1 CRE01 v.03 Credentialing and Recredentialing of Practitioners.pdf VI Procedures, Initial Credentialing for Independent Network Practitioners, A-H pages 7-8 #2 CRE05 v.03 Delegation of Credentialing Activities.pdf Attachment A Delegated Credentialing Letter of Agreement Template DHMP recredentials its practitioners every 36 months, following a formal process which verifies each bullet according to NCQA standards. Furthermore DHMP has a delegation agreement with each entity contracted to perform credentialing activities on DHMP's behalf which requires them to conduct the same recredentialing activities, according to the same standards, and within the same 36 month time frame.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: DHMP's Credentialing and Recredentialing of Practitioners policy required all practitioners to be recredentialed every three years. The Medical Staff Bylaws stated that reappointment (recredentialing) occurred every two years. The recredentialing process, as stated in the policy and the bylaws, included verification of a current license, a valid DEA or Controlled Dangerous Substance (CDS) certificate, board certification, and a history of liability claims within the required time frames. The policy also stated that provider complaints, quality-of-care concerns, site quality issues, and reports from Managed Care Provider Relations would be reviewed and considered when determining the status of an application. On-site review of recredentialing records confirmed that DHHA providers reviewed were recredentialed within two years of the previous credentialing date, DHMP-contracted providers were recredentialed every three years, and primary source verification was completed within the prescribed time frames. On-site, DHMP staff members stated that DHHA practitioners are recredentialed every two years based on The Joint Commission (TJC) accreditation requirements.		
Required Actions: None.		
11. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of (organizational) providers with which it contracts, which include: 11.A. The Contractor confirms that the provider is in good standing with State and federal regulatory bodies. NCQA CR11—Element A1	CRE04 v.04 Assessment of Organizational Providers.pdf VI. PROCEDURES #A & B DHMP performs initial assessment of organizational providers prior to contracting, and re-assessment on 3 year intervals. This process includes confirming that the provider is in good standing with State and federal regulatory bodies by obtaining a copy of all licenses and verifying if applicable through Colorado state web pages.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DHMP's Assessment of Organizational Providers policy included the procedure for confirming that organizational providers are in good standing with State and federal regulatory bodies as part of its initial assessment and ongoing monitoring. On-site review of five organizational provider files confirmed that DHMP staff obtained copies of State licenses for the organizational providers and queried the OIG Web site for sanction information.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11.B. The Contractor confirms that the provider has been reviewed and approved by an accrediting body. NCQA CR11—Element A2	CRE04 v.04 Assessment of Organizational Providers.pdf VI. PROCEDURES #A & B DHMP confirms accreditation if applicable by obtaining a copy of the body's letter of approval; verification may be done through the accrediting body's web page	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Assessment of Organizational Providers policy stated that DHMP would confirm whether organizational providers had been approved by an accrediting body as part of DHMP's initial assessment and ongoing monitoring. The Organizational Provider Tracking spreadsheet and on-site review of organizational provider files demonstrated that DHMP confirmed whether the organization had been accredited.		
Required Actions: None.		
11.C. The Contractor conducts an on-site quality assessment if there is no accreditation status. NCQA CR11—Element A3	CRE04 v.04 Assessment of Organizational Providers.pdf VI. PROCEDURES #B, 8-10 ORG_SITE_TOOL.pdf DHMP's Contracting/Provider Relations Director will conduct an on-site quality assessment of a potential Organization Provider if they are (1) not accredited, and (2) not certified by CMS or have not had a CMS survey within the past 3 years.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The policy described the process for conducting a site visit if the organization is not accredited by one of the accrediting bodies accepted by DHMP. On-site review of organizational provider records demonstrated that two nonaccredited providers had a Colorado Department of Public Health and Environment (CDPHE) site survey in the file and one nonaccredited organizational provider had a Division of Behavioral Health (DBH) site survey in the file. The other two files reviewed on-site were accredited organizations.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11.D. The Contractor confirms at least every three years that the organizational provider continues to be in good standing with State and federal regulatory bodies, and if applicable, is reviewed and approved by an accrediting body. The Contractor conducts a site visit every three years if the organizational provider has no accreditation status. NCQA CR11—Element A	CRE04 v.04 Assessment of Organizational Providers.pdf VI. PROCEDURES #C Reassessment DHMP will reassess providers every 3 years, the same steps followed and criteria used for initial assessment is used for reassessment. A site visit will be conducted if the provider is (1) not accredited, and (2) not certified by CMS or have not had a CMS survey within the past 3 years.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Assessment of Organizational Providers policy stated that DHMP would confirm that organizational providers meet all required standards every three years. The Organizational Provider Tracking spreadsheet and on-site record review demonstrated that organizational providers were assessed every three years.		
Required Actions: None.		
11.E. The Contractor's policies list the accrediting bodies the Contractor accepts for each type of organizational provider. (If the Contractor only contracts with organizational providers that are accredited, the Contractor must have a written policy that states it does not contract with nonaccredited facilities.) NCQA CR11—Element A	CRE04 v.04 Assessment of Organizational Providers.pdf VI. PROCEDURES #B, 3 DHMP lists the approved accrediting bodies in its P&P, accreditation is not a requirement	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The policy listed the following acceptable accrediting bodies: Accreditation Association for Ambulatory Health Care (AAAHC), Accreditation Commission for Health Care (ACHC), Commission on Accreditation of Rehabilitation Facilities (CARF), Continuing Care Accreditation Commission (CCAC), CDPHE, Community Health Accreditation Program (CHAP), The Joint Commission (TJC), and National Committee for Quality Assurance (NCQA). Organizational provider records reviewed on-site included accreditation by CHAP and TJC.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor has a selection process and assessment criteria for each type of nonaccredited organizational provider with which the Contractor contracts. NCQA CR11—Element A	CRE04 v.04 Assessment of Organizational Providers.pdf VI. PROCEDURES #B. Initial Assessment Organizational Providers to be assessed are selected and referred to credentialing by the Director of Contracting/Provider Relations. Assessment is conducted as outlined in P&P Initial Assessment; a site visit is conducted by Contracting/Provider Relations in the case of non-accredited providers. Please see ORG_SITE_VISIT_TOOL.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Assessment of Organizational Providers policy described the criteria organizational providers must meet to contract with DHMP.		
Required Actions: None.		
13. Site visits for nonaccredited facilities include a process for ensuring that the provider credentials its practitioners. NCQA CR11—Element A	CRE04 v.04 Assessment of Organizational Providers.pdf VI. PROCEDURES #B 10 If an Organizational Provider **is not accredited, and is not surveyed by CMS or the State**, the Director of Contracting/Provider Relations shall conduct an onsite quality assessment prior to contracting; the site visit will evaluate the applicant's policies and procedures, quality assurance process, patient safety, medical record keeping practices, and the process for credentialing or screening staff. The Organizational provider must pass the site assessment by a minimum of 85% to be approved. Please see ORG_SITE_VISIT_TOOL.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: During the on-site interview, DHMP staff stated that for nonaccredited organizations also not surveyed by CDPHE, Centers for Medicare & Medicaid Services (CMS), or DBH, the director of provider relations would review credentialing and recredentialing policies and procedures for the organization and document the review in the provider's file at the time of the site review. Staff also reported that although DHMP has a process if needed, it is rare for		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
DHMP to contract with a nonaccredited organization not reviewed by CDPHE, CMS, or DBH. DHMP may want to consider documenting the review of credentialing/recredentialing policies and procedures directly on the site review form.		
Required Actions: None.		
14. If the Contractor chooses to substitute a CMS or State review in lieu of the required site visit, the Contractor must obtain the report from the organizational provider to verify that the review has been performed and that the report meets its standards. (CMS or State review or certification does not serve as accreditation of an institution.) A letter from CMS or the applicable State agency which shows that the facility was reviewed and indicates that it passed inspection is acceptable in lieu of the survey report if the organization reviewed and approved the CMS or State criteria as meeting the organization's standard. NCQA CR11—Element A	CRE04 v.04 Assessment of Organizational Providers VI. PROCEDURES #B 8 If a provider is not accredited, passing a CMS or state review within 3 years of assessment date is acceptable in lieu of a site visit. To verify certification, the provider must supply a copy of the most recent Colorado State survey or a letter from CMS or state agency indicating that the facility passed inspection and the date the inspection took place; the Company may also utilize the CDPHE web page to verify certification status.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Assessment of Organizational Providers policy stated that DHMP credentialing staff has reviewed the State Operation Manual and determined that CDPHE ensures that surveyed organizations credential their practitioners. Staff also confirmed on-site that the DBH site survey form also indicates that DBH ensures that organizations surveyed by DBH credential their practitioners.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The Contractor's organizational provider assessment policies and process include assessment of at least the following medical providers: ◆ Hospitals. ◆ Home health agencies. ◆ Skilled nursing facilities. ◆ Free-standing surgical centers. NCQA CR11—Element B	CRE04 v.04 Assessment of Organizational Providers.pdf III SCOPE DHMP requires assessment of the following medical Organizational Provider types: 1. Hospitals 2. Home Health Agencies 3. Skilled Nursing Facilities 4. Free Standing Surgical Centers. 5. Hospice/Long Term Care Centers 6. Renal Dialysis Centers	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DHMP's Assessment of Organizational Providers policy required assessment of hospitals, home health agencies, skilled nursing facilities, freestanding surgical centers, hospice/long-term care centers, renal dialysis centers, and behavioral health facilities providing mental health or substance abuse services in an inpatient, residential, or ambulatory setting. Organizational provider files reviewed on-site included files for a hospital, a home health facility, and skilled nursing facilities.		
Required Actions: None.		
16. The Contractor's organizational provider assessment policies and process include assessment of at least the following behavioral health and substance abuse settings: ◆ Inpatient. ◆ Residential. ◆ Ambulatory. NCQA CR11—Element C	CRE04 v.04 Assessment of Organizational Providers.pdf III SCOPE DHMP requires assessment of Behavioral Healthcare facilities providing mental health or substance abuse services in an inpatient, residential, or ambulatory setting.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DHMP's Assessment of Organizational Providers policy required assessment of hospitals, home health agencies, skilled nursing facilities, freestanding surgical centers, hospice/long-term care centers, renal dialysis centers, and behavioral health facilities providing mental health or substance abuse services in an inpatient, residential, or ambulatory setting. Organizational provider files reviewed on-site included a substance abuse treatment facility.		

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

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
19. The Contractor has a written delegation document with the delegate that: ◆ Is mutually agreed upon. ◆ Describes the responsibilities of the Contractor and the delegated entity. ◆ Describes the delegated activities. ◆ Requires at least semiannual reporting by the delegated entity to the Contractor. ◆ Describes the process by which the Contractor evaluates the delegated entity's performance. ◆ Describes the remedies available to the Contractor (including revocation of the contract) if the delegate does not fulfill its obligations. NCQA CR12—Element A	CRE05 v.03 Delegation of Credentialing Activities.pdf Attachment A Delegated Credentialing Letter of Agreement (Template) This P&P addresses the requirements for each bulleted item. Attachment A- LOA Template contains requirements for each bulleted item. Available onsite are copies of signed agreements with each delegated entity for credentialing activities.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The delegation agreement between DHMP and DHHA was signed by both parties and included all of the required provisions.		
Required Actions: None.		
20. If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes: ◆ A list of allowed use of PHI. ◆ A description of delegate safeguards to protect the information from inappropriate use or further disclosure. ◆ A stipulation that the delegate will ensure that subdelegates have similar safeguards.	CRE05 v.03 Delegation of Credentialing Activities.pdf Attachment A Delegated Credentialing Letter of Agreement (Template) B #9 Template language: DHMP requires that delegates follow the rules and standards laid out in The Health Insurance Portability and Accountability (HIPPA) Act.	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
◆ A stipulation that the delegate will provide members with access to their PHI. ◆ A stipulation that the delegate will inform the Contractor if inappropriate uses of the information occur. ◆ A stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends. NCQA CR12—Element B		
Findings: Not Applicable.		
Required Actions: None.		
21. The Contractor retains the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision making. This right is reflected in the delegation agreement. NCQA CR12—Element C	CRE05 v.03 Delegation of Credentialing Activities.pdf Attachment A Delegated Credentialing Letter of Agreement (Template) A #3 Template language: DHMP retains the right to approve, suspend, or terminate any provider selected by the Delegate to treat DHMP enrollees.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The agreement between DHMP and DHHA included the required provision that DHMP retains the right to approve, suspend, or terminate providers. DHMP provided evidence of reviewing reports from the delegates to ensure having the required information needed to exercise this right.		
Required Actions: None.		

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

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
24. For delegation arrangements in effect 12 months or longer, the Contractor performs an annual substantive evaluation of delegated activities against NCQA standards and organization expectations. NCQA CR12—Element F	CRE05 v.03 Delegation of Credentialing Activities.pdf VI. PROCEDURES #B Attachment A Delegated Credentialing Letter of Agreement (Template) Attachment B Audit Tool Summary P&P: For delegation arrangements in effect for 12 months or longer, the Company will conduct an annual performance evaluation of the delegate's credentialing, recredentialing, and practitioner monitoring activities Delegated Letters of Agreement have this requirement listed. An audit tool summary is provided to each delegated entity. Documented yearly audits are available onsite for review.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DHMP's annual audit activities included a review of DHHA's policies and procedures against NCQA standards.		
Required Actions: None.		
25. For delegation arrangements in effect 12 months or longer, the Contractor evaluates regular reports (at least semiannually). NCQA CR12—Element G	CRE05 v.03 Delegation of Credentialing Activities.pdf VI. PROCEDURES #C Attachment A Delegated Credentialing Letter of Agreement (Template) Reporting requirements are outlined in the P&P and the Letter of Agreement. Reports are required on at least a quarterly basis, for adds and terms.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: On-site review of DHMP credentialing committee meeting minutes demonstrated that the committee reviewed monthly reports from DHHA regarding credentialing activities performed.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
26. The Contractor identifies and follows up on opportunities for improvement, if applicable. NCQA CR12—Element H	CRE05 v.03 Delegation of Credentialing Activities.pdf VI. PROCEDURES #B #9 For any identified deficiencies, improvement suggestions will be made; the delegate must respond within 30 days with a prospective corrective action plan; if agreed upon the delegate is required to report when CAP is completed.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Delegation of Credentialing policy described the process for corrective action if the delegate failed to meet DHMP's standards and requirements. There were no instances of noncompliance requiring corrective action during the review period.		
Required Actions: None.		

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	45	X	1.00	=	45
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	2	X	NA	=	NA
Total Applicable		=	48	**Total Score**		=	45

Total Score ÷ Total Applicable	=	94%

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an ongoing Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. 42CFR438.*240*(a) Contract: Exhibit A—2.9	1. CHP_QI01 V.01 Quality Improvement Program Description.pdf demonstrates that we have a QAPI Program Description Program. There is documentation of the purpose, scope, policy and the responsibility of the QI Program. The remaining document describes in more detail all of the components of the QI Program. 2. DHMP CHP+_QI_WorkPlan2012_13.docx –demonstrates future QI activities	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The CHP+ QI Program Description policy described the purpose and the major focus areas of the QI program. The program description defined accountabilities and responsibilities of the QI committees and staff. The policy stated that the Board of Directors has ultimate accountability for the QI program, and the Board has charged the DHMP Medical Management Committee (MMC), executive director, and medical director with the oversight and advisory responsibilities for QI activities and outcomes. The CHP+ QI Work Plan documented the planned activities to be performed in the QI program, including review of member satisfaction data (Consumer Assessment of Healthcare Providers and Systems [CAHPS] surveys), Healthcare Effectiveness Data and Information Set (HEDIS) measures, grievance reporting and trending, quality of care concerns (QOCCs), provider access, and performance improvement studies. MMC meeting minutes documented review and approval of the CHP+ QI Work Plan. HSAG recommended that DHMP consider incorporating specific performance benchmarks or measurable goals in the QI Work Plan.		
Required Actions: None.		
2. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42CFR438.240(b)(3)* Contract: Exhibit A—2.9.4.4	1. CO2012_CHP+_HEDIS-Aggregate_Report_F1.pdf - 2012 MCD Choice HEDIS report - demonstrates that we track results from year to year to detect underutilization and overutilization 2. DHMP 2011 Annual QI Program Evaluation Comm CHP final.dpdf – demonstrates both underutilization and overutilization of services [#3-6 shows mechanisms to detect both underutilization and overutilization of services for our members] 3. CHP_Rates only.xls 4. DHMP CHP CHI_STATS 2012.xls 5. DHMPWorkPlan2012_final.doc 6. DHMC SFY 13 Network Adequacy Report.pdf [#7-8 shows evidence of our QAPI initiatives for both underutilization and	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	overutilization] 7. DHMP ER Brochurev1.pdf 8. QI Back to school CHP v1.pdf	
Findings: DHMP submitted sample data reports of HEDIS results used to monitor underutilization of services. During the on-site interview, staff provided evidence of additional utilization tracking reports (e.g., trended inpatient data, emergency room (ER) visits, cost of services). Staff stated that the utilization reports are reviewed by the Retention Committee to identify areas for improvement, as well as operations management personnel (including the QI director), who reports results to the MMC. Staff identified several initiatives that resulted from utilization monitoring.		
Required Actions: None.		
3. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis. The annual QAPI report describes: ◆ The specific preventive care priorities, and services covered in and goals of the program over the prior 12-month period. ◆ The status and results of each PIP started, continuing, or completed during the prior 12-month period. ◆ The results of member satisfaction surveys completed during the prior 12-month period. ◆ A detailed description of the findings of the program impact analysis. ◆ Techniques used by the Contractor to improve performance. ◆ The overall impact and effectiveness of the QAPI Program during the prior 12-month period. *42CFR438.240(e)(2)* Contract: Exhibit A—2.9.4.7, 4.7.2.1 (RMHP—4.6.2.1)	N/A -This is a new contract requirement that is not due until September 2013	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The first annual QI report for CHP+ is not due until September 2013, per initiation of the contract in July 2012. The QI Program Description stated that DHMP will conduct an annual program impact analysis and create a report of the preceding year's quality activity, including techniques used to improve performance, outcomes of each performance improvement project (PIP), and the overall effectiveness of the QI program. The QI annual evaluation will be reported to the DHMP Board of Directors. The CHP+ QI Work Plan included the production and review of the CHP+ annual evaluation report in September 2013. During the on-site interview, staff confirmed that the format and content of the CHP+ annual QI Impact report will be similar to that used for the Medicaid line of business. HSAG recommended that DHMP refer to the elements of the requirement, ensure the inclusion of all elements in the requirement in the QI Impact report, document conclusions and recommendations, and use outcomes from the annual report to establish QI goals for the subsequent year's QI Work Plan.		
Required Actions: None.		
4. The Contractor shall adopt practice guidelines for the following: ◆ Perinatal, prenatal, and postpartum care for women. ◆ Conditions related to persons with a disability or special health care needs. ◆ Well child care. Contract: Exhibit A—2.9.2.1	1. Master Guidelines for DHMP.xls 2. CHP_QI02 Clinical Practice Guidelines and Preventive Care Guidelines.pdf – Under *II. Purpose* demonstrates guidelines for perinatal, prenatal, postpartum care women and well child care.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The CHP+ Clinical Practice Guidelines and Preventive Care Guidelines policy (CPG Policy) included a list of clinical and preventive guidelines adopted by DHMP for special needs members, as well as guidelines for prenatal care and well-child care for all age groups, and for immunizations. The DHMP provider Web site confirmed the availability of all required CPGs. The CPG Policy stated that practice guidelines are not intended to replace a clinician's judgment or establish a protocol for all patients. The policy stated that monitoring compliance with guidelines was performed through HEDIS chart auditing or other QI projects.		
Required Actions: None.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor ensures that practice guidelines comply with the following requirements: ◆ Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. ◆ Consider the needs of the Contractor's members. ◆ Are adopted in consultation with contracting health care professionals. ◆ Are reviewed and updated annually. *42CFR438.236(b)* Contract: Exhibit A—2.9.2.1.2	1. Master Guidelines for DHMP.xls Note: Pediatric and Adolescent Immunization Criteria. Document demonstrates that practice guidelines are based on valid and reliable clinical evidence and consensus of health care professionals in the given field. Additionally, guidelines are reviewed and updated annually. 2. CHP_QI02 v.01 Clinical Practice Guidelines and Preventive Care Guidelines.pdf – Demonstrates that we meet the requirements: - Documentation under the Procedures section, it shows guidelines are based on valid and reliable clinical evidence - Documentation under the Procedures section, Part A it shows how we consider the needs of our members - Documentation under the Procedures section, Part G and Part I, it shows that we review/update annually	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The CPG Policy stated that guidelines are developed through a task force of the Medical Management Committee (MMC). The policy outlined the specific steps in the guideline development process, which addressed each of the elements in the requirement. The policy stated that guidelines are reviewed and updated annually through the MMC. During the on-site interview, staff explained that the DHHA Guidelines Committee oversees all DHHA guideline development and ensures that DHMP guidelines are integrated into the DHHA system-wide guidelines.		
Required Actions: None.		
6. The Contractor disseminates the guidelines to all affected providers, and upon request, to members, potential members, and the public, at no cost. *42CFR438.236(c)* Contract: Exhibit A—2.9.2.1.3	Print screens of the internal website for Providers that demonstrates that we have made guidelines available to our providers. 1. clinical practice and preventive care guidelines.png 2. clinical practice and preventive care guidelines 2.png 3. clinical practice and preventive care guidelines 3.png 4. CHP+ Member Handbook ENG.pdf - pg. 14 under Utilization Management – Demonstrates that DHMP notifies members that they can request guideline information upon request by calling Member Services (can be found in common documents)	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The CPG Policy stated that DHMP disseminates practice guidelines to providers through provider newsletters, the DHMP Web site, the DHHA intranet, or provider mailings. The policy stated that DHMP disseminates guidelines annually to members. However, during the on-site interview, staff clarified that members must request guidelines from member services. The CHP+ Member Handbook did not inform members of the availability of CPGs or how to request them, and DHMP did not provide other evidence of distribution of CPGs to members (per policy). All guidelines are available on the DHHA Intranet for access by internal providers, and contracted providers may request copies. The CPG Policy stated that guidelines are available to members and providers at no cost and to the public at cost.		
Required Actions: DHMP must modify its policy and procedure to allow the public (potential members) to request and receive clinical practice guidelines at no cost. DHMP must also inform members of the availability of CPGs and how to request them.		
7. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42CFR438.236(d)* Contract: Exhibit A—2.9.2.1.4	1. CHP_QI02 v.01 Clinical Practice Guidelines and Preventive Care Guidelines.pdf – aids in the decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The CPG Policy stated that DMHC staff will be educated on clinical guidelines to ensure that utilization and case management decisions, member education, covered benefits, and other clinical materials are consistent with the guidelines. During the on-site interview, staff stated that the DHMP case management staff uses the clinical guidelines for reference when working with members. Staff also stated that many of the activities that require use of the CPGs (i.e., committee review of quality information, development of health education materials, and utilization management) are performed within the DHHA system. Staff stated that representation of DHMP staff and providers in the DHHA activities ensures that DHMP guidelines are integrated into applicable operational processes. The MMC is responsible for overseeing the integration of clinical practice guidelines into DHMP QI processes.		
Required Actions: None.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42CFR438.242(a)* Contract: Exhibit A—2.9.4.10	The Xcelys Claims Based Processing System, Case and Care Management Screens, as well as the Pharmacy PAR Screens, Med Impact RX Navigator and data warehouse Reports will be available during the on-site review. There are no documents for this requirement. These websites, links, reports will be available for onsite review.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: During on-site review, DHMP provided an overview of the XCELYS health information system (HIS), which collects and integrates data from enrollment files, claims, pharmacy, authorizations, credentialing, member services, and case management systems. Data are analyzed and maintained in the data repository to generate files and reports for routine and customized purposes. DHMP presented an overview of the Altruista case management system and multiple HIS reports used for QI purposes, which verified that the HIS integrates information from multiple databases. During the on-site interview, staff stated that DHMP can access and exchange information with the DHHA HIS, which maintains patient treatment records, laboratory data, patient registries, and a data warehouse for reporting.		
Required Actions: None.		
9. The Contractor collects data on member and provider characteristics and on services furnished to members. *42CFR438.242(b)(1)* Contract: Exhibit A—2.9.4.10.2	1. ProviderDirectory2012.pdf - Provider Directory copy for the Web - Description: demonstrates collection of data on provider characteristics and on services furnished to members. 2. 2012_DHMP_AcessPlan-Final Version 5-2-12.pdf – see page 10 for description of services 3. CHP+_Ethnicity composition Summary.xlsx	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: During the on-site interview, staff stated that DHMP collects and maintains provider characteristics in the credentialing database, and collects member demographics and characteristics through the enrollment and eligibility files, updated through member contacts. DHMP collects and maintains information on services provided to members through the claims database, supplemented with data available in the Denver Health data warehouse, such as clinical information and disease registries. DHMP submitted several example reports using member and provider information as the basis for analysis.		
Required Actions: None.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor monitors member perceptions of accessibility and adequacy of services provided. Tools shall include: ◆ Member surveys (Consumer Assessment of Healthcare Providers and Systems [CAHPS]). ◆ Anecdotal information. ◆ Grievance and appeals data. ◆ Enrollment and disenrollment information. Contract: Exhibit A—2.9.4.3.2, 2.9.4.3.1	N/A; DHMP does not participate in CAPH survey's for CHP+ members There were zero QOCC's for 2012 for CHP+ members 1. DHMP CHP+ compliance report 4QFY12.doc 2. CHP+ enrollment and disenrollment 2012.pdf – member #'s per month of enrollment and disenrollment 3. CHP+ Results.jpg screenshot is from the 2011 HEDIS Aggregate Report for Child Health Plan Plus, March 2012 report from HSAG showing evidences of performance of services compared to other like organizations.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:
The CHP+ QI Program Description stated that DHMP would participate in the annual CAHPS member satisfaction survey and review trends of member grievances quarterly. The 2012/2013 DHMP QI Work Plan activities included review of CAHPS member satisfaction data and monthly review of member complaints related to access to care. The QI Work Plan documented that grievance summaries and trending, including any identified QOCCs, were reviewed quarterly. The sample quarterly DHMP report to the Department included a summary of grievances. The DHMP Access Plan stated that member satisfaction data and trends in member grievances were analyzed to determine access to care issues. Staff stated that member disenrollment codes are evaluated monthly and reported that most disenrollments were due to the member's pre-existing relationship with a non-network provider. The MMC meeting minutes documented review of annual CAHPS results, the annual HEDIS report, and grievance and appeals data; however, minutes did not include conclusions or recommendations related to results.

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

Required Actions:
None.

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor develops a corrective action plan when members report statistically significant levels of dissatisfaction, when a pattern of complaint is detected, or when a serious complaint is reported. Contract: Exhibit A—2.9.4.3.5	N/A – there was no significant levels of dissatisfaction	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The CHP+ Quality Improvement Program Description stated that DHMP would develop corrective action plans when members report statistically significant levels of satisfaction, when a pattern of complaints is detected, or when a serious complaint is reported. The Notification and Investigation of Potential Quality of Care Complaints policy outlined the procedures for investigation of QOCCs identified through the member grievance process. The policy stated that potential QOCCs were reviewed, corrected, trended, and reported quarterly to the MMC. A sample quarterly report of grievances and QOCCs documented that there were no trends in member grievances and no identified QOCCs. The Department did not conduct a CHP+ CAHPS survey during the review period.		
Required Actions: None.		

Results for Standard X—Quality Assessment and Performance Improvement							
Total	Met	=	10	X	1.00	=	10
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	11	**Total Score**		=	10

Total Score ÷ Total Applicable	=	91%

The completed record review tools follow this cover page.

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix B. Colorado Department of Health Care Policy and Financing
Credentialing Record Review Tool
for Denver Health Medical Plan, Inc.

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

SAMPLE	1		2		3		4		5		6		7		8		9		10	
Provider ID#																				
Provider Type (MD, PhD, NP, PA, MSW, etc.)	OD		OD		MD		MD		PA		MD		PhD		MD		MD		MD	
Application Date	1/18/10		12/15/09		1/12/09		4/23/12		3/8/12		2/21/12		10/6/11		9/2/11		4/14/11		1/11/11	
Specialty	Optometry		Optometry		Ped Pulm		Dermatology		Orthopedics		Family Med		Psychiatry		Gastroent		Ped Cardio		Psy-Eating	
Credentialing Date (Committee/Medical Director Approval Date)	3/15/10		3/15/10		1/26/09		6/29/12		4/26/12		3/22/12		11/1/11		10/27/11		8/25/11		3/24/11	
Item	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Initial Credentialing Verification: The contractor, using primary sources, verifies that the following are present:																				
♦ A current, valid license to practice (with verification that no State sanctions exist)	X		X		X		X		X		X		X		X		X		X	
♦ A valid DEA or CDS certificate (if applicable)	X		X		X		X		X		X		NA		X		X		X	
♦ Credentials (i.e., education and training, including board certification if the practitioner states on the application that he or she is board certified)	X		X		X		X		X		X		X		X		X		X	
♦ Work history	X		X		X		X		X		X		X		X		X		X	
♦ Current malpractice insurance in the required amount (with history of professional liability claims)	X		X		X		X		X		X		X		X		X		X	
♦ Verification that the provider has not been excluded from federal participation	X		X		X		X		X		X		X		X		X		X	
♦ Signed application and attestation	X		X		X		X		X		X		X		X		X		X	
♦ The provider's credentialing was completed within verification time limits (see specific verification element—180/365 days)	X		X		X		X		X		X		X		X		X		X	
Applicable Elements	**8**		**8**		**8**		**8**		**8**		**8**		**7**		**8**		**8**		**8**	
Point Score	**8**		**8**		**8**		**8**		**8**		**8**		**7**		**8**		**8**		**8**	
Percentage Score	**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**	

Total Record Review Score					**Total Applicable: 79**		**Total Point Score: 79**		**Total Percentage: 100%**	

Notes:

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix B. Colorado Department of Health Care Policy and Financing
Recredentialing Record Review Tool
for Denver Health Medical Plan, Inc.

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

SAMPLE	1		2		3		4		5		6		7		8		9		10	
Provider ID#																				
Provider Type (MD, PhD, NP, PA, MSW, etc.)	MD		DPM		MD		PA		DDS		MD		MD		MD		MD		DO	
Application/Attestation Date	1/26/12		7/11/11		2/17/10		3/8/12		8/8/11		5/19/11		5/6/11		3/31/11		4/29/11		3/15/11	
Specialty	Ped Pulm		Podiatric		Ped Ophthal		Orthopedic		Oral Surgery		Otolaryngology		Internal Med		Infec Disease		Ped Cardio		Emerg Med	
Last Credentialing/Recredentialing Date	1/26/09		8/25/08		4/2/07		5/28/10		9/24/09		9/24/09		8/27/09		7/23/09		7/23/09		5/28/09	
Recredentialing Date (Committee/Medical Director Approval Date)	1/26/12		7/28/11		3/15/10		4/26/12		9/22/11		8/25/11		7/28/11		6/16/11		5/26/11		4/28/11	
Item	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Recredentialing Verification: The contractor, using primary sources, verifies that the following are present:																				
♦ A current, valid license to practice (with verification that no State sanctions exist)	X		X		X		X		X		X		X		X		X		X	
♦ A valid DEA or CDS certificate (if applicable)	X		X		X		X		X		X		X		X		X		X	
♦ Credentials (i.e., verified board certification only if the practitioner states on the recredentialing application that there is new board certification since last credentialing/recredentialing date)	X		NA		X		NA		NA		X		X		X		X		X	
♦ Current malpractice insurance in the required amount (with history of professional liability claims)	X		X		X		X		X		X		X		X		X		X	
♦ Verification that the provider has not been excluded from federal participation	X		X		X		X		X		X		X		X		X		X	
♦ Signed application and attestation	X		X		X		X		X		X		X		X		X		X	
♦ The provider's recredentialing was completed within verification time limits (see specific verification element—180/365 days)	X		X		X		X		X		X		X		X		X		X	
♦ Recredentialing was completed within 36 months of last credentialing/recredentialing date	X		X		X		X		X		X		X		X		X		X	
Applicable Elements	**8**		**7**		**8**		**7**		**7**		**8**		**8**		**8**		**8**		**8**	
Point Score	**8**		**7**		**8**		**7**		**7**		**8**		**8**		**8**		**8**		**8**	
Percentage Score	**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**	
Total Record Review Score									**Total Applicable: 77**				**Total Point Score: 77**				**Total Percentage: 100%**			
Notes:																				

Appendix C. Site Review Participants
for Denver Health Medical Plan, Inc.

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

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

Appendix D. Corrective Action Plan Process for FY 2012–2013 for Denver Health Medical Plan, Inc.

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

Table D-1—Corrective Action Plan Process

Step 1	**Corrective action plans are submitted**
	If applicable, the health plan will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final external quality review site review report via e-mail or through the file transfer protocol (FTP) site, with an e-mail notification regarding the FTP posting to HSAG and the Department. The health plan will submit the CAP using the template provided. For each of the elements receiving a score of *Partially Met* or *Not Met*, the CAP must describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training and follow-up activities, and documents to be sent following the completion of the planned interventions.
Step 2	**Prior approval for timelines exceeding 30 days**
	If the health plan is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.
Step 3	**Department approval**
	Following review of the CAP, the Department or HSAG will notify the health plan via e-mail whether: ◆ The plan has been approved and the health plan should proceed with the interventions as outlined in the plan. ◆ Some or all of the elements of the plan must be revised and resubmitted.
Step 4	**Documentation substantiating implementation**
	Once the health plan has received Department approval of the CAP, the health plan should implement all the planned interventions and submit evidence of such implementation to HSAG via e-mail or the FTP site, with an e-mail notification regarding the posting. The Department should be copied on any communication regarding CAPs.
Step 5	**Progress reports may be required**
	For any planned interventions requiring an extended implementation date, the Department may, based on the nature and seriousness of the noncompliance, require the health plan to submit regular reports to the Department detailing progress made on one or more open elements of the CAP.

Table D-1—Corrective Action Plan Process	
Step 6	**Documentation substantiating implementation of the plans is reviewed and approved**
	Following a review of the CAP and all supporting documentation, the Department or HSAG will inform the health plan as to whether: (1) the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements or (2) the health plan must submit additional documentation. The Department or HSAG will inform each health plan in writing when the documentation substantiating implementation of all Department-approved corrective actions is deemed sufficient to bring the health plan into full compliance with all the applicable federal Medicaid managed care regulations and contract requirements.

The template for the CAP follows.

Table D-2—FY 2012–2013 Corrective Action Plan *for* DHMP					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
Standard VIII—Credentialing and Recredentialing 2.D. The process for making credentialing and recredentialing decisions.	Although the Medical Staff Bylaws stated that the bylaws applied to AHPs, they did not delineate processes used for the AHPs. During the on-site interview, DHMP and DHHA staff members explained that AHPs are credentialed using different processes and a separate credentialing committee. DHMP must either revise the Medical Staff Bylaws or develop policies and procedures that clearly describe the process for making credentialing and recredentialing decisions for DHHA AHPs.				
2.P. The right of the applicant to receive notification of their rights under the credentialing program.	The Medical Staff Bylaws did not address notification to applicants regarding their rights under the credentialing program. HMP must develop or revise documents to address notification to DHHA applicants regarding notification of rights under the credentialing program.				

Table D-2—FY 2012–2013 Corrective Action Plan *for* DHMP					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
2.R. The range of actions available to the Contractor against the practitioner (for quality reasons).	The Medical Staff Bylaws addressed the notification to the provider that an action will be taken, the process for the hearing, and the types of actions available to DHHA; but grounds for actions did not include quality of care reasons. DHMP must revise or develop documents that describe the range of actions available to DHHA for changing the conditions of a practitioner's status based on quality reasons.				
Standard X—Quality Assessment and Performance Improvement 6. The Contractor disseminates the guidelines to all affected providers, and upon request, to members, potential members, and the public, at no cost.	The CPG policy stated that DHMP disseminates guidelines annually to members. However, during the on-site interview, staff clarified that members must request guidelines from member services. The CHP+ Member Handbook did not inform members of the availability of CPGs or how to request them, and DHMP did not provide other evidence of				

Table D-2—FY 2012–2013 Corrective Action Plan *for* DHMP					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
	distribution of CPGs to members (per policy). DHMP must modify its policy and procedure to allow the public (potential members) to request and receive clinical practice guidelines at no cost. DHMP must also inform members of the availability of CPGs and how to request them.				

Appendix E. Compliance Monitoring Review Activities

for **Denver Health Medical Plan, Inc.**

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

Table E-1—Compliance Monitoring Review Activities Performed

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

Table E-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG completed the following activities:**
	◆ The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.
Activity 4:	**Conducted Interviews**
	◆ During the on-site portion of the review, HSAG met with the health plan's key staff members to obtain a complete picture of the health plan's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan's performance.
Activity 5:	**Collected Accessory Information**
	◆ During the on-site portion of the review, HSAG collected and reviewed additional documents as needed. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were of a confidential or proprietary nature or were requested as a result of the pre-on-site document review.)
Activity 6:	**Analyzed and Compiled Findings**
	◆ Following the on-site portion of the review, HSAG met with health plan staff to provide an overview of preliminary findings. ◆ HSAG used the FY 2012–2013 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. ◆ HSAG analyzed the findings. ◆ HSAG determined opportunities for improvement and recommendations based on the review findings.
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 2012–2013 Site Review Report. ◆ HSAG submitted the site review report to the health plan and the Department for review and comment. ◆ HSAG incorporated the health plan's and Department's comments, as applicable and finalized the report. ◆ HSAG distributed the final report to the health plan and the Department.